The Role and Effectiveness of Public – Private Partnerships (NHS LIFT) in the Development of Enhanced Primary Care Premises and Services

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prepared by

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The report is dedicated to the memory of Dr Caroline Hunter Beck, 1957-2005.

1 Introduction-The Context of LIFT

1.1 Background

Difficulties in establishing a strong building infrastructure for primary care existed in UK healthcare well before the creation of the NHS, and are bound up with the problems of defining a clear role for general practice. General practitioners were the most reluctant group to vote to join the NHS at its establishment in 1948 (Klein, 2006). Whereas the hospital consultants, arguably after receiving a range of concessions from Health Minister Bevan, agreed fairly quickly to the government's proposals to nationalise hospitals and for consultants to effectively move from being honorary appointments to salaried state professionals, general practitioners were more wary (Rivett, 1998). This was because of a range of concerns, some concerning remuneration, some concerning the role of the government in general practice.

General practitioners did not want to become salaried state employees like the consultants, but instead fought hard to retain a 'per capita' system whereby their salary was linked to the number of people on their patient lists. There was clearly, therefore, a strong incentive for GPs to attempt to service as big a list as possible, with as few a GPs in each practice as possible.

General practice was barely recognisable from today's service. Around 50% of the 18,000 GPS worked in single-handed practices, a situation which was largely based on the notion of the lone 'family doctor' working from his (this was the era of the male general practitioner) home. In pre-NHS panel days, the GP would often admit patients into his parlour where they would be treated, with fee-paying patients being allowed through the front door, and patients who could not afford to pay the full cost (or perhaps make any contribution to the cost of their treatment) being expected to wait around the back. The gradual extension of national health insurance after the first World War meant that an increasing range of workers was able to access primary care without the need to pay fees, but there was still a huge relief when access to general practice was made universally free at the establishment of the NHS.

GPs, especially those in single-handed surgeries often worked from their own homes rather than from bespoke facilities. This created a number of tensions. First, GPs tended to want to live in good areas – Eckstein (1958) found that practice density in the north of England varied tremendously with Harrogate (an affluent area) having a large number of GPs, but Leeds and Bradford having a scarcity. In the lead up to the creation of the NHS the Socialist Health Association particularly wanted to address this problem,

proposing that the state take greater control over the distribution of GPs so that new practices would not be allowed to be established in areas that were already over-represented (Honigsbaum, 1989), but were met with such anger from the British Medical Association that Bevan was required to drop them between the NHS Act in 1946 and the establishment of the NHS two years later.

Second, because GPs owned their own premises even where they were not their homes, this created problems for new GPs to enter primary care because doing so would often entail 'buying in' to a practice – involving a substantial capital payment to join an existing practice that was meant to cover not only their share of the stake in buildings, but also a payment towards 'goodwill', representing the acknowledgement that existing practices came with established lists of patients that the doctors would otherwise have to build up for himself.

Another area of significant difference between general practice today and 1948 was that GPs, regardless of practice size, made far more visits to patients' homes in the earlier time period – around a third of all consultations in some surveys appeared to take place outside of the practice surgery (Pemberton, 1949). The quality of care offered by GPs appears to have been hugely variable and the source of some concern. Collings (1950 p. 563) suggested that the state of general practice was 'bad and still deteriorating, with inner-city practices criticised for being 'unsatisfactory and at worst a source of public danger'. Hadfield (1953) suggested that around 60% of GPs were in good or adequate premises, but that a quarter still lacked basic facilities and 10% were totally unsuitable. Taylor (1954) suggested that a quarter of practices lacked essential items of equipment, and within that quarter there was a twentieth 'for whom it is difficult to find any excuse' (p. 8).

The infrastructure problems these surveys found were due to there being very few incentives for GPs to develop their surgeries. Because health centres had not taken off, this left the development of services down to GPs themselves, and improved facilities cost money and led to higher costs of practicing, when GPs were paid according to the number of patients they had on their lists rather than the quality of care that they offered. GPs were not only perceived by the government to have been the most uncooperative clinical grouping the founding of the NHS (Greener, 2008), but they were also often regarded by their consultant colleagues as being second-rate doctors who had no specialism, and who often sent them 'GP rubbish referrals' (Payer, 1996 p. 106) where they did not have the opportunity to exercise their specialist knowledge. Because general practitioners had to refer patients onto their specialist colleagues, but specialists, now that they were salaried public professionals rather than depending on GPs to retain their hospital appointments, no longer depended upon GPs for their work or

pay (Greener & Powell, 2008). The GPs needed the consultants for their referrals, but the consultants, as public employees, no longer really needed the GPs. Hospital medicine was the glamorous and exciting end of care, where breakthroughs were being made almost annually and where hi-technology medicine was practiced (Le Fanu, 1999).

Little progress was made in terms of raising the profile of general practice in the 1950s, where debates appeared to be centred mostly on GP pay and conditions, especially for many rural doctors who appeared to be suffering real hardship as a result of the pay system devised for them at the creation of the NHS (Greener, 2008). By the end of the decade, however, Balint's ideas were becoming debated in which General Practice was more about the development of human relationships than biomedical diagnosis (Balint, 1957). Balint's ideas were developed through the 1960s and eventually led to the publication of *The Future General Practitioner* (Royal College of General Practitioners, 1972), which advocated continuity of care for patients as lists grew.

During the 1960s NHS capital building programme, expenditure again focused on hospitals rather than in Primary Care (Minister of Health, 1962), while the debate about the nature of primary care continued to exist largely within general practice itself rather than making inroads into changes in the way that services were funded or incentives for investment in practices provided (Klein, 2006).

By the beginning of the 1970s, the problem of GPs being overly located in affluent areas of the country had not really been resolved. Tudor-Hart (1971 p.?) captured the problem in his phrase the 'inverse care law', where the areas of the country that most needed the support of good local healthcare were often those where facilities were most absent. Although this problem had been acknowledged by the government since before the creation of the NHS, little was done because of the political sensitivities that were involved in forcing GPs to locate in other areas.

The 1970s saw the beginning of the idea of the primary healthcare team. Lewis (1999) suggests that in the early part of the decade, care was 'GP-centred and negative' in that GPs had increasingly employed practice nurses and administrators as their practices had grown, but the other staff's roles were primarily about protecting them from the everyday 'trivia' that come along with general practice. However, as the decade went on, there was a movement to care being 'GP-centred and positive' in that GPs gave an increasing recognition to the contribution that other members of the team might be able to make.

By the end of the 1980s there was an acknowledgement that primary care, as opposed to general practice, was a topic of policy debate in its own right. However, the model the government favoured tended towards considering how individual general practitioners might be incentivised to provide more responsive care for their patients (Department of Health and Social Security, 1987). Two years later, the internal market reforms (Secretary of State for Health, 1989) attempted to redress the power imbalance between GPs and consultants that had existed since the creation of the NHS by giving GPs budgets to purchase care with, so creating the possibility for more sensitive purchasing and for consultants to have to be more responsive to the needs of GP's patients. GP Fundholding also allowed successful practices to retain their surpluses to invest in developing their infrastructure, leading to a growth in investment in those practices that were able to achieve fundholding status and contract successfully (Goodwin, 1998).

The GP contract of 1990 moved preventative screening into the remit of practice surgeries (Lewis, 1999), a move given emphasis by the increased use of targeting in the area of health promotion (Secretary of State for Health, 1992). This led to a growth in the number of staff employed in practices as GPs made increasing use of nurses in order to make sure their practices met the required targets. Additionally, practice managers were employed in order to oversee the increasing range and complexity of the services being offered in surgeries (Huntington, 1995). The model of primary care, and the talk of a 'primary-care led' (Department of Health, 1996b) health service, however, remained focused largely around general practice. What it also led to was an increase need for clinical accommodation, as well as for more flexible accommodation that can provide for services offered on a sessional basis.

If primary care still appeared to be based around general practice, however, it was incorporating an increasing network of community health services (Bailey, Glendinning & Gould, 1997).

By the mid-1990s a range of possible ways of GPs investing in the capital infrastructure of their practices existed, but for various reasons were not well taken-up. As well as having to deal with barriers concerning the availability of suitable land or property and the difficulty of lack of space for expansion in urban properties, the lack of capital funding to build new premises or convert or refurbish existing premises, remained a very significant problem (Bailey et al., 1997). Cost rent schemes were designed to allow GPs to be reimbursed by Health Authorities for the costs of funding new capital developments subject to limits which depended upon the size of the practice including maximum floor areas. A 1996 White Paper (Department of Health, 1996a) attempted to allow funding of larger scale projects than had been the case in the past, as well as for a wider range of facilities. Improvement Grants were also available from Health Authorities to expand and improve surgery accommodation, but not to build new

premises or purchase land, but were cash limited and only 2/3 of the cost of the improvements was potentially available to GPs. In addition, GPs were able to access private finance in the same way as any other small business, but there seemed to be disincentives for GPs taking on loans because of the risk of negative equity and reduced mobility (Bailey et al., 1997).

In 1997, primary care was given a new impetus by Labour's movement to one based instead around partnership or integrated care. Primary Care Groups (PCGs) were established in 1997 and defined as being 'teams of local GPs and community nurses' (Secretary of State for Health, 1997 paragraph 3.6). New targets were also issued for the improvement of the public's health, and, by 2000 (Secretary of State for Health, 2000), PCGs were moving to become PCTs, being given responsibility for providing an increasing range of services as well as spending around 75% of the NHS's budget in a return to the market that Labour claimed to have abandoned in 1997. Finally, the return to primary care commissioning led to Practice-Based Commissioning (Department of Health, 2004c), and scope for GPs invest at least a proportion of any surpluses into their practices, although the scope for this appeared considerably more constrained than it had been under GP Fundholding a decade earlier (Greener and Mannion, 2006).

The problem of a lack of investment in Primary Care health facilities still remained, however. Greater emphasis than ever was being placed on attempting to move care from secondary to primary settings (Department of Health, 2002a), but without the necessary means for GPs to be able to respond to the opportunities the new marketplace for care offered because of infrastructural limitations (Health Policy and Economic Research Unit, 2006). Equally, the gradual shift in emphasis from curative medicine to preventative medicine had created an opportunity for primary care to be far more engaged with public health agendas (Department of Health, 2006c), but the infrastructural limitations of primary care facilities represented a significant barrier to achieving change.

The government then, needed an approach that would be able to meet these challenges in order for the primary care element of their reforms to become coherent. The policy designed to achieve this was LIFT, which itself borrowed heavily from earlier experiences with PFI which had become the principal form of public private partnership in the UK.

1.2 Traditional PFI — the UK Experience

Over the past decade the NHS has increasingly relied on private finance in addressing its capital investment needs. This reliance has centred on the use of PFI, which involves the private sector in the financing, construction and maintenance of facilities, typically on the basis of a 30 year contract, after which the facility reverts to the public sector.

Contrary to public belief, the origins of public private partnership (PPP) can be traced to the Labour administration of the late 1970s. At the time, the US was experimenting with public private partnership as a means of regenerating depressed communities. When Peter Shore, then Environment Secretary, visited the US in 1978, a decision was made to emulate US approaches and plans were made to set in motion the creation of similar groupings in the UK (O'Brien, 1997).

During the 1990s there was discernible decline in public sector investment at both central and local government level (Rutherford, 2003) which resulted in a maintenance backlog for existing facilities and insufficient resources being allocated for new projects (Crooks, 2003). For example, the investment backlog in educational facilities in 1997 was estimated in the range of £7 billion, while the investment shortages in NHS amounted to £3 billion. These deficiencies affected the ability of the local authorities to meet the requirements for quality service provision (HM Treasury, 2003).

When the Private Finance Initiative (PFI) was launched by the Conservatives in 1992, it largely focused on the involvement of private sector companies or consortia in infrastructure projects which were sponsored by central government departments. Its initial uptake was relatively low. Harding et al. (2000) report that during the budget years 1992/93 and 1993/94, only about £500 million was raised for PFI projects originating from organisations such as the London Docklands Development Corporation, and much less by hospital trusts (see also, The Stationery Office, 2000).

The New Labour government initiated a number of initiatives aimed at eliminating obstacles to NHS Trust and LA involvement in PFI (Ball et al., 2000). While re-iterating the expectation that PFI procurement would allow the private sector to introduce cost saving and efficiency enhancing innovations (Birnie, 1999), the new Labour government stated that PFI at all costs was not appropriate. According to the Treasury Taskforce (TTF) (1997 p.?) "PFI solutions should be pursued where they are likely to deliver better Value for Money (VfM)". VfM in this context was assumed to involve a combination of competitive tendering processes and optimum risk transfer. In parallel with the relaxation of the universal testing rule, New Labour's guidance documents sought to emphasise the public-private partnership aspect of PFI over purely economic considerations (Treasury Taskforce, 1997; HM Treasury, 1999). As a consequence, the m requirement became a major criterion in the selection of the procurement method among the options available (Akintoye et al., 2001).

Nonetheless, a number of government commissioned reports have emphasised the need to enhance public sector skills in areas like contract

negotiation and project risk management (HM Treasury, 1999). Specifically, the government commissioned three major reviews which included the first Bates Report (in June 1997), and the Gershon Report and Second Bates Report (in 1999). While the predominant focus of these reviews has been on the public sector deficiencies, all three reports evidence the "increasing recognition of the importance of procurement in government policy and a commensurate rise in the status of the procurement function" (Erridge and Greer, 2000 p.?).

1.3 Local Improvement Finance Trusts (LIFTs) as Second Generation PFI

'Traditional' PFI procurement involves several VfM exercises, which inter alia, include the calculation of a Public Sector Comparator. Although these measures are meant to ensure that PFI projects provide a cost effective response to public infrastructure or service needs, this type of procurement continues to attract criticism (Pollock, 2005). While initially much of this criticism has centred on issues of cost effectiveness and the accounting treatment of PFI (e.g. Heald, 2003) more recent analyses have focused on issues of flexibility and accountability (Froud, 2003; Edwards and Shaoul, 2003). Another area of area of evolving research has focused on managerial and processual problems associated with PFI procurement. In this context a number of studies have identified inexperience and lack of relevant commercial skill on the side of the public sector client, cultural differences between public and private sector project participants which hinder communication, and a lack of standardisation of the procurement process and relevant contractual arrangements as a key obstacle to the achievement of VfM in 'traditional' PFI projects (Akintoye et al., 2001; Asenova and Beck, 2003a,b; Asenova et al., 2003). Furthermore, this research highlighted a lack of competition and market demand in some PFI projects, which characterises the hospital sector in particular (Asenova et al., 2004), as well as a reluctance of smaller organisations to become involved in PFI procurement (Beck and Hunter-Beck, 2003).

Although the LIFT initiative appeared to have been introduced primarily in order to meet the investment needs which arose from the poor state of existing primary care facilities, the initiative also reflected some concerns with 'traditional' PFI, particularly its suitability in the context of smaller projects and perhaps less experienced public sector clients. Thus the LIFT initiative differed significantly from traditional PFI procurement in a number of ways. Firstly, by contrast to standard PFI, LIFT involved significant public sector shareholding, both in form of local trust share ownership and PfH share ownership. Secondly, the governance structures of LIFTs include a public sector director and mandates close collaboration between local LIFTs and local NHS partnering boards. These measures have ensured a closer working relationship between Trust and LIFT than is typical of the arms-length relationship between Trusts and Special Purpose Vehicles (SPVs) in a traditional PFI setup; which should, in theory, have improved

accountability and responsiveness to local needs. In practice, however, such a close working relationship can itself become a source of increased conflicts and/ or obstacles to collaboration.

Another major difference between LIFT and traditional PFI projects concerned the use of the Public Sector Comparator. While traditional PFI procurement mandates the calculation of the PSC as part of a VfM-exercise, there was no such requirement for LIFT projects. Again, in theory, this appears to be unproblematic since LIFT projects were likely to be of a smaller scale than traditional PFI projects and because the calculation of the PSC might have added unnecessary delays and costs to the procurement of such projects. However, in practise, the lack of a PSC requirement, together with the exclusivity clause over the period of the Strategic Partnering Agreement has given rise to criticism (Aldred, 2006).

1.4 Aims and Objectives

Overall the similarities and differences of LIFT as compared to traditional PFI give rise to a series of policy relevant questions which include the following:

- given the need for LIFT to be applied to smaller projects, are there significant obstacles in terms of overhead/transaction costs, skills, cultures, lack of guidance, market factors etc. which would limit its applicab ility?
- what are the key deal breakers and tradeoffs which affect LIFT projects in terms of market demand, affordability, risk allocation ..?
- how can VfM best be assessed and ensured in a LIFT context?
- to what degree can LIFT provide local solutions to local needs, both across different regions and over time?
- what represents best practice in terms of stakeholder (including employee) involvement in LIFT projects?
- what potential conflicts of interest affect LIFT and which governance systems are most appropriate in monitoring and managing these?

While this multi-method study addresses all of these questions it places particular focuses on two related thematic issues. These include, firstly, the role of cultural factors in determining the success, or otherwise, of LIFT partnerships and, secondly, the issue of value for money or financial awareness among LIFT participants. Our concerns with cultural issues are grounded in previous studies which noted that partnership-based procurement poses particular challenges to the parties involved in these projects, which can be partly attributed to cultural differences among NHS organisations and their partners. Since public private partnership and

organisational cultures and behaviours have hitherto been studied in isolation, little is known about the organisational factors, governance structures and processes which contribute to the success of public-private partnerships. This issues are explored here with reference to earlier studies on the role of cultural factors in determining the effectiveness of healthcare organisations (Mannion, Davies and Marshall, 2004; Marshall, Mannion, Nelson and Davies, 2003; Sheaff, Schofield,Mannion, Dowling, Marshall and McNally, 2004) as well as recent anaylsis of organisational learning within the NHS (Greener, 2003; 2004a; 2004b, 2008). Similarly, recent research by the authors has highlighted the increasing complexity of VfM issues alongside the failure of public organisations to fully explore these matters (Asenova, Beck and Toms, 2007; Toms, Asenova and Beck, 2008; Asenova and Beck, 2009), which informs both the qualitative and quantitative financial analysis of this study.

2 Methods / Structure

This study initially envisaged a multi-method approach which would rely on six methods of information gathering (see appendix 2 for original specification). It was expected that these would include the following:

- Document analysis
- Key informant interviews
- Process focused case-unspecific interviews
- Outcome focused case specific interviews
- Financial document analysis

In addition, the team was investigating the possibility of conducting Developmental Case Studies, where fieldwork would be undertaken in areas which was in the process of forming, an/or participating in, a LIFT scheme.

The study, as well as the report presented here, follows this outline with minor modifications. These modifications vis-à-vis the initial specification include the following:

Firstly, the document analysis is now subsumed in a broader literature review (section 3, 'Literature Review') which focuses on publicly available academic and non-academic studies of LIFT and reviews 131 articles. The reason for this was that it was felt that the documents supplied to the researchers by local LIFT schemes were not sufficiently informative to warrant a separate investigation. In any case, where relevant this local information has been included as background material to the case studies of section 7.

Secondly, both the key informant and the process focused case-unspecific interviews (user interviews) have been modified slightly (see section 4, 'Stakeholder Views (Interviews)'). Specifically, having successfully gained access to some of the most senior health policy makers in this area for the key informant interviews, it was decided to also include a senior bank and a senior law firm representative, both of whom specialised in LIFT procurement. Overall, we were able to obtain and analyse transcripts for 9 key informants each of whom attended an interview of circa one hour. As a consequence of this focus on key informants, as well as a discernable repetitiveness of findings the team decided to conduct fewer than the originally planned case-unspecific (user) interviews. Overall the team

conducted 11 case-unspecific interview of circa on hour which involved sample interviewees who had been elected according to the following criteria: urbanity/rurality of the location, north south location, LIFT wave/age of project and organisational position (public/private, with public sector interviewees ranging from Associate PCT Directors and Finance Directors to Centre and Practice managers). Most interviews in this and other sections were analysed with the computer-based software programme DICTION 5 which the team found to perform superior to alternatives (such as Atlas TI) in the given context.

Thirdly, due to the theoretical importance of cultural issues a series of supplementary interviews were conducted with user interviewees and key informants from each of the case studies. This supplementary analysis is presented in section 5 ('Managing Cultural Diversity') as well as being referred to later on in the case-study section (section 7).

Fourthly, as expected, the team encountered considerable difficulties in obtaining financial information about LIFT schemes. These difficulties were eventually overcome, and section 6 ('Financial Analysis') presents the first comparison of the actual cash flows of 3 LIFTCo-s against National Audit Office (2005) predictions; all of which indicated significantly higher private sector returns than expected. One of the LIFTCo-s analysed in this section ('urban North East LIFT') also formed one of the case studies, allowing the report to triangulate findings from the cultural, financial and interview analysis for this case.

Fifthly, while initially encountering difficulties in recruiting LIFTCo-s for the case-study analysis, the team was eventually able to draw a careful choice from a limited number of volunteers, using similar criteria to those used for the selection of case-unspecific user interviewees. Eventually, the team chose to conduct fieldwork for 4 detailed case studies (selected by urbanity/rurality, north/south and LIFT wave), each involving circa 8 detailed interviews, rather than conducting a greater number of less detailed case studies. The findings of this part of the analysis are presented in section 7 ('Case Studies').

Lastly, rather than attempting to conduct developmental case-studies, which had, at the time become almost impossible (as LIFT was being phased out), the team decided to conduct a supplementary analysis of the new Express LIFT scheme, which had been widely publicised in early 2009. In this context, the team was able to conduct 5 detailed interviews with key informants which are presented in an addendum to the report ('Addendum-Express LIFT'). It is believed that the analysis of Express LIFT has allowed the team to explore important aspects with regard to the future of PPP in primary care. Additionally, this analysis forms the basis of an ESRC bid on

the 'Evolving Plurality of PPP' which some of the team members are currently co-authoring with colleagues in Scottish universities.

Further details on methodology are given in each of the relevant sections as well as relevant appendices.

3 A Systemic Review of the Literature and Empirical Evidence on the Role and Implementation of Public-Private Partnerships in Primary Care Settings

This section presents a systematic literature review on the role and implementation of LIFT schemes. Given the paucity of robust empirical evidence in this area, our findings are far from conclusive. Our limited evidence base draws partly on published 'opinion' pieces and anecdotal evidence, accepting that such sources may be biased, subjective and provide an incomplete account.

3.1 Aims and Objectives

This review synthesizes information on the operation of public private partnerships in primary care focusing on identifying relationship issues, success factors and best practice in the design and governance.

The specific objectives of the review were to:

- assess the role and scope of LIFT
- identify relative success factors
- identify barriers to and facilitators of LIFT schemes.

3.2 Search Mechanism

This review follows guidelines provided by the Centre for Reviews and Dissemination at the University of York (see Khan et al., 2001). First, a range of electronic databases was searched using search terms. These were then screened, using a range of inclusion/exclusion criteria.

For the electronic database search, the key search terms used were 'Local and Improvement and Finance' and 'GP practice premises' and 'Primary care premises' and 'GP practice finance' and 'GP premises' and 'LIFT' with the complementary search term 'private finance'.

Searches were made within the following electronic bibliographic databases:

- Health Management Information Consortium (HMIC) [which replaced HELMIS]
- Cumulative Index to Nursing and Allied Health (CINAHL)
- Medline
- PsycInfo
- Web of Knowledge
- PubMed .

The inclusion and exclusion criteria used in the review are as follows:

Box 3.1

Inclusion Criteria	Contents
Settings	Public and private sector (UK)
Language Engl	ish
Date	Since 1992 (Post PFI introduction)
Publication type	Published and unpublished including 'grey' literature
Originality	Primary, secondary data

Box 3.2

Exclusion Criteria	Contents
Language Other	languages
Date Before	1992

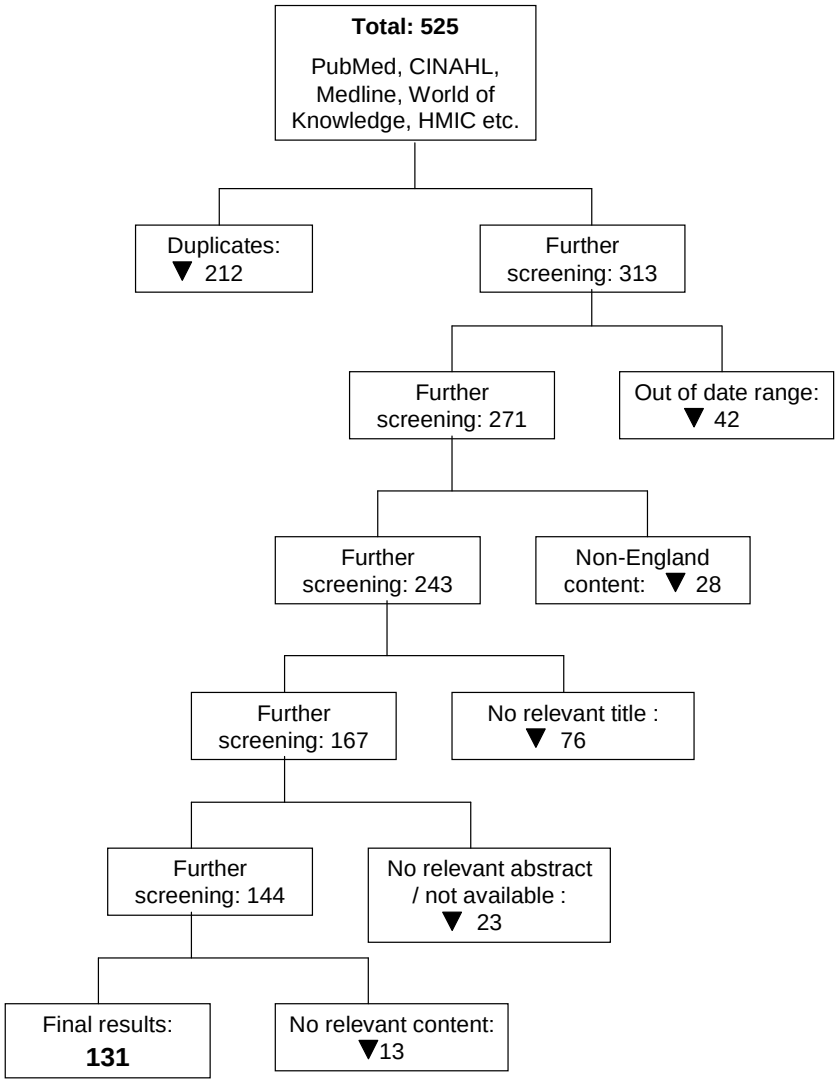
In addition, a manual search of the British Medical and Hospital Development Journals was undertaken together with a search of NHS and DoH sources, a broad internet search and a secondary search for all relevant references cited in articles. Each article was read to assess its relevance.

These references were entered into "Endnote" which was used to screen out duplicate entries.

3.3 Results

524 articles were identified as satisfying the inclusion criteria. Of these, 212 articles were removed following a check for duplicates. 42 publications preceded the introduction of PFI in the UK and were eliminated and 28 articles related to non-English content were excluded. Of the remaining 242 articles, a review of the titles identified 76 were irrelevant to the development and implementation of LIFT. Screening abstracts identified a further 14 that were not related and 9 which were unavailable. After eliminating 13 articles which did not relate to LIFT, a total of 131 articles remained and formed the basis of the review (Figure 3.1 overleaf).

Figure 3.1: Selection Process

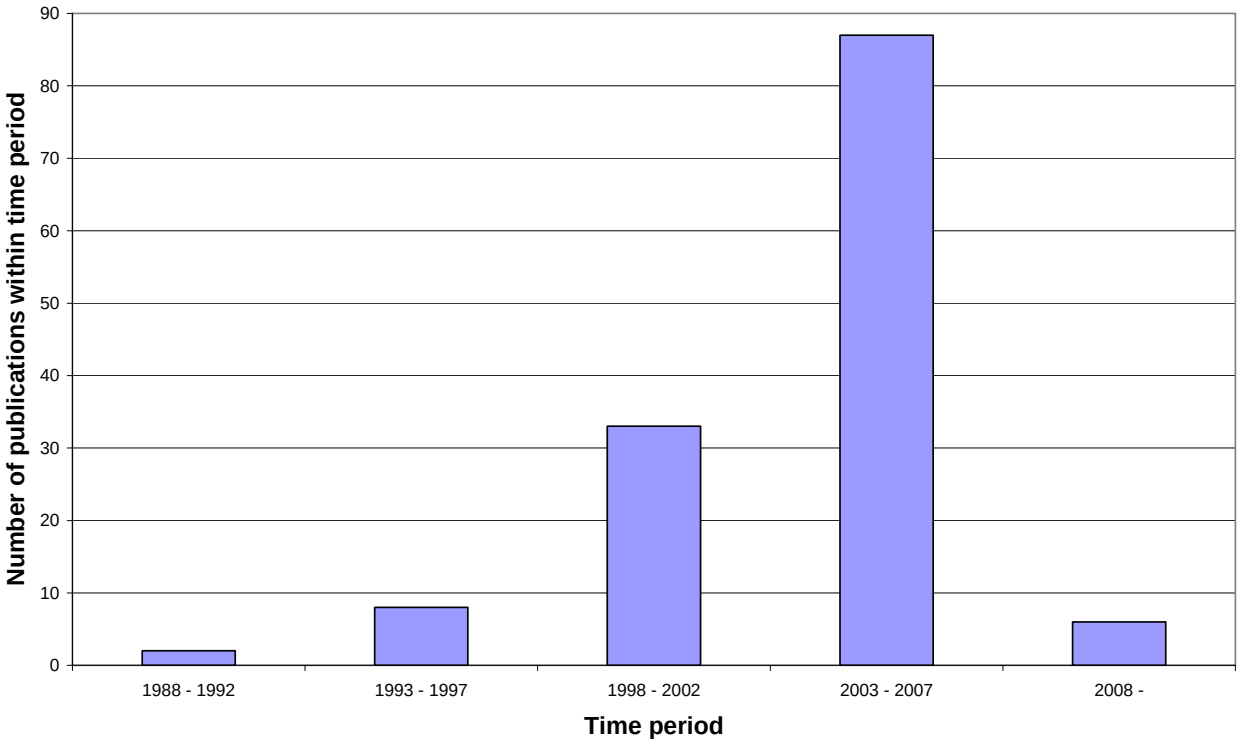


3.4 Overview of the Literature

3.4.1 Descriptive Analysis

The earliest relevant literature dates from 1992 with documents continuing through to 2008. As shown in Figure 3.2 below, only 11% of relevant articles were written between 1992 and 2000, and 56% of articles were clustered between 2003 and 2006. One article from 1988 was retained in spite of falling outside the parameters as it provided insight into the establishment of premises for a new combined GP practice prior to the establishment of LIFT.

Figure 3.2: Number of publications by year of literature



Having restricted evidence to England, the studies demonstrated a relatively even spread across health regions with regard to LIFT projects.

Of the 131 documents identified for inclusion, 30 (22.9%) were empirical studies, whilst 18 (62.1%) of these used mixed research methods; 22 (75.9%) used interviews.

Other methods included:

- Review of third party / published data
- Surveys
- Focus groups
- Non-participant observation
- Review of written correspondence.

In four articles, the research method was not disclosed.

Two articles were included in the empirical group as they reported on direct involvement with LIFT. An independent review commissioned by the DoH (Rassell, 2008) was included as it presented the opinions of staff at various LIFT projects, as was a Value for Money Study for one LIFT project undertaken by Capita Advisory Services (2007).

Twentynine publications were grouped under the heading of 'Guidance' from Government bodies, Partnerships for Health, the NAO, NHS departments, Union organisations, private sector partners or agents of the above; and 10 were news releases about LIFT.

The remaining 62 publications were opinion pieces.

Each literature group is detailed in Appendix 1:

Group 1 – Empirical findings (n = 30)

Group 2 – Guidance material (n = 29)

Group 3 – New releases (n = 10)

Group 4 – Opinion pieces (n = 62).

3.5 Literature Review Findings

3.5.1 Introduction

Several themes were identified which would be examined during the key-informant, case unspecific and case specific interviews. Consequently, a deductive approach was taken when reviewing the literature to determine whether they would provide some insight into these areas including the following:

- Economic and market factors
- Contractual Issues
- Skill requirements
- Local Impact
- Stakeholder views
- Cultural issues
- Conflict resolution.

In the following sections, the a priori questions identified when considering each key theme have been used as an organising framework for analysis. Subsequently, an inductive approach was used to analyse additional themes.

3.5.2 Economic and Market Factors

The a priori questions centred on whether:

- LIFT projects provide VfM
- LIFT projects serve as an incentive for GPs
- LIFT projects are affordable to PCTs
- there are particular 'stumbling blocks' or 'deal breakers' within the LIFT process
- there is a trade-off between incentives for the private sector and affordability for the public sector
- there is adequate interest from the private sector to provide a genuinely competitive environment
- LIFT provides lower overhead and transaction costs compared to standard forms of PFI.

Empirical evidence regarding the first five questions was analysed first.

Is there evidence that LIFT projects provide VfM?

The VfM characteristics of LIFT have not been formally investigated and there is an absence of guidance or published methodology from the DoH or Partnerships for Health (House of Commons Committee of Public Accounts, 2006) regarding how to assess VfM in LIFT. According to the NAO (2005, 22), "The VfM 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". However, to meet this standard, a LIFT project would have had to run the term of the lease before an accurate evaluation could be obtained.

The House of Commons Committee of Public Accounts (2006, 15) notes that "comparing the VfM of LIFT with other procurement routes is not straightforward because the LIFT framework is designed to offer tenants more and better services than obtainable under a standard commercial lease. LIFT also delivers a broader and more complex range of services to patients than typical primary care premises. Moreover, the contribution of the LIFT initiative to better health outcomes or to the wider community in terms of meeting a local regeneration agenda, is hard to quantify". However, Paxton and Lissauer (2000, 56) maintain that the opportunity to provide "soft services" such as laundry and catering, which are frequently out-sourced to reduce the cost of service provision, is not possible in a single, day-use building such as a replacement GPs surgery. To some, it would appear that initial capital spent takes precedence over revenue

generation and this may reduce the sustainability, and affordability, of this process (Hudson et al., 2003).

Some bodies, including the Institute of Public Policy Research and the House of Commons Select Committee, have argued that it is impossible to accurately assess whether LIFT represents VfM (Kmietowicz, 2001, Tyndale-Biscoe, 2003;). Many organisations, including local authorities, struggle to find a methodology to compare LIFT with other financial mechanisms, such as PFI and traditional procurement methods (Ballantyne, 2005).

According to the King's Fund (2001) there were indcidents when the (LIFT) prospectus did not make it clear how VfM was to be defined and failed to specify the requirement for a public comparator. Instead the LIFTcompany once formed appeared to enjoy a local monopoly of health service development. This raised fears that LIFT would become the 'only show in town' whatever its merits (King's Fund, 2001). It is, therefore, unsurprising that assessment of VfM in LIFT schemes has caused controversy. LIFT schemes are currently not valued against real alternatives but against an 'ideal' model (UNISON, 2003). The NAO (2005, 23) suggest that VfM is being 'demonstrated' by evidence of there being a competitive procurement and review of proposed rental costs by the District Valuer and the funding terms". However, the ability of the NHS District Valuer to identify that an NHS project has built new premises for which the resulting rents which are too high has been questioned (Tyndale-Biscoe, 2003).

Do LIFT projects serve as an incentive for GPs?

GPs traditionally invested in their premises with view toward using these funds for retirement (Paxton and Lissauer, 2000, Foster, 2003). Some reports indicate that recently qualified GPs view property ownership as a burden, given the risk of negative equity. This affects deprived areas with high special health needs (Paxton and Lissauer, 2000) in particular where there is an under developed property market (Hudson et al., 2003). GPs may be deterred from investing in premises--either for initial purchase or expansion--and, thus, commit themselves to a lengthy tenure at a specific location (Foster, 2003; NAO, 2005). Others may be tied into financial commitments to their existing premises (DoH, 2000a).

It was hoped that LIFT would resolve these issues by buying out GPs from their existing premises and offering flexible leases within purpose-built accommodation. As the National Audit Office (NAO, 2005, 9) states, GPs can also "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".

Reviewing one-stop health care centres, Andalo (2003) found that by grouping practices, general practitioners developed an enhanced sense of community, increase shared learning and the ability to share costs. Gilbert (2005a) found that group practices in super-surgeries have the ability to provide cover for each other, which may be particularly useful in areas where locums are hard to recruit and by co-locating, practitioners may become increasingly aware of the services their colleagues (i.e., staff in social services) (Gilbert, 2005b). Gilbert (2005a, 21; 2005b) notes the ability of physicians to communicate with colleagues, resulting in a more timely and complete understanding of a particular case and a possible reduction in the potential for errors arising from the transfer of information based on hand-written notes. Gilbert (2005) and Simpson (2007) found that the new centres had a positive impact on staff morale by making personnel 'feel valued'.

Holmes et al. (2006) report that LIFT process participation may be hindered by the fact that some GPs operating in substandard premises prefer to remain where they are and retain their independent contractor status rather than move into a LIFT building where they are forced to co-locate.

Burrell (2006, 31) suggests that "younger GPs are less interested in ownership because of changing career patterns, a desire for flexible working practices and the increasing capital commitment required". He further argues that the need to invest heavily makes succession difficult for a retiring GP with property being as "barrier rather than an inducement to recruitment". One of the aims of LIFT is to "free GPs from the burdens of property ownership" (Dudman, 2003, 24), something Kmietowicz (2001) believes would add flexibility to their careers, allowing GPS to transfer their practices without selling property (Mathieson, 2002).

In some housing areas, buying into a practice is very expensive, and in some inner city areas–with increased special health needs and greater deprivation (Parker, 2005) GPs run an increased risk of negative equity (Mathieson, 2002; Dudman, 2003;; Slingsby, 2004). Additionally, the trend towards "ever larger premises" has been a concern of younger GPs "unable or apprehensive about investing in premises" (Bunce, 1997, 32). LIFT may ease these financial hurdles by offering expanded services without the significant investment required for redevelopment (Burrell, 2006). Whilst independent GPs could still design and build their own buildings, and raise investment from public or private sources, there is little incentive to do so (Godden et al., 2001).

Hellowell (2004) claims that in London many GPs were forced to work in old, insecure facilities, and suggested that many had taken the decision to

leave the (London) area, with few lining up to take their place. Mathieson (2002) observes that the cost of acquiring their own premises is often prohibitive for these GPs. Tredinnick (1993, 17) claims that "46% of premises in inner London were below minimum standards compared to 7% in the rest of England", a view upheld by the DoH, and one of the reasons the area was selected for heavy investment in the first phase of LIFT (DoH, 2003a). However, if negative equity is a risk for GPs, this also applies to LIFTs building in that area, an issue identified by Anthony Harrison (Mathieson, 2002).

Although LIFT offers GPs flexible leases within a building where a management company assumes responsibility for delivering and maintaining premises (Dudman, 2003), in the case where a GP chooses to rent premises and the value of the property falls, the GP would not be risking their investment. However, Mathieson (2002) notes that if GPs chose to invest in LIFT, they may benefit from increases in property value. Burrell (2006, 31) believes that "Many GPs who bought properties in the 1960s and 70s are looking to retire and are seeking to extract the capital equity from the building by selling on to their partners or incoming GPs". With LIFT, if premises are rented, this option is lost to them (NAO, 2005), and if they buy into the LIFTCo they are banking on a secondary market developing and their investment increasing over time. Indeed, it is unclear how readily GPs would be able to withdraw their funds. For those GPs who lease commercial premises and are reimbursed by the DoH, there is no difference between their current arrangement and LIFT. Thus there is no financial disincentive for relocation (Dudman, 2003). Parker (2005) suggests that the construction of high quality buildings which allow for staff integration whilst recognising the need for security in high risk locations may help recruit health care professionals in difficult to recruit locations.

Affordability to PCTs

Aldred (2007, 147) cites an interviewee as stating that LIFT is the "only game in town. If PCTs want new capital facilities, that is the route to get them. There is no alternative that's available". Foster (2003, 13) also highlights voiced by the practice premises subcommittee chairman's concern (General Practitioners Committee) that LIFT "should not swamp other methods" of funding primary care infrastructure development.

Others noted that there is no alternative to LIFT (King's Fund, 2001; Dawson, 2001) and that the process may create an 'affordability gap' (Aldred/UNISON, 2006). Dr Ingrams of the Coventry PCT professional executive committee argues that "we (were) given no option by the DoH other than LIFT schemes. The NHS Improvement Plan says LIFT is the future. It might be the future, but it will bankrupt us" (Comerford, 2004, 10).

Has procurement of LIFT projects led to a reduction in other areas?

There is little empirical on this issue. One exception is the Commons Select Committee on Public Accounts (House of Commons, 2006) in which Dr Kohli is quoted as saying that in Newham, two LIFT buildings serve 8% of the population while using 33% of the premises budget. Foster (2003, 14) quoted Dr. Shubaker, secretary of the Redbridge and Waltham Forrest Local Medical Committee (LMC) who championed a motion at the LMC conference in June 2003 "deploring the fact that since LIFT has been announced, some Primary Care Organisations have not allocated any funds for improvement grants or cost-rent schemes, thereby denying practices the opportunity to improve premises to Disability Discrimination Act 1995 directive standards".

Non-empirical work and opinion pieces reveal concerns that by spending on a few large and expensive LIFT schemes, other practices may be denied the opportunity to obtain funding, even "for the poor chap still consulting from a converted house" (Comerford, 2004; Banyard, 2004; Robinson, 2005). Neal (2005, 2) suggests that LIFT is "devouring nearly all" the national funding earmarked for premises.

Concerns have been raised by the Chairman of the Public Accounts Committee that procurement under LIFT diverts funds away from other primary care needs (Guillochon, 2006). GPs outside the LIFT schemes would appear to be struggling to obtain funds for basic improvements even where LIFT does not apply (Robinson, 2005; Guillochon, 2006; Aldred/UNISON, 2006), denying them the opportunity to bring their practice premises in line with the Disability Discrimination Act 1995 directive standards (Comerford, 2004) or to accommodate the increasing number of GP trainees (Comerford, 2004). With multiple PCTs within one LIFTCo area, there have been concerns that lead PCTs may have access to estates funds leaving the other PCTs worse off (Ward, 2004).

Is there a trade-off between incentives for the private sector and affordability for the public sector?

It was hoped that LIFT would encourage the creation of innovative and exciting buildings but this has not necessarily happened. One author suggested that LIFT, as a vehicle, was not necessarily producing very much better buildings and produced mediocre at best" (Simpson, 2007). Peter Wearmouth, chief executive of NHS Estates, criticised a lack of innovation in NHS design and states "We are still designing buildings that look the same as they did 30-40 years ago. We still have waiting rooms and consulting rooms, but society has changed. Patients are no longer submissive yet we build architecture that is submissive" (Davis, 2002, 8).

The implementation of LIFT has accelerated the regeneration of primary care premises. For example, in Merseyside alone 17 schemes are now open representing a capital investment of £94m. Given that many GP practices

were housed in poor accommodation with only 40% of premises purpose built, and almost 50% in either converted shops or former residential buildings (Montague, 2004), the government may have held high hopes for LIFT-built premises. Mathieson (2003, 33) illustrates this "unimaginative" approach, describing one proposed centre with five stand-alone GP surgeries, each with their own waiting room. Lord Hunt, Ministerial Design Champion, is quoted as saying "It is striking how unambitious the health service has been in the quality of the design of what it produces" (Davis, 2002, 8). Sunand Prasad, commissioner at the Commission for Architecture and the Built Environment, states that "There is a legacy of sub-standard buildings in primary care and we are still, tragically, constructing buildings in PFI that are not buildings to be proud of in the future". Prasad outlines the aims of the NHS Achieving Excellence in Design evaluation Toolkit, yet conceded it would not 'produce genius designs', but 'prevent the worst' and 'increase transparency'" (Davis, 2002, 8).

Designing for a health care market is a new area of activity for many architects/design companies (Holmes et al., 2006). For example, the need to take into account the "unique aspects of each centre such as the acoustic features for those which had audiology departments, the need to develop bespoke characteristic entrances to each site" (Hospital Development, 2006g) and the security concerns of staff (Holmes et al., 2006) are all complex issues requiring bespoke designs. It has been recognised that the health service did not "want to make the same mistakes as we did in the 1950s and 1960s" when "we built health centres, which are now unloved buildings surrounded by security fences and covered in graffiti" (Andalo, 2003, 18). However, some initial designs were apparently likened in a deleterious way to 'car show-rooms' or 'prisons' by lay stakeholders (Holmes et al., 2006, 570).

The LIFT process has been credited with attracting national construction and design teams (Holmes et al., 2006), and for facilitating attention to detail, such as the creation of a design with features to maximise light and ventilation, which previously would not have been possible (Montague, 2004). However, bringing such "sophisticated design expertise" into the procurement process has introduced negotiation teams with greater knowledge of PFI-style bidding processes who "used this experience to drive a hard bargain with the PCT teams for whom each negotiation was a first" (Holmes et al., 2006, 571). One of the main concerns with LIFT was that the health service may be locked into inflexible contracts for poorly constructed buildings with high operating costs for the next 25 years (Paxton and Lissauer, 2000).

Whilst this lack of "flair" was perhaps understandable during the first wave where the focus was on getting projects completed, Parker (2006) raises the concern that there have been few improvement later on. The private sector meanwhile claims that they are "on the hook" to deliver "decent buildings" that are "affordable", "efficient" and "good-quality" whilst being "architecturally-striking civic landmarks" (Sansom,2007). There is also an

economic incentive for the private partner to design and build in a way that will minimise maintenance costs (Dawson, 2001). However, it would seem that for LIFT there is a trade-off between design, quality, maintenance and affordability.

Potential stumbling blocks in LIFT procurement

Whilst the literature search did not identify any 'deal breakers', it did identify two issues which either slowed or limited the adoption of LIFT in primary care settings:

- Relocation concerns by both GPs and patients
- LIFT workload.

Each of these is discussed below.

A-Relocation concerns

A key concern of clinicians and patients is the relocation of premises. Forrest (2004) argues that whilst residents have moved out of many urban centres, many doctors remained in their practice premises. Forrest argues (2003) that patients may be drawn to one of the new one-stop centres rather than staying with GPs in poor quality premises. However this goes against the ethos of a locally based general practice surgery, and Dix (2001, suppl. 2) raises concerns that if the GPs relocate to a new centralised LIFT building, even if it provides extended services, the patients may not follow. Central relocation does not necessarily reduce the amount of, or ease, travel for patients, and the House of Commons Committee of Public Accounts (2006, 13) noted that there should be "provision for the patients within a LIFT area who are likely to find it difficult to reach a LIFT building, such as the elderly and people dependent on public transport".

Davis (2002) reports that the Government is planning 500 one-stop primary care centres by 2010 and according to Dix (2001), approximately 20 GPs would be required to make each of these centres viable. According to Maryan Pye, associated consultant with Dearden, this would mean the relocation of 10,000 GPs, representing over one third of the England's 27,000 GPs (Dix, 2001). This would be in addition to the planned redevelopment of 3,000 GP premises. Dix goes on to identify that if each one-stop centre serves 35,000 patients, 17.5 million patients would have to be written to, asking if they want to stay with their GP, who is moving".

B-LIFT Workload

A recurring theme for GPs, PCT staff and the private partners was the volume of work involved, not only in the negotiation and construction phases of the LIFT process, but also in the ongoing maintenance of the contracts. Therefore, the LIFT process has been described as being time consuming and harrowing (Foster, 2003).

Dix (2001, suppl 2) and Paxton and Lissauer (2000) found that the most significant impact workload impact of LIFT falls upon the staff of PCTs, including GPs, as a LIFT project is outwith their day-to-day business and reduces the time available for clinical practice.

Once Board approval is obtained, the workload is extensive, and the timescales tight. Hines (2003) found that some projects have been forced to reduce the number of schemes to ensure a manageable workload.

Mathieson (2003, 33) states that the DoH now recognises the considerable workload LIFT demands of PCTs and the "challenging timetable" imposed. Before the project can be considered, the PCT must convince their Board that the project has merit, and for the first wave, this proved difficult (Aizlewood, 2002).

3.5.3 Contractual Issues

The a priori questions identified focused on two key questions:

- Whether the length of a LIFT contract posed a problem
- How LIFT participants viewed the exclusivity clause.

Is the length of a LIFT contract seen as a problem?

There is little empirical (or non-empirical) evidence to gain a perspective on this question, so this was identified as an area to be addressed during the interviews.

How do LIFT participants view the exclusivity clause?

As Aldred (2007) argues, GP-owned premises are usually small and their refurbishment is not the type of project that would be profitable for private investors. Inherent in LIFT is an exclusivity clause giving the successful LIFTCo the right to build primary care premises for PCTs in the area (Aldred, 2007). By grouping projects together and including the long-term operation and management of these facilities, the scale of each initiative is increased, making them attractive to private investors (Hudson et al., 2003; NAO, 2005; Holmes et al., 2006).

The House of Commons Committee of Public Accounts (2006, 11) stated that "granting the LIFTCo an effective monopoly for five years, provided the costs are reasonable, is intended to encourage private sector interest. Exclusivity does not have to apply to other premises, for example, mental

health or Local Authority developments. Where LIFTCo fails to demonstrate value in terms of operating costs, through benchmarking or market testing, Primary Care Trusts can use any supplier they choose". Whether any will enforce this ability has yet to be seen.

The House of Commons Committee of Public Accounts (2006, 10) notes that "for the LIFT model to work efficiently there needs to be a continuous flow of developments. The LIFTCo is intended to operate as a local property development business with overhead costs spread over a number of projects. Given the cost to the local health economy of developing LIFT buildings, and the long term funding requirements, there is a risk that a continuous flow of projects may not be taken forward. If so, the model may not achieve the expected benefits".

The non-empirical literature review suggests that some GP practices and local authorities have found innovative ways to create the type of multi-functional, multi-disciplinary approach that the DoH seems to expect from LIFT; but by limiting PCTs to use LIFT, the potential for this innovation may be stifled

Whilst it is recognised that there are ways to enhance premises that may be affordable, particularly if they do not involve a third party seeking to make a profit, there have been concerns that the exclusivity clause of the LIFTCO contracts may preclude GPs from developing their premises themselves (UNISON, 2003).

3.5.4 Skill Requirements

The a priori questions focused primarily upon the skill levels in the public sector, in particular whether:

- public sector staff feel that their understanding is undermined by the complexity of LIFT schemes
- current levels of experience and skill allowed public sector managers to become genuine partners with their private sector counterpoints
- there are any cultural, educational or behavioural barriers within public or private sector organisations which could create a barrier to partnership working
- current guidance on LIFT is sufficient to allow public sector managers to make informed choices in the public interest
- Local Authority, NHS representatives and advisory board members feel they have sufficient understanding of the LIFT procurement process to make informed choices.

Whilst the literature discussed the first three questions, there is little evidence on the latter two, so these were identified as areas to be addressed during the interviews.

Do public sector staff feel that their understanding is undermined by the complexity of LIFT?

Staff acknowledged that they found LIFT to be a lot more complex (Aldred, 2007) and the process was further complicated by frequent changes in rules applied by the DoH including Red book room space allocations in general practice and the availability and use of enabling funds (Hines, 2003). The NAO (2005, 17) found that PCTs found the development of plans understandably "complex and time consuming".

Opinion pieces have expressed similar concerns describing the process as "horrendously complicated" (Dudman, 2003, 24), and the funding mechanism behind LIFT as "very complicated" (Tyndale-Biscoe, 2003). According to UNISON (2003), there is a worry that the contract is so complex that these extra layers of bureaucracy diminish the ability of NHS directors and managers to control the services provided and make it still harder for patients and staff to make their voices heard.

Do current levels of experience allow public sector managers to become genuine partners in LIFT projects?

It has been reported that local authorities and other public sector bodies struggle to become equal partners in PFI projects (Clark & Root, 1999). This arises because of a number of factors. The PFI process inherently suffers from asymmetry of information (Asenova et al., 2002). Private sector partners possess the technical skills required to complete the design, negotiations, construction and management of a new building as they are required to do this on a frequent basis. For the public sector partners, involvement in PFI is often a unique one off experience that challenges their commercial acumen. In theory public sector clients must lead the entire process if they do not wish to be at a relative disadvantage; but in reality many clients feel as though they are "walking in the dark" (Akintoye et al., 2003). Asenova et al. quote one NHS Manager as stating that building a hospital is a once in a lifetime experience (Asenova et al., 2002). Similarly, HM Treasury note that skill shortages occurred in the healthcare sector, particularly in areas such as contract negotiation and project risk management (HM Treasury, 1999). Such skill shortages continue to be apparent many years after PFI has been introduced (Spackman, 2002).

Holmes et al.'s (2006, 570) study of LIFT projects suggested that the "inequality in the size and expertise of the negotiating parties has given the upper hand to the contractors when discussing technical specifications and operational arrangements". To try to overcome this, Hines (2003) found the

PCT needed a project team adequately resourced with the appropriate skills, and management/leadership support. Although this may seem a basic requirement, according to the NAO (2005), 56% of PCTs did not have sufficient resources to complete their project efficiently in 2005.

Are there any factors within public or private sector organisations which could create a barrier to partnership?

PPP requires the agents to come from both the public and private sector, each bringing their particular values, beliefs, skills and experience. The LIFT process inherently suffers from asymmetry of information. Hines (2003) argues that whilst the PCTs have little, if any, experience of property (re)development and management, the consultants required to assist them with those critical skill sets have little, if any, experience of health care and special requirements in terms of design and specifications. The impact of such deficiencies has not been discussed in the literature.

3.5.5 Local Impact

Three a priori questions were identified:

Is there a danger of local interests being marginalised?

There seems to be little, if any, empirical evidence to assess whether LIFT schemes marginalise local interest. In the non-empirical literature the degree of locality of service for patients appears to be mixed. Some claim that the new LIFT premises "can offer many services traditionally only found in hospitals" (Hospital Development, 2006d) and NHS patients can get "minor surgery for hernia repairs, sports injuries and even vasectomies. X-rays, medical tests, speech and language therapy, chiropody and physiotherapy… (in) centres (that) are more convenient for patients, particularly older patients and those with long-term conditions, as they offer more care closer to home". However, Aldred/UNISON (2006, 6) believes that the marginalisation of local people and their organisations is evidenced by "organised opposition to LIFT schemes".

Are smaller organisations able to effectively participate in LIFT projects?

One of the government claims for LIFT is that it will involve 'local businesses delivering local solutions'. Given the scale of the combined LIFT projects, companies bidding for the work must go through a detailed procurement process governed by European legislation. The scale of the projects means that a bidding company must have the requisite skills and adequate resources not only to complete the job, but also to develop and fund expensive, and potentially unsuccessful, bids (Hudson et al., 2003; Holmes et al., 2006). Holmes et al. (2006, 569) argue that submitting a bid may cost an organisation between "£500,000 and £1 million, with only a one-in-three chance of success". Consequently, some smaller developers are unable to compete and are squeezed out by the large companies

(Hudson et al., 2003). However, Hudson et al. (2003) and Holmes et al. (2006) state that these larger, often national, companies often have higher overheads which can be a significant factor in the overall construction costs of the schemes.

A report by UNISON (Aldred/Unison, 2006, 6) challenges the government's notion of local solutions as "smaller organisations generally do not have the resources to bid for such complex contracts. There is no guarantee that large companies will select local businesses as part of their supply chain. They are likely to use their existing, centralised subcontracting networks, which will be cheaper and help support their profit margins – but will not be 'local'".

Local employment generation and urban regeneration

LIFT has been used as a vehicle to regenerate urban areas and to promote healthier living. For example, at Towerhill, after the local population had moved away from the area of the existing clinic, the new site selected was adjacent to a local school and now includes a health care and community facility in one integrated campus aimed at reinforcing the notion of health, recreation and training. The local authority worked with the developer and identified an alternative source of access and location for schools parking, thereby allowing the complex to be traffic-free and encouraging the locals to walk to the complex from their residences (Burton, 2004). A similar approach to urban regeneration is planned for an area of derelict land in St Helens (Burton, 2004; Grice, 2008) where an ambitious project is planned that will include housing, shops, leisure developments and possibly a hotel (Forrest, 2004).

3.5.6 Stakeholder Views

The literature suggests that the LIFT process is facilitated by teamwork, open lines of communication and amicable working relationships (Gilbert, 2005b; Hines, 2003). Simpson (2007) argues that listening to the needs of stakeholders ensures that fewer changes are required at a later date, thus saving time and resources. Involving the local authority, councils, staff, service users and the community at large would seem to ensure that the project retains a strong position in the community and give people a sense of ownership (Hines, 2003; Gilbert, 2005b). It is recognised that local authorities have different priorities and planning cycles to the PCTs, but the NAO (2005) identifies the value of their involvement from the earliest stage

In the early phases of bidding Holmes et al. (2006) recognised that the vendors are competing and the designs are therefore highly confidential and should not therefore involve the community at that time but should strive to do so at later stages. Where projects have failed to do this there have often been problems. For example, for one health centre the GPs

developed the design of the one-stop shop from the perspective of individuals who would work there rather than the patients who would use it.

The a priori questions developed for this study asked:

- Whether stakeholders, such as clinical and non-clinical staff, members of advisory boards etc. feel that they have been sufficiently involved with LIFT projects?
- What were the levels of user and client satisfaction with LIFT projects?
- Whether stakeholders, clients and users feel that LIFT has added extra layers of bureaucracy to primary care provision?
- Whether stakeholders, clients and users feel that LIFT has added extra cost to primary care provision? and
- How LIFT has affected levels of staffing – whether there has been increases in subcontracting and job losses?

Levels of user and client satisfaction

Whilst inside some LIFT buildings, multi-disciplinary and open-layouts have created a "sense of community spirit" that has been well received by some (Gilbert, 2005, 21), it has created problems and concerns. Gilbert (2005) identified that in one location a centralised reception area for four physician practices reduced patient privacy (Gilbert, 2005).

The CABE report (2008) investigated the design quality of 20 of the 82 LIFT buildings through site visits by 10 experts in health care architecture design and delivery, formal interviews with a minimum of six participants in the LIFT process and informal interviews with users at each location. They noted that "many users were happy to be working in their new premises" although they acknowledge that a "greater understanding of these areas of satisfaction and of areas for improvement… could be gained through systematic user satisfaction feedback services". This suggestion has been incorporated into the present study via a user satisfaction survey distributed at the case study sites (section 6).

Do stakeholders, clients and users feel that LIFT has added extra layers of bureaucracy to primary care provision?

Rather than "freeing up enterprise", Aldred (2007, 147) claims that LIFT creates large, legalistic, and bureaucratic systems "locking the NHS into the use of certain buildings and services for a long period. Although the roll-out of LIFT has been quicker than anticipated, with the prospectus for the program released in July 2001, by the end of 2004, only four new buildings were open to the public (NAO, 2005). In part, this has been blamed on Partnerships for Health, which is said to have provided little continuity in the individuals allocated to schemes while being slow in decision-making

(NAO, 2005). According to Aldred (2007) GPs have stated that they believe it to be a very bureaucratic process which is heavily management-led (Aldred, 2007).

Do stakeholders, clients and users feel that LIFT has contributed additional cost to primary care provision?

With the House of Commons Public Accounts Committee (2006, 9) stating that "Primary Care Trust accommodation spending on patients registered with GPs in a LIFT development is up to eight times higher than total primary care spending on accommodation" it is understandable that the Chairman stated that "… really need to know is whether the expected benefits to patients justify the cost of using LIFT to provide the new facilities" (Guillochon, 2006, 64).

The Public Accounts Committee (PAC) recognised that the returns for LIFT were perceived to be high in relation to the levels of risk assumed by the private sector partners, a view shared by Holmes et al. (2006, 571) who believe that "contractors involved in the LIFT process are making a greater return on their investment than the much-criticised PFI schemes". However the PAC (2006, 11) argues that this may have been the case in the early schemes "because of perceived greater risk associated with the newness of the schemes, and uncertainty over the pace of future developments". The NAO (2005) confirmed their belief that the returns should reduce over time as learning curves are overcome.

These criticisms are still being raised by UNISON (Aldred/Unison. 2006, 10) who claim that "the projected LIFT rate of return of 15.1% on average compares with 8-9% for traditional third party development – a lot of extra profit given that a PCT may pay around £1 million per year or more to lease each LIFT health centre". However, a 15% return is considered standard for a low-risk, privately financed project according to Dawson (2001). According to UNISON (Aldred/UNISON, 2006), one of the greater risks of focusing on rates of return is that future schemes may actually draw GPs away from where they are needed.

LIFT is perceived by some as an effective, but lengthy and costly process (Hospital Development, 2006c), and it has been claimed that even "the DoH acknowledges that LIFT is likely to cost PCTs more than other ways of building and refurbishing surgeries" (Aldred/UNISON, 2006).

In the past the NHS, and individual GPs, could choose to reduce immediate expenditure by deciding to postpone building maintenance, and the replacement of equipment. With LIFT, this no longer remains an option as all maintenance falls under the remit of the LIFTCo contract and the PCT

will automatically have a share of these charges routinely included in their fees (Dawson, 2001).

To facilitate the start of LIFT projects, the Government made 'enabling funds' available to the projects to "remove obstacles to a project going ahead by, for example, purchasing sites or releasing GP practices from negative equity" (Hines, 2003, 22). These funds could be used to reconvert primary care premises back into residential premises to make them more attractive to the market and easier to sell if the GPs were prepared to relocate into LIFT premises (DoH, 2000a). These funds are "not automatically refundable" but in the guidance provided by the Government, it was stated that "there may be circumstances in which the Department would be keen to reclaim funding to enable it to be recycled into further LIFT developments" (NAO, 19 May, 2005, 15). The NAO state that one third of project managers were uncertain how to use the enabling funds, leading to "variation" in usage (NAO, 2005; Hospital Development, 2005).

Whilst the LIFT process was supposed to reduce PCT involvement in the construction and day-to-day management of buildings, it would seem that they are still required to take on the initiation and management of revenue contracts, including undertaking "all the leg work, paying solicitors' costs, accountants and consultants when they set them up" (Comerford, 2004, 10); costs which Comerford claims are higher than those under the previous system of fixed cost or notional rent. Whilst this may be done using the enabling funds, it is still an additional cost in the process.

Finally, concerns have been raised about refinancing packages where private sector consortiums have managed to re-negotiate lower rates of interest but may not have passed benefits on to their local authority partner. According to UNISON, "The Government has now said that there has to be a public sector clawback on such-refinancing packages in PFI schemes. It is not clear whether this will apply to LIFT schemes or, if it does, whether it would be the local public sector partners or the national partners who would benefit" (2003, 11).

Rental income has been a consideration of developers given the significant opportunities for revenue raising (Paxton and Lissauer, 2000, 57). Some have designed and built more traditional GP surgeries, preferring GP stability and steady rental income over multi-use facilities with "more risky tenants" (Mathieson, 2002, 31). It is interesting to note that at one LIFT project, the coordinator chose not to discuss rents with its GPs as "it does not want them to become alarmed over figures that are still being discussed: the bidders have put indicative rental figures in their bids and we are in negotiation with them over those figures" (Dudman, 2003, 25) suggesting that the rent would be considerably higher than the GPs would

anticipate. Holmes et al. describe the major concern over rents to be paid by tenants of LIFT buildings perfectly when he states that "there is a perception that the higher costs of LIFT, compared to current rent payments, outweighs the benefits of new, purpose-built premises" (2006, 570).

Obtaining tenants for all LIFT spaces has not been straight forward. Some GPs, including those approaching retirement age, are not in a position to sign a 25 year tenancy agreement. PCTs can take over a head lease with the developer and then sub-let to GPs or other tenants on a shorter-term basis; an option which may be more attractive to practitioners (Paxton and Lissauer, 2000; UNISON, 2003; Aldred, 2007) including those who wish to work in an inner city location or to secure new skills before relocating elsewhere (Sansom, 2007). However, this leaves the NHS at risk of the GPs either leaving or defaulting (Aldred, 2007) or coming to the end of their lease and the PCT being unable to find a replacement tenant (UNISON, 2003).

These concerns are also voiced by Aldred (2007) describing the feelings of dentists, pharmacists and local authorities when asked about LIFT. Holmes goes on to say that "In the case study area the rent charged for the new LIFT premises is in the order of £210/m2… In real terms, the facilities provided are expensive when compared to market rents in the locality" (Holmes et al., 2006, 570). For this reason it is suggested that local authorities and allied health practices including pharmacies and dentists have chosen not to rent spaces in the LIFT buildings, preferring in some cases to rent retail premises adjacent to the doctor's practice at a "considerably" lower rent (Holmes et al., 2006). The reason pharmacies in particular may not wish to relocate into a LIFT building was identified by the NAO who state that whilst primary care providers such as dentists and doctors who receive automatic reimbursement for the rent paid for primary care premises, the PCT determines whether a pharmacy is similarly classified. In the main they tend to be considered as a business and as such will be expected to pay full rent for their space (2005, 23). As the NAO notes that pharmacies are "likely to be the most significant source of third party income" which can be used to "plug funding gaps and reduce the rent levels paid by other tenants" (2005, 23), pricing them out of the market would seem to be a short-sighted approach and this may be why alternatives such as cafes, vending machines, internet training facilities and complementary therapists (NAO, 2005) may be encouraged to locate within the space. In order to encourage healthcare professionals to relocate into the space, some PCTs have agreed to subsidise rents (NAO, 2005). As Andalo states, there are "economies of scale. The more professionals you cram into a one-stop shop, the more profitable the site" (2003, 18).

With the current lack of any form of independent evaluation, it is understandable that costs associated with the LIFT process are being questioned, from initial set-up (Tyndale-Biscoe, 2003), fees payable to Partnerships for Health (NAO, 2005), and operating costs (Comerford, 2004) to the rents being charged to tenants (Holmes et al., 2006).

How has LIFT affected levels of staffing?

There is no empirical evidence to assess the impact of LIFT on staffing levels within the public sector. Non-empirical literature sources identify that LIFTCo contracts group non-clinical services under the heading of "partnering and lease plus services" (Aldred/UNISON, 2006) and can include a large range of support and facilities management services. Furthermore, the terms of the contracts state that these services may be provided not only for the LIFT buildings but also to "other buildings within the contracting authorities' estate" which may "not just mean PCT buildings; potentially it could include staff in local authority buildings and hospitals, as councils and acute NHS trusts are normally additional 'contracting authorities' in the LIFT process" (Aldred/UNISON, 2006). In reassigning some activities to the LIFTCo, affected former public sector employees will be transferred to the privately operated LIFTCos whilst others remain employed by public sector PCTs. This has been seen by some to represent the start of privatisation of primary care (Aldred/UNISON, 2006).

As new positions within the LIFTCO could be subject to different terms and conditions, UNISON (2003, 4) claim "one of the ways in which operators of PFI schemes and private providers of public services have tried to cut costs and increase profits is through worsening pay, terms of employment and career opportunities for new staff, creating a two-tier workforce". As public sector bodies employ significant numbers of women and ethnic minorities in low paid employment, groups that are frequently cited as marginalised in the work force, there are concerns that these are the sorts of positions that may be transferred and at greatest risk from reclassification. Consequently, UNISON (2003, 7) has suggested that policy on equality should form part of the selection process for the private sector partners and "only those services and facilities that are genuinely part of the Strategic Services Development Plan" should be included in LIFTCo contracts. The King's Fund (2001) has also commented on this arguing that "no government should ever privatise an existing public enterprise unless the new company could be allowed to fail. If it cannot, it will blackmail government with an endless need for subsidies".

The introduction of LIFT is accompanied by changes in the structure of organizations participating in the process, creating a number of problems. For example, being aware that their Primary Care Trust (PCT) was due to be merged with others in a region had "implications for their commitment to the LIFT partnership" according to Ballantyne who believes this

"rationalisation of PCTs will have an impact on the number of future projects likely to be undertaken by LIFT, as well as on contractual structures" (CIPFA, 2005). This structural change is not limited to the PCTs. Aldred (2005, 1338) claims "PFI providers will increasingly link up with the private health care companies now running independent service treatment centres, creating giant monopolies, complex subcontracting chains". Much of this belief comes from new language contained in the LIFTCo contracts authorising them to "privatise clinical services in LIFT and non-LIFT buildings" by getting them to "engage private medical companies to provide GP services, or agencies to provide district nursing services" (Aldred/UNISON, 2006, 12). Assuming that LIFTCos do engage others to provide these services, there are fears that such deals would be "shrouded in 'commercial confidentiality'" and embedded in highly complex, long-term contracts making it impossible for others to intercede, even if public safety was at stake (Aldred, 2005,1338). There are also concerns that the planning function of the NHS will be eroded by fragmenting this function and allowing the LIFTCos to determine how, and by whom, service will be delivered (Aldred, 2005).

Where projects have included stakeholders, some surprising benefits have arisen. For example, one PCT asked visually, physically and hearing impaired people to sit on the design team and found that "their input was invaluable – simple things like using contrasting colours and symbols for way-finding and signage, rather than words. We've also got raised bumps on the handrails to denote the beginning and the end of staircases. None of these details have come in as an extra cost because we were able to incorporate them early enough in the process" (Simpson, 2007, 1).

3.5.7 Inductive Themes

After addressing the a priori questions developed by the researcher, a number of important additional themes emerged, including:

- Lack of a Pilot Scheme/evaluation
- Flexibility
- Site selection
- Types of project
- Potential for Influence
- Control over premises
- Poor risk management
- Transfer of assets
- Alterations to Buildings
- Revenue for Upkeep.

Lack of a Pilot Scheme / evaluation

Paxton and Lissauer (2000) argue that the evaluation of earlier attempts to use private finance to fund the development of primary care premises has been limited. Holmes et al. (2006, 569) feel that this is "not only bad practice but… at odds with government guidance on the evaluation of completed health care projects" (2006, 571). The NAO (2005, 3) note that second and third wave LIFT projects were rolled out "before the first wave schemes had completed negotiations" which meant that, as found by Hines (2003) many of the early teething problems had not been resolved centrally before the next round of projects commenced. It has been argued that this expansion of the scheme comes more from a political "imperative for visible investment in the NHS" than from any demonstrable VfM benefit (Holmes et al., 2006, 569).

Whilst the NAO (2005, 30) reiterates that Partnerships for Health and the DoH both "recognise the importance of evaluation", they also note that, at that time, there was "no formal framework to evaluate LIFT" (2005, 3) and "no clear guidance recommending either its nature or timing" (2005, 30). MPs, including Edward Leigh voiced their concerns stating that it was "essential that the department of health and Partnerships for Health speed up their development of a mechanism for evaluating LIFT" in order to demonstrate publicly that funds were being used efficiently and effectively and would not be better used elsewhere (Parley, 2007) yet little evaluation has been undertaken. Whilst there was little, if any, guidance from central bodies, Trusts were left to their own devices in terms of developing performance indicators. However, the NAO report identifies that this had lead to an inconsistent approach and there was little evidence that this had been done in a satisfactory manner (2005).

The NAO (2005, 16) share a similar view to many (Tyndale-Biscoe, 2003; UNISON, 2003; Aldred/UNISON, 2006) when they stated that "it is important that the Department evaluates LIFT in comparison to other available procurement routes… 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".

Flexibility

Flexibility is a loose term that may have several meanings when considered in relation to a LIFT project. As Aldred (2007, 146) states "Analysts should ask: flexibility for what, and for whom?" She goes on to say that the "LIFT structure allows flexibility for capital to move in and out of holding companies, but this does not equate to flexibility in service provision". Flexibility of design can refer to the ability to adapt the building to suit the immediate needs of the occupants. Whilst it would seem that some LIFT buildings are being designed with this in mind (Hospital Development,

2002), through the use of multiple-use rooms and strategically placed reception areas (Simpson, 2007) and movable partitions (Parker, 2005), there are concerns. Whilst the LIFTCos are responsible for the maintenance of facilities, there is "no minimum cost for minor alterations" Guillochon (2006, 64). In the past, owner-occupier GPs could go to the open market and obtain quotations for the work and the NHS would reimburse them at the rate of the lowest of the three. However, the LIFTCos now have a monopoly and may charge what they wish for the duration of their contract (Aldred/UNISON, 2006).

Flexibility may also refer to the ability of the building to be adapted to meet changes in functional use in the future. With the 25 to 30 year expected life of the PFI project buildings, the DoH's head of capacity planning, Bob Ricketts, said that the NHS was building "unwanted and inflexible 'monuments' on 30 year hospital contracts through PFI. Many of these, he said, would be redundant in five years. A report by UNISON (Aldred/Unison, 2006) has suggested that LIFT is in danger of replicating this expensive mistake in primary care centres across the country. Paxton and Lissauer (2000, 65) state that "At the moment there are no break-out clauses in PPP contracts, allowing the PCG/T to terminate its lease. This means that the PCG/T has little leverage by which to hold the developer to account".

Although many developers try to create adaptable buildings (Hospital Development, 2006g), through the use of movable partitions (Samson, 2007) and steel frame construction (Parker, 2005), it is difficult to predict changes in services provision and population need and that the required flexibility to adapt comes at an added cost (NAO, 2005). Hudson et al. (2003) argue that specifying standards and mandatory requirements reduce the opportunity to achieve innovation in design and make it less likely that the tender or Invitation to Negotiate documentation will include either prescriptive or performance requirements for items relating to sustainability.

The NAO (2005) states that in spite of the above, "some" first tranche projects have been designed to allow for future changes in use. While many new centres have chosen a more traditional 'hub and spoke' design model, others are using more innovative approaches, such as a 'stem and leaf' design which allows for future growth through the addition of additional 'leaves' of accommodation in the future connected by the central 'stem' as services expand or new ones are introduced. It is claimed that this simple model "offers opportunities for a high level of standardisation in construction, systems and components with the potential for progressive improvements across the supply chain as a series of schemes are delivered" (Burton, 2004, 11). However, changes in government policy and technical changes in treatment methodology could still render them redundant (Simpson, 2007; Dawson, 2001).

Site selection

As the early LIFT projects were implemented in highly populated urban areas, several authors have identified the difficulty in finding a site suitable for the build (Dix, 2001; NAO, 2005; Parker, 2006) which has resulted in the construction of some buildings with "less than satisfactory views or ambiance" (Parker, 2006) or poor patient access (DoH, 2000a). Developers seek to avoid deprived areas as they provide poor returns on investment (DoH, 2000a; Holmes et al., 2006), but development in affluent areas involves competing with residential developers for sites (Holmes et al., 2006). Consequently, LIFT developers have had to employ a range of creative solutions, such as the inclusion of residential apartments in the complex. Thus, new housing may significantly subsidise the cost of the project (Sansom, 2007). However, this approach increases the risk for the developer from a downturn in the residential property market (Holmes et al., 2006). Additional revenue may also be received from the sale of any sites previously occupied by the PCT that become vacant once the new build is complete (Burton, 2004). It has been noted that some LIFT projects outside the big cities, where the opportunity to make additional income will be more difficult, are struggling to attract bidders (Mathieson, 2003).

Types of project

Whilst the new LIFT finance and the model of GP super-surgeries should transform disadvantaged communities in areas with the worst health care inequalities, and "counteract the current fragmentation of GP provision" in some areas (Forrest, 2004, 34), there are concerns that "wholesale development of extremely large practices could work against the ethos of family medicine that patients value and want" (Little, 2006, p.?). Currently there is little guidance from the DoH on these 'poly clinics' who state that "it is up to local trusts to do what they think best to meet local need" (Little, 2006, 26).

Potential for Influence

In the NAO study (2005), two thirds of Primary Care Trust Chief Executives or Finance Directors had been appointed to act as public sector directors on their LIFTCo. In their employment contracts they were charged with a duty to protect the interests of the PCT, such as minimising the costs of purchasing services from the LIFTCo. However, their new roles with the LIFTCo would require them to act in the interest of the LIFTCo board, including maximising profits for the shareholders which could clearly create a potential for conflict of interest (UNISON, 2003; NAO, 2005). There are similar concerns over the potential conflict for any GPs who become members of a local LIFT company and their requirement to act in the best interest of their patients (Mathieson, 2002). A report by the King's Fund (2001) suggests that, whilst the private sector will be seeking to develop sites with profitable complementary uses, the public shareholders will be

seeking to ensure good locations and a good mix of (non-profit making) users.

Similarly, the recruitment of independent non executives to Chair the PCT and strategic Partnering Boards has proved difficult for many LIFT areas (NAO, 2005). Whilst it is recognised for the board to have the requisite skills to protect public interests, in practice this has resulted in the recruitment of individuals with conflicting interests.

Control over premises

Doctors have expressed concerns over the loss of control over their premises when they choose to become involved in a LIFT project rather than owning their own premises (Foster, 2003; NAO, 2005). One key aspect of this is the control over tenancy agreements and sub-letting. Their concern relates to two areas. In their contracts with the LIFTCo, PCTS have the right to decide whether they wish the company to provide any clinical services. Whilst they could request that the LIFTCo restricts service provision to one discrete area, such as diagnostics, allowing the LIFTCo to provide x-ray services for example, some PCTS have chosen what UNISON (Aldred/UNISON, 2006, 12) states is "the most radical" option and is including clinical services in the most general terms within their contract with the LIFTCo. Thus, it is argued that giving the private companies the right to determine how, and by whom, services will be provided for the local population, a role typically performed by healthcare planners (Aldred, 2007).

In the same way that the LIFTCo can determine which clinical businesses are given tenancy agreements, they can determine which private businesses can move in, a key concern of GPs. As one respondent told Dix (2001, suppl. 3), they did not want to see a McDonald's next to the waiting room, something that has appeared in some NHS hospitals (Aldred/ UNISON, 2006). Some LIFT project managers have negotiated the right of veto so that public sector partners can determine who tenancy agreements are awarded to. In one such project the co-ordinator explained that other complementary shops and services can rent spaces on the site. They may also allow third party revenue generation from private businesses. In a number of sites, the space provides a base for the local housing team (Montague, 2001; Hospital Development, 2007c) and others are seeking to provide "open access to information for the local community" in the form of an internet café, for example (Hospital Development, 2007c). Whilst this may be an appropriate use of the space, UNISON (Aldred/UNISON, 2006, 7) has argued that there should be "proper scrutiny to ensure service integration puts the needs of local people first, before LIFT company profits. In particular, to ensure that 'retail units' developed within LIFT sites are appropriate to health care facilities". By co-developing one-stop, mixed-use facilities in, which are more likely to obtain local planning consent (Holmes et al., 2006), it is argued that public sector will be forced to consider how

the profitability of new premises can be maximised whilst enhancing the services available (Aldred, 2007).

Poor risk management

In interviews with members of public sector bodies undertaking LIFT projects, Aldred (2008) noted that they believed that private sector companies, in particular banks, were highly risk averse and suggested that the public sector would not get good VfM when attempting to transfer risk to the public sector. The Public Accounts Committee (PAC) recognised that the LIFT returns were perceived as high in relation to the level of risk assumed by the private sector partners, a fact confirmed by Holmes et al. (2006). However, the PAC argues that this may have been the case in the early schemes because of perceived greater risk associated with the newness of the schemes, and uncertainty over the pace of future developments" (House of Commons, 2006a). This is confirmed by the NAO (2005) who noted that the returns should reduce over time as learning curves are overcome.

Notwithstanding the above, criticisms remain with regard to the risk premium achieved by LIFT companies, UNISON (Aldred/UNISON, 2006, 10) claims that "the projected LIFT rate of return of 15.1% on average compares with 8-9% for traditional third party development – a lot of extra profit given that a PCT may pay around £1 million per year or more to lease each LIFT health centre". Others, including Dawson (2001) argue that a 15% return should be considered standard for a low-risk, privately financed project. Overall, there appears to be little agreement as to how private sector companies involved in LIFT projects should be rewarded for the investment risk.

Transfer of assets

Although some LIFT projects comprise bespoke buildings on new sites, others involve the purchase and redevelopment of publicly owned properties. At the end of the contract, unlike PFI where premises may revert back to the public sector, LIFT premises remain under the ownership of the LIFTCo (UNISON, 2003). This transfer of public assets into private ownership is a source of concern, and it has been suggested that the NHS should be appropriately represented during these negotiations (Dudman, 2003). At the end of the lease, organisations may have the opportunity to purchase the LIFT building from the LIFTCo, but as UNISON (2003) points out, the sites may not then be affordable.

At the start of the LIFT process, some PCTs encountered problems where asset ownership has been transferred to them in advance of the formation of the LIFTCo. These assets attract capital charges, for which the PCT would appear to be liable even though it was made clear that the LIFT

process should not financially penalise any PCT (Hines, 2003). How this would be resolved has not been identified.

Alterations to buildings

Health care professionals working within LIFT buildings have argued that contracts make it difficult and expensive to undertake minor alterations to the property once completed (House of Commons Committee of Public Accounts, 2006).

Revenue for upkeep

Although LIFT provides the capital to build new buildings, in the opinion of Comerford (2004) and Ward (2004m) there are concerns that additional revenue will be required for upkeep. Dr Grant Kelly, former Chair of the Practice Premises Subcommittee of the General Practitioners Committee, allegedly said that if the Government doesn't provide the running costs for buildings, you would be mad to build them (Comerford, 2004), a view shared by UNISON (2003, 7).

3.6 Discussion

At the start of this chapter, the objectives of the review were identified:

- To assess the role and scope of LIFT
- Identify relative success factors
- Identify barriers to and facilitators of LIFT schemes.

3.6.1 Role and Scope of LIFT

There is recognition of the previously poor state of many primary care premises and a need for investment and improvement. LIFT is credited with attracting national construction and design teams and bringing more sophisticated expertise to the development of purpose built primary care premises.

LIFT projects can appear an attractive option for GPs, helping them to improve on their current premises, reduce negative equity and requirement for heavy financial investment and offering the opportunity to relocate into purpose-built accommodation. It offers the opportunity for flexible working, the possibility of relocation, and a chance to work as part of a group practice which facilitates a range of benefits including shared learning, cost reduction, vacation coverage, extended services and improved communications between health care professionals.

3.6.2 Relative Success Factors of LIFT schemes

Evidence suggests that LIFT projects have extended local primary care delivery, providing services, previously available only in hospitals. Enabling funds would appear to have successfully supported the removal of obstacles to project progression, although the use of these funds has been criticised.

There is a view that the LIFT process may have supported urban regeneration and promoted healthier living in some locations. However, this kind of programme is unlikely to be able to take advantage of any fortuitous opportunities for economical and efficient redevelopment that may arise. While LIFT has created a number of striking landmark buildings, there are concerns that this has been to the detriment of other smaller GP projects which have been subsequently unable to secure funding.

There is limited evidence albeit not fully evaluated, that users and client staff are satisfied with the new buildings.

Where stakeholders are involved with LIFT projects, there is an increased sense of ownership of the project and innovative benefits have been realized.

LIFTCos recognise that demand for primary health care services is likely to change during the contract period, and many seem to be incorporating a degree of flexibility into their designs to meet changes required in the future, although it is recognised that such changes seem to come at a very high price, and it has been argued that the incorporation of flexibility requires a higher initial cost. However, the sites selected for some LIFT projects make this type of flexibility impossible, and it is also recognised that subsequent changes in government policy or changes in treatment modalities could render the new building obsolete regardless of any attempt to make them 'future-proof'.

3.6.3 Barriers to and Facilitators of LIFT schemes

The LIFT process appears to be facilitated by the perception that it is the only option for practices seeking to improve their premises. The role and scope of LIFT, together with the success factors outlined, identify many of the facilitators of the process. This section considers the barriers to LIFT schemes.

While all schemes involve some degree of bureaucracy, for LIFT this is widely perceived as being excessive and slow. In addition, one key barrier to the LIFT procurement process identified in the literature was the heavy

burden of workload for both public and private sector partners. It was noted by HM Treasury (1999) that the public sector did not have all the required resources, particularly in areas such as contract negotiation and project risk management. Whilst it was suggested that additional professional resources would be required, obtaining such support was inconsistent. Also noted was the complexity of the process, compounded by frequent changes in rules and staff guidance.

One policy barrier is the lack of evidence of whether LIFT projects provide VfM or central guidance to support projects trying to establish comparative value between LIFT and traditional procurement methods. The returns to the private sector appear higher than anticipated and do not adequately reflect the level of risk transferred from the public to the private sector. Whilst the LIFT process should reduce the involvement of the PCTs in construction and management of the new buildings, in reality it may increase both the workload and risk, with the PCTS becoming responsible for high-value contract negotiation and management.

It has been argued that the exclusivity clause associated with LIFT can potentially reduce the procurement workload by eliminating duplication. This may increase the potential for excluding smaller private sector partners who may have insufficient resources for a complex multiple project development. This could, in turn, reduce the VfM achieved under this procurement methodology. It was also recognized that this marginalization of local companies applied to some prospective tenants of LIFT buildings, with local independent pharmacies being dissuaded from competing.

There is a trade-off between attractiveness to the private sector and affordability to the public sector which would appear to take the form of less exciting designs or a lack of expected functionality. With regard to the latter, the private sector's lack of experience in designing health care facilities has resulted in some basic oversights, but some argue that with experience, this should be less of a problem. For PCTs there are concerns over the long-term affordability of LIFT projects. There are concerns that these new buildings will require additional revenue for their upkeep and this is compounded by the inability of the PCTs to postpone/stage any maintenance payments or equipment replacement to reduce immediate expenditure. Some projects offer subsidies to attract tenants, leading to a reduction in the cost effectiveness of the project, and there have been concerns that rents within LIFT buildings are higher than would be anticipated compared to local market rates, with the result that health care professionals are relocating in proximity to, but not within, the new LIFT buildings.

Further barriers to LIFT include the reluctance of some GPs to relocate their practice, the loss of independent contractor status and the requirement that they co-locate with other health care providers. Prior to the current economic down turn, GP property owners benefited from the significant increases in property values in the UK: an opportunity which will be lost if they chose to take up a lease in a LIFT building (unless they swapped investments and bought into the LIFTCo). With regard to relocation, some GPs are concerned that their patients may be reluctant to relocate to the new LIFT location, preferring to transfer to another GP closer to home. There is a larger question – whether polyclinics or super surgeries are the form of service provision actually wanted by patients. There is recognition that some of the project buildings have been developed in areas with limited public transport, creating problems for patients. There are also issues for GPs approaching retirement who may be unable to take advantage of LIFT as they are not in a position to sign up for a lengthy tenancy agreement.

Whilst the Committee of Public Accounts identified that benefits from the LIFT procurement approach would only be realized if there was a continuous flow of projects, in reality this does not appear to be occurring and some contractors indicating that planned projects have been cancelled or subsequent phases have failed to progress..

3.7 Conclusion

Many have welcomed LIFT as a way to improve general practice premises, although the scheme has also been the subject of criticism. This could, perhaps, have been circumvented had LIFT been piloted before national roll-out, or if there had been a detailed, public examination of the practical and financial viability of LIFT compared to other procurement methods.

Aldred (2007) has argued that the organisational networks surrounding LIFT have developed in a way that muffles criticism or even suggestions for improvement. This encapsulates the belief that regardless of the appropriateness of the model, LIFT is being aggressively promoted as the only way for PCTs to improve their estates. The King's Fund (2001) has suggested that the prospectus for some LIFT projects does not contain any analysis of the reasons why the state of much of the local health capital stock is in poor condition. They believe that this was due to the cost, and risk, of developing inner city sites, an issue which is not addressed by LIFT which merely provides the funds for such undertakings.

4 Stakeholder Views (Interviews)

4.1 Stakeholder Views: Study Design and Methodology

The LIFT and Express LIFT initiatives are embedded in an evolving policy arena thatincludes a multitude of decision makers and stakeholders. In order to gain a fuller understanding of this policy arena, a number of interviews have been undertaken with individuals who have, and are, playing key roles in the development and implementation of the LIFT initiative.

For the purpose of this report, these interviews have been grouped into two broad categories. The first category includes key informant interviews (subsections 4.2.1 to 4.2.6). Key informant interviews are defined as those interviews that have been conducted with 'high level' individuals who have been involved in the design of the LIFT initiative and/or have acted as advisors to groups of LIFT users, but who have not actively participated in specific LIFT projects as public sector clients or private sector partners. The second category of user interviews took place with individuals who have been involved in specific LIFT projects either on the public sector client side or as private sector partner (subsections 4.3.1 to 4.3.6). Some of the user interviews involved individuals who had been interviewed at the beginning of the project but who had not been part of a full case study analysis which constituted much of the second phase of the fieldwork. Other user interviews discussed here emerged as part of the case study analysis which was discussed in greater length in section 7 ('Case Studies') of this report. The decision to include some case specific interviews as user interviews in this section was based on the recognition that the case specific interviews yielded, in addition to the case study-relevant information discussed in section 7, significant findings with regard to the policy aspects of LIFT procurement. All interviews conducted in connection with this project were semi-structured while giving ample opportunity for respondents to provide additional impressionistic views in an unstructured setting. In the following subsections, key informant interviews and user interviews are discussed separately in order to highlight differences in the views gathered from actual LIFT users as compared to those acting in a policy design or advisory capacity.

As a whole, this section is based on twelve key informant interviews and nearly eleven user interviews. Most of the key informant interviews, which are discussed in the first part of this section, were conducted during the early phase of the project in 2007. However, these key informant interviews were supplemented with a small number of additional interviews which were conducted in 2008. The reason for the addition of these interviews was that contact gained during the fieldwork highlighted the role

of these individuals as crucial bearers of information with regard to general issues surrounding LIFT procurement. All of the supplementary, later stage, key informant interviews involved individuals who act or acted in a general advisory capacity to potential LIFT, and now Express LIFT, clients.

As a general principle, all interviewees were contacted well in advance of the interview. This typically involved the interviewees being sent a letter describing the purpose of the study and the nature of the study, i.e., our position as a group of university researchers conducting a project funded by the SDO. Once initial agreement to be interviewed was gained, the interviewees were usually contacted by telephone and given a brief summary of the questions that they should expect to be asked, as well as pertinent information about the interview process. As part of this pre-negotiation phase, most interviewees agreed to be interviewed at their place of work for a period of forty minutes to one hour with the interviews being taped and subsequently professionally transcribed. Most interviewees agreed to this process: however, a small number of key informant interviewees—two in total—asked for the interviews to be minuted by the interviewer rather than being taped. For reasons of consistency, all interviews were conducted by the same research team member. Moreover, all interviews were professionally transcribed, again by the same professional transcription company throughout the study. As a further quality control measure all interview transcripts were individually checked by the interviewer for potential transcription errors. Taken together, these measures helped ensure that high quality interview transcripts were obtained which could later be subjected to thematic analyses by different team members as well as a detailed analysis via the computerised content analysis programme DICTION 5.

Although it was initially assumed that the project would utilise the software package Atlas-TI on account of its suitability for grounded research based designs, it was decided later on to employ the potentially more advanced software package DICTION 5 for this purpose. This decision was based on the fact that DICTION has a number of attractive features which can be used to analyze unique elements of language in texts related to management and policy research (Short and Palmer, 2008). As a consequence of these advantages DICTION has recently been applied in a number of contexts where researchers have sought to assess the verbal tone of statements made in business and policy contexts (see e.g., Bligh, Kohles and Meindl, 2004 a,b; Rogers, Dillard, Yuthas, 2005;Hart and Childers, 2005; Short and Palmer, 2008) and, in particular, where it was deemed desirable to conduct comparisons among such statements (Rogers, Dillard, Yuthas, 2005). With regard to the origins and applicability of DICTION, Short and Palmer (2007) noted that one of the advantages of DICTION is that it was originally created for considering a range of types of text, including business texts such as annual reports, corporate public relations statements, mission statements, CEO speeches, f nancial news,

legal documents, and magazine and TV advertisements. This has allowed published research using DICTION to examine a number of "organizationally-produced texts with relevance to management research such as CEO letters to shareholders, management discussion and analysis sections from annual reports, and press releases". According to Short and Palmer (2008) research using DICTION has been published in a number of management-oriented journals such as Journal of Applied Psychology, Journal of Business Ethics, and Leadership Quarterly, and has been used to examine conceptual ideas in management such as charismatic leadership, organizational image, and organizational identity.

Based on lexicographic theory, DICTION uses 33 different dictionaries, containing over 10,000 search words, to analyze a text passage. These dictionaries are context specific, allowing the user to specify the analysis of a text in comparison to DICTION's repertory of text in specific areas, such as "politics", "business", "scholarship", with further subcategories such as "corporate financial reports, "corporate public relations" and others for "business" or "campaign speeches", "public policy speeches", and "political debates" in the "politics" setting. DICTION's dictionaries contain individual words whereby homographs are explicitly treated by the program through statistical weighting procedures which partially correct for context (Hart, 2000; Bligh, Kohles and Meindl, 2004a). By comparing a specific text passage with a specified repertory of texts, DICTION generates scores for word passages of text of ca 500 words for a set of each of its pre-set variables. For instance, DICTION provides a straightforward measurement of the levels of 'certainty' which underpins a textual passage of a speaker or author by combining totals from dictionaries signalling assuredness (allness words, uses of the verb 'to be', collectives, etc.) and subtracting from them dictionaries connoting tentativeness (e.g., ambivalent words, hyper-specifications) by comparison across passages (Bligha, Kohles and Meindl, 2004a). While DICTION could be criticized for imposing a significant set of assumptions in deriving its output scores on account of the pre-supplied repertories of text with which imported text passages are compared, this problem is significantly reduced by comparing thematically categorized imported text passages derived in similar settings with each other (Rogers, Dillard, Yuthas, 2005). As a consequence, our own DICTION- based analysis, which is discussed in greater detail in the subsequent subsections, primarily relies on supplementing software-based output scores with inter-textual comparisons of theme specific views (issues relating to the effectiveness of LIFT, views pertaining to partnership …) of different interviewees. This analytical approach was greatly facilitated by the fact that interviewees had been ab inito deliberately selected to represent the views and attitudes of different organisations and stakeholders involved in policy issues related to LIFT (key informants) or the procurement and management of LIFT facilities (user interviewees).

The following subsections analysing key informant interviews and thereafter user interviews are structured, as far as possible, in a similar fashion so as to allow for an overall comparison. The first part of the analysis within each of these subsections follows a traditional approach to qualitative research whereby interview transcript is examined along core themes (see e.g., Miles and Hubeman, 1994). These themes reflect, with minor modifications, the research design as described in the initial research proposal with six broad sub-themes and associated questions relating to:

LIFT as incidence of policy learning: What were the key rationales, goals and objectives for the introduction of LIFT? How does LIFT figure into overall strategic developments within the health sector? To what degree was the design of LIFT influenced by earlier experiences of public private partnerships and PFI-based procurement? What are the key deal breakers and stumbling blocks in LIFT procurement? What lessons appear to be emerging at this stage?

Effectiveness of LIFT: In which terms, if any, can LIFT be described as a success? Does the current approach to LIFT provide for significant improvements over other forms of procurement? Are LIFT projects sufficiently financially attractive to ensure competitive participation by the private sector? Is LIFT sufficiently attractive to public sector clients, given issues such as the exclusivity clause, contract length or head leasing?

Partnership and Skill Requirements: Do members of the public sector feel that they have a sufficient understanding of the LIFT procurement process to make educated choices? Do they feel that their understanding is undermined by the complexity of these schemes? Is current guidance on LIFT sufficient to allow public sector managers to make educated choices in the public interest? Is there a need for further guidance or for public sector skilling? Do current levels of experience and skill allow public sector managers to become genuine partners to their private sector counterparts in LIFT projects? Are there cultural, educational or behavioural barriers to such partnering on either side, and if so, how can these be overcome?

Cultural Issues and Conflicts: How do the different values and beliefs of the public and private sector affect collaboration, for good or ill, in a LIFT context? Are there conflicts between different professional cultures and working patterns of the pubic and private sectors? How are private sector values and beliefs affecting professional cultures within the public sector? In general, is there a contradiction between the investment culture of private sector LIFT participants and public need? What mechanisms or processes are in place to avoid, or resolve, conflicts?

Targeting and Local Impact: In light of the need for investment returns, have LIFT projects targeted areas of deprivation of greatest need? Is there evidence of local involvement and urban regeneration through LIFT projects?

Value for Money and Related Financial Issues: Is there evidence that LIFT projects provide VfM and, if so, is this performance widely and evenly distributed? How can the VfM of LIFT projects be assessed and what difficulties, if any, does this issue pose? Is it appropriate to draw comparisons with non-LIFT projects? How does the cost of finance affect LIFT projects and their affordability? Are there indirect financial advantages to LIFT in terms of timely completion within existing budgetary parameters?

Subsections 4.2.4 and 4.3.4 analysing respectively key informant and user views on 'Cultural Issues and Conflicts' are supplemented by a more detailed analysis in section 5 ('Managing Cultural Diversity in LIFT Partnerships') which investigates these issues in detail in relation to the main case studies of the report (see also section 7, 'Case Studies'). This is based on the importance attributed to these issues in the original research design as well as the fortuitous fact that the team was able to conduct a set of separate interviews on these matters.

Likewise, subsections 4.2.6 and 4.3.6, analysing respectively key informant and user views on 'Value for Money and Related Financial Issues,' are supplemented section 6 ('Financial Analysis') which provides a detailed financial analysis of cash flows and operating profits for a number of LIFT projects.

It should be noted that, although the researchers sought to maximise comparability between key informant and user interviews, the two groups of interviewees differed in terms of the extent to which they addressed these questions. As expected, key informants with senior policy roles, or advisors with senior management roles in organisations were more likely to address questions relating to organisational learning and policy design as well as broader issues relating to VfM. User interviewees, meanwhile, were more likely to address issues relating to relatively detailed procurement matters, conflicts and skills. In order to compensate for these differences it was decided that responses to more detailed technical issues associated with the operation of specific LIFT projects would be discussed in connection with the specific case studies of section 7 ('Case Studies'). These questions include, inter alia, the following: Do stakeholders, such as clinical and non-clinical staff, members of advisory boards, etc., feel that they have been sufficiently involved in LIFT projects? Do stakeholders, clients and users feel that LIFT has added extra layers of bureaucracy and cost to primary care provision? In general, what are the levels of user and client satisfaction with LIFT

projects and the project specific impact of LIFT projects? Have there been increases in subcontracting and job losses?

4.2 Key Informant Interviews

As noted earlier, most of the key informant interviews were conducted during the early phase of the project in 2007. This means that the majority of these interviews neither reflect the recent impact of the credit crunch on financial environment of the UK, nor its hitherto unclear implication for public finance and procurement.

On the positive side, it is likely that the absence of this information impacted advantageously on the willingness of senior policy and managerial staff to participate in the study. Overall, the researchers were able to interview nine individuals who were placed in very senior positions, with diverse backgrounds including a senior finance official of the Department of Health [DoH representative] (full interview transcript based on a taped interview), four senior members of Community Health Partnerships [CHP] with different functional responsibilities (two full interview transcript transcripts based on a taped interview [CHP representative 1 and 2], and two minuted interviews), a senior representative of Partnership UK [PUK representative] (full interview transcript based on a taped interview), four senior representatives of the Public Finance Unit [PFU] of the Department of Health with different functional responsibilities (two full interview transcript transcripts based on a taped interview [PFU representative 1 and 2], and two minuted interviews), a senior representative of the NHS confederation [NHS Conf representative] (full interview transcript based on a taped interview), a senior partner at a law firm which represents public sector clients in LIFT negotiations (full interview transcript based on a taped interview[Law firm representative]), a senior representative of a bank which has been a leader in the financing of LIFT projects (full interview transcript based on a taped interview [Bank representative]).

The following six subsections present a thematic cross-section of the views of these key informants with regard to six themes and question groups highlighted above. Each of these six subsections includes a DICTION-based content analysis in which the verbal characteristics of the respective key informants are assessed and compared across a number of characteristics.

4.2.1 LIFT and Policy Learning – Key Informant Views

This group of questions focused on a number of issues, including the rationales underpinning the creation of the LIFT scheme and its goals, its relationship to PFI and other experiences of public private partnership as

well as issues of uptake and interest among public and private sector parties.

While there is extensive literature around policy learning and policy change (Bennett and Howlett, 2004), only a small number of researchers have explored this issues in the context of PPP (see, e.g., Osborne, 2000; Asenova and Beck, 2003a). The motivation for this set of questions was, therefore, to probe how different key informants viewed the rationales, goals and objectives of LIFT in relation to their earlier experiences of PPP. As expected, this question elicited the most extensive and detailed responses from those key informants who had been involved in the design or implementation of LIFT at government level.

Although there was a relatively broad consensus that LIFT had evolved from a need to improve primary care facilities in the UK and attract private investment into this sector, there were some differences with regard to how different key informants viewed the origins and goals of the scheme. This indicated that different policy makers tended to associate different expectations and ambitions with the scheme.

This was exemplified by the statement of the senior finance official of the Department of Health [DoH representative] who viewed LIFT primarily as a response to existing shortcomings in primary care premises:

"LIFT was started off as a response to poor GP facilities particularly in urban areas. That is where the whole concept of LIFT almost really came from, originally. If I go back to the original policy thinking around, it was very much about--we have got a lot of very poor quality GP premises in some pretty poor areas where we need to improve them, well, what is the mechanism for doing it because clearly over the years nothing had happened about that. So the aim was to do that, and I think the distribution has broadly worked."

This contrasted to the perspective of a senior Partnership UK representative [PUK representative] who, having also participated in the design of LIFT, viewed LIFT primarily as a means of engaging PCTs in long term strategic planning:

"LIFT was designed to deliver a programme solution rather than an individual deal, recognising that the actual responsibility for local primary care rests with PCTs which are devolved entities. … There was a recognition that actually what we needed is strategic planning and delivery over the long run. … A local LIFTCo is a strategic planning vehicle."

The latter view was echoed by the senior representative of the Pubic Finance Unit [PFU representative 1], who viewed LIFT both as a means for PCTs to adopt a long-term perspective on estate planning and as a means for addressing deficiencies of market-based procurement:

"The issue about primary care property under doctors, the old model, under third party developers, is that essentially a group of GPs are approached by a developer who then looks at what can be built under a cost rent scheme for a location, and offers GPs a building of a certain size, because the scope is dictated by what can be reimbursed on the rent scheme. The PCT has no direct input into that. It was left to GPs to position their buildings in a way that suited them, and then the rent stream was linked to office rents in the locality. That was great if you were a GP, or builder to be precise, in London, because your cost of building was recouped many times over. It was very poor if you were a GP in a city location like Liverpool, where rent reimbursements never met the cost of building. Buildings were either under scale, where GPs had to rent over shops or whatever, or they were not built because they could not be afforded. The vision is how do you find something that stabilised costs. With LIFT, rents were linked to the retail price index rather than the market, there was an approval that went through the PCTs so what was needed was done, and the PCTs became a stakeholder in the company to make sure the locations were right."

Overall, our interviews indicated that most policy makers tended to view LIFT as a means of addressing immediate shortcomings in primary care facilities as well as an approach that would force, or allow, PCTs to rationalise estate planning. The latter difference in viewpoints was indicative of broader differences in terms of underlying perspectives about the capabilities of PCTs as planners and procurers. Thus, there was a tendency amongst the key informants to either assume that PCTs were eager to engage in long term estate planning, but were prevented from doing so on cost grounds or due to the interference of market forces, or that PCTs lacking long term strategic views could be encouraged to engage in strategic planning via their involvement in LIFTCo-s.

Despite these divergences there was a broad consensus that LIFT had evolved from a recognition that procurement via PFI was, for several reasons, not appropriate in the primary care context.

This view was again expressed most clearly by the senior finance official of the Department of Health [DoH representative]:

"For the type of things we were looking at doing, the PFI model just did not work properly. LIFT provides a lot more shared direction and shared ownership than the PFI model. PFI is more than a form of sort of off balance sheet borrowing, but it is a pretty rigid contractual model. With LIFT we tried to build in more flexibility and more local ownership as well as a lot more NHS engagement."

This view was mirrored by the senior representative of Partnership UK [PUK representative] who described how LIFT evolved away from the PFI model:

"We worked out that if we were to get an effective engagement on smaller projects, we needed to look at them on a programme basis rather than as individual projects. … The overall objective headline was, from Alan Millburn all those years ago, I want to improve the level of primary health care, particularly in deprived areas … what is the best way to deliver that? LIFT, which is different to PFI, was designed to deliver a programme solution, recognising that the actual responsibility for local primary health care rests with PCTs which are devolved entities."

This informant also further elaborated on his organization's involvement in the development of LIFT:

"From our point of view, it is our job to engage in solutions for that sort of thing. So we worked with the Department of Health to design a solution that involved in the end setting up Partnerships for Health, which we took 50% stake in and held until this time last year. At that point we completed waves one, two and three and the model was established. As far as PUK was concerned, we had established the market, got it to a stage of maturity and it was time for us to look at putting our resource elsewhere and the Department actually approached us to say we would like to buy your stake back, so we exited out of PfH this time last year."

While the representative of the NHS confederation [NHS Conf representative] broadly agreed with the notion that PFI could not deliver primary care facilities in the same way as LIFT did, there was less certainty with regard to the question as to whether LIFT had helped overcome some of the problems associated with PFI. Specifically, this informant noted that many PCTs continued to struggle with the complexities of LIFT:

"Both LIFT companies and people in PCTs struggle with complex procurement. PFI is in some ways it is quite simple, it is very standardised and people have done it for longer than they have done LIFT, and there are fewer stakeholders as well. The thing about LIFT is that you have got

your Local Authority in there, you hook in Mental Health Trusts and all of these people are potentially equity partners and it is a different set up, a different set of interests and a different model."

The senior partner at a law firm [Law firm representative] also expressed doubts about the advantages of LIFT over PFI and voiced particular concerns over the exclusivity agreements which are a part of LIFT contracts:

"Lawyers and accountants will have a very different impression of how LIFT works, because they deal with the bowels of the partnership. You have at the top of this document the [S]trategic [P]artnership [A]greement, and it gives exclusivity, and it can never be terminated which from a lawyer's perspective is quite an awkward position. This is meant to be a partnering arrangement, and everybody is tied. For the PCT this means that every time they build a project above a particular threshold, usually £10K, in its patch, it will be done by the LIFTCo unless they have listed it upfront as being excluded. There are a couple of other defined exceptions, but otherwise everything they develop will have to be given to LIFT. It is very difficult to terminate this agreement."

Overall most key informants appeared to agree that LIFT should be seen as an adaptation of existing practices of public private partnership to primary care, which had been necessitated by a need to make these approaches work in a primary care context. However, while government officials tended to argue that LIFT was well suited to these needs, other key informants suggested that LIFT still presented major problems for public sector clients or created new risks for them.

These differences also characterised the views of the informants with regard to the level of public and private sector interest in LIFT. While representatives of the Department of Health, Community Health Partnerships, Partnership UK and the Public Finance Unit suggested that public and private sector interest in LIFT had been adequate, this was not the case when it came to the representatives of the NHS Confederation and the law firm. Specifically the representative of the NHS Confederation [NHS Conf representative] noted that:

"The problem with most LIFTs is that they have not been around a very long time. They also have not had enough projects so all these extra benefits that we are supposed to have from the partnerships and proper joint venture structure, I really do not think we have seen them. It has been like the deal flow has been so weak that it is just been a series of individual projects, and each one has been in effect treated like an

individual project; so all these synergies where we will roll the same design forward and we will help you with your service planning are not happening as much as people initially thought they would do. The reason, I think, is that we cannot afford to do more projects, and it was a bit of a false expectation that we were going to have all these huge deal flows and all these ventures would sort of flow from that and it just has not happened. Some LIFT companies … will probably say that they are actually struggling to make any profit out of this, because they simply have not got enough work going through."

Overall, there was a strong indication that key informants associated with the government tended to associate LIFT with an ambitious reform agenda. This agenda expected the LIFT initiative to trigger extensive investment in primary care together with the adoption of long term strategic and synergistic procurement strategies by PCTs. Meanwhile, other key informants expressed more cautious views which, while recognizing LIFT as a policy refinement, questioned whether it could help achieve these ambitions goals, or indeed should be expected to do so.

This pattern was broadly confirmed by the computer-based contents analysis with the software package DICTION which was conducted for the relevant subsections of the interview transcripts for all nine key informants for whom tape-based transcriptions were available. As part of this analysis the relevant subsections were first isolated as separate texts. Next, the interviewers' questions were removed from each of the transcripts. Lastly each text was separately imported and analysed under the "politics" setting with the sub-setting "political debates".

The table below reports the relevant results of this analysis whereby each standardised score represents the deviation of a particular group of words of the imported text from DICTION's text and dictionary bank. In addition, scores are marked with an asterisk where this deviation is statistically significant. As a means of interpretation, it is important to note that a significant positive score indicates that the use of terms denoting, for instance 'praise', significantly exceeds that of the chosen DICTION text bank, whereas a significant negative score denotes the opposite.

Table 4.1, DICTION output, Key informants, 'policy learning' text segments,standardized scores and significance

Interviewee	Praise	Satisfaction	Inspiration	Accomplishment	Certainty+
DoH representative	-0.37	-0.50	-0.62	1.40*	0
CHP representative 1	0.21	-0.17	-1.01	0.21	+*
CHP representative 2	-0.02	0.81	0.08	0.68	0
P-UK representative	-0.23	-0.27	-0.47	0.81	0
PFU representative 1	-0.08	1.26*	-1.01	0.61	+*
PFU representative 2	-0.13	0.07	-0.58	0.51	+*
NHS Conf representative	0.07	0.31	-.79	-0.26	0
Law Firm representative	-1.30*	-0.85	-1.06*	-0.33	0
Bank representative	-1.12*	-0.35	-0.37	-0.46	0

+ As composite variable 'certainty' produces spurious standard scores and requires varying significance thresholds, therefore only the sign and significance are recorded (0=within .05 confidence interval, +=above .05 confidence interval, -=below .05 confidence interval).

Looking first at statistically significant results only, significant positive results are detected for the variable 'accomplishment' in case of the DoH representative and for 'certainty' in case of the CHP representative-1, the PFU representative-1 and the PFU representative-2, as well as for 'satisfaction' for the PFU representative-1. By contrast significant negative results are detected for the variable praise in case of the Law Firm representative and the Bank representative, as well as for the variable 'inspiration' in case of the Law Firm representative. This confirms the incidence of significantly more negative attitudes among non-governmental key informants with regard to their view of LIFT as an incidence of policy learning.

An alternative way of interpreting the above table, that does not rely in equal measure on the DICTION text repertory as a means of detecting outliers, is to compare standard scores across key variables. This is particularly useful in the case of the key variable 'accomplishments' which shows positive standard scores for all key respondents associated with governmental organizations and negative, albeit insignificant, standard for the other three key informants (NHS Confederation representative, Law Firm representative and Bank representative).

4.2.2 Effectiveness of LIFT – Key Informant Views

Our literature review (section 3) indicated that, while there is an extensive literature on the effectiveness of PPP as a procurement mechanisms in different contexts (see, e.g., Akintoye and Beck, 2008; Akintoye, Beck and Hardcastle, 2003), relatively little has been written about these issues in connection with LIFT. This group of questions, therefore, sought to gauge whether, and in what respects, key informants viewed LIFT as a success or otherwise. As part of this research, the interviewees were asked to describe whether the then current approach to LIFT met existing objectives and provided for significant improvements over other forms of procurement. Additionally, the key informants were questioned about their views with regard to the attractiveness of LIFT projects to private and public sector organisations and the resultant competitiveness, or otherwise, of the LIFT market. Finally, they were presented with relatively open ended prompts which enquired about their views with regard to LIFT's contribution to an overall emerging health strategy.

As a general pattern, most key informants tended to focus on different aspects or issues relating to LIFT in responding to questions relating to the effectiveness of LIFT. Although the key informants working for, or with, governmental organisations again tended to take a more positive view of the LIFT initiative, there was a significant degree of reflexivity among all key informants in addressing this question. This reflexivity related primarily to problems in measuring and identifying success and was particularly noticeable in connection with statements pertaining to the overall success, or otherwise, of LIFT as well as to more specific statements relating to issues of process or competitiveness.

As an example of such a reflective assessment of LIFT, the senior finance official of the Department of Health [DoH representative] suggested that LIFT could overall be described as a success particularly in terms of project completion, but emphasised that many users still perceived LIFT as exceedingly complex and bureaucratic:

. "*I think LIFT has partly been effective. We have delivered an awful lot through LIFT programmes, which is a good thing. We have had more clinical involvement in LIFT than we ever did with PFI. I am not sure that we have sorted out the complexity issue. When I talk to people in the NHS, there is still a feeling that perhaps the structure of LIFT ends up being more bureaucratic and less flexible than they actually wanted it to be. If you talk around, you will get quite a lot of positive comments from within the NHS but the negative stuff will be views about the bureaucracy, because they still feel it is not flexible enough.*"

This perception of LIFT as an essentially successful policy which required further refinement in order to simplify the procurement process, of course, relates closely to the creation of Express LIFT which is discussed in greater detail in section 7. For the purpose of this subsection it is interesting to note that statements by a senior DoH official made in 2007 already indicated a movement towards a simplification of this procurement process.

The above-mentioned view was largely echoed by key informants who had participated in an advisory capacity for a number of LIFT projects, such as the senior Community Health Partnership representatives. These key informants also viewed LIFT as a largely successful approach which required refinement at the margins [CHP representative 2]:

"Some places have done very well. We have got 220 schemes, £1.5B capital invested, 47 LIFT companies, they can't all be perfect. Some are brilliant and some are not. One of the things our knowledge transfer programmes have been doing is taking all of the good practice and sharing with people who have got a poor experience of LIFT for whatever reason and actually, you know what, this does work. The reasons it works are because you invest time, you invest effort, you actually do not listen to the rhetoric and you look at what you can deliver."

However, in line with earlier statements by the DoH official, these key informants also expressed the view that LIFT, as a procurement process, required simplification and streamlining:

"There is strong argument that says LIFT its not flexible enough. But again some people do it pretty well, some people do not. The DoH is looking at making the business case process much more streamlined and more flexible and a more commonsense approach really. … that business case process is a pain in the bum."

This view of LIFT as a qualified success which required further refinement was further elaborated upon by the representative of Partnership UK [PUK representative], who noted that LIFT had by and large fulfilled its mission, but did not necessarily represent an optimal procurement process:

"To me the overriding success of LIFT is that before you set up the LIFT programme there was limited private sector investment in primary health care facilities that was pretty much focused on affluent areas. What LIFT was seeking to address was to get efficient investment in primary health care facilities into deprived areas, where the typical scenario was a sole practitioner operating out of the basement of a semi--detached or terraced

house in pretty grotty circumstances. If you look at the facts, a billion pounds of investment has been delivered from a new supply market, into areas that had never previously attracted investment and they are one stop shops with different practices coming together. So the overarching success so far is, forget individual VfM for the moment, actually we have delivered new primary health care facilities in areas which never previously had it. So the overarching objective has been achieved. Then comes the secondary question of whether the methodology that has been used is better than the alternative? Well, I think it is better than PFI, but it is not ideal. I am not sure you should be comparing it against design and build, or individual procurements or open market operating or anything else, because PFI would never have been the right solution for that."

Further on, in the same interview, this informant noted that there were also questions about LIFT having achieved some of the broader objectives of strengthening strategic planning in the primary care sector:

"I always hoped that LIFT would deliver the original objective and deliver a lot more. I think its capability to deliver a lot more has been constrained. To me it was always more than just delivering that initial billion pounds of primary health care--it has done that and I think they would have struggled to deliver that through any other means. But the potential for LIFT is greater and that has been held back and the great thing about it is that that potential has not gone, it is just sitting there."

This view contrasted with the NHS Confederation representative [NHS Conf representative] who expressed doubt as to whether PCTs should focus on these broader planning issues:

"We are not in the business of property management, we are in the business of providing clinical care. The problem is that PCTs, even after their mergers a couple of years ago, are still a bit small so they are inevitably going to have to rely on external advice and they get a bit through Partnerships for Health. … it does not make sense to say you should do something which you are not very good at. There is plenty of evidence that when we try to do it ourselves we do not do it terribly well. Now that is not to say the private sector automatically does better. They need managing better, undoubtedly, and we could probably structure some of these procurement methods better."

Taken together, these views were indicative of disagreements about the current and future role of PCTs in this area, which appear to underpin some of the disagreements about the efficiency and efficacy of LIFT as a procurement method. Speculatively speaking, this situation could be taken

to reflect a situation where LIFT as a policy was introduced without the role of key players having been fully clarified or agreed upon; thus giving rise to widely divergent expectations for this policy instrument together with similarly contradictory evaluations of its success.

This point was further illustrated by the way some of the key informants who described how, in their opinions, PCTs, who had engaged, or were planning to engage, in LIFT, viewed these schemes. Thus, one of the Community Health Partnership [CHP representative 1] representatives noted that:

"We did six national workshops which took in all 10 SHA areas and we said to people, do you think LIFT worked for you? Most of them said it did. Next we asked who was interested in LIFT. … About 80% of people put their hand up."

This contrasted sharply with the senior law firm partner [Law firm representative] who suggested that only a minority of PCT were satisfied with LIFT:

"I would say that a few think that LIFT works for them. Yes about 20 or 30% would say that their LIFTCo does a good job for them. And often, that is because they know that they are being paid and they do not care. They think we have that expertise and we pay them to do it, otherwise we are not going to get these buildings. Others really resent the idea that they are paying out these fees."

Another area in which there was some level of disagreement concerned the issue of competition and private sector interest around LIFT. Again, informants working for, or advising, government tended to view this issue as largely resolved with the DoH representative suggesting that "we have managed to make it financially attractive to all sides". This contrasted with the NHS Confederation representative [NHS Conf representative] who suggested that competition around LIFT was limited and also proposed that it had been declining for some time:

"I suspect the LIFT market is declining because there just is not the deal flow and I suspect what will happen, is that we will see some of the LIFT companies merging or being taken over in effect. …. if you go back to when I started doing this, so late 90's early '00s, if you did a procurement you would get somewhere between 4 and 6 companies bidding, credible companies. Now you are looking at 2; and 2 is not terribly competitive."

Regarding the contribution of LIFT to an overall emerging health strategy, there was some consensus that this issue had not yet been fully clarified. Again, this theme was addressed with some candour by the senior DoH representative [DoH representative] who noted that there was a need to clarify the role of LIFT and other procurement mechanisms within a future strategy for primary care:

"Rather than sort of stream off and go to something like an independent treatment centre type approach with GPs, we do need to sit back and think about primary care and LIFT in general. That is the bit I keep coming back to, where does LIFT fit within our overall strategy around primary care? This is the one thing I am not sure we have quite got right."

Similarly the Partnership UK representative [PUK representative] suggested that LIFT should evolve as part of a new primary care strategy:

"We do not know fully where primary care is heading. But LIFT has a lot of potential. I would push for more investment through it. I would push the community hospital programme through it, including the polyclinics. I mean essentially you have got two things, you have got a very capable team in PFH that has a proven track record in delivering small schemes locally--you do not see many of those in the public sector--and you have got an established infrastructure and delivery platform locally."

Overall this analysis indicated that views around the effectiveness of LIFT were rich and nuanced. While a minority of primarily non-governmental informants doubted that LIFT was an efficient means of procurement, the majority of informants suggested that, particularly with further refinement, LIFT-based approaches had considerable potential for the future. In parallel with these generally positive views with regard to potential of LIFT-based approaches, there was, however, a general acknowledgement that LIFT had yet to be embedded in a broader strategy for the future of primary care provision.

Needless to say, the short summary of these views cannot do full justice to the nuanced positions taken by most key informants. However, there is again evidence of a relatively pronounced split, whereby LIFT is seen in considerably more positive terms by those key informants who are associated with government as compared to others. This split is again confirmed, albeit less clearly, by the contents analysis presented below, which again relies on nine text segments of topical statement of more than 500 words which were excerpted from the interview transcripts.

Table 4.2, DICTION output, Key informants, 'effectiveness' text segments, standardized scores and significance

Interviewee	Praise	Satisfaction	Inspiration	Accomplishment	Certainty+
DoH representative	-0.17	1.56*	-.077	-0.91	0
CHP representative 1	-0.47	0.06	0.35	-0.25	+*
CHP representative 2	-0.46	-0.76	-0.13	0.37	0
P-UK representative	2.13*	-0.12	0.06	0.54	+*
PFU representative 1	1.19*	-0.18	-0.20	1.52*	+*
PFU representative 2	-0.07	0.79	-0.30	0.51	+*
NHS Conf representative	-0.60	-0.68	-0.73	-0.57	-*
Law Firm representative	-0.21	0.42	-1.00	0.15	0
Bank representative	1.20*	-0.06	-0.93	0.46	+*

+ As composite variable 'certainty' produces spurious standard scores and requires varying significance thresholds, therefore only the sign and significance are recorded (0=within .05 confidence interval, +=above .05 confidence interval, -=below .05 confidence interval).

Looking at significant positive results first, it can be noted that these occur exclusively in connection with government officials and advisers and the bank representative. As concerns non-composite variables, this applies to the 'praise' variable in case of the P-UK representative, the PFU representative 1 and the Bank representative as well as the 'satisfaction' variable in case of the DoH representative and the 'accomplishment' variable in case of the PFU representative 1. In case of the composite variable 'certainty' significant positive scores can also be found for CHP representative 1, the P-UK representative and the PFU representative 1, the PFU representative 2, and the Bank representative 1.

Taken together these results indicate that there is a significantly greater incidence of affirmative and positive verbiage associated with the effectiveness of PFI amongst interviewees associated with government. However, there is no clear pattern as to which type of underlying pattern these statements attach themselves to (such as 'praise' or 'accomplishment') which may be due to the relatively high level of reflexivity with which all of the interviewees have approached this group of questions.

4.2.3 Partnership and Skill Requirements – Key Informant Views

Previous research on PFI-based procurement has tended to highlight the difficulty these types of public private collaborations pose in terms of the creation of 'genuine' partnerships (see, e.g., Asenova and Beck, 2003a, b; Asenova et al., 2004). These problems have been attributed to a large degree to the very different set of skills that public and private sector organisations bring to public private partnerships as well as specific characteristics of the procurement process. Specifically, there is significant evidence that because private sector companies and/or consortia are typically involved in bidding for, project managing or constructing numerous projects, substantial inequalities are created with public sector clients, who are often involved in only public private partnership.

Based on these considerations, this group of questions was aimed at exploring how key informants viewed the development of partnerships within the LIFT context, and specifically the issue as to whether current levels of experience and skill allowed public sector managers to become genuine partners to their private sector counterparts in LIFT projects. Specifically, this group of questions explored whether it can be assumed that members of the public sector have a sufficient understanding of the LIFT process to make educated choices and/or whether this understanding was potentially undermined by the complexity of these schemes. Furthermore, this analysis sought to assess whether, in the view of the key informants, public sector managers received sufficient guidance and support when engaging with LIFT. Lastly, key informants were asked whether they felt that there were cultural, educational or behavioural barriers to such partnering on either side, and if so, how these could be overcome.

With regard to the issues of partnership, there was some consensus that partnering was easier in the LIFT context as compared with other forms of public private partnership. However, this view was usually qualified by the fact that most key informants expressed concerns about the levels of complexity that the LIFT framework appeared to inevitably impose on public sector managers.

Again, this issue was expressed concisely by the senior DoH official [DoH representative] who suggested that LIFT had encouraged the creation of genuine partnerships to a far greater degree than earlier schemes:

"The way we have tried to structure the governance of LIFT has created far more genuine partnership than we have ever had with PFI. The whole way we got the LIFTCo structure working at a local level with all the different parties involved is a very different sort of partnership model. … you also have got more parties involved in LIFT than you do in a standard

PFI scheme where basically you have just got the hospital involved and a whopping great big contractor and probably a facilities person."

This view was echoed by one of the Community Health Partnership representatives who suggested that, as a rule, existing LIFTs tended to work as partnerships, but that issues remained in relation to the locus of decision making:

"*Most LIFTs are genuine partnerships. A proper LIFTCo, a good LIFTCo will act as a partnership. But this still leaves questions open about that relationship. So if a Client turns round and says no, that is what we want, then the LIFTCo will invariably say well of course if that is what you want then we will deliver what you want. What we are saying is we think there is a better way to do it. Now that means you have got to have a grown up relationship with the client. The client has got to be grown up and commercially aware and actually accept that they might know more than we do."*

Similarly, the bank representative [Bank representative] noted that successful partnerships involved a mutual acknowledgement of differences in working patterns:

"*The private sector works in different ways and the public sector is different; due diligence is different, you know. The private sector respects the processes the public sector has to go through and I think the public sector does understand some of the processes that the private sector has to go through. Overall, they work quite well together and it is really down to the individuals involved."*

Responding to the same issue, one of the representatives of the Public Finance Unit [PFU representative 2] suggested that 'partnership working' was achieved more easily where smaller PCTs co-operated with smaller private sector organizations:

"*You need the right engagement locally. That is often more difficult with larger companies but its not impossible. If they have got the right people and they are encouraging the joint venture and enabling it to have its own identity. It needs people at ground level to be able to make a decision, and the smaller organisations find that easier. Probably a bit more education is required for larger organisations that will tend to see LIFT like a project, whereas smaller organisations will understand that the LIFTCo is a company, and they will need to look after its business holistically rather*

than as a series of projects. The larger companies are not necessarily an obstacle, they just take a bit longer getting there sometimes."

As concerns the issue of potential skill gaps, a number of key informants highlighted that this was still a serious issue. This view was exemplified by the representative of the Private Finance Unit [PFU representative 2] whose statements implied that there was a further need for reform in central government:

"You need to just keep working on the skill issues. I try and bring people in from the private sector on secondments and contract basis to learn from them. It is specific skills that they have to learn, but it is not impossible. We are not incompetent, we just need to learn different skill sets. …But we are our own worst enemy. We tend to employ people for a two year period and they have to move to a new job, because of a new challenge in the public sector, whereas in the private sector it is much more job specific. You know you get your rewards for being good at that job and you specialise. Whereas we value generalists in management. In the civil service, most departments move people on every two years and it is deemed to be a good thing to be a generalist. … It is a false economy. You need to spend more money on people who monitor the contract but actually a person monitoring the contract properly can save you their salary "X" times over by running that contract properly."

This view was mirrored by the DoH representative [DoH representative] who suggested that providing adequate support for the public sector was an ongoing issue:

"We tried to work originally with Partnerships for Health. We tried to work out a way of providing support throughout the process. But I am not totally sure that we have always had the right level of support for PCT level. Because PCTs handle large amounts of money and employ a lot of people, we sometimes have the wrong view about their abilities. PCTs are organisations with big responsibilities, but not big organisations. And part of the model we've got to continually work through with LIFT, is how do we provide support for PCTs? If we ask them to do something how do we provide the support, and have they got the expertise to do it."

Highlighting similar issues, the representative of Partnership UK [PUK representative] suggested that these problems were best resolved by expanding the role of advisory organisations such as Partnership for Health:

"Public sector people tend to rotate at an alarming rate. So even if you develop a skill in one person, they tend to move to a completely different job and that happens all over the place. A PCT creates a LIFTCo once, whereas the private sector is doing it on multiple occasions. So PCTs probably have never done that before, whereas the private sector recruits specifically for people to have those commercial skills. PCTs will not often recruit specifically to handle these challenges, so they will just say who have we got who could do this? Because of these skill gaps we the need organizations like PFH. … the PFH people are coming together and exchanging good practice. We can afford this. It is a simple thing. You can justify paying someone in a central unit who is actually quite experienced and quite senior, and costs quite a lot, if they are spread around 5 or 6 different LIFTCo-s, whereas one PCT looking at one LIFT arrangement is going to struggle to afford that sort of person."

One of the Community Health Partnership representatives [CHP representative 1] suggested that support and advice from central advisory bodies had to be supplemented by knowledge transfer activities:

"We need to address the existing management training gap. What is coming through for us is the need for more information to allow us to effectively train people who, maybe, are doing a partnership for the first time."

Moreover, the same Community Health Partnership representative suggested that:

"However, what we must not do is replicate the knowledge base of the LIFTCo inside the PCT. There is no value in that, because all you are doing is paying twice. PCTs need to feel comfortable that they have now outsourced their estates elements, that they have transferred the risk. The LIFTCo brings that added value and that knowledge. … Some PCTs have almost man-marked person for person across the team so the public sector ends up paying twice."

This view contrasted with statements by the law firm representative who suggested that there was a need for public sector clients to closely scrutinize the activities of their private sector partners. Moreover, the law firm representative [Law firm representative] generally shared the view that PCTs were, at times, ill-equipped to handle the demands involved in creating a LIFTCo, but argued that this situation was only partially alleviated by the involvement of advisors:

"There is an imbalance of skills between PCTs and the private sector. The PCTs then have to buy in those skills. There is this idea that we can rely on LIFTCo advisors because their interests are always aligned. Now, in my view, the interests are aligned for about 70% of the time, but on some really key issues, these interests are not aligned, because the PCT is their only customer and, ultimately, where the PCT is concerned as a customer and a supplier, the interests diverge. I don't think that that tension has been adequately resolved yet. Sometimes it has, and people have given a good argument, such as I want a better bank document because this affects me. In some cases the PCT has not understood what a bad deal it was getting, and it says I have signed up to a standard document and everything is fine. They think the private sector can do it all."

She further suggested that the way LIFTs were structured could give rise to conflicts of interest which could have been avoided had the PCT fully understood the implications of the deals they entered:

"Most problems come down to conflict of interest, and dealing with the conflicts or people recognising the conflicts in the different positions of their organisations. What happens if, hypothetically, a building was built and there was something structurally wrong with it? Now I know this has happened on a couple of buildings. In that situation the PCT has got two interests. First of all it is a minority shareholder. But fundamentally it is the provider of health care in the area and the tenant. If it goes to its LIFTCo and it says we have got a problem with a building, they may well have just voted on the board and decided that there is no problem, because they have been outvoted. It gets to be a real problem because the PCT ultimately needs to sue itself. So there is a real friction and a difficulty to deal with that issue. I think that if the PCT was very sophisticated and understood the funding deal and the implications of funding deals, and management deals, they could avoid these problems."

While not necessarily sharing the negative views of the law firm informant, several other interviewees highlighted problems with regard to aligning the values and interests of different parties in LIFT projects. This was exemplified by the statements of one of the Public Finance Unit representatives [PFU representative 1] who noted that there was a need for private sector partners to prioritise co-operation over competition:

"I think the biggest obstacle is public sector people behaving like public sector people, and private sector people behaving like private sector people. This is a new model, it should give people the confidence to work together in a new environment. If you replicate processes that go on in a competitive environment, you do not get good communication and that for me is the biggest challenge."

The same informant suggested that there was a need for partners, particularly in the private sector, to avoid short-termism:

"It is really about making that step from intense contract documents to a situation where everyone is happy. It is about getting to that point and that is what everything should be aimed at: to recognise where your partner gains you will gain, if your partner loses you will lose. If we can create that, then we get a model of public-private partnership where goals are aligned. If we do not get that, and the private sector still considers the first projects to be the projects they have to make money on, then you never get there."

Interestingly, this view was closely related to statements by the Partnership UK representative [PUK representative] who highlighted the key role private sector participants played in creating genuine partnerships:

"There are important differences in public sector values and private sector values. So the challenge is to make sure there is sufficient alignment of interest so that these differences do not actually matter. The private sector's is job is to earn a return for their shareholders, that goes without saying. The public sector has no such aspiration. But actually what both want, is to deliver high quality new facilities. … The challenge for LIFT is to get the private sector to recognise that they are in a partnership and that, if they go for a short term win in terms of profit, that is going to damage the partnership."

The latter statement, in particular, was echoed by the NHS Confederation representative [NHS Conf representative] who, while supporting partnerships in general, suggested that some private sector organisations misunderstood this relationship:

"I am quite pro-partnership. I am sure you will get some fairly negative views from other people. My view is that it is important for us all to deliver what we want, which is improved health outcomes and healthier people. We have as much interest in the private sector for doing that, because they have got to make a long term living out of this. So if you were to turn round and start screwing the public sector for every penny they have got, you are never going to win another piece of work, and it does not take much of a grapevine to get the message around."

In summary, this group of questions highlighted two core themes. These included, firstly, the need for ongoing improvements in the support and

resources made available to potential public sector clients, together with a refinement of the procurement mechanisms themselves. Secondly, there was an implicit consensus across governmental and non-governmental informants that the success of LIFT-type approaches rested on a willingness of private sector parties to forgo short term profit maximization in favour of building long term working relationships. It is interesting that both themes, refinement and simplification of process on behalf of clients and greater selectivity among private sector providers, resurface as a key motivation for the creation of Express LIFT as discussed in section 7.

Overall, it is worth noting that the there was far less of a split of opinion between informants working for government or as advisors to government as compared to other key informants. This is reflected in the DICTION-based content analysis presented below, which reflects a lesser divergence of attitudes among informants across most variables. In particular, the prevalence of negative signs on most non-composite variables is indicative of a situation where most informants actually view and describe 'partnership' as a problematic issue. Possible exceptions to this are the positive and significant scores in case of the 'satisfaction' variable for the PFU representative 2 and the 'praise' variable in case of the bank representative.

Table 4.3, DICTION output, Key informants, 'partnership and skill requirements' text segments, standardized scores and significance

Interviewee	Praise	Satisfaction	Inspiration	Accomplishment	Certainty[x]
DoH representative	-0.58	0.15	0.07	-0.42	+*
CHP representative 1	-0.62	-0.19	-0.01	-0.65	0
CHP representative 2	-0.62	-0.19	-0.01	-0.65	0
P-UK representative	.074	-0.68	-0.59	-0.21	+*
PFU representative 1	~	~	~	~	~
PFU representative 2	0.17	1.32*	-0.53	0.98	+*
NHS Conf representative	0.38	-0.68	-0.39	0.53	0
Law Firm representative	0.00	-0.18	-0.48	-0.26	0
Bank representative	1.14*	-0.68	-0.74	0.14	+*

x As composite variable 'certainty' produces spurious standard scores and requires varying significance thresholds, therefore only the sign and significance are recorded (0=within .05 confidence interval, +=above .05 confidence interval, -=below .05 confidence interval).
~ Results omitted due to lack of data.

4.2.4 Cultural Issues and Conflicts – Key Informant Views

In recent years, a number of researchers have explored the cultural implications of partnership working (see, e.g., O'Toole, 1993; Hebson et al., 2002). This literature has generally tended to highlight cultural differences between public and private sector managers (see also Poole et al., 1995) as well as investigating their implications on partnership working (Osborne, 2000). This subsection was originally intended to cover a broad range of issues relating to the interviewees' views on differences in the values, beliefs and cultures of the public and private sectors and their impact on collaboration and partnership. However, since these issues are now covered in greater detail in section 5 ('Managing Cultural Diversity in LIFT Partnerships') which is based on separate case-specific interviews, this brief subsection focuses primarily on the issues of cultural conflicts and conflict management in LIFT projects. The reason for this particular focus is that the issue of conflict was addressed by almost all informants, most of whom attached particular importance to mechanisms for conflict management.

Taking a relatively unusual view as compared to other interviewees, the DoH representative [DoH representative] attributed potential conflict between the public and private sector to the public sector's seeming obsession with contracts and contractual terms. This, he suggested, was due primarily to the accountability requirements faced by public sector organisations and in particular the threat of audit:

"The public sector does tend to come in thinking "contract" when they are dealing with the private sector. If you look at the ways different private sector organisations work together, it is almost that, if you pick up the contract and look at it, you have sort of failed. … Now I do not think we have quite got that. I don't know how much of it is a cultural issue, and how much of it is just the way the accountability structures in the public sector work. … But when something goes wrong, and you have to appear before Public Accounts Committee, or you have the National Audit Office or the Audit Commission over you, it is their immediate thing to look back to the contract. So there might be something more fundamental within the public sector about relationships with the private sector due to the accountability process."

By contrast to this view, the Partnership UK representative [PUK representative] saw the principle challenge of LIFT framework in getting the private sector to avoid adversarial attitudes in order to build long term relationships with the public sector:

"What the private sector should be looking for is a win/win scenario where the it makes a return but recognises that a fair and reasonable return over

the long term is better than just going for the quick buck because they are never going to get another deal."

The same informant further argued that unproductive conflicts around LIFT projects could be avoided if the public sector placed less emphasis on competition:

"It is a difficult concept. Effectively the public sector is saying that, if you create a good partnership you will get better long term VfM as opposed to competing for everything at every possible opportunity. But it makes people nervous when you do not compete. …. I think there is too much competition, certainly with the initial bidders. There were 19 different consortia that won the 42 deals. … In my mind the ideal supply market would have been 8 consortia with the highest market share being about 20%, maybe a couple at 20%, and a few at 10-15% and in that way you are creating companies that have critical mass, in terms of numbers of LIFTCo-s which they control. That would encourage them to invest in central resources and all the rest of it. The problem, when you have 19 different ones, is that there are not enough companies that have sufficient critical mass to invest in it as an industry."

Noting that obstacles and conflicts around LIFT project originated from both public and privates sector attitudes, one of the PFU representatives [PFU representative 2] suggested that LIFT required a change in the attitudes of both groups. This is included a recognition by the public sector that the private sector needed to be profitable, and a recognition by the private sector, that it was more useful to aim for repeat business rather than quick returns:

"The hard bit for the public sector is to recognise that profit is not a dirty word for example. They have to make a profit and they are not going to be here if they do not. And similarly from the private sector's point of view, to understand that it is not about cost, but about overall cost and value. And most importantly the private sector needs to recognise the rewards for them are through the repeat business, without competition. And that only comes from a satisfied customer. It's no good relying on contracts to get in."

Focusing on the operational side of LIFT contracts, the NHS Confederation representative [NHS Conf representative] noted that working under the new regime brought significant changes to all parties which could give rise to conflicts:

"Let us just say it is something trivial like you do not get your bins emptied … Most people would not do anything about it in the public sector. The culture should be, we have a payment mechanism and we have a system when you have to report this to the healthcare centre and nothing will happen until you do that. And that is a very alien culture for the NHS. But to make it work that is how you have to do it. Now that is a very trivial example, but you see it an awful lot and then you end up with a kind of precedent because your partner turns round and says well you have not been reporting any of these things, we do not know about it and there is no system here. You might argue that could be over–contractualised, which I think is possible. They think it is perfectly normal to report things and log them and then act on the log, whereas we think it is perfectly normal just to have a chat with Joe down the corridor saying, can you do it?"

While this interviewee suggested that the initial adjustment to different working practices was a major source of problems in the early days of LIFT, he suggested that these problems had now been largely overcome:

"We had to learn on both sides. It was quite confrontational and quite a stark distinction emerged in the early days, but I think it developed and changed over time. … I think it was very much a learning thing, it was about realising that it is not helpful to distinguish ourselves and we are all actually part of the NHS."

In contrast to the previous interviewees, the law firm representative [Law firm representative] was far more critical about the possibility of LIFT to overcome competitive and adversarial attitudes. Specifically, she suggested that there was an implicit limit to public sector learning in this context, because, ultimately, a highly effective public sector would disincentivise private sector participation in these projects:

"I think PCTs suffer from a lack of confidence in their own abilities. … You know, an effective PCT with good representation and a good understanding of the deal should be able to get a good deal out of its LIFTCo. But you can see that there is a perverse effect; the more efficient you are, the more you disincentivise the private sector. I have had this discussion with people in the DoH. People know about these issues; you may not hear them."

Excepting the last interviewee, there was a notable consensus among the interviewees that the successful, conflict-free, implementation of LIFT required a change in culture. However, several informants felt that this cultural change had not yet progressed far enough and that existing

adversarial and competitive attitudes continued to hamper the implementation of LIFT.

This was reflected in the DICTION output which, while not following a clearly discernable tended to show negative signs for a great number of variables, such as 'praise', 'satisfaction', 'inspiration' and 'accomplishment'. A unique outlier to this was one of the CHP representatives, which could be attributed to the fact that this interviewee cited a number of successful examples of collaborative approaches to the management of LIFT projects.

Table 4.4, DICTION output, Key informants, 'cultural issues and conflicts' text segments, standardized scores and significance

Interviewee	Praise	Satisfaction	Inspiration	Accomplishment	Certaintyx
DoH representative	-1.28*	-0.85	-1.00	-1.20	0
CHP representative 1	-1.18*	-0.20	-0.88	-0.60	0
CHP representative 2	6.80*	-0.42	0.80	-1.03	0
P-UK representative	~	~	~	~	~
PFU representative 1	-0.46	-0.68	-0.53	0.42	+*
PFU representative 2	-0.10	0.32	-0.76	-0.11	+*
NHS Conf representative	0.31	0.64	-0.73	0.16	0
Law Firm representative	0.92	-0.33	0.35	0.76	0
Bank representative	0.35	-0.85	-0.68	0.90	+*

x As composite variable 'certainty' produces spurious standard scores and requires varying significance thresholds, therefore only the sign and significance are recorded (0=within .05 confidence interval, +=above .05 confidence interval, -=below .05 confidence interval).
~ Results omitted due to lack of data.

4.2.5 Targeting and Local Impact – Key Informant Views

Issues relating to the targeting of primary health care services have been by a number of researchers in the recent and past (see section 1.1. 'Background'). However, relatively little has been written about the potential economic impact of health care investment in the UK (see section 3). This section analyses the views of key informants with regard to the targeting and local impact of LIFT. This set of questions was based on ongoing debates about the willingness of the private sector to invest in areas where potential returns from property may be limited as well as more general doubts about the ability of public private partnerships to service these areas. In addition, the team sought to investigate the perceptions of

key informants with regard to the local impact of LIFT projects. Interestingly, the expectation that LIFT generates positive benefits to local areas was part of a number of early policy documents (see section 1), but appears to have received less attention later on in the implementation of the LIFT initiative.

It should be noted at the outset that a number of key informants, including the law firm and bank representatives, chose not to comment on issues of targeting as they felt that their knowledge of these areas was limited. However, this was largely compensated for by the full and nuanced statements made primarily by key informants associated with government and advisory bodies.

Regarding these key informants, there was some consensus that LIFT had originated from a perceived need to improve primary care facilities, particularly in deprived urban areas. In addition, most key informants agreed that this had largely been accomplished during the earlier phases of the LIFT roll-out allowing the scheme to move on to other areas.

These developments were described by the DoH representative [DoH representative] as follows:

> *"Targeting deprived urban areas was where we started off, … that is where the whole concept of LIFT came from. If I go back to the original policy thinking, it was very much about that problem."*

This view was reiterated by one of the Public Finance Unit [PFU representative 1] representatives who suggested that, in terms of targeting, LIFT had achieved its initial goals early on, allowing the scheme to be applied to areas of rural deprivation.

> *"We have got 47 LIFT companies, and the vast majority of those are in the lowest deprived areas, highest index of multiple deprivation areas predominantly for that reason. LIFT was developed to increase or improve infrastructure in the poorest areas because there was no way on earth that in parts of Lambeth for instance, you would get a third party developer wanting to own land. You could not sell it on for housing afterwards because nobody would want to live there, not residential, so how would you get round it? So that is really why places like Liverpool, Newcastle, Manchester, Leeds, most of London, started LIFT companies in the poorest areas. …. What we're seeing now is the next draught of LIFT companies coming out and they are into rural deprivation so you have got Norfolk and York to a certain degree. There are many areas of rural deprivation which now have LIFT projects. Derbyshire is a good example of this. … LIFT*

started off as being about poor quality primary care premises in urban areas. But now it has gone well beyond that."

While broadly agreeing with this view, another Public Finance Unit representative [PFU representative 2] suggested that, despite these accomplishments, there were still areas of need where LIFT-type approaches could play a major role. In his view this included, in particular, those under doctored areas where there was a lack of office rental equivalents:

"All the LIFTs are targeted at areas of urban or rural deprivation. There is a map that shows the concentration in the North East, the North West and Cornwall. There are a few outliers. By and large the rural areas and Surrey and Sussex have not been touched, but all the major conurbations have got them. I accept that, since LIFT was conceived, property prices in certain parts of inner cities have really rocketed, so that the market would have adjusted to allow things in places like Manchester. But then Liverpool still is a declining city and other parts of the country will also find it difficult to build. Also there are problems in areas where there is not a great deal of office rental equivalents such as Cornwall and Norfolk. …. In terms of targeting in the right place, there is the concept of underdoctored areas, which are deemed to be areas in which there is insufficient GP coverage in ratio per capitation. Today 80% of those are covered by LIFTs. We were talking about how we can roll out LIFT further. We are talking about developing ways in which a LIFT is piggybacked out of its current area into a surrounding area in a way that there is a chance for local companies to win it."

Looking at the future of LIFT, the NHS Confederation representative [NHS Conf representative] proposed that LIFT had now moved well beyond geographic targeting and that some LIFT projects had now emerged in relatively affluent areas. He further suggested that LIFT, as a procurement mechanism, was still developing in the sense that some LIFTCo-s were now involved in the creation of multi-purpose service facilities which included social and/or mental health services. Although this informant felt that there was a possibility that these developments were driven by private sector partners seeking to secure a stream of deals, he felt largely positive about these changes:

"LIFT was targeted at deprived areas and there is no doubt that the first wave of LIFT schemes were in deprived … Nowadays LIFT has moved on and you only have to look at a map and say well that is obviously not a deprived area. What I find interesting is not so much where LIFT schemes are now being developed but what these schemes cover. We are now seeing LIFT being used for more than just a very straightforward replacement of old tatty GPs surgeries into Health Centres and we are

seeing combined health and social care centres or even some mental health type facilities. In some sense it is because these PCTs have already done their procurement so they might as well use it for other purposes. But you could argue that it is more positive; that people like LIFT and therefore want to use it in interesting ways."

Responding to claims that property prices in London had hampered the introduction of LIFT in areas of need, one of the Community Health Partnership representatives [CHP representative 2] argued that this was not necessarily the case. According to his views the greater London area had, in fact, been targeted by a large number of projects, but there was less awareness of this on account of the fact that the area was rarely perceived as one unit:

"There is this real undersold story in London as to the actual amount of infrastructure that has been delivered and the amount of investment that has gone into London. When you look at London purely from an objective manner, it is actually no worse than in some of the other areas, but it does not speak as an area."

Regarding the issues of regional ownership and involvement, there was a broad consensus that this had by and large been accomplished. For instance, one of the Community Health Partnership representatives [CHP representative 1] noted that successful LIFT projects were often seen as a form of regional accomplishments by both public and private sector partners:

"One of the things I find is that when I go out to the regions, is that they are very regionally focused. They are very proud of their region and very quick to shout about the successes in their region; this applies to the private sector as well."

Similarly, another Community Health Partnership representative suggested that many LIFTs had been able to draw on local expertise and leadership [CHP representative 1]. He cited a number of examples suggesting that, where this had been the case, there where significant benefits to in terms of the contribution of LIFT projects to regeneration and community development.

"What you tend to find is that the LIFTCo itself reflects the area. Liverpool is a great example of this. It is a big region. The CEO comes from a regen background. He has got immense knowledge and he is very well tapped into the local Council and the local PCTs because he has worked

with them for years. He also has a property understanding, so he gets estate, he gets building, he gets planning, and that is excellent."

Although the number of statements relating to issues of targeting was, as previously noted, more limited than in the case of the other topics, there was a broad consensus that LIFT projects had indeed been successfully targeted to areas of greatest need. These generally positive views on this topic are reflected in the DICTION analysis of these text segments, with output being characterized largely by positive scores and several significantly positive outputs.

Table 4.5, DICTION output, Key informants, 'targeting and local impact' text segments, standardized scores and significance

Interviewee	Praise	Satisfaction	Inspiration	Accomplishment	Certaintyx
DoH representative	0.11	0.73	-0.55	0.04	0
CHP representative 1	~	~	~	~	~
CHP representative 2	0.70	0.73	0.06	0.07	+*
P-UK representative	2.45*	0.06	0.56	1.54*	0
PFU representative 1	1.55*	0.15	-0.76	1.39*	0
PFU representative 2	~	~	~	~	~
NHS Conf representative	0.45	0.15	0.30	-1.00	0
Law Firm representative	~	~	~	~	~
Bank representative	~	~	~	~	~

x As composite variable 'certainty' produces spurious standard scores and requires varying significance thresholds, therefore only the sign and significance are recorded (0=within .05 confidence interval, +=above .05 confidence interval, -=below .05 confidence interval).
~ Results omitted due to lack of data.

This is particularly noticeable where the significant positive scores in case of both the 'praise' and 'accomplishment' variables for the P-UK representative and the PFU representative 1. The scores are indicative of a strong underlying support for the view that LIFT had delivered at, or beyond, expectations in this respect.

4.2.6 Value for Money and Related Financial Issues – Key Informant Views

The issue of VfM has attracted a host of research contributions, many of which have focused on the PFI in the health care sector (for a recent

contribution, see, e.g., Broadbent, Gill and Laughlin, 2008). This group of questions was therefore aimed at exploring issues related to VfM money and other financial issues associated with LIFT. Specifically, the key informants were asked whether they perceived LIFT projects as providing for money, or otherwise, and which evidence they could cite in support of their views. In addition, the informants were asked whether they felt that the performance of LIFT projects in terms of VfM was widely and evenly distributed. Focusing on methodological issues, the informants were further asked whether they felt that there were difficulties in evaluating the VfM aspects of LIFT projects and, in particular, whether it was appropriate to draw comparisons with non-LIFT projects. Lastly, the key informants were asked to describe the potential impact of LIFT on issues of affordability as well as any indirect financial advantages to LIFT in terms of issues such as the timely completion of projects within existing budgetary parameters.

Regarding the issue of VfM in general the DoH representative [DoH representative] responded relatively cautiously by stating that this had been the case if the speed with which these facilities were procured was considered:

"I think LIFT has been VfM because it has allowed us to significantly improve Primary Care premises, no question about that at all. I think we have done it quicker than we would have done by other mechanisms. Although it is always difficult when you are comparing with some sort of counterfactual, I think we could have done it more efficiently. There was the NAO report a couple of years ago, on LIFT, it was pretty positive about how well the LIFT model works."

While this informant suggested that there was no evidence that speedy construction resulted in higher returns to the private sector, he implied that there was a need for more detailed analysis beyond the six case studies conducted by the NAO (2005a, table 10).

This view was mirrored by one of the CHP representatives [CHP representative 1] who suggested that, apart from the speedy delivery of facilities, one of the advantages of LIFT was that it had created greater awareness about possibilities of value creation:

"LIFT has brought a much broader view of value to infrastructure in Primary and Social Care. We tend to think that VfM really just exists at the competitive tender process where the margin is quite small for improvement or loss. But VfM is created in different places in the development of a scheme right back to needs assessment, outcomes, etc."

This view was echoed by another CHP representative [CHP representative 2] who suggested that, apart from requiring accurate needs assessment, LIFT allowed for improved value creation on account of the requirement for partners to jointly decide on a number of deals over time:

"Value is about outcomes, not about the cost … When you know what the needs are and the services required to meet the need, then look at what you need in order to deliver services and if it is a building, work with your LIFTCo and make sure that building exactly what you need. … You can have disagreements with your Client, your PCT, your Local Authority and the LIFTCo going backwards into its supply chain; you have this chain of relationships that gets stronger over time because you are delivering more and more."

Expanding on the idea of ongoing collaboration as a source of value creation, the same informant noted that the absence of joint decision making was a key impediment to value creation in LIFT projects:

"*Where some LIFTCo-s fall down, and it is by no means the majority, just a handful, is when they completely step out of it and say to the client you know what, take your Tenants Requirements and just take them straight to the supply chain and the builder and architect … That is not what LIFT was about. LIFT is about taking the problem off the PCT and delivering a solution that they need. When this happens you start getting the arguments based around cost because the LIFTCo does not offer VfM, and it is not seen as that extra department which the PCT does not have."*

Taking a potentially more radical position, the NHS Confederation representative [NHS Conf representative] suggested that LIFT and similar approaches could create value because they allowed the NHS to move its estate outside its core business, where it could be more effectively managed by the private sector:

"One paper we have been working on most recently is in effect saying why does the NHS own these assets at all? Why on earth do we have to be involved? … Capio do not own any of their hospitals, any of the big office companies, they do not own anything … We should think a little more about why you really honestly have to own a building. … We have sold off most of our surplus estate. The problem is, are we getting the best deal for that and there is an argument actually if you went down this property development type route, is the best deal actually to change its use into residential or whatever? It might be better to do that than take a rental stream just actually sell it outright. In some ways partnership is actually

quite helpful in that it allows you to be a bit more interesting and innovative in how you deal with these things."

The bank representative viewed the issue of VfM as being largely related to the cost of finance [Bank representative] and, as such, a matter of prudent financial engineering.

"Most of these projects are highly geared which means that if a project costs £20M and that's all costs including advisors, interest costs, the works, there's a rough rule of thumb, very rough, £18M of that would come from the bank. The other £2M would come from the private sector partner, your equity provider, and some would come from the PCT. The PCT owns the other bit, the LIFTCo obviously is owned 60:20:20. Now we go to the LIFTCo and flow down, so you end up with a gearing ratio of debt to equity of round about 90:10; so 90% bank debt, 10% equity. It is a lot higher than you would normally see. Corporate gearings are often only around 30 or 40%. Property deals maybe 60 or some go up to 80, but 90:10 is very very high and it is a very small amount of equity. … It is about VfM; bank debt is a lot cheaper than equity so therefore the more bank debt you can get into a deal, the cheaper it is for the PCT."

The same informant further suggested that another major element in achieving VfM, from the standpoint of financiers and investors, concerned the contractual allocation of risks. This typically involved a transfer of most risks to private sector partners:

"I think risk allocation in LIFT is probably reasonably fair because the cost risk for construction is fully passed on to the private sector and the cost risk of operations is passed onto the private sector. The delivery risk is passed onto the private sector and the only risks that the PCT retain are risks that could not sit with the private sector … It would not be fair for the private sector to take on board risks with adverse weather or strikes because its something they cannot control. The only people, not that the public sector control can control them, but at least it is a risk that the public sector is aware of and a risk that obviously no private sector could put a fair price on. I think that is the key for VfM."

According to this informant, any serious deviation from these typical financial structures and risk allocation arrangement would adversely impact on the value of such deal for financiers and investors and potentially act as deal breaker. This would apply in particular to additional risk transfers to the private sector which would be likely to significantly increase the financial cost of projects.

The question as to whether the performance of LIFT projects in terms of VfM was evenly distributed was addressed by one of the PFU representatives [PFU representative 2]. While noting that, as a whole, most LIFT had achieved VfM criteria, this informant felt that there were some projects where this had not been the case:

"There are some buildings that are outstanding VfM and … there are others that are probably only average or poor VfM. That is no different from other attempts at building and signing agreements … The real question is whether the mechanisms are in place to learn from that."

The PFU representative further suggested that the financial success of LIFT projects was largely a "people issue" rather one of delivery mechanisms:

"It is not the delivery method that is at fault … it is people and the knowledge of what you want. LIFT offers you that because it is a continual cycle you have got the chance to re-learn; as opposed to, we build a new wing of a hospital and then no-one ever does anything like that again."

This view was contradicted by the Partnership UK representative [PUK representative] who felt that the financial success of LIFT project was influenced by systemic factors such as the bargaining power of public sector organisations. Specifically this informant noted that VfM was affected by the degree of leverage exerted by public sector clients which, in turn, was related to their size:

"The PCT is much less powerful in dealing with a relationship than the Department. If, as an example, Laing are an investor which they are in six LIFTs, well the fact is that Laing are also bidding on acute hospitals, and bidding on this and that so you know. A little old PCT managing its relationship with Laing is going to be much less effective than someone sitting in Central Department even if it is PFH. I think the Department just needs to use that greater leverage."

Expanding on this line of argument, the same informant suggested that the ability of PCTs to strike effective deals was hampered by the restructuring of PCTs and uncertainty over future deal flows:

"The fact that in the course of LIFT we have been through two major restructurings of the PCTs is unhelpful to say the least. I think the fact that we have gone through major policy shifts in terms of the way that healthcare is delivered in the community is difficult to cope with. … If you

are looking parochially at the LIFT programme, actually the best scenario would have been a continuous predictive investment programme. However, there has been a hiatus in investment in the last two years around the community hospital programme. The whole point of the LIFT programme was that it was set up to deliver predictable investment and provide a mechanism for good strategic planning. If the policy environment is shifting at a national level it is very difficult to do local strategic planning with any confidence … when we talk to the private sector they will just say there has not been enough of a deal flow."

A broadly similar view was expressed by the Law firm representative [Law firm representative] who suggested that the VfM of a LIFT depended to a significant degree on the financial and legal astuteness of individual PCTs:

"People say it is expensive, and when they are saying it is expensive they do this because they are looking at the machinations behind the deal; there are complicated money arrangements behind these LIFT projects. I am not saying that they cannot work, but the PCT has to be sophisticated. The PCT have to understand the importance of what terms it has got from the bank for its future projects."

A number of informants addressed other potential impediments to value creation. Apart from the issue of partnership discussed above, these views typically focused on the issue of flexibility, which a number of informants saw as a key to value creation.

This view was exemplified by one of the CHP representatives [CHP representative 1] who suggested that some LIFT project suffered from over-specification on account of compliance requirements with regulatory guidance such as the Health Building Notes:

"It is not LIFT that specifies the building. It is the DoH that specifies it with its Health Building Notes … The LIFTCo is building to the quality that the PCT has told it has to build to by its governing body which is the Department. A LIFTCo could build a very low spec building but the PCT through its approvals process has to demonstrate that the LIFT structure has been delivered to the standard as prescribed by HTMs and HBNs ... A LIFTCo as a private company can deliver anything. It is what the PCT as the tenant is allowed to ask for, and that is either because it has to comply with DoH specifications or it has to ensure that it is not challenged under Public Sector Procurement rules."

Similarly, another CHP representatives [CHP representative 2] suggested that impediments to VfM often arose from the inflexible attitudes of PCTs towards commissioning, and suggested that it was essential for successful LIFTs to adopt flexible solutions:

"*If the tenant's requirements are wrong then LIFTCo to a certain degree is screwed, because it gets the blame for building a building that no-one wants. Actually I can take you to buildings that are non-LIFT where exactly the same happens. As an example, a PCT says right we have got a shortage of dentistry, we have got loads of revenue, we want 5 dentistry booths built into that LIFT premises. The LIFTCo says right, not a problem. Three quarters the way into the build, the PCT decides that it does not want to commission dentistry anymore. The LIFTCo then gets the blame for a building with 5 dental suites that are completely empty. … Invariably the LIFTCo should be looking at building a flexible buildings knowing that the needs of that community will change over time, because you want that building to last 20 or 30 years, that is the whole point of it!*"

Similar comments were made with respect opening hours with the CHP representatives in particular which highlighted the need for LIFTCo-s to adopt flexible and where possible, future-proof solutions.

With regard to the question of how VfM of LIFT projects could be assessed, there was broad agreement among most of the key informants that this presented significant difficulties. This issue was expressed in different terms as well as being attributed to different causes by the informants.

One example of an informant who warned against comparing the cost of LIFT and non-LIFT projects was the DoH representative [DoH representative], who emphasized both the difficulties of separating out different types of cost and of comparing different types of facilities and management approaches:

"*It is very difficult for people to separate out the expense of the process from the fact that you are actually moving from pretty crappy premises into something that is fit for purpose and is a modern set of premises; and people, when they compare costs are not comparing like with like. This is similar to new PFI hospitals where you know that you are paying more for something that is new, that is quality, than you were for something that was something totally hopeless. The other element is the extent to which, and this again is within both PFI and LIFT, you are actually tied into continually maintaining the quality.*"

This view was echoed by one of the PFU representatives [PFU representative 1] who suggested that it was difficult to assess the intangible components of VfM:

"VfM is meant to take intangibles into consideration. There is price which is the cheapest but VfM is a much broader range of measures … VfM for me includes all the things that you are talking about so better quality of care, better outcomes, better working and buildings. Some of those you cannot price so in a sense you price what you can price, you value what you can value but then it might give you a result where the cheapest is not much different from the – how can I put it? If you do all those things you can price by costing or giving a value … Even though it still might show that the one with the cheapest construction costs is still overall cheapest you can then reverse it all by saying, ah, there is always the intangibles that we have got, we cannot price, that we think it is worth paying for."

Given these difficulties this informant concluded that it was important to base decisions regarding VfM on defensible choices which were based on an understanding of desired outcomes:

"The system is that if you want to pay more for a product that gives you better tangibles and better intangibles and if you say that this is why we are doing it, then the system allows you to do it. The system allows you to buy Audis rather than Fords if you want to on the basis you believe it's going to give you better value over time and the PAC, as long as you sit down and you make that conscious decision, then they will back you on it."

Taking an even more critical position towards the issue of VfM, the NHS Confederation representative [NHS Conf representative] suggested that, although it was worthwhile assessing some intangibles, VfM itself was possibly not a useful concept:

"It is very difficult to prove the outcomes are the result of whatever they are a result of … I mean you cannot necessarily prove that giving a new building will improve health outcomes, but there must be enough evidence, or I hope there is enough evidence out there, where you can look at it sort of historical examples and say before and after. If I was the DoH … I would be looking and saying, actually, it is a good thing to refurbish or replace our estate because we can demonstrate, okay within a big margin for error, … that at least you are healthier and you live longer and you pay more taxes and at a very macro level, it might actually be beneficial. … I do not think VfM is helpful in achieving this. I mean you are

just doing comparison of funding routes basically and say we will make a few slightly spurious assumptions about how much risk there is, it is all very subjective. But it misses the point about actually this is about will our staff be happier? Will our patients be happier/healthier? … We do not really quantify any of that so in that sense it is very difficult to know what VfM means."

As regards the issue of affordability, there was some agreement that there was a financial burden associated with LIFT projects. However, virtually all of the interviewees who addressed this issue noted that the cost of LIFT projects had to be assessed in the context of the comparative benefits this type of procurement was likely to deliver. This view was expressed by the Partnership UK [PUK representative] representative who stated that:

"Part of the problem with affordability is that you do pay for what you get. Undoubtedly one of the objectives of the programme was to produce decent facilities, well we now have much better facilities than previously existed. One of the things that I am slightly nervous about is cost comparisons, whether you are comparing apples and pears. … Sustainable solutions do not come cheap."

In addition to this, the same interview suggested there were examples where private sector initiatives led to reductions in cost:

"The interesting thing about this is that there are some deals where the private sector has done a larger development than the Primary Health Care requirement so they might have built some social housing or they maybe have done a retail development … That is something that would never have happened within a public sector context. And that will bring down the cost of Primary Health Care, and social housing will create a community asset which would otherwise not have been produced so you get those sorts of things that need to be taken into account."

The NHS Confederation representative [NHS Conf representative], meanwhile, expressed concerns over the affordability of LIFT projects, but argued that these problems where not specific to LIFT:

"There is a big issue in affordability. And I am not sure it is got anything to do at all with LIFT, PFI or anything. The problem we have is that, if you want decent facilities, they cost money and I think no-one has really grasped that. The fact that if you are going to design things that are therapeutically healing environments, that can be put to a different use when you no longer need them, that has a cost attached to it."

While this interviewee was keen to highlight the potential benefits of newer and potentially expensive facilities, he regretted that the DoH had not undertaken more research in identifying the benefits of these investments.

"Looking at these key informants interviews as a whole, it is fairly clear that the majority of the interviewees took a relatively unenthusiastic view of the financial benefits of LIFT. In particular, there was a remarkable absence of any expectation that LIFT projects would lead to major cost savings or show significant gains in terms of VfM vis a vis potential alternatives such as the public sector comparator."

This pattern was confirmed by the DICTION analysis of the interviews which, while not following any particularly pronounced pattern, showed that even interviewees for governmental organization, or organizations affiliated with the government, took a mixed view of the financial aspects of LIFT. This was particularly pronounced in case of the DoH representative, whose statements yielded significant negative scores for 'praise', 'accomplishment' and 'certainty'. Meanwhile, significant positive scores could be detected for the one of the CHP representatives for 'accomplishment' and 'certainty', the PFU representatives for 'satisfaction' and 'accomplishment', and 'certainty', respectively. This pattern was not necessarily surprising, given that one of the primary tasks of the CHP and PFU representatives is to promote the financial attractiveness of LIFT. This situation would also explain the unusually high positive score for the 'praise' variable in case of the bank representative.

Table 4.6, DICTION output, Key informants, 'value for money and related financial issues' text segments, standardized scores and significance

Interviewee	Praise	Satisfaction	Inspiration	Accomplishment	Certainty[x]
DoH representative	-1.03*	-0.35	-0.70	-1.20*	-*
CHP representative 1	-0.63	0.62	-0.02	1.36*	+*
CHP representative 2	-0.84	0.77	-0.76	-0.75	-*
P-UK representative	0.24	-0.60	0.28	0.03	0
PFU representative 1	0.80	1.66*	0.65	054	0
PFU representative 2	0.05	0.74	-0.43	1.02*	+*
NHS Conf representative	0.24	-0.60	0.28	-0.03	0
Law Firm representative	-0.93	-0.68	-1.11*	-0.33	0
Bank representative	2.65*	0.52	-0.93	0.84	0

x As composite variable 'certainty' produces spurious standard scores and requires varying significance thresholds, therefore only the sign and significance are recorded (0=within .05 confidence interval, +=above .05 confidence interval, -=below .05 confidence interval).
~ Results omitted due to lack of data.

4.3 User Interviews

The majority of the user interviews were conducted during the middle and end-phase of the project in 2008. This meant that some of these interviews already reflected the impact of the recent crisis. The research team would have liked to investigate user views on the effects of the crisis and its potential implications on the future of LIFT in greater detail, for instance by introducing a specific set of new questions investigating these issues. However, it was felt that this was not possible, as it would have introduced some asymmetry to this interview series which could have made their analysis significantly more difficult. Nonetheless, where interviewees referred to the crisis as part of their views, this was included in the analysis.

As a general rule, the interviews discussed in this section cover a variety of LIFT users ranging from CEOs of major LIFT companies to practice managers. The principal criterion for selecting interviewees was that they possessed intimate knowledge of operational LIFT projects. In addition, an attempt was made to ensure that there was a sufficient geographic spread among these interviewees as well as a sufficient representation of urban and rural participants. Lastly, in selecting the user interviews discussed in

this section, an effort was made to avoid duplication with the case studies discussed in the consecutive sections. This meant that the majority of user interviews discussed in this section were conducted in areas other than the core case studies. In the few instances where this was not the case, these interviews were conducted separately from the case study, with the interviewees being asked prior to the interview to express their general views and experiences in relation to LIFT.

Overall this section pertains to eleven user interviews, including seven with public sector employees and four with senior private sector representatives. All eleven interviews were taped and professionally transcribed and lasted between forty minutes to over an hour. The public sector representatives included a Partnership Director from an urban PCT in the North West [Part Dir, urban NW], the Associate Director of an urban PCT in the South West [Assoc Dir, urban SW], the Associate Director of a rural PCT in the East Midlands [Assoc Dir, rural E Midl], the Project Director of a mixed rural and urban PCT in the North West [Proj Dir, mixed NW], the Project Director of a predominantly rural PCT in the West Midlands [Proj Dir, rural W Midl] and two Practice Managers working in the same PCT [Pract Mgr, rural W Midl, 1 and 2].

The private sector representatives included the CEO of a LIFTCo operating in an urban PCT in the North West [CEO, urban NW], the CEO of a LIFTCo operating an urban PCT in the South West [CEO, urban SW], the CEO of a LIFTCo operating an urban PCT in the West Midlands [CEO, urban W Midl] and the CEO of a LIFTCo operating an urban PCT in the North East [CEO, urban NE].

In terms of the timing of the respective LIFT schemes, the interviewees were distributed as follows:

urban PCT in the North West	first wave
urban PCT in the South West	third wave
rural PCT in the East Midlands	third wave
mixed urban and rural PCT in the North West	third wave
predominantly rural PCT in the West Midlands	second wave
urban PCT in the West Midlands	second wave
urban PCT in the North East	second wave

Although the researchers would have wished for the inclusion of interviewees from a fourth wave project, the given distribution of user interviewees reflects the relative concentration of LIFT schemes in the second and third waves.

As far as possible, the user interviewees were asked questions which were similar to those given to the key informants. However, due to their different experiences, their responses varied greatly. Specifically, while some interviewees addressed general policy issues, others tended to focus more strongly on their own experiences. Following a pilot interview, it was decided that the same basic orientation and order of questions as in case of the key informant interviews could be maintained. This approach facilitated the comparison of key informants and user interviews which is discussed in the conclusion of this section (subsection 4.4 'Stakeholder Views: Concluding Remarks') as well as the application of DICTION as a means of supplementary contents analysis.

4.3.1 LIFT and Policy Learning – User Views

Following the layout of the previous subsection, this part focuses on user views with regard to LIFT as an incidence of policy learning and/or a policy innovation. Since many of the user interviewees were primarily familiar with LIFT from an operational rather than a policy perspective, this subsection focuses on a limited number of issues. These issues include user views with regard to workability of LIFT as a policy instrument, desirable future developments in this area in general, and the specific issue of uptake and interest among public and private sector parties. Due to the relatively brief statements which the interviewees made with regard to this issue, a computer aided content analysis has been omitted from this subsection.

Regarding the role of LIFT as policy innovation, the Partnership Director from an urban PCT in the North West [Part Dir, urban NW] felt that LIFT was an important part of urban regeneration. Specifically she suggested that LIFT was most successful where it was a part of broader strategic regeneration activities:

LIFT works well where there is a strong need for regeneration and a strong City Council does help. If you look across at Liverpool, Manchester, Salford you know, go across to Sheffield, Leeds, you look at the development of these cities and it has been absolutely tremendous. There is a great ambition and desire and that is helpful. London has developed tremendously but it is probably been more of a private sector boom.

While acknowledging these broad successes, the same interviewee noted that it was far more difficult to pinpoint the advantages of LIFT where these initiatives had not been part of broader strategic initiatives.

This view was echoed by the Associate Director of a rural PCT in the East Midlands [Assoc Dir, rural E Midl] who argued that LIFT had to be embedded in a broader strategic context:

"LIFT works well when you have a need and plans, and a strategy about where you want to go with your services. There has got to be a map of current services and a strategy around future services."

While welcoming the overall strategic direction of LIFT, this interviewee noted that the NHS had yet to fully adopt the requisite strategic outlook in which LIFT had to be embedded:

"The one good thing about Darzi is that it horizon scans and we are not good at that in the NHS and then when we do it, we are not good at following it through. Sometimes it is because of other demands for organisational change. But anyway, I think that is what LIFT genuinely needs. … If you can get that, LIFT can thrive on a number of things, not just in terms of providing buildings but by being a facilitator in achieving that and the estates part of it, the advice part of it, and everything that comes with it."

The view that LIFT utilisation had yet to evolve into a broad movement toward strategic planning in primary care closely mirrored earlier statements by key informants such as those of the senior DoH representative.

Arguing that LIFT in its traditional form represented a complex and, at times, difficult procurement mechanisms, the Project Director of a mixed rural and urban PCT in the North West [Proj Dir mixed NW] welcomed the introduction of Express LIFT:

"If I could do LIFT again, we would have gone through the Express LIFT process. I think the central procurement of getting people on the framework and then your PCTs, and being then able to get those people who have already been through a gateway, a much better process. It reduces time and reduces legal costs and things. This is a much better way to take the process forward."

This view was echoed by the Project Director of a predominantly rural PCT in the West Midlands [Proj Dir, rural W Midl] who argued that LIFT was a broadly sound procurement mechanisms which should adapted to future needs rather than discarded or displaced by alternative strategies:

"To come back to that point, if LIFT had not been invented, how would we have done what we wanted to do? The fact is that somebody actually put in the 2000 NHS plan that we would invest £1B in primary care, at least

somebody at that stage strategically recognised that something needed to be done. LIFT might not be overall the best mechanism but at least it was a mechanism that got something achieved and in the future, if we want to do something, then it's about adapting that. Not as we tend to do, saying oh it has not worked so let us start something else off, because actually that will have its own pitfalls. It is about shaping LIFT to do something and I think it is a mechanism that can be extended, and some of the Local Authority projects are things into which it can be extended once you have got the company."

However, the same interviewee was critical of the contractual part of the LIFT procurement process:

"PPPs for very small premises were being treated as a major PFI and I think that is where it did go slightly astray. You have got two very different risk profiles and some of our advisors were seeing PPP primary care premises akin to PFI for a significant hospital. We were saying hang on a minute, those are very different risk profiles in primary care premises. Things like Community Hospitals sit somewhere in between, but actually we were putting perhaps too much belt and braces in but what that is--but you learn that as you go along."

While most of the public sector interviewees felt that LIFT required only minor modifications, this was not necessarily the view of the private sector interviewees. Thus the CEO of a LIFTCo operating an urban PCT in the North East [CEO, urban NE] noted that LIFT, in its current form, was overly bureaucratic and complex:

"I think the LIFT process and the documentation around it is incredibly complex. I understand why. It has to protect all the interests but that puts a lot of people off because they cannot get their head around it. The other thing that is incredibly complex is that, until you have done an outline design, got some initial costings, and you know roughly what its going to look, feel and be like, you cannot run a first cut of a financial model which means you cannot tell them what the price is. I could do that almost like a fag packet appraisal, a development appraisal saying around £14 sq. ft, but am not allowed to."

This view closely mirrored the statements of some of the key informants, such as the NHS Confederation representative, who had also noted that the complexity of LIFT posed problems for both private and public sector representatives.

Similar views were expressed by another CEO [CEO, urban W Midl] who argued that LIFT lacked flexibility both in terms of project design development and in terms of the way the schemes were governed. Regarding the issue of project development, this interviewee felt that there was currently an excess of regulation which undermined the possibility of local approaches:

"We have to match a national standard no matter what, and there is little flexibility at a local level. I mean the reason that I am always given by PFU and the people who make these kinds of decisions is that they do not think the PCTs are knowledgeable enough to understand what the private sector is doing and the private sector might be trying to pull the wool over their eyes. I mean why would a LIFTCo want to do that?"

The same interviewee noted further that, from the standpoint, this issue was aggravated by the standard lease contracts prescribed by central government:

"Another issue is the Lease Plus agreement. The biggest change in policy that has had the biggest impact was the change in the version of the Lease Plus Agreement and that has caused us quite a lot of issues really. People talk about LIFTCo needing to be flexible but do not afford us the level of flexibility and I am not quite sure how that is reconciled at Departmental level. It is very centrally governed, it is a dictate you know, it has come down from the centre saying you will use that version of the Lease Plus Agreement ... So probably the biggest issue that we have in our LIFT companies is not having local flexibility. Having too much determined by the centre. As the relationship matures, a LIFTCo should be able to deliver a very appropriate product for the type of individual scheme that they are doing at a local level, but the paperwork does not really let you, it is very standardised at the moment."

Overall there was some indication that public and private sector interviewees felt that LIFT had yet to accomplish its full potential as an integrated procurement strategy. In addition, both public and private sector interviewees felt that LIFT, in its current form, was overly complex and bureaucratic. However, while most public sector interviewees noted that these problems could be overcome through minor modification and, in particular the introduction of Express LIFT, some of the private sector interviewees suggested that LIFT suffered from more fundamental problems. In particular, there seemed to be some consensus among private sector interviewees that, primarily due to over-regulation, LIFT eroded opportunities for flexible local arrangement and approaches.

Regarding the issues of uptake and private sector competition, there was some consensus that private sector interest in LIFT had insured sufficient participation in the bidding process. Thus the Project director of a predominantly rural PCT in the West Midlands [Proj Dir, rural W Midl] noted that even at the early stage of LIFT there was sufficient interest to allow for competitive bidding to take place. However, the same interviewee suggested that private sector participation could adversely affected by overly tight time frames:

"There was a fair amount of interest from people. We actually got down to 6 expressions of interest that were put in; two were not of a particularly good quality. I think part of the difficulty was that at that stage … it was a very tight time schedule, with 12 projects in parallel. I think that probably cut down the people who might have been interested."

While most public and private sector interviews agreed with the view that there was adequate private sector interest, they expressed doubt as to whether this would be the case in the future. This view was expressed, among others, by the Associate Director of a rural PCT in the East Midlands [Assoc Dir, rural E Midl] who made the following statement:

"I think in the past bidding was very competitive. … We were looking at the redevelopment of a community hospital and we certainly saw a lot of competition around that. We felt that we got VfM around that particular case. … I am not sure whether the competition is there now but that is a reflection of the economy, not necessarily anything to do with dynamics in the north of the county or LIFT in particular. I think beforehand we had seen the competition there."

Similarly, the Project Director of a mixed rural and urban PCT in the North West [Proj Dir, mixed NW] felt that that there was a dilemma between ensuring adequate private sector competition and controlling cost, which was likely to become more pronounced in the future:

"Where you have a LIFTCo who has a private sector partner who is a constructor, a builder, who is either the sole private sector partner or a part private sector partner, and they are also the builder of the building for LIFT, I think that that creates tremendous stresses in terms of are we getting VfM or not. I have seen a few examples where the construction prices proposed by those companies have been a problem in that they are too high, or perceived to be too high. There are some big issues there. I think they will be dealt with by the fact that, after five years, they have to be market tested and everybody is just about starting to go through that now if they have not already. Also the economy will have an impact on

this--but the problem there is that some private sector players will be reluctant, or unable, to take the risk of being involved."

By contrast to these views, several of the private sector interviewees suggested that competition around LIFT was not a major issue and that the success of LIFT project depended primarily on the level of partnership or cultural fit which could be achieved; rather than the number of competitors. This view expressed most clearly by the CEO of a LIFTCo operating in an urban PCT in the North East [CEO, urban NE] who also highlighted the importance of involving locally committed partners:

"Government ends up being overly bureaucratic to try and ensure that there is a certain outcome but at the end of the day it is about whether the bidding teams have the right cultural fit for what you are trying to achieve for your business from. 'S developer' [name of a private developer] who had a big part in that original LIFT sort of, led the team that bid to be a partner of the NHS. There is nothing he would not do for this City and the number of times he falls on his sword on commercial deals because he wants what is right and he is not going anywhere. … He wants it done right and he wants the NHS to have an improved estate and he is passionate about it and that has influenced everybody else so the whole team gets it and I have never heard anything cynical or crass coming from the supply chain."

Despite some positive comments, there was some evidence that both public and private sector users were more critical toward LIFT as a policy instrument than the policy makers and advisers interviewed in the 'key informant' subsection (with the possible exception of statements by the Law Firm representative discussed in the 'key informant' subsection). In particular there was a tendency among users on both sides to stress the issues such as complexity, lack of flexibility, bureaucracy and over-regulation which they believed to be associated with LIFT. This situation may be due to a number of factors. One possibility is that several key informants may have based their positive view of LIFT on their previous experience with PFI, while many of the user interviewees could not draw on such a comparison. Another, equally likely, explanation is that some of the key informants, particularly at government level, were unfamiliar with the relatively high level of complexity LIFT posed for users on the ground, and hence tended to underestimate the bureaucratic and regulatory burden which had been associated with this form of procurement.

4.3.2 Effectiveness of LIFT – User Views

In line with the previous analysis of key informant interviews, this part sought to gauge whether, and in what respects, LIFT users viewed the scheme as a success or otherwise. While the researchers sought to pose

questions similar to those discussed with the key informants, there was again a tendency among user interviewees to emphasis areas which differed from those discussed by the key informants. This was particularly noticeable with regards to issues such as resourcing, the length and risk associated with leasing arrangement, and the complexity and inflexibility of the procurement process; all of which appeared to be of central importance to public and private sector LIFT users.

Regarding the overall view of LIFT, most user interviewees tended to suggest that LIFT had been successful in terms of its immediate goals of procuring and improving primary care facilities. This view was expressed, among others, by the Associate Director of a rural PCT in the East Midlands [Assoc Dir, rural E Midl] who suggested that LIFT had brought important private sector skills to the PCT:

"The big advantage was that it was a means of bringing investment into the Primary and Community Care sector at a time when it was desperately needed. It has brought some skills into the NHS which we have not got probably and if I think of site procurement, site identification, putting sites together, that sort of negotiation which we did not have, to make sure we get buildings into places where we want them. It has given us a framework to take those developments forward. … I think it was a vehicle that was needed at the time, it's making its inroads and we must be at about 250 premises. … I bet if you went round all the PCTs and said, would this have been done? The answer would be no."

While agreeing with this positive view of LIFT, the Partnership Director from an urban PCT in the North West [Part Dir, urban NW] felt that the overall success of LIFT was often overlooked on account of relatively minor complaints:

"I think LIFT has been a tremendously successful vehicle. It could be more successful if we take what works well and expand that. I think it delivers reasonable value as well and it is important that it is perceived as such. People very much look at small things, like a couple of benches being in what they believe to be the wrong position, rather than focusing on what the shift has been between facilities that were in place to what is now present."

This view was echoed by the Associate Director of an urban PCT in the South West [Assoc Dir, urban SW] who suggested that the key advantages of LIFT were often too subtle to be broadly acknowledged:

"LIFT works in a certain way in terms of how the building is maintained in its best condition, in terms of who owns the building and so on and so forth. But because that is quite a subtle argument it is often lost and people still come back to the fact, well of course these LIFT buildings they are really fancy and they are really expensive."

A broadly similar view was taken by the practice manager of a predominantly rural PCT in the West Midlands [Pract Mgr, rural W Midl 1] who highlighted the benefits of LIFT in terms of improved patient services:

"*For us for this partnership has been a giant leap forward. We were in a small old house, we had completely outgrown it. We only had three consulting rooms and we had five GPs so they were hot-seating all the time. To be honest the place was falling down around us. The patients were not getting the service they deserved and it was not like a clinical environment at all in terms of contamination control and all these issues, it was extremely difficult to meet all the requirements because of the resources we had. Since we have moved we have increased surgery time and the amount of surgeries we have got going, we have extended hours and done a whole host of things, we have taken on additional services because we have the space. In actual fact we have probably got one and a half to twice the space we had in our old premises and yet we are only 9 months into this building and we want more and that is how it has been, because we now realise how we can develop and increase the services we provide and it's been great."*

Similarly a practice manager working for the same PCT [Pract Mgr, rural W Midl 1] commented enthusiastically on the additional services which had become available to patients on account of a LIFT project:

"We have taken on more patients, list size has grown. Patients have come here because they do live locally and maybe their neighbour is a patient here and oh you know they have got a lovely new building and lovely doctors and we have got lady doctors as well which some patients prefer to see a female than a male. … We do advanced access appointments so there are always appointments on the day and we do a triage service as well but these are services that we have had a long time. …. It has enabled us to increase the teaching activities so we can do more training, and the nurses do more services, they do some smoking cessation clinics and some weight clinics. We now have two healthcare assistants whereas we only had one part-time one before because our healthcare assistants can deal with things now which means that the more experienced nurses can get on with doing the more complex stuff for which they have been trained, so they can do a lot more chronic disease management, again taking that away from the GPs."

While acknowledging the overall success of LIFT both in terms of facilities procured and services offered, the Associate Director of a rural PCT in the East Midlands [Assoc Dir, rural E Midl] suggested that the effectiveness was at times adversely affected by a lack of strategic vision:

"We have got shareholding arrangements, we have got a vested interest, but LIFT needs to link to our space and our strategic plan. What we need is more of a clear joined up approach … what we cannot have is a fragmented approach across the County. I think what we need is one strategy around what is commissioned, what services do we want, what does that mean for buildings as a provider, what services are you going to provide, what is your risk profile like with your commissioners and what does that mean for the buildings? And perhaps the one way of managing the risk is to push the risk of the assets onto a third party."

Interestingly, this view was echoed by some of the private sector interviewees who suggested that it was important to take a strategic view on service needs, even if this were to lead to disagreement with the PCT. In this context, the CEO of a LIFTCo operating in an urban PCT in the North West [CEO, urban NW] noted that this process often involved reducing the size of a scheme:

"To make LIFT work you have to be very clear with the users upfront about their requirements, what they want the scheme to deliver, not what they feel like and look like but, what you want it to deliver is a first point. Being explicitly clear about challenging the requirements and driving the scheme down in size if you need to. Also really drilling down into the personal behaviours … and seeing how that can be made to work rather than assuming it will work because you want the same thing."

Arguing along different lines, the CEO of a LIFTCo operating an urban PCT in the North East [CEO, urban NE] noted that LIFT procurement was often hampered by the inability of PCT to engage in long term planning:

"Not everybody is in a position to do long term planning, and it is difficult for us to get really stuck in if we are not sure if there is going to be more than one scheme. The basis on which we are competitive and efficient for the NHS means that everybody is taking risks, all of us taking chances, not charging them too much money upfront, because we bear the cost until they have got approval basically."

In addition, the same interviewee noted that problems arising from a lack of planning were of particular concern at the early stages of LIFT procurement, as they could prevent the progression of projects:

"I cannot really spin the repeat business line with my supply chain when I do not know whether I am going to get more than one building off them. So things have to be costed and paid for because they could just take our intellectual property and run with it with a different delivery model so it s difficult to get that first scheme going. Once you have got the first scheme going, it is a lot easier but to break the cycle."

While most user interviewees were relatively positive in terms of the quantity and quality of services provided, this was not the case with regard to other issues such as resourcing, leasing and, in particular, bureaucracy.

Regarding resourcing issues, a number of public and private sector interviewees noted that lack of clarity over resource implications of LIFT projects was one of the factors that constrained effective procurement. This view was expressed, among others, by the Partnership Director from an urban PCT in the North West [Part Dir, urban NW] who suggested that involvement in LIFT had created unique resource requirements on several levels which PCTs had found difficult to meet:

"I think one of the main issues has been resourcing and we would have needed a far clearer understanding of the availability of resources. Because of this, we have compromised on a number of sites. It is important to make sure you put the right resources in the right place to really take things forward. That becomes one of the constraints. This includes, financial, human, intellectual, the whole piece."

Similarly, the Associate Director of a rural PCT in the East Midlands [Assoc Dir, rural E Midl] commented that, when compared to the private sector, the resources available to a PCT were often inferior and insufficient:

"I do not think we have been able to call on the resources that perhaps a private company would, in terms of the marketing analysis, in terms of promoting itself, advertising itself. We could have done a bit more around market sensitivity analysis, opportunities, land acquisition maybe and that type of thing. The resources we have are sometimes a little bit back room and perhaps we should push them a bit more to the forefront."

While most public and private sector interviewees appeared to agree that a lack of access to resources by the public sector could adversely affect the effectiveness of LIFT schemes, views with regard to the impact of leasing arrangements were more divided. Thus one of the public sector interviewees, namely the Partnership Director from an urban PCT in the North West [Part Dir, urban NW], suggested that she did not view the existing leasing arrangements as problematic:

"If you have located the facilities in the right place and you have done the right work upfront then a 25 year lease is not actually an issue. I think it is just working through that sensibly and understanding what the impacts are and having flexibility to deal with that … so you can change a Health Centre into an office, after 10 years."

Other public sector interviewees, like the Associate Director of a rural PCT in the East Midlands [Assoc Dir, rural E Midl], noted that the existing leasing arrangements created inflexibilities which could adversely affect future developments:

"I think we need more freedom with things like national agreements and the leases. I think the LIFTCo needs a bit more freedom to act like any other private developer. The Lease Plus Agreement and some of the lease agreements are helpful in some ways, but they probably tie their hands in another. Particularly as future providers will not want to take on big long leases. The arrangement needs to be more flexible and more competitive particularly around the smaller end of the market around primary care."

Interestingly, these views were echoed by a number of private sector interviews. For instance, the CEO of a LIFTCo operating in an urban PCT in the North West [CEO, urban NW] suggested that the length of the existing contract could become a problem once the planned provider commissioner split was implemented further:

"The length of the contract could become a problem for the PCTs. There is still some work to do in terms of how the provider commissioner splits it, because I suspect providers will not be taking 25 year contracts … and that is linked to discussions of where the Estate sits, whether it sits with the provider or commissioner arm of the organization."

Similarly, the CEO of an urban PCT in the West Midands [CEO, urban W Midl] whose misgivings about the Lease Plus arrangement have already been discussed in the previous subsection, noted that there were ongoing

problems in attracting GPs to new premises on account of inflexible and complex leasing arrangements:

"We have had one building where the GPs just dug their heels in and refused to move in. The new building would be a fantastic opportunity, but we have got a group of GPs that are steadfastly saying we are not moving in. It is because they just were not engaged in the process and given a lease by the PCT almost at the 11th hour that was 200 pages long or something ridiculous, which takes some chewing for a small business."

This view was echoed by the CEO of a LIFTCo operating an urban PCT in the South West [CEO, urban SW], who suggested that the existing Lease Plus agreement was not fit for purpose:

"The complexity that is involved in a Lease Plus Agreement is completely way beyond what is needed for the scale of development and investment that is going into an individual scheme. If our bread and butter schemes are sort of £5 million buildings, the fact that we have got a lease plus agreement that is almost as complex as a PFI set of paperwork, that might be used on a multi hundred million pound hospital, does not seem right. You know the payment mechanism is as complex, and requires as much detail to describe it and it does not feel like the balance has been got right in that regard."

The same interviewee suggested that these problems were aggravated by variations in these agreements which made it difficult for the private sector to economise on legal expenses:

"One of the key things we were looking for at the outset of LIFT was the idea of consistent contract agreements because being able to pull it off the shelf and use a deal that we have already previously agreed was the way to get things to happen quickly. But every tranche of schemes we have placed here has been on a different version of the lease plus agreement. So that benefit has just never materialised so we are always into quite expensive and long discussions with lawyers and financial advisors on every deal. Until that settles down, you will never realise that benefit which is one of the driving forces behind LIFT. Maybe it will in time, the trouble is the longer it takes before it does settle, the more the pipeline may have dried up."

While a number of interviewees expressed concerns over resourcing issues and leasing arrangement, the universally most critical comments related to the perceived inflexible and bureaucratic nature of the LIFT procurement

process. Interestingly, this issue cuts across virtually all interviews irrespective of their position and/or the timing of their engagement with LIFT.

One of the informants who strongly expressed his dismay with the procedural ballast of LIFT was the Project Director of a predominantly rural PCT in the West Midlands [Proj Dir, rural W Midl]:

"I think the steps they took with the business case approval and the new standard documentation was absolutely crass. There is no two ways about it … they were doing something which just did not reflect the type of projects we were talking about. I think where LIFT is difficult is where you do have a really small scheme which you need as part of the network, and it is a sledgehammer to crack a nut when you get all the legal stuff to go with it."

Having participated in the first wave of LIFT projects, the Associate Director of an urban PCT in the South West [Assoc Dir, urban SW] complained that there had been an initial lack of guidance to help PCTs cope with the complexities of LIFT procurement:

"One of the things we felt we suffered from was the fact that the process had not really been established. Therefore, we were having to wait for that and we went through quite a difficult period where we appeared to be being told that LIFT would not work for this sort of scheme, and that we needed to use PFI documentation. We actually lost something like a year, really, in that dialogue, and interestingly, eventually, we were told that we could go ahead with LIFT."

Although acknowledging that this situation had now improved, the same interviewee suggested that LIFT procurement still encountered bureaucratic, barriers which, at times, could only be overcome through external intervention:

"Even with a 30 million or 40 million scheme, it feels that the process is a bit disproportionate. I think everyone grapples with how do you get good due diligence and good checks and balances, without it being so big that actually it kills the scheme. There have been a few points where our scheme could have been easily killed off had it not been for some quite forceful interventions which were outwith any process."

This view was mirrored by the Associate Director of a rural PCT in the East Midlands [Assoc Dir, rural E Midl] who took a fairly pessimistic view about the future use of LIFT-type approaches:

> *"It is difficult when you have only known one model to then say whether it is good or bad … But I certainly think LIFT feels cumbersome and I think that might restrict the LIFTCo in some ways and I think it certainly restricts us. Like I say LIFTs are going through a process of trying to diversify, but I am not sure they will be able to do it. I am not sure the market is there for it and the appetite is there for something that is so cumbersome. And that would probably be the single thing for me. It needs to be a bit more flexible and it needs to be able to move a bit more and respond and react to political changes, organisational changes as well. It is always going to be a moving market."*

Interestingly, complaints about the bureaucratic burden associated with LIFT were even voiced by the practice managers who had otherwise been fairly enthusiastic about their projects. Thus one of the practice managers [Pract Mgr, rural W Midl, 1] noted that:

> *"Moving here was almost like an audit process for us. It was so in terms of registrations, patients registered and it has been the same for all the practices. Then we had to go through another audit of all the people we have on our lists again since we had to clear up certain errors."*

Lastly, all of the private sector interviewees suggested, in some way or another, that the LIFT procurement process was overly complex and bureaucratic. This view was exemplified by the CEO of a LIFTCo operating an urban PCT in the South West [CEO, urban SW] who strongly criticized existing arrangements:

> *"I think one of the failings with LIFT at the moment is it is just too damned complex. It takes too long to get what are essentially very simple buildings, well, fairly simple buildings delivered, and it should not be that difficult. So from that respect the cost of them can look high to people who are used to looking at existing buildings. … that makes it difficult for people to consider that we should be used more broadly to deliver schemes for Trusts and Local Authority and whatever else. … We are being forced to work in a system that is far too complex and therefore more costly than we would like it to be."*

Overall, there was a strong indication that both public and private sector interviewees were relatively confident that LIFT had been able to achieve its

principal goal of ensuring improvements in the quantity and quality of primary care facilities. However, both groups of interviewees tended to qualify these views with observations about the inflexibility and complexity of the existing arrangement. This consensus stands in marked contrast to the key informant interviews, where LIFT was seen in considerably more positive terms by those key informants who were associated with government as compared to others.

This relatively high level of consensus in combination with a relatively high degree of indecisiveness was confirmed by the DICTION output, which produced an unusually small number of significant scores for the non-composite variables (4 in total). Even in the few cases in which significant positive scores were identified for non-composite variables, such as in cases of 'satisfaction' for the Project Director mixed NW [Proj Dir, mixed NW], the case of 'inspiration' for the Project Director rural West Midlands [Proj Dir, rural W Midl], and 'satisfaction' for the CEO urban West Midlands [CEO, urban W Midl], the same interviewees show near-significant negative score on other relevant variables.

Table 4.7, DICTION output, User Interviews, 'effectiveness' text segments standardized scores and significance

Interviewee Prais e	Satisfaction	Inspiration	Accomplishment	Certaintyx
Part Dir urban NW	0.16	-0.43	-0.78	-0.27	0
Assoc Dir Urban SW	0.67	0.66	-0.65	0.86	0
Assoc Dir Rural E Midl	-0.54	0.29	-0.67	-0.97	0
Proj Dir Mixed NW	0.85	1.15*	-0.94	0.52	0
Proj Dir Rural W Midl	-0.98	-0.10	3.87*	-0.83	-*
Pract Mgr Rural W Midl 1	0.12	0.49	-0.66	-0.74	0
Pract Mgr Rural W Midl 2	0.60	-0.11	-0.94	-0.16	0
CEO Urban NW	-0.93	-0.68	-1.11*	-0.33	0
CEO Urban SW	-0.52	-0.12	-0.43	0.88	0
CEO Urban W Midl	0.99	4.09*	-0.98	-1.01	+*
CEO Urban NE	0.69	0.12	-0.53	-0.45	0

x As composite variable 'certainty' produces spurious standard scores and requires varying significance thresholds, therefore only the sign and significance are recorded (0=within .05 confidence interval, +=above .05 confidence interval, -=below .05 confidence interval).
~ Results omitted due to lack of data.

4.3.3 Partnership and Skill Requirements – User Views

This group of questions was aimed at exploring how interviewees viewed the development of partnerships within the LIFT context. In addition the questions of this subsection gauged user views with regard to skill requirements and skill levels among public sector managers and their impact on partnership.

On the whole there was a strong consensus among public and private sector interviewees about the importance of strong and committed partnerships in the LIFT context. In addition, public and private sector interviewees indicated that LIFT presented unique challenges to the skills of their peer group. These views contrasted markedly with those of the key informants who tended to attribute skill shortages almost uniquely to the public sector and, at the same time, presumed that the private sector was fully equipped to handle these matters. While it is possible that this difference already reflects the repercussions of the recent economic crisis in terms of declining confidence in the private sector, it is also plausible that actual involvement of the user interviewees in LIFT projects helped temper their view with regard to alleged skill differences and inequalities. The latter explanation is supported by the fact that several of the user interviewees placed strong emphasis on the need for mutual trust and respect as well as expanded collaboration and information sharing as a means for enhancing the success of LIFT schemes.

Representative of the view that partnership was essential to success of LIFT projects, the Partnership Director from an urban PCT in the North West [Part Dir, urban NW] stated that partnership involved a sharing of skills between the sectors, rather than the dominance of one over the other:

"*I think within LIFT it is a partnership and in terms of what makes a partnership work, you have got to have a common objective, you have got to have respect for each others points of view, you have got to have the ability to communicate, you have got to understand each others principles and defend those principles and you have got to have a route to resolve issues; that is the important fundamental. Once you have got that common objective then … you have got a relationship that will go forward and you can use the skills as they exist in each of the areas. I think its a little naïve to expect any one party to have all the skills. It is about partnership and sharing those skills to deliver benefits to all the partners.*"

Arguing along similar lines, the Associate Director of a rural PCT in the East Midlands [Assoc Dir, E Midl] suggested that there was not necessarily a skills imbalance but rather a skill differential between the public and private sectors:

"I worked in the private sector for two or three years before I came into the NHS. Instead of skills imbalance we should probably speak of differential skills, definitely. Different skills, different mentalities, different cultures, different philosophies … Whether that means we have got the wrong skills, culture to work with LIFT, I doubt that. … You will normally be clear what industry you are in, and the processes and transactions within that. With the NHS you have to be a lot more generalist. We have to be a lot more ready for change and we have to be a lot more used to change. Okay patient care is at the heart of it but the tools we've got and the tools we're allowed to use to get there change frequently."

Both views were supported by the statements of a Project Director from a predominantly rural PCT in the West Midlands [Proj Dir, rural W Midl] who argued that the uniqueness of LIFT posed challenges to both public and private sector participants:

"I think the private sector partners were much more used to doing commercial deals than we were. Having said that they were also having to learn about what LIFT would mean in practice … what the long term partnerships was going to be because I do not think their mode was not really partnership. Their mode was: We will do a PFI, get in, do it and then someone else will take it on so they were very much one offs. Therefore there was that exploration phase, using an analogy it was rather like creating a marriage because there was courting time and then you were making a commitment but you knew damn well that it was not just going to last for 18 months or two years, but actually you are looking at potentially 50 years plus …They were having to bring in people themselves who had that sort of community partnership type focus to give them the skills that they wanted."

This position was mirrored by the view of the Associate Director of an urban PCT in the South West [Assoc Dir, urban SW] who suggested that both the public and private sector had to expand their skills in order to deal with the challenges of LIFT partnership. Looking at the public sector side, this interviewee further suggested that the need for new skills within the public sector was best addressed through the recruitment of individuals with a private sector background into this sector:

"We have brought in someone from a commercial background to help us with that dialogue, and that has paid dividends. I have not talked to many colleagues, they may have done that themselves to start with … but I would certainly urge others to do that. I think you need someone in who is equally au fait with how the private sector works."

Arguing from a private sector perspective, the CEO of a LIFTCo operating an urban PCT in the South West [CEO, urban SW] suggested that it was important for the public sector to feel confident about the deals it was involved in. He further suggested that both external advisors and advisory organisations such as Partnership for Health played a key role in ensuring that there was an atmosphere of trust:

"The PCT would not be as knowledgeable a client as the private sector would whose main interest is understanding the commercial deal that is on the table … So there would just be a natural difference in experience because the PCT does not have a lot of people who are used to doing a commercial deal like that. When it comes to negotiating, sometimes the points that the PCT find they feel anxious about, the private sector might sometimes be surprised … The thing that the PCT rely on, apart from external advisors that it might buy in to help it, is Partnerships For Health as the custodian for the contracts and the lease-plus agreements in the first place. I think that relationship is extremely important for the PCT to feel secure in signing up to a deal and not feeling exposed."

This view was shared by the CEO of a LIFTCo operating in the North East [CEO, urban NE] who further suggested that there were significant opportunities for trust building and cost saving, if different parties to a LIFT agreement were able to share external advisors:

"Every so often we challenge and we irritate the lawyers by challenging why they have to do it in this way. We were desperate to try and save costs in the NHS. We said to them: One of our significant costs is lawyers on each deal, it i not a huge cost but in the grand scheme of things we pay for a lawyer, the bank has a lawyer, the NHS has a lawyer all working on the same contract documentation and it just seems ridiculous because actually. These deals have been done now seven times so all the problems have been worked through and it seems daft really but we were told hard and fast that we cannot … share lawyers. We were happy to go with their lawyers and for us to pay them, it was not about getting them to use our lawyers, but they just would not do it and they could not do it they said. I think another LIFTCo has done it, so these things are probably urban myths."

With regard to the issue of consultation, most of the senior user interviewees tended to suggested that their LIFT projects had provided adequate opportunities for consultation for relevant stakeholders. This view was exemplified by Partnership Director from an urban PCT in the North West [Part Dir, urban NW] who suggested that consultation was an integral part of the LIFT procurement process:

"In the past we have always taken consultation very seriously …. For the schemes we are looking at now, we have refined that engagement process and are engaging very early on with the local people about what makes sense. At the same time we are being careful that we have got some framework within which we know we can operate when we go out because there is always the risk that you get a huge list of things that you cannot deliver."

This view was confirmed by both practice managers who noted that they had considerable input during the project phase [Pract Mgr, rural W Midl, 1 and 2]. However, one of the practice managers [Pract Mgr, rural W Midl, 1] noted that this was now no longer the case:

"We do not have a great deal of contact with LIFT at all. We are kept away from that and the Project Manager sees to that side of it. I do know because the Project Manager and her team works across the road … I meet them occasionally but in relation to this build we have nothing to do with them."

Looking at these interviews as a whole, there was strong evidence that public and private sector interviewees perceived close partnerships as key to the success of LIFT schemes. At the same time, there was an indication that virtually all interviewees felt that creating strong partnership was not easy and required considerable effort from all parties. As part of this view, most, if not all, of our interviewees rejected the notion that the public sector lacked the skills to play a significant role within these partnerships. These findings significantly deviated, not only from the key informant interviews, but also from an extensive literature academic and public policy literature (Gershon, Bates) which has highlighted skill imbalances between the public and private sectors as a key problem of PPP procurement and management. Although some of this could be attributed to recent events, such as the credit crunch, which appear to have reduced the general confidence in private sector skills, a more likely explanation is that these views are reflection of the leveling effects of real world experiences with partnerships. This would fall in line with earlier research (Asenova and Beck, 2003a) which has indicated that, although the public sector often enters partnerships with less initial experience, this situation changes over time as public sector partners gain relevant experiences during the operational phase of these projects.

The DICTION output for the 'partnership and skill requirements' text segments confirmed the general impression that partnership was perceived as a problematic area that required work and effort from all parties. This was illustrated by, among others, the fact that all interviewees showed

negative scores for the variable 'inspiration' and predominantly negative scores for 'praise'. In addition, the fact that both practice managers showed significantly negative scores for 'inspiration' [Proj Dir, rural W Midl 1] and for one of them [Proj Dir, rural W Midl 1] significantly negative scores for 'praise' and 'accomplishment', could be taken as indication for the fact that this area was perceived as being particularly problematic by these two interviewees. This pattern is likely to reflect the fact that working within LIFT partnerships created particular difficulties for those operating at the ground level of practice management.

Table 4.8, DICTION output, User Interviews, 'partnership and skill requirements' text segments, standardized scores and significance

Interviewee	Praise	Satisfaction	Inspiration	Accomplishment	Certainty[x]
Part Dir urban NW	~	~	~	~	~
Assoc Dir Urban SW	-0.86	0.20	-0.80	0.24	0
Assoc Dir Rural E Midl	0.08	0.52	-0.80	0.50	+*
Proj Dir Mixed NW	~	~	~	~	~
Proj Dir Rural W Midl	-0.54	0.26	-0.50	0.87	+*
Pract Mgr Rural W Midl 1	-0.73	-0.08	-1.11*	-0.01	+*
Pract Mgr Rural W Midl 2	-1.85*	-0.05	-1.20*	-1.72*	0
CEO Urban NW	-0.03	-0.11	-0.33	-0.13	0
CEO Urban SW	-0.15	0.09	-0.35	1.54	+*
CEO Urban W Midl	-0.76	-0.19	-0.70	0.33	+*
CEO Urban NE	0.34	0.23	-0.50	-1.02*	0

x As composite variable 'certainty' produces spurious standard scores and requires varying significance thresholds, therefore only the sign and significance are recorded (0=within .05 confidence interval, +=above .05 confidence interval, -=below .05 confidence interval).
~ Results omitted due to lack of data.

4.3.4 Cultural Issues and Conflicts – User Views

Following the layout of the 'key informant' subsection, this brief analysis focuses primarily on issues of cultural conflicts and conflict management in LIFT projects; with the topic of cultural differences and diversity being discussed in greater detail in section 5 ('Managing Cultural Diversity in LIFT Partnerships'). Due to the relatively brief statements which the

interviewees made with regard to this issue, a computer aided content analysis has been omitted from this section.

Representative for several other public sector interviewees, the Associate Director of a rural PCT in the East Midlands [Assoc Dir, rural E Midl] suggested that differences in value orientation between public and private sector organizations were not necessarily a source of conflict. However, this interviewee felt that the public and private sector had to deal with different types of uncertainties which could create difficulties in goal alignment:

"I am not sure whether the fact that we have got very different goals and different aims creates conflicts. I also could not say whether it has any impact on LIFT really. … In a private company you have always got the risk of the marketplace but you can set yourself a plan based on influencing factors of the marketplace. In the NHS we can set ourselves a 10 years plan based on the influencing factors of the marketplace, but we are always going to have to take account of the political agenda. We can see that at the moment with the credit crunch on. Obviously this affects the private sector … but there are political agendas and that makes it difficult to predict our policies."

This view was echoed by the CEO of a LIFTCo operating an urban PCT in the South West [CEO, urban SW] who argued that it was important for both sectors to recognize the uncertainties and resource constraints they faced:

"The way the partnership comes out is how you deal with issues and problems. Both parties do need to respect the others position. The private sector does have to respect the difficulties that the PCT is working with; all the issues of the NHS where policy changes are the law and wholesale changes in the organisation come round very quickly. At the PCT, as much as we would like them to prevent policy changes coming through which affect the way that we are working with them, we have to understand that they cannot do that. So we have to respect that they have got limits to what they can do. The PCT also has to respect the commercial pressures that we are under to deliver a scheme to them, to maintain it, to keep it in good condition and to be able to make decisions about what represents VfM. That means understanding principles of business beyond what an individual brick might cost. It is about understanding complex deals … how the costs are developed and how those costs and providing a reasonable return to investors is important in making sure the deal goes ahead at all. It has got to work both ways and you do need that respect and understanding."

Focusing on the issue of conflicts, the CEO of a LIFTCo operating in an urban PCT in the North West [CEO, urban NW] similarly suggested that the constraints which both sectors faced was often the root cause of debates. The same informant further suggested that these issues could be resolved within strong partnerships by focusing on possible resolutions:

"Some of the constraints we are facing, in terms of external directives and financial resources, certainly will lead to concerns and debate but that is where the partnership has to have a framework for resolving that conflict. So you have to build that trust and that trust bounds you. You have to say right, we recognise that constraint there, but we want to find a resolution that can be explored in terms of parties involved."

Following a similar line of argument, the Associate Director of a rural PCT in the East Midlands [Assoc Dir, E Midl] suggested that there were no inherent conflicts between the private sector partners and PCTs as long as all parties had an interest in ensuring future growth:

"It is just a fact of life in business that you have to make a profit to keep a business working properly. In the discussions we have had about the business plan for LIFTCo with the PCTs, everybody wanted the LIFTCo to remain as an entity which is growing and right for the future. … We know that the number of LIFT schemes will slow down in the next three years, but we want the LIFTCo to stay as a vital organisation, growing and changing rather than rather than just being a company that just looks after the existing buildings."

In highlighting the issue of resource constraints, several informants implied that there was a possibility that the joint management of LIFT schemes would become more difficult in the future when planned changes were implemented or constraints became more pronounced. This view was expressed explicitly by the Associate Director of a rural PCT in the East Midlands [Assoc Dir, rural E Midl] who suggested that:

"We are seeing a big push for lots of diversity and polarity of providers. I think that presents them with problems as well, because traditional providers are going to be a lot less prepared to take risks. I think they have to be more flexible to meet demands of commissioners and they have to be more flexible to tender for services and be prepared to even risk losing services. I really don't think that will work in LIFT's favour either. All of this could give rise to new types of conflicts which we are not prepared for."

Although there was a broad consensus that the current governance structure of LIFT projects provided for adequate means of conflict resolution, this was not necessarily the case with regard to conflict resolution mechanisms at the ground level. Thus one of the practice managers [Pract Mgr, rural W Midl, 1] noted that:

"Other than talk there are no mechanisms in place for conflicts resolution. We also have not had an official building meeting. Our steering group, when we were the steering group prior to coming in here, is now going to form up under another title. I am not quite sure what it is yet, and I think we are due to meet for the first time because they said they would let things settle down and there would be problems initially. If we have the meeting too early it would not give them chance to iron out."

Overall, there was some indication that most senior user interviewees felt that the governance structure of LIFT schemes provided for adequate means of conflict resolution. However, these views were often tempered with the proviso that this situation could become more unstable and difficult on account of future constraints faced by both the public and private sectors. In addition, the small number of practice managers who were interviewed in this context indicated that they were not necessarily satisfied with existing provisions for conflict resolution and noted that the creation of appropriate committees had been delayed.

4.3.5 Targeting and Local Impact – User Views

Following the structure of the key informant interviews, this subsection analyses the views of user informants with regard to the targeting and local impact of LIFT. Specific areas of interest included how users viewed willingness of the private sector to invest in areas where potential returns from property may be limited. In addition, the team sought to investigate the perceptions of interviewees with regard to the local impact of LIFT projects.

It should be noted at the outset that a number of user interviewees chose not to comment on issues of targeting as they felt that their knowledge of these areas was limited. However, this was again largely compensated for by the full and nuanced statements made primarily in particular by those users who had experience with multiple or heterogeneous localities. Due to the limited number of interviewees commenting on this issue, a computer aided content analysis has been omitted from this subsection.

Working in a city with large wealth differentials, the Associate Director of an urban PCT in the South West [Assoc Dir, urban SW] noted that his PCT had

made a concerted effort to locate LIFT projects in the most deprived areas. Specifically, this informant suggested these location choices had been self-evident on account of the fact that these areas also had the poorest buildings:

"The poorest buildings were in the poorest areas anyway, and our city its often referred to as two cities in one in the sense that there are some very affluent areas, and some very poor areas with some of the highest indices of deprivation that you will find nationally. So, on the whole, in fact all four of the buildings are on the sites of the buildings they replaced, because the buildings were largely in the right place."

This view was mirrored by the Associate Director of a rural PCT in the East Midlands [Assoc Dir, rural E midl] who suggested that targeting deprivation had not only been a key but also continued to inform ongoing activities:

"Certainly as we have thought about our commissioning strategy, health inequalities has been our number one priority. Now that knocks on to our estates strategy or how we want our providers to look and we want them to do …"

Further on in the same interview, this informant qualified his view by explaining that the effort to target deprivation within his old PCT was probably less obvious now as it had been merged with a rural area:

"For the old PCT deprivation was a key factor. If you look now at our new PCT … you would probably think well why did you do that? But for that particular locality at the time it was the right thing to do."

While discussing the complexities the merger of PCTs had created for his area, the same informant noted that that the rurality of the new PCT created particular challenges in terms of commissioning:

"Rurality … is a challenge for us, we have to take account of our rurality, you look at the diversity of our population and you look at the inequities in our population all of which creates challenges to us as a commissioning organization. … We have not got any big urban areas. Obviously one large city … and if you look at the LIFT schemes that is probably where they have benefited most from the volume. But in terms of need, the County would have presented many opportunities."

These views contrasted to some degree with those of the Project Director of a mixed rural and urban PCT in the North West [Proj Dir, mixed NW] who suggested that his PCT had taken issues of deprivation into account but noted that the characteristics of the existing estate had also played a role:

"Deprivation played a big role, but I think the other aspect is assessing the quality of existing stock, existing estate. It has always been a bit of a combination of deprivation, having to improve health, having to change services to help make people healthier and prevent illness. … In a lot of cases in our area the quality of the estate has been very poor and there has been a lack of investment historically and also hardly any money put into maintenance. So those two features alongside an increased budget have really enabled the PCTs to start moving."

Addressing the issue of developing LIFT projects in deprived areas, the Project Director of a predominantly rural PCT in the West Midlands [Proj Dir, rural W Midl] noted that involving the local population of such areas often posed particular difficulties:

"To give them that vision and start saying it will be different and, yes, there is some trauma to deal with; like we have just knocked your pub down. I think in … deprived areas, people have got low expectations about what they can get. It is important to raise their expectations and get them to realise there are ways of doing things and getting involved in the process and engaged in what is happening. The other partners also have to get involved in that."

Speaking from the private sectors perspective, CEO of a LIFTCo operating in an urban PCT in the North West [CEO, urban NW] noted that deprivation and need had been a central criterion for LIFT procurement. However, the same informant further suggested that he had observed that exceptions to this could be made where PCTs saw unique opportunity for development:

"Deprivation and health need is always on top of the list. There are schemes that come up that may not score highly on those premises but are opportunistic, you know, if there is a very exciting scheme and we might be able to engage with sports or engage with leisure. Then clearly we do not rule that out, but ultimately GPs and deprivation and health need is the PCT's top priority."

The same informant further discussed his belief that deprived areas in particular benefited from integrated design of LIFT facilities and stressed his

company's efforts to promote facilities which promoted joint service provision:

"The projects we have done in our city are full Joint Service Centres. We opened a scheme a matter of weeks ago. There is one reception, one building, a library, one stop social services, the waiting area is library space … It is a total sea change in how we have done the buildings. The library is the obvious way for drawing people in routinely. If the Council do not want a library in that locality, we are still looking at how do we make that a non clinical or non institutional environment, and how do you draw people in on a more routine basis."

Arguing along similar lines, another CEO working in an urban PCT in the South West [CEO, urban SW] argued that some of the opportunities for joined up development had not materialised for a number of reasons. These reasons included, among others, GP resistance, the lack of availability of suitable land and competition with residential developers in inner city areas:

"With regard to deprivation, there are some big opportunities that have not necessarily been tackled yet. I know when we were trying to get the first schemes … we went to some of the more deprived parts and we were talking to GPs in Health Centres owned by the PCT. Sometimes it was a real struggle to convince the GPs that they wanted to be part of LIFT. … There were opportunities discussed with certain schemes which did not go ahead … because it was difficult in the time that was available to get buy-in from the GPs to take part. … There are undoubtedly still some very high priority schemes out there which have not been tackled yet for various reasons … such as that there is not the land available to actually redevelop on. There are pressures, particularly in inner city areas where land, any free land could be sold for residential. We are always competing with residential property prices at well over a million pounds an acre even in more deprived parts."

In addition, the same informant noted that the cost of land in these areas created affordability issues which could adversely affect the targeting of these areas:

"Even before anything else, the cost of putting a new facility in is pretty high and there is no answer to that in terms of being able to deal in reduced land values. Even if it is PCT owned land and they have to sell it to the LIFTCo, they still have to sell it at market value which means I have to charge them a rent having bought the land off them at market value. That is an expensive way to proceed. That is part of the accounting rules,

which I understand why they are there, but it makes it more difficult to make these deals work. Again there is always a principle behind LIFT that we could do more third party development to offset some of these costs, which you can only do if there is sufficient land available to build extra houses on, and we have never found a site that is big enough to do anything other than put the Health Centre on with the parking it needs and put a pharmacy in there."

Further on in the same interview, this informant suggested that having targeted inner areas had created uncertainties which primarily affect the PCT:

"The private sector has not struggled to invest in any of these schemes because it has taken the PCT as the main tenants so the covenant strength is through the PCT being able to pay the rents. The difficulty is more about making it affordable for the PCT. Trying to maximise the residual value that we are demonstrating in each scheme that we build is something we have to work quite hard on. But it is guesswork, you know, what is the worth of that piece of land in 30 years time. It is whatever we can convince the bank that they will take a risk against lending us against a preferred value. There has not been any issue about the private sector wanting to invest, it is more trying to make it affordable for the PCT."

Despite critical comments regarding the problems of targeting deprived areas in inner cities in particular, there was some consensus among public and private sector user interviewees, that where LIFT projects had been successfully developed, this had typically resulted in significant benefits in terms of regeneration. Positive statements about these benefits, moreover, were made by informants working in both rural areas with only one or two interviewees stating that they lacked the information to comment on this issue.

One example of informants highlighting these benefits included the Project Director of a mixed rural and urban PCT in the North West [Proj Dir, mixed NW] who noted that new LIFT buildings had had a major positive impact on formerly deprived areas:

"*Our new buildings have hugely contributed to regeneration. There is one example where both the existing old health centre and the library were in a very deprived shopping area and it was appalling. The whole lot was terrible. We have put the new health centre there and it has made a massive difference to regenerating that area. Off the back of it, the LIFT are bidding to be the developers to redevelop all the shops. In another area we were able to develop a health facility adjacent to a primary*

school, link the two things together with a sort of drop off centre like a campus which has made a big difference to regeneration. Anywhere we did a facility this has contributed in one way or another to the regeneration of a deprived area."

When queried about the issue of employment generation, several informants noted that number of additional local jobs created by these jobs had perhaps been small, but that the economic benefits of this should nonetheless not been underestimated. This view was again exemplified by the Project Director of a mixed rural and urban PCT in the North West [Proj Dir, mixed NW] who recalled how the creation of new facilities had led to recruitments form the local population:

"*There are some good examples of our contractors using local employment during the construction phase so they could potentially be short term. But nonetheless they have taken on a few trainees as well. I do not know if they have stayed with the company but the fact that they took them on and helped to train them up is great. There will be some other small elements of local employment and perhaps extra receptionists or staff to work in the new centres. Although it tends not to be loads of new jobs because a lot of people relocate from other facilities, but you will get the odd couple of jobs. I recall some of the parents dropping kids off at the school adjacent, when they knew the new facility was going up, they turned up and knocked on the site office to say have you got a job? One of the ladies turned up in her nightie with her slippers on and got a job--she must have been quite impressive--as a receptionist for the building site. That has happened on quite a few occasions and there have also been jobs with security as well because security firms recruit local people."*

While generally very positive about these developments, the same informant noted that the recent economic downturn had made things more difficult and stated that he was unsure whether other planned developments would go ahead:

"It has been slightly messed up, that second part of the project, because of the change in economic conditions. Macroeconomics meant that the land values have all changed so it has not gone as fast as it should have done to regenerate the shops because the people who were going to develop the shops, the land values changed. So it is extremely difficult."

These comments were mirrored by several of the private sector interviewees, who, like the CEO of a LIFTCo operating an urban PCT in the West Midlands [CEO, urban W Midl] noted that the investment of their company had been closely aligned with the activities of the LA:

"Our investment has targeted the most deprived communities that have the poorest health outcomes, that have got the poorest economic indicators, totally aligned with the investment that the Local Authority is making in housing. So there is no area of the City … where the Local Authority is not developing with us. The strategy is about joint investment into those areas and that is why it makes so sense. … It has been a very logical public health based series of investments that we were making where primary care was poorest in terms of supply, highest degree of single-handed practices, all the usual kind of stuff you would expect to see. There is a real logic behind what we are planning to do and it makes it quite easy to deliver as a LIFTCo. We believe in the logic, and we can already see the value that that is bringing."

Overall there was a broad consensus that LIFT projects had been targeted to the areas most in need of investment. These views, however, were tempered by the observation of some public sector interviewees that targeting had become obscured through PCT mergers which had change the boundaries in which LIFTCo-s operated. Similarly, on the private sector side, interviews operating in areas of high and growing land value noted that their situation could militate against the targeting, or affordability of LIFT schemes. Lastly, several interviewees stressed the adverse impact the economic downturn was already having on the development of planned schemes and, in so doing, highlighted the vulnerability of these projects to complex macro and micro economic factors.

4.3.6 Value for Money and Related Financial Issues – User Views

This group of questions was aimed at exploring issues relating to VfM for money and other financial issues associated with LIFT. Specifically, the users interviewees were asked whether they perceived LIFT projects as providing for money, or otherwise, and which evidence they could cite in support of their views. The informants were further asked whether they felt that there were difficulties in evaluating the VfM aspects of LIFT projects and, in particular, whether it was appropriate to draw comparisons with non-LIFT projects. Lastly, the key informants were asked to describe the potential impact of LIFT on issues of affordability.

As in the case of the key informants, the user interviewees tended to agree that LIFT schemes provided VfM, but qualified their views with statements about difficulties in measuring this purely in cost terms. This view was exemplified by the Partnership Director from an urban PCT in the North West [Part Dir, urban NW] who emphasised the advantages of LIFT schemes in terms of service delivery:

"Yes I think our buildings are VfM. I think if they were not affordable they would not happen … I think there is always a question as to how you measure value. When you are looking at value, the first thing people tend to look at--because it is quite tangible--is cost. That is clearly a very important element but if you were to look at some of our recent schemes. We have just opened two joint service centres, which I think if you looked at the actual base cost, you would say those are expensive. I think you need to look at … what the buildings are, what they are doing and how they are bringing together services. It is a true partnership between the PCT and the City Council, the building will become one facility, one joined up facility for the delivery of services that will benefit the community in terms of library, internet café, council services one stop shop, GP services, rehabilitation facilities, audiology, dentistry, etc. And when you see a building that is completely integrated, when you see as you walk in, it is not about services that just happen to be co-located, it is about the operation together connected, you walk in at reception and you can book an appointment with your GP and check out a library book at the same time. That is fantastic and people have got one staff room, and understand what else is there in the building, how one service might support the other services and the opportunities for cross referrals."

This view was echoed by the Project Director of a mixed rural and urban PCT in the North West [Proj Dir, mixed NW] who argued that the VfM of LIFT projects had to be assessed in relation to the additional benefits these projects provided:

"I think one of the problems with LIFT is that when you look at some of the headline figures for lease costs per square metre, or how much a building is costing per year, a lot of people try to relate that to other commercial buildings that they have got … or compare it to third party developments like GP practices and they say wow that is a lot more money. So there is an education issue around about what LIFT includes compared to other schemes and the LIFTCo need to be in a position to break that down and say, this third party development here is different to what the LIFT building is because of X, Y and Z. There are all sorts of extras you get, all the maintenance is included, law changes are included, you get insurance and the specification of the building will be higher as well."

Similar views were expressed by some of the private sector interviewees, who, like the CEO of a LIFTCo operating an urban PCT in the South west [CEO, urban SW], argued that debates over VfM often overlooked the benefits of LIFT projects in terms of improved maintenance and improved services:

"VfM is not easy to measure, because there are many different views about what value you are trying to deliver. You could say that there is VfM in terms of that if you did not build it through LIFT, it would not get built at all. It is sometimes difficult for the PCT to understand VfM in terms of we are providing a building where we are taking the risk on the maintenance and lifecycle costs for 30 years. So we have to show what our costs are in their plan and the PCT would not typically think about budgeting maintenance costs for any of its buildings for that period of time. They do not really have a concept of whole life cost and … typically look at comparing it with what they currently spend on a building. … Overall, the total cost of putting the building up is outweighed by the cost of operating that building over 25 years by at least, you know, 5 to 1 or more. … I think all of those things need looking at. How are you going to measure that? You can measure it in the cost of bricks, but really what you want to measure is health outcomes. How on earth do you do that?"

Arguing along similar lines, the Project Director of a predominantly rural PCT in the West Midlands [Proj Dir, rural W Midl] suggested that the prerequisite of VfM in LIFT projects was that existing opportunities were fully exploited and the buildings were adequately maintained in the future:

"LIFT is VfM, if you have the means to get the GPs making good and positive use of it, and the PCT services making good and positive use of it and ensuring that that buildings assets are sweated. I mean we provided for the fact that it would be open 70 hours a week in the first instance. One of the other bits which relates to VfM is that, no matter what happens with public sector budgets, you can guarantee those buildings are going to be maintained. Providing you have got a good maintenance bit in your contract, you can guarantee it."

While agreeing with the notion that measuring VfM was difficult, the Associate Director of a rural PCT in the East Midlands [Assoc Dir, rural E Midl] suggested that it was difficult to evidence this beyond the formal approval process:

"We have very set and strict processes around any business case regardless or whether it is LIFT or not and we will go through the same process … we will go to outline business case, full business case, we will do the work to ensure we are getting VfM for patients and so on and so forth. Even the smaller schemes LIFT have done for us have gone through a similar process, obviously on a smaller scale. We have also heavily involved our own estates department who had the experience … But whether LIFT itself represents VfM that is the thing I am still unsure of. There are intangibles in the Lease Plus Agreement and we need to see in 5 years how that is working and how much benefit it has given to us

because I guess you could almost do a discount and cash flow … There is certainly a perception out there around the VfM issue. But to be fair to them, I am not so sure we have ever evidenced it. We can certainly show to the public that we have met our processes and ticked our boxes around VfM but about LIFT itself I am not sure."

While most of the public sector interviewees expressed some concerns over costs, this was not necessarily the case with the private sector interviewees. Thus, several private sector interviewees suggested that cost issues were mostly attributable to a lack of clarity or excessive ambition on the side of the public sector client. This view was exemplified by the CEO of a LIFTCo operating in an urban PCT in the North West [CEO, urban NW]:

"When you are absolutely clear what you want and absolutely clear what it should deliver, there is no reason why LIFT cannot do that for you. Some of the issues that have been attached to LIFT are not LIFT issues. They are about people not understanding what they are asking for, like asking for a Landmark building when they do not actually want one. I know of an example where they ended up with a huge atrium which was costly and unnecessary."

This view was mirrored by the CEO of a LIFTCo operating an urban PCT in the West Midlands [CEO, urban W Midl] who suggested that it was often the private sector which encouraged the adoption of cheaper solutions:

"If you specify a tin shack, the market will give you a price for a tin shack. It depends what you want. … We are constantly saying to PCTs that we think there is a cheaper alternative you could consider which would not give you a worse outcome. It would give you an equal standard but it's a cheaper alternative. We are constantly having that dialogue as we develop these buildings. We go to the construction market with every single project, which is quite labour intensive but it does give you sharp prices that are very open and transparent, you know they are there on the table--so they can make the right decision."

Another private sector interviewee, the CEO of a LIFTCo operating in an urban PCT in the North East [CEO, urban NE], suggested that there was a possibility that once all costs were considered, LIFT schemes were actually cheaper than older facilities:

"I think you pay for what you get. I think the reality is that the NHS does not really know what it is paying for its shoddy old stock and a few LIFTCo-s have now done comparisons and found LIFT to be cheaper

actually. Whether you agree with the inputs is another issue. I think the problem for Local Authorities is that they do not necessarily know what they are paying for … because they are paying through dozens of budgets."

However, in further discussing the issue of cost control, the same interviewee suggested that perhaps not all LIFT companies were similarly cost conscious and noted that much of this had to do with the specific relationship the company maintained with a socially responsible local building firm:

"I know that some of my peers in the LIFT network have entirely different relationships with their shareholders and their construction arm. … I worry about what will happen if we choose a different firm … So far we had a consensus that, if we keep doing a good job for the NHS and we are getting the best deal, we will have repeat business. But I do not know what happens when people are in it for the quick buck."

Although most interviewees avoided discussing the potential adverse effect of shareholders on the cost of LIFTs in any detail, there were several public and private sector informants who, like the previously quoted interviewee, touched on this issue. On example of this was the Project Director of a mixed rural and urban PCT in the North West [Proj Dir, mixed NW] who implied cautiously, that there was a temptation for shareholders to push for 'healthy' returns especially in the early phase of a project. This informant therefore argued that it was advisable to approach the issue of shareholding and contract awards cautiously:

"*I can see a lot of logic if the private sector partner is not the shareholders, the private sector shareholders are not the construction company or they may be but you do not use them at the outset as the builder; that is a much better situation to be in, I think. Our own situation is like that: We have not got a builder, we use mid-size construction company and we are quite happy with it, as we have been able to reduce the construction costs which is probably almost unique in LIFT. If they would have been a shareholder, it might have been a different story. So I think that is a big issue for LIFT."*

Another, perhaps less important, financial concern which was raised by some public sector interviewees related to the issue of billing delays. This issue was discussed, among others, by the two practice managers working for a predominantly rural PCT in the West Midlands [Pract Mgr, rural W Midl, 1 and 2]. Thus, one of these practice managers [Pract Mgr, rural W Midl, 1]

noted that delays in billing had made it impossible for him to assess costs and forced him to speculate about future expenses:

"I cannot give you any detailed information on costs because we have not had any bills yet. I am putting aside money to meet all our expected costs but I would think that cleaning services would be on a par … In relation to telephones, I would expect to make a saving there because we had our own exchange if you like, and we were direct customers with BT whereas here we are taken in on the bigger scheme of things and it's all networked and all works with computers as well so… so I would expect to see a saving there. As for utilities it remains to be seen. Bit scary on that one …"

Upon further prompting, the same practice manager noted that this problem had persisted for some time and was shared by other practices in the area:

"*We have gone eight months now and we have not a clue what the utilities is going to be. I am putting aside money every month because I have got no choice but I think that when you speak to my colleague this afternoon, she will tell you that she has been in there for about 18 months, and she still has not got any bills in relation to some services … I cannot really understand what the problem is or what a lot of the delay is, they must be paying the bills because the electric company and gas company do not keep pumping it in, do they, unless they are receiving payments."*

In addition, the same practice manager noted other concerns over a lack of control over expenses, which arose in connection with shared areas:

"On a number of occasions I have lodged a complaint if you like about the temperature of the waiting room downstairs because that has just been roasting hot and we are trying to sort of keep our place at a nice workable temperature, because at the end of the day I will pay an element of that bill. The bill for the whole building will be taken and then it will be apportioned by space. So there is an issue there."

This view was echoed by another practice manager [Pract Mgr, rural W Midl, 2] who also had not received service bills for a lengthy period:

"*I have no idea whether these premises are reasonable financially. We are almost two years on and we still have not had our first year's service charges … I do not quite know why the hold up is, we have been asking them hundreds of times. … Previously we just paid our own phone costs*

and phone maintenance, so that is something now that comes within our service costs. We had to do some clever budgeting really and do best guestimates of what we think it is going to cost. We always knew it was going to cost us more money."

Taken together, these interviews gave a very mixed picture of how LIFT users perceived the VfM aspects of their schemes. While the majority of public and private sector LIFT users, with the exception of the CEO of a LIFTCo operating in an urban PCT in the North East [CEO, urban NE], appeared to acknowledge that these projects were potentially more costly than conventional buildings, they typically attributed this to improved service delivery and/or maintenance. However, even where these provisos were made, several informants suggested that it would be difficult to evidence the benefits of LIFT quantitatively; beyond assurances that existing procedural guidelines for VfM for money exercises have been followed. In addition, at least some of the informants felt that the desire of shareholders to secure adequate returns particularly during the early years of a scheme could adversely impact on the costs of LIFT projects. Lastly, our admittedly small and potentially unrepresentative sample of practice managers highlighted concerns over delayed billing.

These patterns are roughly confirmed by the respective DICTION output which shows significant negative scores for a number of variables and respondents. These include the Practice Manager Director working for a predominantly rural PCT in the West Midlands [Pract Mgr, rural W Midl 1] for the 'praise' variable; the Project Director working for a rural PCT in the West Midlands [Proj Dir, rural W Midl], both Practice Managers working for the same PCT [Pract Mgr, rural W Midl, 1 and 2] and the CEO of a LIFTCo operating in an urban PCT in the North West [CEO, urban NW] for the 'inspiration' variable; the Project Director of a predominantly rural PCT in the West Midlands [Proj Dir, rural W Midl] and the CEO of a LIFTCo operating an urban PCT in the North East [CEO, urban NE] for the 'accomplishment' variable.

Table 4.9. DICTION output, User Interviews, 'value for money and related financial issues' text segments, standardized scores and significance

Interviewee	Praise	Satisfaction	Inspiration	Accomplishment	Certaintyx
Part Dir urban NW	0.30	-0.25	-0.43	.020	0
Assoc Dir Urban SW	0.23	0.56	-058	-0.48	0
Assoc Dir Rural E Midl	0.17	1.54*	-0.62	-0.04	0
Proj Dir Mixed NW	0.25	-0.23	0.14	0.54	0
Proj Dir Rural W Midl	-0.44	0.40	-1.56*	-1.14*	0
Pract Mgr Rural W Midl 1	-1.05*	0.14	-1.11*	-0.70	0
Pract Mgr Rural W Midl 2	0.15	0.38	-1.01*	-0.42	0
CEO Urban NW	0.12	-0.27	-1.07*	0.15	0
CEO Urban SW	-0.08	-0.43	-0.85	1.29*	0
CEO Urban W Midl	-0.12	0.77	-0.60	1.52*	0
CEO Urban NE	-0.28	1.15*	-0.84	-1.06*	0

x As composite variable 'certainty' produces spurious standard scores and requires varying significance thresholds, therefore only the sign and significance are recorded (0=within .05 confidence interval, +=above .05 confidence interval, -=below .05 confidence interval).
~ Results omitted due to lack of data.

Meanwhile the number of significant positive scores is much smaller, including the Associate Director of a rural PCT in the East Midlands [Assoc Dir, rural E Midl] and the CEO of a LIFTCo operating an urban PCT in the North East [CEO, urban NE] for the 'satisfaction' variable; the CEO of a LIFTCo operating an urban PCT in the South West [CEO, urban SW] and the CEO of a LIFTCo operating an urban PCT in the West Midlands [CEO, urban W Midl] for the 'accomplishment' variable.

The notable feature of the DICTION scores is the lack of consistency horizontally by respondent. Most see some positive and negative aspects of LIFT in VfM terms. Reconsidering the quoted evidence above in conjunction with the DICTION evidence, it would appear that respondents might be positive about the process but not about the outcome, or vice versa (contrast praise and inspiration with satisfaction and accomplishment respectively). For example, the urban CEO's are satisfied but not inspired, and satisfied but not praiseworthy suggesting they are happy with the outcome but not the process.

Complicating this pattern is tentative evidence of a spatial divide in opinions concerning VfM. Rural respondents (such as Rural West Midlands) were significantly negatively disposed to their scheme's accomplishments compared to the significantly positive results for at least some of the urban respondents. Urban NE is the only exception to this, where the respondent took a negative view of accomplishment, but was nonetheless significantly positive about satisfaction. A possible reason for this divergence of views is evidence that urban practices deliver services at lower cost per patient than rural practices as a result of their greater capacity to combine GP practices in a single location (see subsection 6.3).

4.4 Stakeholder Views: Concluding Remarks

The previous subsections indicated that key informants and user interviewees tended to differ in how they view the partnership aspects and cultural issues surrounding LIFT. Specifically there was evidence that key informants viewed cultural differences between the public and private sector, as well as a potential lack of commercial skills within the public sector as a more severe impediment to partnership working than user informants did. This pattern suggests that many PCTs may indeed have indeed coped successfully with many of the challenges as well having been able to learn from these partnerships. This finding would contradict some of the earlier literature on partnership working which has suggested that PPPs continue to be hampered by skill differentials and resultant inequalities in bargaining (see e.g., Broadbent, Gill and Laughlin, 2003; and also Pollock, 2004) while confirming earlier research which has highlighted the learning abilities of the pubic sector (see, e.g., Asenova and Beck, 2003a). These issues are therefore examined further in section 5, which analyses the cultural characteristics of LIFT projects in greater detail with reference to categories such as *synergy, segregation, domination* and *breakdown.*

As far as VfM was concerned, there was considerable uncertainty in the responses. For many, VfM was beyond quantification either because outcomes could not be measured or because they lack the means to compare like with like. Several users were pleased with their new facilities, but at the same time felt that they had accrued perhaps significant and as yet unknown costs. One reason for this is was a pattern of delayed billing, which may have been a function of financial arrangements between LIFTCo-s and PCTs aimed at enticing practices to subscribe to the new arrangements. As far as LIFTCos and PCTs are concerned there was little evidence of delayed billing, indeed as discussed in section 6 later on, LIFTCo revenue had built up faster than anticipated in the first three years of operation. A possible explanation is therefore that PCTs either induced delayed billing or lacked of capacity to cost accurately. Overall, considering that LIFT is fundamentally a financial vehicle, the lack of concern with cost from most of the informants was surprising. In view of the concerns raised by the Public Accounts Committee as early as 2005 about the lack of quantitative evidence concerning VfM (see subsection 6.2), a similar lack of awareness from key stakeholders and end users can only add to these

problems and ultimately calls into question the long-run financial viability of the scheme or its suitability for more widespread implementation. In summary, whilst there is some evidence of satisfaction with the benefits, there is a disjuncture with costs, such that VfM is not well understood. The question of VfM therefore remains an important topic for research, which is explored further in section 6.

Managing Cultural Diversity

5.1 Background

NHS LIFT companies are local joint ventures between private sector property development agencies, local health services, local authorities and central government (Partnerships for Health), bounded by a long-term partnering agreement to deliver investment and services in local primary care facilities. Unlike traditional public–private partnerships, public sector partners are active, responsible and accountable members of the private company and are shareholders and directors of that company in their own right. LIFT projects, therefore, represent a complex of interest groups brought together to serve a common purpose.

The public and private organisations which comprise a LIFT partnership each have their own distinctive norms of behaviour, shared values and acceptable working practices--ultimately different organisational cultures. Previous research has identified the many ways in which culture can create barriers to collaboration between organisations, and yet how, at the same time, the knowledge and repertoires embodied in cultures can provide a valuable resource for relationship building and partnership working (see, e.g., Asenova et al., 2002).

This section explores the role of culture in facilitating (or impeding) successful LIFT partnerships. Firstly we unpack what is meant by organisational culture and introduce some of the key concerns with using a cultural approach to understanding inter-organisational relations. We then explore key informants' views on how culture affects LIFT partnerships, drawing on freshly collected qualitative data, before going on to examine how cultural diversity has been managed in four LIFT partnership case studies.

5.2 The Nature of Organisational Culture

The notion of 'organisational culture' became prominent in the management literature of the 1980s and has increasingly found its way into the discourse of those who advocate organisational change in health systems. Notwithstanding its widespread use by researchers, managers, and policymakers, the concept of organisational culture has no broadly agreed meaning and is far from being conceptualised universally (Alvesson, 2002). For example, Ott (1989) lists 74 elements of organisational culture which have been put forward by various authors, while a review of the organisational culture literature by van der Post et al. (1997) identified over 100 dimensions of culture. Any such definitional problems are confounded

by the fact that there is little agreement on the meaning of either of the underlying concepts, 'organisation' or 'culture'. For example, a critical review of dimensions associated with the term 'culture' by Kroeber and Kluckhohn (1963) identified 164 unique definitions of the term, the overall number almost reaching 300.

In broad terms, the study of organisational culture focuses on that which is shared between people within organisations, for example:

- beliefs, values, attitudes and norms of behaviour
- routines, traditions, ceremonies and rewards
- meanings, narratives and sense-making.

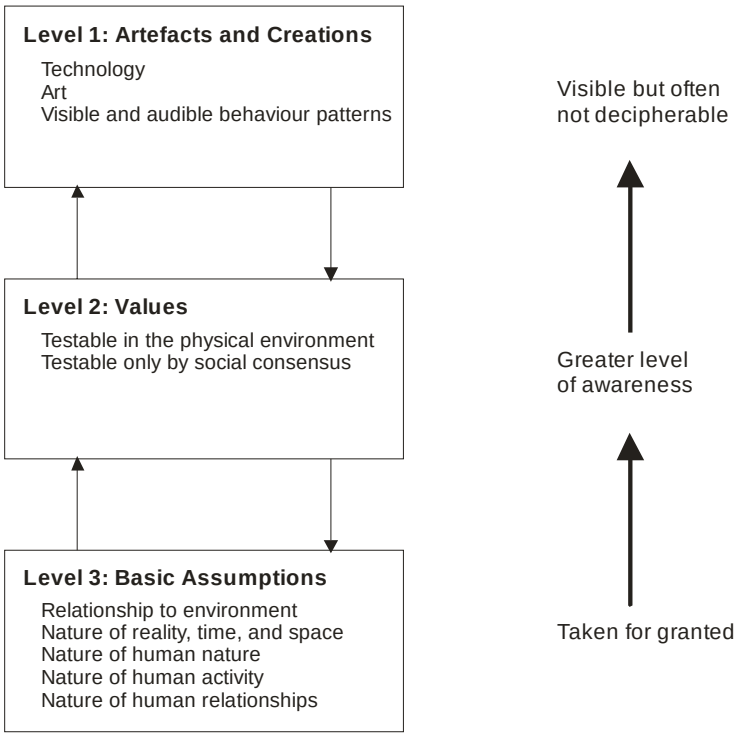
Such shared ways of thinking and behaving help define what is legitimate and acceptable within an organisation; they are the social and normative glue that holds an organisation together, and in colloquial terms 'the way things are done around here'. Culture is a lens through which an organisation can be interpreted both by its members and by interested external parties through an appreciation of an organisation's symbolic codes of behaviour, rituals, myths, stories, beliefs, shared ideology and unspoken assumptions.

Perhaps the most critical cleavage in contemporary definitions is that identified by Smircich (1983); who treats culture as a property of an organisation (something it 'has') or something that the organisation 'is'. The former approach defines culture as the values and beliefs in an organisation that organisational members have in common. Thus, this approach treats culture as a variable or attribute, alongside organisational structure and business strategy that can be managed or manipulated to improve performance. In contrast the latter approach implies the existence of fewer levers by which management might secure change, since the entire organisation is seen as a cultural system in itself with analytic interest focused primarily on how it is accomplished and reproduced.

Culture is also gen erally con sidered as a mu lti-layered an d mu lti-level phenomenon; with the most commonly cited conceptual framework being Schein's (1989) distinction of artifacts, values, and basic assumptions which is illustrated in figure 5.1. Artifacts that form the top level of an organisation's culture are the most visible an d t angible man ifestations thereof. The second level is made up of values which underlie and influence behaviour. Un like a rtifacts wh ich can be perceiv ed as 'what is', v alues represent 'what ou ght to be'; th ey incorporate mora l and ethical codes, ideologies, and philosophies. The final level forms the basis for real cultural understanding; it comprises basic underlying ass umptions: e nshrined

fundamental beliefs, values and perceptions that impact on individuals' thinking, behaviour, and feelings. This level differs from values, which are espoused, in that assumptions are those values which have become so internalised as to drop out of consciousness (Schein, 1989).

e 5.1 Schein's Levels of Organisational Culture and their Interaction



Adapted from Schein (1989):14

Dimensions of organisational culture identified in the literature as being important mediating factors in facilitating (or impeding) successful alliances, partnerships and joint ventures, include:

- attitudes towards cooperation and team working
- beliefs about the motivations and working practices of partners
- perceptions regarding the trustworthiness of partners
- assumptions concerning the competence and skills of partners
- attitudes to risk taking and dealing with change and uncertainty
- the influence of professional norms and working practices
- values relating to ethical conduct
- views relating to appropriate arrangements for conflict resolution and dispute settlement.

Child and Faulkner (1998) have developed a useful typology to assess approaches to managing inter-organisational relationships and partnerships in the face of cultural diversity. Their analysis is structured by two fundamental choices. The first concerns whether one sub-group's culture should *dominate*, as opposed to striving for a balance of contributions from the contributory cultures. The second relates to the decision to either integrate different subcultures (in order to derive synergy between them) versus a preference segregating the various cultures within the partnerships (with the aim of avoiding conflict or efforts devoted to culture management). These strategic partnership choices give rise to four possible bases for accommodating cultural diversity: *synergy*, *domination*, *segregation* or *breakdown* (see figure 5.2). The first three offer some scope for establishing a cultural fit, whilst the fourth may give rise to serious dysfunctional consequences.

Figure 5.2: The Meeting of Cultures: Achieving a Cultural Fit

	Integration between cultural groups? Yes	No
Domination by one sub culture? No	1) Synergy The objective is to meld both partners' cultures and to achieve the best possible fit between the two. The best elements are combined with the objective of making the whole greater than the sum of its parts.	2) Segregation Here the aim is to strike an acceptable balance between different cultures by virtue of maintaining separation rather than seeking integration.
Yes	3) Domination This is based on recognition that integrating organisational cultures may prove impossible and accepts the right of dominance of one sub-group's culture.	4) Breakdown This occurs when one culture seeks domination, integration or mutually acceptable segregation but fails to secure the acquiescence of the other organisational culture.
	Yes No	
	Integration	

Derived & expanded from a classificatory scheme on strategic alliances developed by Child and Faulkner, 1998.

The theories and conceptual frameworks outlined above for understanding culture and cultural diversity in inter-organisational alliances informed the design and data gathering during the empirical phase of the project, to which we now turn.

5.3 Key Informant and User Views on the Role and Impact of Culture in LIFT Partnerships

This section pertains to the interviews discussed in sections 4.2 and 4.3 ('Key Informant Interviews' and 'User Interviews'). These interviews were supplemented by a number of case-specific telephone interviews which are discussed in the consecutive subsection 5.4 ('Case Study Based Views on the Role and Impact of Culture in LIFT Partnerships).

There was a general view across key informants and users that public and private partners had different cultures, values and motivations for being

involved in a LIFT Partnership. PCTs and other public sector organisations were characterised as being motivated by the opportunity to improve the delivery of health care services provided to the local population. Private sector providers, on the other hand, were (unsurprisingly) believed to be motivated by the opportunity to make a profit from the company. However, there appeared to be a broad consensus that although public and private interests differed, they could, in successful partnerships be aligned in the pursuit of developing high quality local premises which would benefit the local community. This view was expressed by, among others, the Partnership UK representative [PUK representative] who highlighted the importance of interest alignment between the sectors:

"I think there are complete differences in public sector values and private sector values, so the challenge is to ensure there is sufficient alignment of interest for those interests not to matter. So the private sector's job is to earn a return for their shareholders; no public sector has no such aspiration, but actually what both want is to deliver high quality new facilities and there is a total alignment of interests there."

Arguing along similar lines, the Partnership UK representative [PUK representative] suggested that the public sector's approach to commissioning had already become similar to that of the private sector:

"The public sector is becoming much more like the private sector in knowing what it wants to do and wants to deliver and I think that is a whole new set of skills that have developed over the last 10 years as we have moved into contracting in the broadest sense of the word."

There were mixed views in terms of whether the different cultures and motivations of partners were adversely affecting relationships within LIFT schemes. Most thought that public and private organisations worked together well in the vast majority of LIFT partnerships, not least because of the hard work of key individuals involved in the process. It was also pointed out that General Practitioners themselves, operated small independent businesses and that as such their business culture and motivations may not be that far removed from those of private sector partners. This view was expressed by, among others, the bank representative who noted that both sector collaborated effectively:

"The private sector respects the processes the public sector has to go through and I think the public sector does understand some of the processes the private sector has to go through. Overall they work quite well together and it's really down to the individuals involved."

This view was echoed by the DoH representative [DoH representative] who suggested that collaboration was perhaps easier in primary care on account of the commercial outlook of GPs:

"There is a key difference between hospitals and primary care in that GPs are actually self-employed, they are small businesses. This is really helpful when we engage with them."

Meanwhile the Partnership UK representative [PUK representative] suggested that one of key factors linked to successful partnerships was the ability of private partners to resist the urge to seek to maximise their short term profit at the expense of establishing good long-term relations between partners, which may be more beneficial in the long run because of the possibility of regaining business:

"The challenge for LIFT is to get the private sector to recognise that they are in a partnership and that if they go for short term win in terms of profit, that is going to damage the partnership and what they should be looking for is a win/win when the private sector makes a return but recognises that a fair and reasonable return over the long tem is better than going for a quick buck because they're never going to get another deal."

Similarly, the DoH representative [DoH representative] noted that both the public and private sectors had to recognize each others' interests around partnership working:

"There is a fear of being open with one another and the difficulty of understanding what the other party needs from it….The hard bit for the public sector is to recognise that profit is not a dirty word and to recognise that they have to make a profit …and most importantly the private sector needs to recognise the rewards for them are through repeat business without competition."

A key identified difference between public and private partners was that the former has a focus on the needs of the community rather than those of professionals working within the facilities. This was thought to require a cultural shift on behalf of private sector in order to accommodate the priorities of the local community in influencing how LIFT partnerships operated. In this context the CEO of a LIFTCo operating in the West Midlands [CEO, urban W Midl] suggested that the private sector had to cultivate an awareness of the community it was operating in:

"The thing the public sector brings to the table is increasingly an emphasis on engaging with people and the Central Government policies have driven in that direction over the last few years. Certainly for the private sector partner in my LIFTCo that has meant quite a dramatic change in the way they operate in developing these new buildings, in that in the past I think it was always seen as it was the professionals that told you what they needed and you delivered a building solution …now increasingly the public sector are pushing is towards a community facing model, where, yes, it is important to have the right environment for professionals to provide clinical services, but it must be cognizant of the community that it is operating in. So we are seeing our bigger buildings increasingly shaped by the community' desire for a facility that means something for them."

5.4 Case Study Based Views on the Role and Impact of Culture in LIFT Partnerships

As highlighted above, LIFT projects join together in common enterprise a range of organisations with different cultures, values and established ways of working, not least how inter-organisational relationships should be nurtured and managed.

In the empirical phase of the project we were, therefore, interested in exploring how cultural diversity was managed in the case study sites. To explore this issue in some detailed, it was decided that separate interviews should be conducted on this matter once the core aspects of the case study fieldwork had been concluded. These case-specific telephone interviews, therefore, were conducted during the months of March and April 2009, that is at a time when the case studies themselves had been completed for some time. The purpose of this approach was to give some of the case studies interviewees a period of reflection during which they were able to view some of their own interview transcripts and were able to place their own organization in a specific cultural context. For the purpose of the supplementary interviews each of the case study specific interviewees was also given a copy of some parts of the case study analysis. The purpose of these supplementary case-specific interviews was to allow key users from each of the case study locations to place each of the case studies in a specific cultural context. To focus these supplementary interviews, each of the participants was given a copy of Child and Faulkner framework (see Figure 5.2) and asked to describe her or his organisation in relation to these categories. Overall, these supplementary interviews were conducted for three of our four main case studies, all four of which are discussed in fuller detail in section 7 ('Case Studies'), and involved between one and two key informants to the case study. These interviews covered the following case studies: Urban North East LIFT (see also subsection 7.2), rural East Midlands (see also subsection 7.3), and urban South West LIFT (see also subsection 7.5); but not mixed East Midlands LIFT (subsection 7.4), where

it was impossible to obtain an additional interview with the individual in question due to retirement.

5.4.1 Cultural Issues, Urban North East LIFT

Urban NE LIFT is a second wave LIFT scheme, which saw financial close towards the end of 2004 and saw capital investments in excess of £17 million. The principal informant for the purpose of these interviews was the Director of Finance of this urban NE PCT [Fin Dir, urban NE] who had also made a major contribution to the case study analysis (see section 7, subsection 7.2).

In terms of the Child and Faulkner's framework, staff at this PCT positioned themselves somewhere in the top half (i.e. no dominance by one organisational culture) between Box 1 (*Synergy*) and Box 2 (*Segregation*). This was expressed by the interviewee [Fin Dir, urban NE] as follows:

"I do not think that there is one dominant culture. I think we are probably between box 2 and box 1 (relating to Figure X). I would not say we have got absolute synergy, but I would probably say that we've got more synergy than segregation if that makes sense…I do not think there is much in terms of breakdown."

There was a belief on the part of PCT staff that following an initial phase of misunderstandings and subsequent learning and renegotiations that their private sector partner was now quite sensitive to the value and ways of working in the health service and that this had enabled a strong bond to be forged between LIFT partners [Fin Dir, urban NE and associated staff]:

"I think their values (private sector) are quite public sector…. they (values) have become very intertwined."

"I think there is a better understanding of public sector governance which I know on occasions has been a bit of a frustration to the private sector."

There was a general feeling among PCT staff that there had developed a degree of trust between public and private partners and that both recognised that the success of the project depended upon them working together and following a common agenda. Nevertheless it was felt that there did remain some suspicion about each others' motives which formed a backdrop to negotiations [Fin Dir, urban NE and associated staff]:

"There is a level of trust now and if any thing went horribly wrong we would have to help each other out - one party would not leave the other to flounder as it would not do either of us any good. So if something major happened we would try to help each other out and not just turn to the legal documents … There are always people on both sides of the camp who either do not trust the other party, or certainly from the PCT side there are people who consider that that the private sector is just out for a quick buck and their fine words mean nothing."

Overall the PCT staff were very happy with the relationship that had developed with their private sector partner and during the interviews LIFT project was frequently cited as a model that other projects should follow. This view was expressed again most explicitly by the Director of Finance [Fin Dir, urban NE] who doubted that other PCTs had as good a relationship with their LIFTCo:

"I think we are an outlier, but an outlier in a positive sense, because I do not think most places have the strong relationships and partnership arrangements that we have. … We are probably more advanced and more integrated and are working in a true partnership way than a number of LIFT companies."

5.4.2 Cultural Issues, Rural East Midlands LIFT

Rural E Midl LIFT is a third wave LIFT scheme which, after merging with the PCT of a unitary authority, saw capital investments of almost £42 million. The principal informant for the purpose of these interviews was the Director of the county PCT [PCT Dir, rural E Midl] who had also made a major contribution to the case study analysis (see section 7, subsection 7.3).

Staff from the PCT believed that their organisation was in the top half of the diagram (i.e., that no one organisation dominated the Partnership) and was positioned somewhere between Box 1 (*Synergy*) and Box 2 (*Segregation*) in Figure 5.2. There was a strong feeling that, although there needed to be a melding of cultures between partners to manage the cultural diversity, there also needed to be some form of separation so that PCTs for example could focus on addressing the needs of their patients and the wider health community. This was expressed by the Director of the PCT [PCT Dir, E Midl] who highlighted the dual role of the PCT as partner and customer:

"I would say that we are in the top half between segregation and synergy. We would not have got to financial close with our private sector partner if there was any degree of melding cultures, and get the best combination out of the team. But there is a slight feeling within the PCT about

difficulties. We are partners in LIFT but also we are a customer of them (the private partner) so that is where there is separation, but still a feeling that there needs to be a degree of separation because we need to make sure that the PCT's interests are safeguarded."

Although the ideal for the PCT would be to move across to Box 1 (Synergy) it was recognised that there would probably always be a degree of separation between public and private partners because each have different fundamental values. Again, this view was expressed most clearly by Director of the PCT [PCT Dir, rural E Midl] who noted that there was a need to understand differences in values while working for a common purpose:

"For me it is about understanding each other's values. And in some area there are clear overlaps and similarities but there are some things where there are fundamental differences, generating surpluses and being part of a profit making chain somewhere along the line …. So I think it is about recognising the common purpose, but also understanding that to some extent we have got different value bases."

5.4.3 Cultural Issues, Urban South West LIFT

Urban SW LIFT is a third wave LIFT scheme, which saw financial close towards the end of 2004 and saw capital investments in excess of £28 million. The principal informant for the purpose of these interviews was the CEO of the urban SW LIFTCo [CEO, urban SW] who had also made a major contribution to the case study analysis (see section 7, subsection 7.5).

The main interviewee in the supplementary interviews relating to urban SW LIFT believed that their LIFT Partnership could best be characterised as being in Box 2 (*Segregation*) although at times (and also perceived as the ideal situation to be in) was the partnership could be characterised as being in Box 1 (*Synergy*):

"In our case there been on the whole a pattern of segregation. Synergy is the ideal, but segregation is as good as its likely to get because there are different entities involved. If you were applying this to one organisation with different partners it would be easier to arrive at synergy. We have been aiming at segregation, where there is a balance between the needs of different parties. We have different legal entities so there is a difference, and it is necessary to maintain a sense of independence, in a commercial, legal and business sense."

However, as a private sector partner, this interviewee [CEO, urban SW] highlighted that there had been times when the public sector had dominated

the relationship. This was particularly the case when the public sector forced through initiatives (or suspended them) because of wider political considerations which the private sector partner found difficult to challenge:

"On the whole, it has been the case that there has not been domination, although at times there has. At the moment I can feel aspects of domination, that is because there are lots of pressures at the moment, economically, with policy changes, with political uncertainty. That forces, or creates a sense that leads to domination or even breakdown, where there are stresses on the partnership. You might get one organisation saying 'we' are going to focus on this now to the exclusion of all else … We go through different phases … I think the public sector dominates the private sector. I have see this on a couple of schemes .. there is a certain jockeying for position…the public sector can go away and then turn around and say 'we've decided we can not do that –so they are dominant if they want a redesign."

Apart from stressing the possibility of public sector domination, the above statements are interesting in that they indicate that the current economic climate may be changing the balance of power in favour of the public sector. While we have little evidence of the cultural effects of the credit crunch and the ongoing recession on relationship between LIFT partners, it stands to reason that these events will have far reaching effects on how future negotiation will be conducted, with a strong possibility that the public sector will be able to attract favourable concessions from its partners. These possibilities, of course, will be constrained by the need for private sector partners to ensure their profitability during these difficult times.

Expanding on the issue of cultural dynamic, the same interviewee [CEO, urban SW] noted that any pattern of domination by either sector was necessarily temporary. Thus this interviewee explained further that relationships in the LIFTCo were dynamic and in flux and at different times either the public or private sector had been the stronger partner in determining how the LIFT project was run:

"Within our activity the relationship could change at different times –and could be stronger or weaker depending on which stakeholder we are talking about. We are dealing with lots of stakeholders who represent other cultures, and the relationships are not fixed, for every individual for every organization."

5.5 Discussion: LIFT and Cultural Diversity

Conceptualising LIFT partnerships in terms of 'organisational culture' resonates with a wide variety of key stakeholders and forms an intuitive way for them to understand inter-organisational dynamics. Thus the key overall finding from the interviews with Key Informants and the case studies is that organisational culture matters, and is seen to matter in the formation and maintenance of LIFT partnerships. Managers at all levels in the public and private organisations recognised the significance of culture and were either trying to actively interested in shaping it or felt constrained by its pervasive influence on inter-organisational relations.

We identified a range of key differences in the values, working practices and cultures of private sector organisations. In some LIFT projects different assumed motives had created a degree of suspicion and lack of trust between partners, with public organisations sometimes uncomfortable with the underlying profit motive of private sector organisations, and private sector organisations worried about the perceived bureaucracy, 'red tape' lack of financial acumen and political interference under which public organisations laboured. However, on the whole, the partners within LIFT projects appeared to be working together well and differences in culture were being managed and accommodated as partnerships matured.

6 Financial Analysis

6.1 Introduction/Study Design and Methodology

This section addresses the general question of whether the LIFT method of procurement represents good VfM. To do this, three case studies are used. These are urban NW LIFT, mixed West Midlands LIFT and urban NE LIFT . The first case, urban NW LIFT, was chosen because of the six studies in the NAO (2005a) report and Mahmood (2004), it contains the most detailed accounting data. In particular Mahmood (2004, annexes III and IV) includes detailed ex ante pro forma profit and loss accounts and balance sheets. These detailed figures can be used for two purposes. To begin with they offer the opportunity to examine urban NW LIFT as a detailed financial case study. Second, using the data in Mahmood (2004) in conjunction with NAO (2005), a detailed 'base case' replication of the NAO model can be constructed which reconciles to forecasted internal rate of return (IRR) outputs reported in NAO (2005, 36). Using the base case model with actual accounting data for the three case studies for the first three years of their operation, adjusted IRRs can be calculated by modifying the base case model with outturn (i.e. full accounting data for the first three years) data.

The remaining cases, mixed West Midlands LIFT and urban NE LIFT were chosen because mixed West Midlands LIFT was also included in the NAO (2005) and Mahmood (2004), and urban NE formed one of the case studies discussed in subsection 5.4.1 ('Case Study Based Views on the Role and Impact of Culture in LIFT Partnerships') and section 7 ('Case Studies', specifically subsection 7.2 'Urban NE LIFT'). These choices allow in and out of sample comparisons of the NAO cases and allow the financial analysis of urban NE to be triangulated with the results of the interview evidence.

In the detailed subsections that follow, subsection 6.2 provides an introduction to the financial analysis offering some explanation of its potential importance. Section 6.3 presents an analysis of the urban NW LIFT as a case study. Financial and accounting data is used in conjunction with desk research and press reports about the development. The base case financial model and ex post financial model is presented and discussed. Section 6.4 presents further models in comparison with urban NW, mixed West Midlands and urban NE. Reasons for differences in forecast and actual costs are examined. In subsection 6.5 conclusions are drawn highlighting some of the reasons for the apparent high cost of LIFT projects.

6.2 Financial Issues Regarding LIFT

Since the publication of the National Audit Office (NAO) report of May 2005 on Local Financial Improvement Trusts (LIFT) in the NHS, there has been much debate concerning the scheme. When the NAO (2005) report was presented to the House of Commons Committee of Public Accounts (CPA), it explained that there was considerable interest in the set up and 'ongoing value for money' and accountability arrangements, and argued that whilst not necessarily the best procurement method in all areas, in general LIFT offered 'advantages over the alternatives' (NAO, 2005, 2). Because the NAO reached a conclusion supportive of the scheme whilst acknowledging the absence of quantitative evidence, the call for a credible system of VfM evaluation has intensified. Pressure for such evaluations has come not only from LIFT stakeholders themselves, including investing organisations, but also from the UK's senior institution of public accountability.[1] As a specific form of public private partnership (PPP) for the design, construction, financing and operation of general practice health centres, these criticisms are similar to those levelled at PPP more generally. These include excessive private sector returns (Toms et al., 2008), which may be the corollary of poor VfM outcomes. In the absence of a financial evaluation model for LIFT, costs associated with the process remain open to questions that have been largely unresolved since the inception of the scheme, in terms of set-up costs (Tyndale-Biscoe, 2003), operating costs (Comerford, 2004) and rents charged to tenants (Holmes et al., 2006). Evidence from the House of Commons CPA suggests that primary care Trust (PCT) accommodation spending per patient registered with GPs in a LIFT development is up to eight times higher than total primary care spending on accommodation.[2]

In view of these concerns it is surprising that the costs of LIFT have not been more systematically evaluated. It is also surprising that post project evaluations have not been conducted. A memorandum from the Centre for International Public Health Policy (House of Commons, 2006, ev.25) critiqued the NAO Report (2005) for not having done this, and now that the schemes are 4 years older it is even more remarkable that such analysis has not been conducted. It was a recommendation of the NAO Report (2005) that the Community Partnerships for Health [CPH] should issue guidelines as to how such evaluations should be conducted (House of Commons, 2006, ev.29-30). In the absence of these, meanwhile, it is

[1] Please note that this chapter utilises footnotes and page numbers for non-quoted references in order to facilitate an evaluation and replication of his analysis. LIFT Liaison for Business Investors (LOBI) Memorandum, CPA, minutes of evidence (ev.22); Report (House of Commons, 2006), recommendation 5, 5.

[2] CPA, Report (House of Commons, 2006) 10; the Mixed West Midlands example shows average annual cost per patient in the PCT to be £3.84 and £31.41 as the annual cost per LIFT registered patient, a ratio of 8.17:1.

important to provide some quantitative evaluation of LIFT scheme performances to date.

These issues and debates in themselves would appear sufficient to generate a robust financial analysis by government agencies, even though one has not been carried out to date. However, it is not simply a matter of finding a cheaper solution. The VfM solution is not necessarily the cheapest, or indeed the one that produces the lowest private sector return, because any evaluation should also include risk transfer from the public to the private sector. In the wider context of PPP there is little evidence that the substance of such risk transfers have been systematically evaluated (Pollock and Price, 2008). Moreover, there is no clear pricing mechanism of such risk.

For all these reasons, a financial evaluation of LIFT is potentially useful, particularly if risk transfer and cost/benefit considerations can be incorporated. In the light of the issues raised above, the absence of quantitative data is surprising, and seems to both enhance the intensity of the debate whilst reducing the possibility of its conclusion. In the absence of such evaluations, LIFT has generated considerable debate, which can perhaps move nearer to resolution if helpful figures can be provided.

6.3 A Case Study of Urban NW

The purpose of this subsection is to provide a detailed financial analysis of one LIFTCo (LIFTCo). The urban NW LIFTCo was chosen primarily for reasons of data access and was at the time of writing still the only LIFTCo with sufficient public domain information to allow such an analysis to be conducted. The case study is set out below in several subsections. The first subsection gives some background to the case study based on an overview analysis of the urban NW LIFTCo. A second subsection then introduces an evaluative financial model, describing first the difficulties experienced obtaining financial data and then describing the construction of a model designed to overcome these problems. Subsection three then presents results from analytical manipulations of the model showing in turn the comparative cost of the project using a public sector comparator, the realism of the projected assumptions pre-bid in terms of costs and, finally, to evaluate risk, a sensitivity analysis of the cash flows in the model. Finally the above debates are reassessed in the light of the evidence presented.

6.3.1 Background and Overview Analysis

Urban NW LIFT was established on 11th June 2003 when X Group [name of local construction company] was appointed as the preferred bidder. Three new health centres were scheduled to be open for patients in Town A (March 2005), Town B (May 2005) and Town C (June 2005). It was in the

second wave of LIFT projects.[3] In line with the general LIFT model, the urban NW LIFTCo is 40% owned by public sector stakeholders, including the local PCTs and the Partnerships for Health (now Community Health Partnerships), and 60% owned by the X Group, a major regional; construction and facilities management company. The X Group was to provide all construction and facilities management services for the 25 year contract period. Senior amortising debt provided the majority of the required finance (Mahmood 2004, 20), and Y Bank [name of a national Bank group] provided this funding (NAO, 2005, 25). Construction began immediately at the financial close and the first facilities were typically in operation within 18 months.[4]

Table 6.1 provides details of the three Health Centres funded by the scheme, including the approximate split of the £19.3m projected cost. It shows the size of the centre in terms of square meters and number of GPs and associated core provision.[5] It then computes per capita cost measures with reference to the number of patients served and size of the practice, utilising revenue (annual projected cost to the PCT) and capital cost (initial cost of the investment).

According to the CPA Report (House of Commons, 2006, table 3), at a cost of £32.88 per patient to the revenue budget of the PCT, LIFT is much more expensive in per capita terms than conventional procurement, for which there is an estimated per patient cost of £5.88.[6] Considering the Health Centres individually, it can be seen that the cost per patient can vary considerably by location. No doubt there are similar variations in conventional schemes, for the same reasons, such as local population densities. Town A Health Centre, for example, in a more sparsely populated area, has a higher unit cost whether considered in revenue or capital terms. The corollary is that if LIFT is more expensive using this measure compared to conventional procurement, then the effect is likely to be amplified away from the main population centres, and if LIFT is to deliver VfM, then it has a better chance of doing so in the conurbations where economy of scale is more pronounced. The K Health Centre [name one of the health centres],

[3] NAO Memorandum, CPA, House of Commons, 2006, ev. 15.

[4] Second LIFT scheme signs (Local Improvement Finance Trust, UK National Health Service). *Public Private Finance*, November 2003, No. 78.

[5] The LIFT scheme is intended to attract a number of associated services, but for the purpose of the analysis at this stage the two core ones analysed were pharmacies and dentists.

[6] At a cost per square metre of £180, the scheme is similar to the Lyng Health Centre third party development (£195) and cheaper than the Oldbury Health Centre (House of Commons, 2006, ev.20), bearing in mind that such data is only available at scheme level for Urban NW and there is no information about rental charges for individual health centres.

which serves the large industrial town of Town B, is relatively efficient at a revenue cost of £25.31 per patient, uniting seven doctors' practices and eighteen GPs under one roof. It has also attracted core associated services highlighted as an objective of the scheme, and has both a pharmacy and dental practice on site. Factoring in these benefits, it is in the interest of investors as well as PCTs to concentrate on urban centres since the per capita capital cost can also be reduced by achieving greater concentration in areas of higher population density.

Table 6.1: Urban NW LIFT, Health Centres

Health Centre	Size Sq m	GPs[1]	Services[2]	Number of Patients	Initial Cost £m	Cost per GP £	Cost per sq m £	Cost per patient £		
							Capital	Capital	Capital	Revenue[3]
Town A Health Centre	3,500	8	P	13,560	5.5	687,500	1,571	405.	60	46.35
K Health Centre, Town B	4,650	18	D, P	33,000	6.3	350,000	1,354	190.	91	25.31
Town C Health Centre	5,500	15	P	28,000	7.5	500,000	1,363	267.	86	35.27
Combined scheme	13,650	41		74,560	19.3[4]	470,732	1,413	258.	85	32.88

Sources: Compiled from: *This is Lancashire*, 19th May, 29th October, 2005; *Name of Local Newspaper*, March 5, 2004, *Contract Journal*, October 29, 2003 CPA (House of Commons, 2006), ev 21, table 3. NHS. UK Service Directories.

Notes:
1. GPs in situ February 2009
2. Services D = Dentist, P = Pharmacy, in situ February 2009.
3. Estimated by allocating 2004/05 cost (PAC, 2005/06, table 3, 10) by size pro-rata
4. Initial cost at planning stage. Outturn cost = £23.9m (NAO/Operis models)

6.3.2 The 'Base Case' Financial Model

Previous Models, Data Sources and Commercial Confidentiality

A major objective of the research is to assess whether or not LIFT represents VfM. An important component of such an assessment is to build a financial model so that a base case for a planned LIFT project can be compared with alternative models, sensitivities can be manipulated to assess risk and risk transfer, and the model assumptions can be tested and modified in the light of ex post financial results. Analysis of each of these aspects is presented in the financial case study of urban NW LIFTCo below.

Quantifying projects in this fashion is particularly valuable, in view of the absence of quantitative evaluations noted by the CPA. One member of the Committee described the NAO Report (2005) as 'bereft of financial analysis…' and lacking in independence.[7] It is true that the Report (NAO, 2005, table 10, 25) presented only limited figures, in the form of internal rates of return (IRRs) for six LIFT case studies. The six case studies were East London and the City, Barnsley, Sandwell, East Lancashire, Barking and Havering, and Ashton, Wigan and Leigh. Data for the IRR table in the NAO report was obtained from financial models developed by the Business Engineering firm Operis (NAO, 2005, Appendix 1, note 3). A conclusion from the CPA report (2006, 5) was, therefore, that a 'meaningful quantitative evaluation of the VfM of the LIFT programme and its schemes' should be made as quickly as possible.

A consequence of the NAO procedures is that there are no obvious sources of public domain information that might allow a robust and detailed assessment of VfM. Indeed the absence of comparable and timely data was a reason offered by the NAO to the CPA for not undertaking a financial analysis (House of Commons, 2006, ev.28). Another consideration, according to table 10 (NAO, 2005, 25), is a note stating 'our case studies are anonymous to protect commercial sensitivities', so that it is not possible to match the reported IRRs to specific LIFTCo-s. For the same reason the Operis financial models are not in the public domain. Appendix 1, note 3 (NAO, 2005) also states that Arshad Mahmood also provided assistance with the financial analysis. As part of our investigation we requested the Operis models from the NAO who confirmed their commercial confidentiality. Their spokesperson also confirmed that they had used Mahmood's models and that there were small differences between the Mahmood and Operis models due to a four month time lag and that the Operis models were 'tweaked' to make them consistent.[8]

In his MSc Dissertation, Mahmood (2004) provides detailed financial extracts from the six Operis/NAO case studies. For urban NW LIFTCo alone he includes an appendix showing pro forma profit and loss accounts (Annex III) and pro forma balance sheets (Annex IV). He also details the input assumptions used in the models. Although the source of data is an unpublished dissertation, it is nonetheless appropriate to rely on it, not least because it has also been relied upon by the NAO. It has been relied upon only as a data source, and its reproduction of unedited financial model data makes it a valuable source of public domain information in this respect. It is sufficient for us to be aware that the model outputs from Mahmood's data are very similar to the Operis results as admitted by the NAO above.

[7] Jon Trickett, MP, CPA, (House of Commons, 2006) ev.9, qq.62, 65.

[8] Communication from the NAO, 15th October, 2008.

Equipped with model input data from Mahmood (2004) and the model outputs reported in NAO (2005, table 10), it is a relatively straightforward task to construct a financial model that reconciles the two. For the urban NW LIFT case alone, this can be achieved using public domain information and therefore the commercial confidentialities that are of concern to the NAO can be respected. The process is a matter of modelling a set of forecast cash flows that produce IRRs within the range of those reported in table 10. Confidence in the model is made higher by the relatively narrow range of IRR outputs reported by the NAO. The average IRR across the six case studies (including residual values) is 14.97% with a standard deviation of 0.5% (calculated from NAO, 2005, table 10). Because table 10 also includes a residual value column and Mahmood (2004, Annex II-c) reports a residual value for urban NW of £8.25m, the model can be refined further by assuming that urban NW is case study 3, where the NAO report a residual value of £8.3m.[9] If this assumption is valid then the cash flows need to be modelled to show an IRR excluding residual value of 14% and including residual value of 15.1%, which are the figures in NAO (2005) table 10 for case study 3.

Financial Model Construction: Assumptions and Inputs

The resulting financial model is presented in full in appendix 6.1. Generic input variables such as inflation, tax and debt amortisation rates are shown in the yellow zone of the model. Outputs are shown directly underneath in the red zone. These are also set out in detail below in table 6.7. Post tax nominal blended equity IRRs are highlighted as these figures can be compared directly with the NAO results in table 10.[10] However, there are other permutations of IRR, such as project IRR, pre and post tax variants, real and nominal, including and excluding residual value, and the model was developed to allow the calculation of these potentially useful metrics. Detailed financial inputs are developed from the pro forma profit and loss accounts in Mahmood (2004, Annex III) which contain five years' of forecast data at six monthly intervals and a total figure for the full 25 year life of the project by each category of income and expenditure. Analysing these figures, apart from the first two years, when cash flows build up from a low start up base, almost all were inflated using an annual rate of 2.5%. This

[9] Table 10 (NAO, 2005) reports residual values in £m to 1 decimal place. It also reports the residual value as a percentage of construction cost. Dividing 8.3m by the reported percentage of 38.9, gives an estimated construction cost of £21.33m. This corresponds to the ex ante planning stage estimates of c. £20m given in the local press and to the scheduled expenditure in Mahmood (2004, Annex IV) of £23.9m, more closely than any of the inferred construction costs for the other five cases. The assumption that case 3 is Urban North West is therefore a reasonable one to make.

[10] Blended equity IRR is defined as the rate of interest that balances the present value of cash outflows attributable to equity and subordinated debt from the project with the discounted cash inflows attributable to equity and subordinated debt of the investment.

value was, therefore, used as an input assumption in the model yellow zone and the cash flows forecasted for the remaining 20 years. These were summed to give the total column and cross checked against the totals appearing in Mahmood (2004) Annex III. In all cases there were fairly close correspondences.[11] Depreciation is recorded in the model, but is ignored for the purposes of computing cash flows. A further model subsection deals with balance sheet cash flows and these are computed for each item by taking the difference between the balance sheet values at corresponding year ends. For example, the expenditure on fixed assets is the difference between the values at the beginning of each year. Depreciation is not charged to these accounts until the capital expenditure phase is completed (Annexes III, IV). The value at the end of the project and cash received/repaid from/to lenders can be computed in similar fashion. Debt amortisation assumptions were derived by computing annual repayments from the diminution in outstanding balance sheet debt in annex IV. Repayments were added to interest charges so that the total capital and interest charge for each year could be determined for each class of amortising debt. Capital and interest payments were then forecasted using the assumption of this constant total cash payment. The implicit rate of amortisation (or write down) of the outstanding capital balance is used to compute the capital repayment element for the remaining term of the loan. Bullet debt was treated as interest only. The timing of these cash flows is important because it affects the lump sum repayable from the residual value at the end of the project and where using blended equity IRRs, because the model needs to obtain the remaining cash flow once payments to senior debt classes have been met.

6.3.3 Model Results and Analysis

The Base Case

As can be seen from the red zone model outputs in appendix 6.1, post tax nominal blended equity excluding and including the residual value are 13.9% and 15.1%. The residual value inclusive result corresponds exactly to the 15.1% reported in table 10 NAO (2005) for case study 3 and the residual value exclusive result corresponds fairly closely to the 14.0% for the same case. These results are merely confirmatory of the accuracy of model assumptions rather than of interest in their own right.

More importantly, the model can be described as a robust base case, which can now be used to conduct a detailed VfM analysis. There are three dimensions to this, analysed below in turn. These are first, a comparison with alternative methods of finance, which can be achieved by substituting public debt finance into the base case model. Second, the model assumptions are tested and reviewed in the light of ex post financial results.

[11] There are some inevitable rounding differences and the net effect of these was to produce a total gross profit across the 25 years of £61.77m compared to the £61.9m reported in Mahmood (2004) Annex III.

Third sensitivity analysis is performed to provide an assessment of risk transfer.

Public Finance Comparator

A useful question to ask is would the project have offered greater VfM if conventional public sector debt had been used to finance the project. The effect of such an arrangement can be computed by modifying the urban NW LIFTCo base case using the assumption of public sector debt finance for the entire project at 6%. To arrive at the public sector cash flow in this scenario it is necessary to add back taxation to the project flows as this charge would not arise under public sector control. Even so, under LIFT style finance, the taxation charge represents a contribution of the project to the exchequer, which is represented as earlier by using the post-tax cash flows for the computation of the blended equity IRRs.[12] Although these are important methodological assumptions for the base case, in the urban NW example calculations, taxation is immaterial to the comparisons of pre and post tax IRRs and has relatively less impact when discounted on the public sector comparator since tax deferral has the effect of eliminating any tax charges to the project before 2018. A further difference between public and private sector provision arises from the structure of repayment schedules. In the LIFT base case, capital repayment elements of senior and bullet debts are relatively slow so that most of the debt is not repaid until the later stages of the project. Under public financial arrangements there would be nothing to prevent the use of project cash flows from paying down the debt more quickly, which is an assumption used here for comparison purposes. Alternatively, from a public sector point of view, the benefit of early debt redemption might be translated into a reduced requirement on the PCT budget for unitary change rentals. From a private sector point of view, as in other PFI style activities, this benefit exists as an opportunity to realise a capital profit from debt refinancing.

[12] To assess VfM as the absence of abnormal returns to the private sector, it is appropriate to compute such returns after any taxation contributions.

Table 6.2: Urban NW LIFT, Financing Cost Comparatives

	£m	£m	£m
	LIFT	**Public Sector**	**Difference**
a) Gross cash flows			
Total interest charges	26.16	10.38 15.78	
Taxation charges	7.66	Nil	7.66
Net cost	**18.50**	**10.38**	**8.12**
b) Net present value*			
Total interest charges	15.05	7.75	7.30
Taxation charges	3.71	Nil	3.71
Net cost	**11.34**	**7.75**	**3.59**

Sources: model inputs (appendix 6.1 and table 6.7 below)

Notes: * Computed using a discount rate of 6%.

The differences occurring as a result of the public sector finance option are shown in table 6.2. The table shows the respective costs of interest payments using LIFT and conventional public sector methods respectively and the differences between them allowing for the taxation contribution of the LIFT option, a) in terms of gross interest charges over the life of the project and b) as net present values using a 6% discount factor. As the table shows, the savings arising from the public sector alternative method of financing are significant in gross terms, amounting to £8.12m, or 34% of the total invested in the three health centres of £23.9m. This is the amount, or percentage reduction, in required borrowing had the project been funded through the public sector. In present value terms the saving is £3.71m, or 15.5%, which represents the increase in wealth for the taxpayer that would have occurred has public finance been used. Or put another way it is the amount by which the taxpayer is immediately worse off as a result of the choice of the LIFT financing method.

A possible criticism of this approach is that it does not correspond to the actual financing pattern of any current third party development (NAO Memorandum, House of Commons, 2006, ev.28). Whilst this is undoubtedly the case, there is no theoretical reason why a project should not be evaluated using an opportunity cost based discount rate for the alternative source of finance. Whether or not such a source of finance is actually available is a matter for regulation and policy.

Ex-Post Comparison

Another method of evaluating VfM is to compare the forecasted financial performance implied by the modelling assumptions underpinning the decision to use the LIFT approach with the results that have been achieved since the decision was made. In the case of urban NW, the investment was made in 2004 and there are accordingly three full years of financial results available for the LIFCo SPV at the time of writing.[13] The annual accounts for the LIFTCo were obtained and the proforma forecasts in appendix 6.1 reformatted for comparative purposes using the same summary headings. Table 6.3 shows the results of this comparison.

[13] *Name of Company*, source: Nexis UK.

Table 6.3: Urban NW LIFT, Forecast and Actual Performance

	PROFIT AND LOSS ACCOUNT Actuals			cumulative	growth rate
Date of Accounts	**31/12/2007**	**31/12/2006**	**31/12/2005**		**07:05**
Total Sales	2,912,000	2,862,000	1,890,000	**7,664,000**	**1.54**
Cost of Sales	726,000	723,000	419,000	**1,868,000**	**1.73**
Gross Profit	2,186,000	2,139,000	1,471,000	**5,796,000**	**1.49**
Operating Profit	1,374,000	1,332,000	884,000	**3,590,000**	**1.55**
Nontrading Income	143,000	69,000	7,000	**219,000**	**20.43**
Interest Payable	1,698,000	1,659,000	1,055,000	**4,412,000**	**1.61**
Pretax Profit	-181000	-258000	-164000	**-603,000**	**1.10**
Taxation 69,	000	74,000	23,000	**166,000**	**3.00**
Profit After Tax	-250000	-332000	-187000	**-769,000**	**1.34**
Dividends Payable	0	0	0	**0**	
Retained Profits	-250000	-332000	-187000	**-769,000**	**1.34**
	PROFIT AND LOSS ACCOUNT Forecast				
	31/12/2007	**31/12/2006**	**31/12/2005**		
Total Sales	2,914,000	2,604,000	244,000	**5,762,000**	**11.94**
Cost of Sales	910,000	895,000	612,000	**2,417,000**	**1.49**
Gross Profit	2,004,000	1,709,000	-368,000	**3,345,000**	**5.45**
Operating Profit	1,314,000	1,019,000	-1,058,000	**1,275,000**	**1.24**
Nontrading Income	28,000	28,000	0	**56,000**	**0.00**
Interest Payable	1,616,000	1,647,000	0	**3,263,000**	**0.00**
Pretax Profit	-274,000	-600,000	-1,058,000	**-1,932,000**	**0.26**
Taxation 0		0	0	**0**	
Profit After Tax	-274,000	-600,000	-1,058,000	**-1,932,000**	**0.26**
ASSETS					
NET ASSETS	22,185,000	22,748,000	23,385, 000		
RATIOS					
Actual sales/ forecast sales				**1.33**	
Actual Return on capital employed	**6.84%**	**6.16%**	**3.81%**	**5.60%**	
Forecast return on cap	**6.05%**	**4.60%**	**-4.52%**	**2.04%**	
Actual gross margin	**75.07%**	**74.74%**	**77.83%**	**75.63%**	
Forecast gross margin	**68.77%**	**65.63%**	**-150.82%**	**58.05%**	

Sources: Nexis UK and appendix 6.1

In general the financial performance of the LIFTCo has been stronger than predicted in the NAO/Operis model. Sales turnover to date is about 33% higher than assumed and the rate of profit margin is also at least six points higher (75.07% vs 68.77%) even in 2007 where the difference is the narrowest. There is a three point difference in return on capital employed (5.60% vs 2.04%).

A notable feature is that, subject to the variation in gross margin, the NAO model is a good predictor for the 2007 results and the actual results appear

to be converging quite closely on the model parameters. Some confidence can therefore be attributed to the base model's ability to predict the cash flows for the remaining 22 years of the project. A further step is therefore to recompute the base model using actual results for years 0-3 and forecasted results for years 4-25 inclusive. The full model is reproduced in appendix 6.2 and detailed assumptions set out in table 6.7 below. The comparative model output results are shown in table 6.4.

Table 6.4: Urban NW LIFT, Comparative IRRs for Base Model and Revised Forecast

	Base model	**Revised model**
Nominal post tax blended equity excluding residual value	13.90% 43.95%	
Nominal post tax blended equity including residual value	15.00% 43.97%	

Sources: Nexis UK and Appendices 1 and 2.

As table 6.4 shows, the IRRs are significantly higher in the revised model. The principal reason for this is the higher revenue and lower cost in the first three years. In the Mahmood/Operis model, the costs and revenues build up slowly using fast growth rates in the first three years, and then level off to inflation based 2.5% increases from then on. The actual results do not however reflect this pattern. There are two particular aspects. First PCT payments have come on stream more quickly than predicted. A possible interpretation of this is that it is a positive pay-off for the investors for on time completion against construction cost risk. More importantly, and having the greatest impact, operating costs (cost of sales) are 23% lower than predicted in the model. In combination with accelerated revenue, this accounts for the increase in gross profit and return on capital employed discussed above. Differences in cash flows in earlier years have a large impact on the IRR, whereas inaccuracies in later years have progressively less impact, which is why the of relatively small differences in accounting rates of return are amplified in the IRR differences in table 6.4. In VfM terms it would appear that realisable profits to investors are potentially much higher than the models in the NAO (2005) report would suggest. In summary, the evidence suggests that the models relied upon by the NAO are sensitive to assumptions about early years' cash flow and that these should be scrutinised more closely, not least because short run cash flows, such as PCT payments are more easily predictable.

Sensitivity Analysis and Risk Evaluation

LIFT is a type of design, build, finance and operate (DBFO) scheme, and it is therefore appropriate to analyse the risk of the scheme under these headings with reference to the cash flows that correspond most closely. The model analyses only the financial aspects of these risks. Table 6.5 shows a sensitivity analysis for urban NW LIFT using the base model in appendix 6.1 and the revised model from table 6.4. The table facilitates comparison between the models used by NAO/Operis and the revised model which is the model that would have been used had early year revenue and costs been forecasted more accurately. As in the NAO Report (2005) the variants are computed without and with residual values (columns 1 and 2 respectively).

Table 6.5: Urban NW LIFT, Sensitivity Analysis

	Base model		**Revised model**	
	1	2	1	2
Start value	14.06%	15.10%	43.95%	43.97%
Design and construction risk				
Construction cost	-3.01%	-2.27%	-6.49%	-6.29%
Year 1&2 revenues	0.67%	0.55%	2.50%	2.49%
Year 1&2 costs	-0.36%	-0.30%	-0.50%	-0.50%
Financing risk				
Interest rate	-2.29%	-1.70%	-0.91%	-0.90%
Operating risk				
Gross margin	3.51%	2.91%	3.59%	3.59%
Life cycle cost	-0.35%	-0.18%	-0.12%	-0.12%
Hard FM cost	-0.91%	-0.62%	-0.20%	-0.20%
Residual value	N/A	0.06%	N/A 0.00%	

Sources: Nexis UK and Appendices 1 and 2; Mahmood (2004).

Notes:
The table shows the percentage increase in IRR for a 1% increase in the relevant cash flow category.
1 = Nominal Post-Tax Blended Equity IRR no RV
2 = Nominal Post-Tax Blended Equity IRR with RV

IRR is highly sensitive to construction cost risk in all variants. If revised model assumptions are used, the risk is more than doubled, although the variation is to a much higher base IRR. Even so, the figures clearly demonstrate that the construction phase of the contract and the possibility of cost over-run is a very significant determinant of overall risk. That said, it should be noted that high sensitivities are partly that result of financing arrangements, since if a similar test is conducted on the project cash flows (as opposed to blended equity cash flows) the sensitivities fall to about a third of those reported in table 6.5. When these sensitivities are compared to impacts from other factors, it can be seen that construction phase risk

management should be of top priority to LIFT partners and investors. Such a conclusion is reinforced if the sensitivities of early phase cost and revenue variations are examined. All models are sensitive to revenue changes in years 1 and 2, and somewhat less so to cost changes. Taken together, it is clear that there is a very strong incentive for the LIFTCo management and investors to manage construction within budget and to build up early phase revenues as quickly as possible. As the PCT is a stakeholder in the LIFTCo it has an incentive to ensure that revenues come on stream quickly and can do this for example by taking on the head lease in cases where the premises cannot be filled quickly with medical practices.

Financing risk is also of some importance, and more so for the base model assumptions than for the revised model. Increases in interest rates have a disproportionate effect on IRRs. Because LIFTCo-s rely as in this case quite heavily on structured finance, they can achieve some insulation from interest rate risk increases, whilst downward movements in rates may create relatively profitable refinancing opportunities.

As far as operating risk is concerned, all the models are equally and highly sensitive to changes in gross profit margin. As illustrated already in tables 6.3 and 6.4, the seven point increase in gross profit is a major contributor to an IRR increase of approximately twenty eight points, which is in line with the sensitivities highlighted in table 6.5. Because, the NAO/Operis and Mahmood (2004) models use nominal rates, Mahmood argues that his calculations are sensitive to assumptions about inflation. However lease payments are inflated at 2.5% (the assumed increase in RPI) and therefore reasonably predictable after the first two years, and possibly before then as has already been suggested, the only risk from inflation comes from cost pressures exceeding the RPI and thereby eroding margins. The calculations in table 6.5 suggest that the risk in this respect is only moderate. Individual cost categories such as hard FM and life cycle costs were also analysed. Individually these are less sensitive and are of lower risk. Even if a poor design or construction therefore results in higher maintenance and asset replacement rates, they are not likely to affect the outturn IRR too significantly.

Finally, residual value was also considered under the heading of operating risk. If the building is well maintained and regularly refurbished, the project should generate a relatively high residual value. In risk terms, generating a residual value is important because of the slow rates of senior debt amortisation and the use of bullet debt, which imply high outstanding debt balances at the end of the project. As can be seen from table 6.5 changes in the residual value do not have a significant impact on IRR. Mahmood (2004, 35) draws the same conclusion. However, the implication of the NAO's (2005, table 10) presentation, is that the residual value is a key sensitivity. However this does not turn out to be the case in either model, not least the

base model which has the same assumptions as those underpinning their own analysis. In fact, the residual value only appears sensitive in NAO (2005) table 10 because it is either included or excluded. As the above analysis shows, when variations in the level of residual value are examined, the sensitivities are insignificant.

6.3.4 Discussion and Evaluation

The major conclusion from the above analysis is that LIFT schemes can yield much higher investor returns than suggested by the NAO Report (2005). In that report, the six schemes reviewed all had very closely clustered returns, suggesting the likely variation from the 14% average benchmark would be unlikely. In contrast, the above results suggest that returns can be much higher and are indeed very sensitive to small changes in key assumptions. Those highlighted are the achievable gross margin, including the rate of early phase revenue growth. Possible reasons are the systematic over-estimate of cost (by about 23% in this case) in the NAO/Operis models. Under the LIFT scheme such savings accrue to the investor rather than the taxpayer and therefore do not translate into VfM considerations. On the contrary the higher potential returns represent an excess profit possibility from the scheme at the expense of the taxpayer. Moreover, it is also clear that the cost of using direct public finance would generate substantial savings for the taxpayer.

Such considerations do not necessarily translate into VfM without factoring in risk transfer. However, the NAO has stated that it identified no VfM concerns about the allocation of risk under the LIFT model (House of Commons, 2006, ev.29). Such concerns obviously do exist if there are potentially large profits to be made without an equivalent risk transfer. As has been shown by the sensitivity analysis, there are some important risks embedded in construction and financing activities. In order to realise the upside potential of LIFT, the LIFTCo management must ensure that facilities are constructed on budget. There is thus at least one powerful and positive incentive built into the scheme, and this may be one reason why LIFTCo-s in general have delivered on time. As was also noted however, capital costs per patient can vary considerably and there are dis/economy of scale factors that help detract/promote the efficiency of the LIFT model. Larger investments proximate to population centres also seem to be better at drawing in associated dental practices and pharmacies (East Midlands LIFT). Finally, sensitivities would be much lower in a public sector comparative case since the project IRRs are much less sensitive to construction cost over-runs than blended equity IRRs.

Blended equity IRRs also amplify the risks associated with loan finance. Because cash from borrowings offsets major capital expenditure cash flows, the rate of profit, whether computed as an accounting rate of return or an

IRR can be enhanced considerably because of the low net equity outlay required. The introduction of debt therefore merely introduces risk as possibilities that the distribution of project cash flows between debt and equity holders will vary in some measure other than planned. Because the public sector is a residual equity stakeholder under LIFT, it therefore faces financial risk arising from high borrowing that would not exist if it were sole owner and operator of the asset. In other words, although the blended equity IRRs are sensitive to interest rate changes, there is no transfer of risk away from the public sector as a result of these financial arrangements.

The only remaining point to consider is the positive effects from leveraging other sources of local finance. For example, L Partnership [name of a regional development authority] contributed £723,604 to the K Health Centre project in grant aid in the hope that the centre will aid the regeneration of the town.[14] However, such decisions are a function of the investment per se rather and the use of LIFT structured finance would be immaterial.

In terms of evaluating VfM, evidence from this case suggests that LIFT offers considerable upside potential to private sector investors and conversely offers an expensive option to the taxpayer. In return for getting new facilities built and on time and within budget, the rates of return are about one and a half points higher on the NAO figures (House of Commons, 2006, ev.26), or anything up to twenty eight points higher in at least one credible scenario presented here. Savings from using alternative direct public finance are conservatively estimated at £3.5m on this £20m scheme suggesting a national saving on tranche 1 alone of £124m. Of course, such extrapolations are dangerous on the basis of one case and further research is needed. The point has already been made about access difficulties and the paucity of public domain data, and this alone should increase the value of the study presented here. More importantly, by establishing a public domain and detailed base case, the possibility of similar evaluations for other schemes is now offered.

6.4 Comparative Financial Models: Urban NW, Mixed West Midlands and Urban NE

The purpose of this subsection is to compare the internal rates of return (IRRs) across three different LIFTCo-s. These IRRs are also compared to those reported in NAO (2005). Two of the case studies, urban NW and mixed West Midlands featured amongst the six reported in the NAO report. The third, urban NE, was analysed so that the financial outcomes could be assessed in conjunction with the interview evidence on VfM gathered elsewhere in the report. Subsection 6.3 above has already considered urban NW, as the detailed accounting data required to build a base case that

[14] *This is Lancashire*, 6th January, 2004.

reconciled to the NAO (2005) IRR outputs were only available for that case study LIFT (Mahmood, 2004, annex IV). Once constructed, such a base case can be modified using reasonable assumptions to reflect the financial circumstances of other LIFTCo-s. Although the precise inputs cannot be known from public domain information, these can be approximated and assumptions tested using sensitivity analysis.

In the analysis that follows, each LIFT is considered in turn. The basis for each case is three tables: a model input table, an ex post profit and loss comparison, and the financial model. The latter, due to their size and detail, are shown as appendices, and key highlights reported in the narrative below. A further subsection then conducts a systematic comparison across the three cases.

6.4.1 Urban NW: The Base Case

Table 6.6 shows the breakdown of revenues, costs and margins, as forecast in 2004. These data provide some detail of the inputs used in the NAO (2005) report, which produced an IRR of 15.1% for urban NW. As can be seen from table 6.6, a striking feature of the forecast is the rapid build up of revenue from a low base in the first three years of the project. Once these inputs have been modelled, it becomes clear that the IRR is extremely sensitive to the assumed rate of growth and initial level of revenue. Pessimistic assumptions, for example about the 2005 inputs, have a powerful effect on levering down the IRR. The principal costs in arriving at gross profit are facilities management and administrative and secretarial. Assumptions about starting levels and growth rates also have significant impact on the IRR, albeit less so than the revenue assumptions.

Table 6.6: Urban NW LIFT, Revenue, Cost and Gross Margin

Proforma P&L a/c	**30/9/05**	**30/9/06**	**30/9/07**
Lease plus payments	98.00	2274.00	2576.00
Third party revenues	24.00	53.00	54.00
Recovery of pass through costs	80.00	182.00	186.00
Recovery of utilities costs	42.00	95.00	98.00
Total revenue	**244.00**	**2604.00**	**2914.00**
Admin and secretarial	274.00	139.00	143.00
SPV Management	21.00	49.00	50.00
External fees	4.00	10.00	10.00
Bank fees and charges	1.00	2.00	2.00
Insurance 38.00		87.00	90.00
Hard FM Operating Costs	174.00	380.00	381.00
Pass through costs	58.00	133.00	136.00
Utilities costs	42.00	95.00	98.00
Total costs	**612.00**	**895.00**	**910.00**
Gross profit	**-368.00**	**1709.00**	**2004.00**

Source: Compiled from Mahmood (2004, annex III).

Using the data in table 6.6, the base case can be constructed by factoring other known inputs (for example debt ratios, interest costs, debt repayment schedules and residual values) and modifying remaining variables to produce an IRR of 15.1% as reported in NAO (2005, 26 and c/f. Mahmood, 2004, 35).

Model inputs and outputs for urban NW LIFTCo in terms of Nominal Post-Tax Blended Equity IRR without and with residual values are shown in table 6.7. In the urban NW case, the majority of the inputs are taken directly from the forecast accounting data in Mahmood (2004, annexes III and IV). Growth rates, for costs and revenues are calculated variables for the urban NW model, whereas they are input variables in other cases. They are shown here in the same format for consistency and comparability with other tables.

Table 6.7 in conjunction with Appendix 6.1 can be used to generate further bespoke modelas that can be used to compute IRRs on the same basis as the Operis method. The required steps are as follows:

1) Determine base case input assumptions (complete the input variables listed in table 6.7).
2) Create columnar extensions for each flow category following the format in appendix 6.1.
3) Use growth and amortisation rates, capital costs, debt finance splits and residual value assumptions to map cash flows in individual years (see alsp the descriptions on pp 154-55 above). Note: Include depreciation charges in order to forecast the cash flow consequences of tax deferral.
4) Compute the belnded equity post tax IRR with and without RV using the definition in note 10 above.

Table 6.7: Urban NW LIFT, Model Inputs and Outputs

Input variables	**Actuals**	**Base case**	**Base case assumptions**
Revenue starting value, £'000s	1,890	244	Pro-forma P&L account (Mahmood, 2004, annex III)
Cost starting value, £'000	419	612	Pro-forma P&L account (Mahmood, 2004, annex III)
Year 1 revenue growth	1.51	10.67	Pro-forma P&L account (Mahmood, 2004, annex III)
Year 1 cost growth	1.71	1.200	Pro-forma P&L account (Mahmood, 2004, annex III)
Year 2 growth, costs and revenues	1.081	1.11	Pro-forma P&L account (Mahmood, 2004, annex III)
Years 3-25 growth, costs and revenues	1.025	1.025	Steady state inflation rate (Mahmood, 2004, 32).
Senior debt amortisation rate	0.96	0.96	Pro-forma Balance Sheet (Mahmood, 2004, annex IV)
Subordinated debt amortisation 0.93		0.93	Pro-forma Balance Sheet (Mahmood, 2004, annex IV)
Tax rate	0.27	0.27	Estimated applying 2004-05 tax rates to average forecast annual profits
Capital cost £'000s	23,498	23,501	Pro-forma Balance Sheet (Mahmood, 2004, annex IV). Estimated by differencing balance sheet values
First year	62.41%	62.13%	Pro-forma Balance Sheet (Mahmood, 2004, annex IV)
Second year	37.59%	37.87%	Pro-forma Balance Sheet (Mahmood, 2004, annex IV)
Residual value (RV) £'000s 8,250		8,250	Mahmood (2004, 45)
RV/Cap cost	0.351	0.351	Calculated from above inputs
Borrowing ratios*			
Senior debt amortising	80.00%	80.00%	Mahmood (2004, 69)
Senior debt bullet	9.00%	9.00%	Mahmood (2004, 69)
Subordinated debt	11.00%	11.00%	Mahmood (2004, 69)
Total	**87.00%**	**87.00%**	
Outputs			
Nominal Post-Tax Blended Equity IRR no RV	**43.95%**	**14.00%**	Mahmood (2004, 35); NAO (2005, 26)
Nominal Post-Tax Blended Equity IRR with RV	**43.97%**	**15.10%**	Mahmood (2004, 35); NAO (2005, 26)

Sources: LIFTCo actuals, Nexis UK. Forecasts per model calculated from figures in Mahmood (2004) and NAO (2005). Tax rates taken from: http://www.scopulus.co.uk/taxsheets/uktaxrates2004-5.htm#CorporationTax4-5

Note:
* Debt divided by capital cost

Urban NW model results have already been reported in the detailed financial case study analysis for the urban NW LIFT and are not discussed in

individual detail again here. For the purposes of the comparative an analysis below however, the appropriate data is reproduced in table 6.8.

Table 6.8: Urban NW LIFT, Model Forecasts and Actual Comparisons

	Actuals			sum	Forecast			sum	diff
Date of Accounts	**31/12/2007**	**31/12/2006**	**31/12/2005**		**31/12/2007**	**31/12/2006**	**31/12/2005**		
	£	**£**	**£**	**£**	**£**	**£**	**£**	**£**	**£**
Total Sales*	3,055,000	2,931,000	1,897,000	**7,883,000**	2,942,000	2,632,000	244,000	**5,818,000**	2,065,000
Cost of Sales	726,000	723,000	419,000	**1,868,000**	910,000	690,000	612,000	**2,212,000**	344,000
Gross Profit	2,329,000	2,208,000	1,478,000	**6,015,000**	2,032,000	1,737,000	-368,000	**3,401,000**	
Depreciation	812,000	807,000	587,000	**2,206,000**	690,000	690,000	690,000	**2,070,000**	-136,000
Operating Profit	1,517,000	1,401,000	891,000	**3,809,000**	1,342,000	1,047,000	-1,058,000	**1,331,000**	
Interest Payable	1,698,000	1,659,000	1,055,000	**4,412,000**	1,616,000	1,647,000	0	**3,263,000**	-1,149,000
Pretax Profit	-181000	-258000	-164000	**-603,000**	-274,000	-600,000	-1,058,000	**-1,932,000**	
Taxation	69,000	74,000	23,000	**166,000**	0	0	0	**0**	-166,000
Profit After Tax	-250000	-332000	-187000	**-769,000**	-274,000	-600,000	-1,058,000	**-1,932,000**	**1,163,000**
Gross profit/Sales	*76.23%*	*75.33%*	*77.91%*	***76.30%***	*69.01%*	*65.99%*	*-150.81%*	***58.46%***	

Sources: Actuals taken from LIFTCo accounts, Nexus UK, forecasts per model input assumptions, table 6.8 and model in appendix 6.2.

6.4.2 Mixed West Midlands LIFT, Financial Model

Model inputs and outputs for mixed West Midlands LIFTCo in terms of Nominal Post-Tax Blended Equity IRR without and with residual values are shown in table 6.9. Two columns of figures show actual values that are used to update the model from published accounting data and the input columns show a base case constructed to approximate to the NAO models. Approximation is achieved by varying the inputs according to reasonable assumptions to produce the IRR outputs close to those relied upon by the NAO. Model inputs are only allowed to vary within certain parameters, namely the post-tax blended equity IRR should correspond to the two figures (with and without residual values) shown in NAO (2005, 26). Debt ratios and residual values are known from public sources of information, so these are treated as fixed inputs. Other inputs are treated as fixed as far as possible and the year 1 operating cost starting value is set to correspond to year 1 actual values from the accounts. The procedure therefore allows as few inputs as possible to vary and these are marked with an asterisk in the input table. These consist of a starting figure for revenue and growth forecasts for costs and revenues in the early years of the project. The effect of developing the model in this fashion is to focus on the accuracy or otherwise of cost and revenue forecasts whilst holding other parameters relatively constant.

As growth rates in the later years are known to be assumed stable, the model is naturally sensitive to changes in the early years build up. Because financial results for the early years of the project are available at the time of writing from published accounts, typically three years, a useful comparison can be drawn. A comparison showing the first three years from the base

case forecast model and the first three years actual trading results from the accounts is shown in table 6.10.

From table 6.10, it can be seen that the model provides a reasonable approximation to the actual financial results. In addition to providing columns for each of the first three years of the project, the table also computes the summed values in each case and the difference between actuals and forecast is shown in the final column. Favourable variances against forecast are shown as positive figures and unfavourable variances as negatives.

Table 6.9: Mixed West Midlands LIFT, Model Inputs and Outputs

Input variables	Actuals	Base case	Base case assumptions
Revenue starting value, £'000s	839	404.5	Variable adjusted to produce base case IRR (Mahmood, 2004, 35; NAO, 2005, 26)*
Cost starting value, £'000	146	146	Set to equal 1st year actuals
Year 1 revenue growth	1.715	4.400	Simulated growth rates based on Urban NW base case and Mahmood (2004, annex III)*
Year 1 cost growth	0.000	1.200	Simulated growth rates based on Urban NW base case and Mahmood (2004, annex III)*
Year 2 growth, costs and revenues	1.124	0.100	Simulated growth rates based on Urban NW base case and Mahmood (2004, annex III)*
Years 3-25 growth, costs and revenues	0.025	0.025	Steady state inflation rate (Mahmood, 2004, 32).
Senior debt amortisation rate	0.96	0.96	Urban NW base case, Mahmood (2004, annex IV)
Subordinated debt amortisation	0.93	0.93	Urban NW base case, Mahmood (2004), appendix 1
Tax rate	0.27	0.27	Estimated applying 2004-05 tax rates to average forecast annual profits
Capital cost £'000s	15,420	18,508	Estimated as RV x 0.389
first year	100.00%	100.00%	All construction completed in first year
second year	0.00%	0.00%	
residual value (RV) £'000s	7,200	7,200	Mahmood (2004, 45)
RV/Cap cost	0.467	0.389	Estimated comparing Mahmood (2004, 34) and NAO (2005, 26) case study 3
Borrowing ratios			
Senior debt amortising	77.00%	77.00%	Mahmood (2004, 69)
Senior debt bullet	10.00%	10.00%	Mahmood (2004, 69)
Subordinated debt	0.00%	0.00%	Mahmood (2004, 69)
Total	**87.00%**	**87.00%**	
Nominal Post-Tax Blended Equity IRR no RV	**20.63%**	**14.02%**	Mahmood (2004, 35); NAO (2005, 26)
Nominal Post-Tax Blended Equity IRR with RV	**21.21%**	**15.29%**	

Sources: See table 6.7.
Notes:
* Variables adjusted iteratively to produce approximations to IRR's reported in Mahmood (2004, 35) and NAO (2005, 26).

Table 6.10: Mixed West Midlands LIFT, Model Forecasts and Actual Comparisons

	Actuals			sum	Forecast			sum	diff
Date of Accounts	**31/03/2008**	**31/03/2007**	**31/03/2006**		**31/03/2008**	**31/03/2007**	**31/03/2006**		
	£	**£**	**£**	**£**	**£**	**£**	**£**	**£**	**£**
Total Sales	1,618,000	1,439,000	839,000	3,896,000	1,957,780	1,779,800	404,500	4,142,080	-246,080
Cost of Sales	146,000	185,000	146,000	477,000	353,320	321,200	146,000	820,520	343,520
Gross Profit	**1,472,000**	**1,254,000**	**693,000**	**3,419,000**	**1,604,460**	**1,458,600**	**258,500**	**3,321,560**	
Depreciation	973,000	720,000	292,000	1,985,000	452,320	452,320	452,320	1,356,960	-628,040
Operating Profit	**499,000**	**534,000**	**401,000**	**1,434,000**	**1,152,140**	**1,006,280**	**-193,820**	**1,964,600**	
Interest Payable	1,008,000	969,000	572,000	2,549,000	1,238,893	1,289,376	0	2,528,270	-20,730
Pretax Profit	**-509,000**	**-435,000**	**-171,000**	**-1,115,000**	**-86,753**	**-283,096**	**-193,820**	**-563,670**	
Taxation	0	-16000	14,000	-2,000	0	0	0	0	2,000
Profit After Tax	**-509,000**	**-419,000**	**-185,000**	**-1,113,000**	**-86,753**	**-283,096**	**-193,820**	**-563,670**	**-549,330**
Gross profit/Sales	*90.98%*	*87.14%*	*82.60%*	***87.76%***	*81.95%*	*81.95%*	*63.91%*	***80.19%***	

Sources: Actuals taken from LIFTCo accounts, Nexus UK, forecasts per model input assumptions, table 6.8 and applied to model in appendix 6.3.

Reviewing table 6.10 in conjunction with the output values in table 6.9, in general the LIFTCo has been more profitable than average levels suggested by the NAO Report models (2005, 26, table 10). Nominal Post-Tax Blended Equity IRRs are 20.63% and 21.21% without and with residual values respectively. The reason for this circa 7% premium is that operating costs (measured by cost of sales) have been much lower than predicted, and have shown no growth trend between 2006 and 2008. Lower than forecast revenues have been more than offset by lower costs, so that the average gross operating margin (gross profit/sales) is also circa 7% above the level implied by the model assumptions. Interest charges are as predicted and taxation does not have a large impact on the model or actual results. Depreciation is therefore the other major factor explaining the aggregate underperformance of actual results compared to the model predictions. Depreciation is an accounting transfer and does not affect cash flow directly. The depreciation values in the model assign the difference between the capital cost and residual value on a straight line basis over 25 years.[15] There is only an indirect effect on cash flow as the depreciation charge is included in the computation of early year losses to create a tax deferral effect in the model. Consequently, the timing of tax cash flows are affected, and these have a higher weight later in the model due to the deferrals. The higher levels of depreciation that are being charged in the first three years of the LIFTCo's accounts would seem to be significantly greater than necessary to write off the asset cost over 25 years, suggesting that an accelerated depreciation policy is being applied.

[15] The applied assumption is that tax and accounting depreciation rates correspond closely over the long run.

6.4.3 Urban NE LIFT, Financial Model

Model inputs and outputs for determined on the same basis as mixed West Midlands above for the urban NE LIFTCo are shown in table 6.11. Similar assumptions are made except for certain non-simulated variables where input data is not available from Mahmood (2004) or NAO (2005). For the purposes of constructing a base case therefore, the average IRR's without and with residual values were computed from NAO (2005, 26, table 10), thereby imposing the base case assumption that urban NE is an 'average' LIFT. No information was available for the estimated residual value, and these varied quite dramatically in the NAO (2005) report.[16] However, if the residual value is adjusted to produce a similar differential to the without and with blended IRRs, it can be estimated by simulation. The resulting residual value is therefore the figure that corresponds to the average differential for a LIFT of the size of urban NE. Unlike mixed West Midlands capital cost is allocated across three years as the expenditure built up at approximately that rate in the LIFTCo balance sheets, reflecting the phased opening of four health centres, starting with #1 in December 2006 and ending with #4 in December 2007. The individual costs of these are summed together with an estimate of purchase and legal costs to compute total capital cost inputs.[17] Other inputs are determined in a similar fashion to the mixed West Midlands case.

In similar fashion to urban NW LIFT and mixed West Midlands LIFT, a comparison showing the first three years from the base case forecast model and the first three years actual trading results from the accounts is shown in table 6.12. In the base case model the inputs must be constrained to a gross profit equivalent to 57% in order to produce IRRs as low as in the NAO Report. The actual gross profit for the first three years is 80.5%, which is similar to, if slightly lower than mixed West Midlands. A differential gross profit of circa 23% between the model and actual explains to a large extent why, when actual numbers are substituted into the first three years of the model, the IRR rises to circa 200%.

[16] Ranging from 12.6% - 131% of land and construction costs (NAO, 2005, p.26, table 10).

[17] Based on Mahmood (2004), the approximate costs for a LIFT of this size was £2.5m.

Table 6.11: Urban NE LIFT, Model Inputs and Outputs

Input variables	Actual	Base case	Base case assumptions
revenue starting value 70		52.04	Variable adjusted to produce base case IRR (Mahmood, 2004, 35; NAO, 2005, 26)
cost starting value	18	18	Set to equal 1st year actuals
year 1 rev growth	11.086	9.000	Simulated growth rates based on Urban NW base case and Mahmood (2004, appendix 1)
year 1 cost growth	7.722	15.000	Simulated growth rates based on Urban NW base case and Mahmood (2004, appendix 1)
year 2 growth	2	2	Simulated growth rates based on Urban NW base case and Mahmood (2004, appendix 1)
years 3-25	0.025	0.025	Steady state inflation rate (Mahmood, 2004, 32).
senior debt amortisation rate	0.96	0.96	Urban NW base case, Mahmood (2004), annex 4
subordinated debt amortisation	0.93	0.93	Urban NW base case, Mahmood (2004), appendix 1
tax rate	0.27	0.27	Estimated applying 2004-05 tax rates to average forecast annual profits
capital cost	22,100	15,000	Aggregated costs of Alexandra, Park, Calvert Lane and Longhill Health Centres + estimated legal fees
first year	33.00%	33.00%	All construction completed in first year
second year	33.00%	33.00%	
third year	33.00%	33.00%	Mahmood (2004, 45)
residual value	9,393	4,200	
RV/Cap cost	0.425	0.280	Variable adjusted to produce average differential in base case IRR (NAO, 2005, 26)
Borrowing ratios			
senior debt amortising	92.00%	92.00%	Urban NE LIFTCo balance sheets
senior debt bullet	8.00%	8.00%	Urban NE LIFTCo balance sheets
subordinated debt	0.00%	0.00%	
Total	**100.00%**	**100.00%**	
Outputs			
Nominal Post-Tax Blended Equity IRR no RV	**199.98%**	**12.95%**	Approximations to average IRR of the six NAO (2005, 26) case studies
Nominal Post-Tax Blended Equity IRR with RV	**199.98%**	**14.96%**	Approximations to average IRR of the six NAO (2005, 26) case studies

Sources: See table 6.7.

Notes:
* Variables adjusted iteratively to produce approximations to IRR's reported in Mahmood (2004, 35) and NAO (2005, 26).

Table 6.12: Urban NE LIFT, Model Forecasts and Actual Comparisons

Actuals				**Sum**	**Forecast**			**sum**	**difference**
Date of Accounts	**31/12/2007**	**31/12/2006**	**31/12/2005**		**31/12/2007**	**31/12/2006**	**31/12/2005**		
Total Sales	1,543,000	776,000	70,000	2,389,000	1,405,080	468,360	52,040	1,925,480	463,520
Cost of Sales	278,000	139,000	18,000	435,000	540,000	270,000	18,000	828,000	393,000
Gross Profit	**1,241,000**	**632,000**	**52,000**	**1,925,000**	**865,080**	**198,360**	**34,040**	**1,097,480**	
Depreciation	510,000	328,000	133,000	971,000	432,000	432,000	0	864,000	-107,000
Operating Profit	**731,000**	**304,000**	**-81000**	**954,000**	**433,080**	**-233,640**	**34,040**	**233,480**	
Interest Payable	982,000	465,000	25,000	1,472,000	854,076	891,392	0	1,745,468	273,468
Pretax Profit	**-227000**	**-156000**	**-106000**	**-489,000**	**-420,996**	**-1,125,032**	**34,040**	**-1,511,988**	
Taxation	167000	0	0	167,000	0	0	0	0	-167,000
Profit After Tax	**-60000**	**-156000**	**-106000**	**-322,000**	**-420,996**	**-1,125,032**	**34,040**	**-1,511,988**	**1189988**
Gross profit/sales	***80.43%***	***81.44%***	***74.29%***	***80.58%***	***61.57%***	***42.35%***	***65.41%***	***57.00%***	

Sources: Actuals taken from LIFTCo accounts, Nexus UK, forecasts per model input assumptions, table 6.10 and applied to model in appendix 6.4

6.4.4 Comparative Analysis

Individual reasons for difference between the base case model and ex post adjusted models have been discussed. In general the LIFTCo-s are performing above the expected levels predicted in NAO (2005). Some of the general reasons for these differences are now explored.

Gross Margins, IRR and After Tax Cash Flow

A summary is provided in table 6.13 showing differences between forecast and ex post gross margins, IRRs and after tax cash flows for the three case studies and an overall average.

Table 6.13: Comparative Gross Margins, IRR and After Tax Cash Flow

	Urban NW	Mixed West Midlands	Urban NE	Case study average
COMPARATIVE MARGINS*				
Average 3 year ex post gross margin %	76.30 87.76	80.58 81.54		
Implied ex ante average margin per NAO model assumptions %	58.46 80.19	57.00 65.22		
Difference %	17.84 7.57		23.58 16.32	
COMPARATIVE IRR**				
IRR adjusted for 3 years ex post data %	43.97 21.21	199.98		88.39
IRR implied by NAO assumptions %	15.10 15.29	14.96 15.12		
Difference %	28.87 5.92		185.02	73.27
COMPARATIVE AFTER TAX CASH FLOW†				
After tax non-balance sheet cash flows 3 years ex post £'000	1,437 872		649 2,958	
After tax non-balance sheet cash flows* for first three years per NAO assumptions £'000	138 794	-648		284
Difference £'000	1,299 78		1,297 2,674	

Sources: LIFTCo actuals, Nexis UK. Forecasts per model calculated from figures in Mahmood (2004) and NAO (2005).

Notes:

* Profit after direct operating costs and before depreciation and interest charges divided by revenue

** Blended nominal internal rate of return. Rate of interest required to equalise the present values of post interest and tax cash flows, including residual value, attributable to equity and non-senior debt holders

† Profit after tax plus depreciation

As can be seen from table 6.13, in no case is an ex post adjusted margin or IRR calculation below the forecast level implied by the NAO assumptions. It is difficult to infer too much from ratios since there is clearly scope for them to take on potentially unrepresentative large values, as is the case here with the very high IRR for urban NE. In purely cash flow terms however it is also clear that the after tax cash flows of all three projects are much higher than the cash flows implied by the Mahmood/NAO assumptions, which are needed to constrain the IRR to the 14-15% range. As table 6.13 shows, aggregate cash flows are £2,674,000 higher than implied by the NAO models across the three LIFTs. Only mixed West Midlands compares fairly closely with the original models, whereas in the other cases the NAO models were overly pessimistic.

Depreciation Charges

One reason why the LIFT's report low profits but high IRRs apart from the sensitivity of early years' revenue and cost growth in the NAO models, is the use of accelerated depreciation. In two cases depreciation charges were much higher than required to write off the assets of the LIFT over 25 years factoring in the residual value. In the case of urban NE (where depreciation charges were not higher), depreciation may not have reached steady state by year three due to the slower build up of capital cost (33% per year over three years). In the case of urban NW and mixed West Midlands there appears to be systematic over-depreciation of the assets, leading to possible understatement of reported profits, undisclosed reserves and the possibility of a larger capital profit at the end of the project. Theoretically, these reserves could be realised if the project were to be refinanced in the future.

Table 6.14: Comparison of Required and Actual Depreciation Charges

	LIFTCo			
	Urban NW	**Mixed West Midlands**	**Urban NE**	**Case study average**
Original cost of assets *	23,498 15,420		22,100	61,018
Residual value**	8,250 7,200		9,393	24,843
Steady state actual depreciation charge†	812 973		510	2,295
Average depreciation charge required to write of assets over useful life‡	630 328		557	1,644
Difference	182 645		-47	780

* LIFTCo balance sheets
** Model assumptions
† Year three depreciation charge
‡ Original cost minus year one and year two depreciation minus residual value divided by remaining useful life (22 years).

Interest Charges

Although predicted costs seem much lower for the LIFTCo-s, in practice when compared to the ex ante models, in the case of interest charges there is a possible tendency for costs to be higher or at least in line with NAO forecast model assumptions. Table 6.15 compares financial costs across the three cases. As noted above in the detailed urban NW case study, interest charges were particularly significant and high compared to the alternative cost of public sector finance. However, the pattern is not repeated in the other two cases. Mixed West Midlands is close to the predicted cost and in the case of urban NE, interest charges are lower, possibly as a result of a slower draw down of debt linked to phasing in construction. If financing costs do turn out to be higher than the NAO models, the result will be a redistribution of the profit as reflected in the ex post IRR's in favour of the senior debt holders and at the expense of equity shareholders. The underlying profitability of the LIFT is not affected nor is there additional cost to the public sector. As noted in the urban NW, however, the charges shown in table 6.15 may be considerably in excess of the rates at which the public sector might borrow funds.

Table 6.15: Comparison of Financial Costs

	LIFTCo			
	East Lancs	**Mixed West Midlands**	**Urban NE**	**Case study average**
Interest charges, ex post three year average £'000	4,412	2,549	1,472	8,433
Interest charges per NAO model assumptions £'000	3,263	2,528	1,745	7,536
Difference £'000	1,149	21	-273	897

6.5 Conclusions

The strong general direction of the evidence in this chapter is suggestive that LIFT is an expensive form of procurement. Evidence discussed in Parliament in 2005 had already suggested this (see subsection 6.3.1), and this report offers some confirmation. In the case of urban NW, there is some evidence that although expensive in comparison to conventional procurement, per capita costs are lower where LIFT is delivered in areas of higher population density, due to their ability to attract greater concentrations of GPs. Such differences may explain why urban stakeholders are less satisfied with the process but happier with the outcome (see section 4, subsection 4.3.6).

An important reason for the overall cost differential in LIFT schemes when compared to conventional procurement is the level of interest charges. As the urban NW case demonstrates, these are much higher than conventional procurement (subsection 6.3.3) and also can overrun the assumptions in the ex ante planning models. In the latter case however there is no extra cost to the public sector and in the other two cases interest charges were more in line with overall expectations.

A very significant cost to the public sector however, would occur in cases where excessive profits are available to private sector providers. The ex ante planning models examined by the NAO showed a reasonable range of IRRs (13-15%) for six case studies. Re-examining these with the benefit of three years actual financial data would suggest that the LIFTCo-s are easily exceeding these levels of return and by some considerable margin. Urban NW LIFTCo can perhaps expect an IRR in excess of 40% over the course of the project (subsection 6.3.3). Returns for mixed West Midlands are less than this and returns for urban NE are greater, but in all three cases, returns exceed NAO models by some degree (subsection 6.4.4). The reasons in urban NW are also present in the other cases, which are: faster build up of revenue in early years to forecast levels, lower operating costs in facilities management and administration, leading to higher gross profit margins. Apart from construction cost, the financial models are most sensitive to changes in assumptions affecting gross margin. Residual value, which attracted some attention in the ex ante models, is immaterial at the higher levels of IRR at which the case study schemes seem to be operating ex post. Compared to the difference of gross profit against forecast, operating profit margins and net profit margins have smaller differentials due to the use of accelerated depreciation (in the case of urban NW and especially mixed West Midlands, see subsection 6.4.4) and higher than predicted interest charges (in the case of urban NW, see subsection 6.4.4).

The analysis of these three case studies suggests that, in general terms, LIFT is expensive. But is it, therefore, poor VfM? The interview evidence suggests that many key stakeholders felt that LIFT offered important benefits and many of them also believed that these were difficult to quantify. Many also had a perception of the cost of LIFT, but offered very little quantitative evidence in support of their perceptions. This chapter has suggested a methodology and provided evidence against which the benefits highlighted elsewhere can now be assessed.

7 Case Studies

7.1 Case Studies: Study Design and Methodology

This section pertains to the four case studies that, together with the 'stakeholder' chapter of section 4, form the analysis of the qualitative fieldwork conducted by the research team. Although initially the team hoped to conduct a greater number of case studies, this was not feasible on account of the reluctance of LIFTs and PCTs to engage, despite repeated requests, in this process. However, the LIFTs and PCTs that did participate in this research project did so with enthusiasm and, most importantly, gave the research team access to large number of diverse stakeholders who, in turn, provided extensive, detailed and knowledgeable interview data.

On the whole, each of the case studies entailed circa eight interviews (more than 30 interviews in total) which involved public and private sector staff with functional responsibilities for the areas of finance, project management, estate management, as well as directors and/or assistant directors of PCTs. In addition, the team was able to interview a number of centre and practice managers who provided valuable information on various operational aspects of their LIFT facilities.

Following the format of the stakeholder section (section 4), all interviewees were contacted well in advance of the interview. This typically involved the interviewees being sent a letter describing the purpose of the study and the nature of the study, i.e., our position as a group of university researchers conducting a project funded by the SDO. Once initial agreement to be interviewed was gained, the interviewees were usually contacted by telephone and given a brief summary of the questions they should expect to be asked, as well as pertinent information about the interview process. As part of this pre-negotiation phase, most interviewees agreed to be interviewed at their place of work for a period of forty minutes to one hour with the interviews being taped and subsequently professionally transcribed.

For reasons of consistency all interviews were conducted by the same research team member. Moreover, all interviews were professionally transcribed, again by the same professional transcription company throughout the study. As a further quality control measure all interview transcripts were individually checked by the interviewer for potential transcription errors. Although these measures helped ensure that high quality interview transcripts were obtained which could have been subjected to computerised content analysis. However, the thematic heterogeneity of the interview responses made this impossible. While this may initially be considered a disadvantage, it has to be acknowledged, that this heterogeneity is itself the reflection of the specific subject expertise of the

informants which has to be seen as an advantage to the study. This advantage is reflected in particular in the fact the interviews allowed for specific comparisons of processual and operational aspects of individual case studies which could, in turn, be linked to the characteristics of the underpinning partnership.

As previously mentioned, the team made an effort to stratify its case studies among rural and urban, as well as northern and southern, locations. As a result the four case studies include a LIFT scheme in the urban North East LIFT [urban NE LIFT] (subsection 7.2), one in the rural East Midlands [rural E Midl] (subsection 7.3), one in a mixed area in the East Midlands [E Midl LIFT] (subsection 7.4), and one in an urban area in the South West [urban SW LIFT] (see subsection 7.6).

In terms of timing, the first case study interviews were conducted in 'urban South West LIFT' in November 2007 up until July 2008. This lengthy period of interviews for urban SW LIFT, however, was not due to delays, but rather to the fact that key participants in this scheme were particularly helpful to the research team and continued to make available additional interviewees over time. This was followed by interviews in 'rural E Midl' and 'mixed E Midl LIFT' which were conducted during the months of September to December 2008. The last set of case study interviews involved 'urban North East LIFT', with interviews conducted from November 2008 to February 2009. The latter interviews, in particular, provided interesting insights into user views on the actual and potential future impact of the current economic crisis on their partnership (see also section 9, 'Express LIFT').

While differing in terms of location and levels of urbanity or rurality, the four case studies also differed significantly terms of the levels of investment undertaken. Specifically, the investments undertaken in mixed East Midl LIFT and rural East Midl which jointly amounted to circa £42 million, far exceeded the levels of investment undertaken in urban South West LIFT (circa £28 million) and in urban North East LIFT (circa £13.5 million).

In terms of timing the four case studies were stratified as follows (year representing approximate date of financial close):

urban PCT in the North East [urban NE LIFT]	second wave	end 2003
rural PCT East Midl [rural E Midl]	third wave	merger with existing LIFT
mixed PCT East Midl [mixed E Midl]	third wave	end 2004
urban PCT South West [urban SW LIFT]	third wave	middle 2004

While the team would have liked to have included case studies from the first and fourth waves, this was sadly not possible. In any case, the analysis of interviews from the stakeholder and case studies sections (see sections 4 and 7) highlighted that the differences resulting from the phasing of LIFT schemes were negligible in comparison to those which arose from an area's rurality.

7.2 Case Study - Urban North East LIFT

The Urban North East LIFT is located in a city of roughly 250,000 inhabitants. According to the 1991 census, the city had a relatively small population of slightly less than 2% of people from black and minority ethnic backgrounds. More recently, the city underwent significant changes in terms of its ethnic diversity, with recent estimates showing a population of about 4% black and minority ethnic (BME) residents. A significant proportion of this appears to be due to the settlement of asylum seekers and refugees in the city.

The number of sole occupied households in the city exceeds the national average of 30% by several percentage points, as does the percentage of inhabitants with a long-term limiting illness which amount to almost 21% (as compared to 18.2% for the population of England and Wales).

The city has a high birth rate and high teenage conception rate in relation to the national average. In terms of under-19 conceptions per 1000 population, the city reports a figure of nearly 70 (which compares to 42.3 nationally). These factors have results in a skewing of the demographic profile of the city towards the younger age ranges relative to other cities of a similar size.

The city's economy is dominated by low wages, areas of high unemployment and inactivity rates and, for those in employment, low value/low paid professions. In 2007, the city's unemployment rate amounted to nearly 5.7% which compared unfavourably to the national average. These conditions have contributed to the status of city as one of

the 10 most deprived of 354 English districts (by average of ward scores). Almost half of the people in the city live in electoral wards that are amongst the 105 most deprived wards in the country.

The city is currently serviced by a single PCT which was established in 2006 with the merger of two existing PCTs. The city's single PCT has a budget of nearly £500m (as at 2008/09) and employs over 1,500 members of staff.

The PCT area includes six completed and operational and the planned LIFT facilities. These include, firstly, a multipurpose health centre which offers minor surgical procedures, baby/child health clinics, a range of therapy services, dental surgery and an integrated on-site pharmacy. The centre which resulted from a capital investment of slightly more than £2 million also serves as a base for district nurses and health visitors serving the local population and includes modern public library facility.

A second health centre involved an investment of slightly less than £2 million. This facility accommodates two practices with six consulting rooms. The centre also provides a range of therapy services, out-patient clinics with visiting health staff, clinical and treatment rooms for visiting healthcare professionals, consulting and treatment rooms for teams of nurses who run a range of clinics for people living in the area and additional office space

The third centre is a primary care "spoke" within the city's health and community infrastructure. It accommodates GPs, seven modern and fully accessible consulting rooms and two treatment rooms for both doctor and nursing consultations and treatments and training facilities for medical student undergraduates on placement from the nearby medical school.

The fourth centre supports general practitioners community health and nursing services. It provides accommodation for GPs, a new "Darzi" practice, and office accommodation for local NHS.

The fifth centre was been developed as a designated "primary care plus centre" within the city's health and community infrastructure. It replaces four existing single-handed GP practices and was developed to accommodate the following services: GPs, some specialist nursing services, minor surgery, allied health professions, diagnostic testing, a pharmacy, dental services and a modern library including internet access.

The sixth centre involved an investment of circa £2 million and constituted the first LIFT building in the area which housed health and council facilities under one roof. The centre provides accommodation for GPs, consulting

rooms and treatment facilities and a base for community and nursing staff covering the local population.

Facilities currently under construction include a new centre which joins up health, council and community services in a building which is expected to cost slightly less than £15 million. This centre is the largest facility set to be delivered by the LIFTCo to date, and completes the first tranche of the city's NHS LIFT programme. The centre is expected to house GPs, a pharmacy, council customer service centre, health visitors, dental suite and dental training, intra oral x-ray, podiatry, ultrasound, diagnostic x-ray, school nurses, treatment suites, computer/seminar suite, meeting rooms, offices, a cafe and adult learning facilities.

Another planned centre is currently under construction in the North pf the city where it forms part of a new village centre. This centre will provide accommodation for GPs (with extended opening hours between 8 am and 8 pm, from Monday to Friday, as well as Saturday mornings), a pain management clinic, community gynaecology, and speciality services in for ear, nose and throat, neurology, and mental health.

Another development which is currently under construction is scheduled to house a relocated GP practice and other associated health services, such as new training facilities for GPs, accommodation for and an ambulance standby point.

There is also a plan for a city centre facility which recently obtained planning permission from the City Council, following a formal public consultation. This centre is scheduled to include two city centre-based GP practices, as well as a range of other health services.

7.2.1 Methodology - Urban North East LIFT

As previously stated, the team conducted its fieldwork at urban North East LIFT from November 2008 to February 2009. In this context, the team was able to interview six individuals who were involved in the management of LIFT projects in a number of different capacities, including the PCT's Director of Finance and the CEO of private sector LIFTCo partner.

Specifically, interviews were obtained with the following individuals: The Director of Finance of the PCT [Fin Dir, urban NE], the Director of Provider Services [ProvS Dir, urban NE], the PCT's Estates Manager [Est Mgr, urban NE], the PCT's Assistant Director of Facilties [Asst Dir Facl, urban NE], a PCT Project Manager [Proj Mgr, urban NE], the CEO of the private sector LIFTCO partner [CEO, urban NE]. Although the balance of the interviews was skewed towards public sector representatives (with five as against one

private sector informant), this was partly offset by the seniority of the private sector informant as well as the fact this interviewee participated in a very lengthy and informative interview which exceeded two hours.

7.2.2 Background - Urban North East LIFT

The fieldwork provided strong evidence that the involvement of urban NE PCT in LIFT was, from the public sector perspective, primarily driven by a history of under-investment, a need to upgrade existing facilities and a lack of alternative means of finance. However, while the public sector attempted to target areas of greatest need and deprivation, its decisions also appear to have taken into account practical aspects such as GP interest and site availability. In addition, there is evidence that the decision of the PCT to invest via LIFT was facilitated by strong private sector interest in the area.

In contrast to mixed East Midl PCT (see subsection 7.4) where public sector informants described their involvement in LIFT as an enthusiastic buy-in which had been based on prior experiences with PFI, public sector informants from urban NE PCT tended to describe their involvement with LIFT as a primarily pragmatic decision. Accordingly, the Director of Finance of the North East PCT [Fin Dir, urban NE] noted that his PCT became involved in LIFT because the appalling conditions of their primacy care facilities could, at the time, only be addressed through partnership with the private sector:

"It was really a very pragmatic decision. Our Primary Care estate was and in some parts maybe still … appalling. GP surgeries worked out of end terrace Victorian houses and in many areas the conditions were … absolutely appalling. The prospect for NHS capital funded schemes was very slim. The Government, I guess it was about the time of private finance, did not want to spend tax payers' money on NHS capital building things, so things went down the PFI route. Then LIFT came into being, as the kind of Primary Care equivalent of the PFI … If we wanted to improve … buildings the only real way to do it was through LIFT. That was why we put the application in."

This view was echoed by the PCT's Estates Manager [Est Mgr, urban NE] who suggested that there had been a history of underinvestment in primary care facilities in the area which had become of considerable concern:

"We had those sort of okay type buildings which had been done in the 70s and had not really moved with the times. … We had something like twenty odd practices operating out of old houses that were in a terrible state. There had been many years of under-investment in these premises because they were independent GP contractors and they were not putting the money into them."

The same informant further suggested that, although there was some hesitation to involve private finance, urban North East PCT ultimately came to see this as the only means for required capital investments:

"Although private finance had its critics, and the critics said in the longer term it may cost more, the fact is without it we would never have got off the ground, and we would still have been operating out of these old houses."

Although most public sector interviewees from urban North East PCT described their involvement with LIFT as being based, in part, on the absence of alternatives, there was a tendency to take a more positive view with regard to the bidding process. In particular, several public sector interviewees noted that they had been positively surprised by the level of interest from private sector bidders as well as the nature of the proposals submitted. This view was exemplified by the PCT's Assistant Director of Facilities [Asst Dir Facl, urban NE] who noted his astonishment with the level of interest the LIFT bidding process attracted:

"We were really surprised by the number of expressions of interest we received. I think we got seven in the end. I think our city was seen as somewhere that had a lot of regeneration still left in it so it was perhaps a good place to get into. We got quite a lot of interest from the big players, certainly more than we expected to."

While taking a generally positive view of the competitive process through which his PCT had procured its facilities, the same informant [Asst Dir Facl, urban NE], nonetheless, noted the location of LIFT facilities in the area involved compromises which, at least in one case, diverted investment from areas of greatest need:

"The choice of schemes that went forward in the OJEU and the original SSDP was kind of a combination of areas that desperately needed new Primary Care premises, GPs who were prepared to embrace the concept and go with it, and site availability. Having said that, they are all in reasonable locations and with the benefit of enormous hindsight, there is only one we would probably put in a slightly different location."

Overall, urban NE PCT represents an interesting case, in which an area which experienced high levels of need appears to have opted for LIFT primarily because this was the only option for attracting a high level of investment over a short time period. While the literature has discussed this pattern in some detail (see, e.g., Aldred, 2006, 2007) it is important to note that urban NE PCT is the only one of our four case studies where public

sector informants expressly noted an initial reluctance to engage with private sector finance.

7.2.3 Procurement - Urban North East LIFT

While most of the public sector informants of urban NE PCT expressed relatively positive views about the initial procurement process as well as their eventual choice of a private sector contract partner, this was not the case with regard to the contractual framework which LIFT had imposed on them.

These concerns were expressed by, among others, the private sector interviewee [CEO, urban NE] who compared LIFT to her previous experience in regeneration:

> *"It is amazing anything ever gets done. The NHS is pretty similar to that. Some of their individuals are very dynamic but there is the process and bureaucracy that ties their hands and the worry about doing something wrong; this innate fear of taking risks that some of the key people have. But we muddle along because we know that is what they have to do, we know the procedures."*

Additional concerns about the contractual framework underpinning LIFT were expressed in some detail by the Director of Finance of urban NE PCT [Fin Dir, urban NE], who noted that issues of risk allocation and risk pricing had been a point of contention in negotiations with the private sector partner. However, he said that both the public and private sector had become more proficient in working with these constraints:

> *"The contractual framework is quite restrictive. You cannot vary some of the contractual framework. I think it is partly around keeping central control of the whole LIFT programme by the DoH. But it can be a frustration sometimes. In the earlier days of LIFT there were some partnership tensions. It was difficult to reach agreement because of the legal framework. Part of LIFT is about individuals taking risks that can manage that risk, and some of the contractual requirements required the private sector to carry risk, which, okay, they kind of priced for in the overall scheme of things. But they felt they could not actually influence or manage that risk. But the contractual framework was fixed, there was no variation. It has not been a show stopper in any of our schemes. It is just now recognised that we just need to work around it or one of the parties might need to take a bit more risk."*

Although several of our informants felt that LIFT suffered from excessive central control and bureaucracy, some of the interviewees suggested that this was a part and parcel of partnership working. This view was expressed, among others, by the PCT's Assistant Director of Facilties [Asst Dir Facl,

urban NE] who suggested that the amount of documentation required for LIFT might be a necessity for ensuring the cooperation of all parties:

"The amount of documentation to close a LIFT building is absurd and it takes a lot of time just to put it all together and a lot of trees to print it all. This is silly. But I am not sure all the parties could get as comfortable with the deal if there were not all that documentation in place."

While the public sector respondents differed in their evaluation of LIFT bureaucracy in the context of the initial procurement of facilities, virtually all of them took a critical view towards the exclusivity requirements of the LIFT contract. This view was expressed most openly by the Director of Finance [Fin Dir, urban NE] who described these requirements as a downside of LIFT:

"It is fair to say that the exclusivity clause has thrown up several issues over the last couple of years. Because the LIFT contract was very prescriptive and was not something we could opt out of so it was a necessary evil. If you want the whole package you have to take a bit of downside. So I think with hindsight we might have wanted a higher limit on the exclusivity, I think it is at £25K for any minor works at this time."

This view was echoed by the PCT's Director of Provider Services [ProvS Dir, urban NE] who suggested that inflexibility of the LIFT contract had required the PCT to plan and assess its needs carefully:

"We have worked hard to really embed a project and programme management approach. Also, being clear about the multi-dimensional approach to the development of the LIFT building. The specification is really important to meet the nature of the services."

7.2.4 Learning and Understanding - Urban North East LIFT

There was a broad consensus among the public sector informants that their involvement with LIFT had a presented them with a steep learning curve. Within this consensus, they differed in terms of what they described as being most helpful in dealing with the demands LIFT had posed for them. Thus, a small group of interviewees cited external advice as one of the principal means for accessing necessary expertise. Meanwhile, a number of informants noted that some of the requisite expertise had become available to them via their involvement with their private sector LIFT partners. The latter statements closely matched the cultural analysis of section 5 (subsection 5.4.1) which described urban NE LIFT as being positioned between *Synergy* and *Segregation*.

Representative for the view that their LIFT involvement presented a steep learning curve to PCT staff, the Director of Provider Services [ProvS Dir, urban NE] noted that this represented unique challenges:

"When we started commissioning through LIFT, I absolutely did not have a clue. I had to learn it in the last year and pick it up, about the partnership approach and some of the ULPs and some of the terms, the under leasing arrangement, you know what does that mean? Some of that I just had to learn as I was going along."

This view was echoed by the Director of Finance [Fin Dir, urban NE] who argued that much of the required knowledge had become available to the PCT through outside consultants, while the PCT itself focused on its core activities:

"I do not think the PCT needs to have architectural skills or financial modelling skills, because that is not our core business. So what we are doing is we are buying that expertise …. We have business development skills, skills relating to developing tenants' requirements, in other words knowing the Health business and how that translates into requirements for facilities."

Meanwhile, the PCT's Estates Manager [Est Mgr, urban NE] noted that, although there was only limited official guidance, his team had been able to draw on the expertise of its private sector partner:

"I think for anyone coming in new to the process there is not a lot of guidance and it is a case of a steep learning curve. But we have got a pool of expertise within our private sector partner and I find that quite helpful in some of the big schemes that I have done.

Because our partner is a construction company, I was able to draw on such a variety of expertise within that industry that we certainly did not have internally. Without that it would have been dragged out and would have taken an awful lot longer as an individual to do … I think that is really the advantage of the exclusivity arrangement."

Similarly, the PCT's Assistant Director of Facilities [Asst Dir Facl, urban NE] noted that collaboration with the private partner had allowed the PCT to build a dedicated team of experts who were proficient in continuing this type of work:

"What we have tried to achieve is having a dedicated team that learns with the LIFTCo and its supply chain, and in theory, if I moved on, there would be other members of the team that would have a level of history and a level of knowledge that they would be able to step into my shoes and its kind of a succession planning."

This notion of mutual learning was amplified by the private sector representative [CEO, urban NE] who noted that her organisation also learned from NHS staff who, in turn, benefited increasingly from a large knowledge sharing network:

"The NHS locally is quite innovative in that it deals a lot in common sense. Something makes sense and they can prove a business case for it so they can see that its VfM in the long term and deal with whatever issues it needs to deal with. There has not been much that we have been stopped from doing. I sometimes feel almost conversely, because the NHS has more opportunity to go to all the innovation conferences and seminars where you might have the gem of an idea. … For them what is important is being able to commission a scheme. So often we learn as much from them, because they are in that big network."

Overall there was a strong indication that, although urban NE PCT may perhaps have entered the LIFT process more reluctantly than other PCTs, there is now a feeling that the organisation has developed a detailed and valuable understanding of the LIFT procurement. Additionally, it is interesting to note that both public and private sector informants felt that this understanding had developed as a part of mutual collaboration and information sharing.

7.2.5 Partnership - Urban North East LIFT

The previous section, as well as the cultural analysis of section 5 (subsection 5.4.1), has already indicated that both the public and private sector value the relationship that has developed around LIFT in urban NE PCT. This view was generally confirmed by most informants. However, a number of informants noted that this relationship had taken some time to develop and had required both parties to overcome frustrations in order to gain a greater understanding of the specific constraints which they faced. Moreover, one of the PCT informants implied that there was now a danger that this partnership had become too close and that there was a need for the PCT to maintain a broad focus on health care provision beyond its immediate involvement with the LIFTCo.

Speaking for a number of public sector informants who stressed the importance of the good working relationship their PCT had achieved with its

private sector, the Assistant Director of Facilities [Asst Dir Facl, urban NE], noted that the PCT made every effort to involve the LIFTCo in its decisions:

"We treat our partnership as sacrosanct. If we can do something with the LIFT Company involved we will attempt to do it that way, providing there are no absurd additional costs involved. So in some cases we have taken leases and the LIFT Company is paying the head lease with a direct path through to a sub lease to us. We do that just to maintain that partnership and the perception of partnership within the City."

Further on, the same informant suggested that the shared philosophy of the PCT and its private partner had made it possible to avoid conflicts and focus on future developments:

"Partnership and understanding and shared philosophy are an enormous bonus. It is strange for me when we I go to national LIFT events, hearing some of the tales people tell about the falling out and the lack of movement between public and private sectors. We just do not approach it that way and I think it has made us a lot stronger and more able to see a programme going forward."

This view was echoed by the PCT's Director of Finance [Fin Dir, urban NE] who suggested that the progress that had been made in this area had largely been due to the strength of this partnership. Interestingly, the same informant noted that this level of partnership, as yet, did not extend to the Local Authority and other health organisations (see also subsection 7.4 where a similar statement was made in connection with mixed East Midland LIFT):

"The relationship between our private sector partner and the PCT is absolutely crucial and if you have got a good working relationship and a good partnership then you can deliver LIFT. … I have no experience of it, but I think if you did not have that good partnership then it would be difficult to make LIFT work. I was going to say that an added bonus would be greater Local Authority involvement and maybe that of other Health players, but you have got to start somewhere."

The private sector informant [CEO, urban NE] similarly proposed that a working partnership not only required effort and time but also openness and transparency:

"I think it is only a partnership because we work at it, and we work really hard at it. We spend a lot of time with the NHS who are our main partners … We are open and transparent and very honest with our key customer and we share things with them and it means that we are not behaving in the way that you see some private companies do to try to get public contracts. … That kind of openness and transparency filters right down through our supply chain and it leads to a kind of team ethos."

In connection with this discussion of partnership, a number of public sector informants also highlighted the crucial role of trust. This was exemplified by the PCT's Assistant Director of Facilities [Asst Dir Facl, urban NE] who noted that gradual elimination of mistrust among key stakeholders had played a crucial role in the development of this partnership:

"There are people within the PCT who consider that the private sector is just out for a quick buck and the fine words mean nothing and so forth. And equally, I am certain there are people in the private sector side who think we are just a complete set of morons with horribly bureaucratic processes, and sometimes they are right! I think the people who are most involved have very much got over that perception and there is a lot of respect."

This view was mirrored by the Director of Finance [Fin Dir, urban NE] who noted that it had taken some time to build the current relationship. This being said, the same informant suggested that this process ultimately had become a major factor in the efficient procurement of facilities with which urban NE PCT prided itself:

"I think we have got a very solid and effective partnership now, but it has taken a few years to shake down. There is a better understanding of public sector governance which I know on occasions has been a bit of a frustration to the private sector … We have now got a good understanding of where each of the parties is coming from and what each party's limits and boundaries are. You only have to look at what we have delivered."

Similarly, the PCT Project Manager [Proj Mgr, urban NE] noted that the existing relationship played a key role in facilitating communication around procurement issues:

"If this relationship was not in place, our LIFT would not have achieved what it has done. It is very much a trust thing. Our private sector partners in the LIFT Company let us speak directly to a lot of their contractors. They are quite happy because they know that everybody is

familiar with the process and if there were any issues it could be raised informally and it would be dealt with."

Although there was a broad agreement among public and private sector informants that urban NE PCT had achieved a strong partnership around its LIFT schemes, some informants noted that it was important for the PCT not to lose its focus on health care provision in general. This view was expressed explicitly by the Director of Finance of the PCT [Fin Dir, urban NE] who concluded one of the interviews by stating that it was important to recognize that LIFT was only one part of the PCT's activities:

"LIFT is just one element of a fairly big business and so we are not solely focused on delivering LIFT. It is very important and we put a lot of time and effort into it but there are other pressures and priorities. The private sector, as a company, just focuses on delivering one thing."

Overall, there was strong evidence that the key stakeholders of urban NE LIFT felt that their collaboration was grounded in a strong partnership which had developed over time on the basis of growing mutual trust. However, these generally positive views did not preclude more critical attitudes toward the cost aspects, which are discussed in greater detail in the consecutive subsection.

7.2.6 Cost Issues - Urban North East LIFT

Urban NE LIFT was the only case study area for which the research team obtained sufficient data to conduct a preliminary analysis of cash flows (see section 6). This preliminary analysis, which was grounded in a number of assumptions, indicated that private sector profits associated with urban NE LIFT considerable exceeded the typical profitability the NAO (2005a) identified for LIFT schemes (specifically it suggested a differential gross profit of circa 23% as compared to the NAO estimate of 14 % to 15 %, see section 6, subsection 6.4.3).

While the urban NE LIFT informants were not aware of the potentially higher cost estimates which are part of the financial analysis conducted by our team, it was noticeable that they tended to take a less enthusiastic view of the cost aspects of their LIFT involvement. This view was expressed among others by statements which indicated that there were compensating benefits to the potentially higher costs of these facilities, or alternatively, that a reliable cost estimate could only be conducted after several years.

Representative for the first view, the Director of Finance of urban NE PCT [Fin Dir, urban NE] noted that the cost of LIFT facilities had to be seen in relation to the quality of the build and the level of long-term maintenance obtained:

"We need to be clear what we are comparing LIFT with. Prior to LIFT when Government money, Treasury money, was used to build hospital buildings or community premises, it was on the basis of you built them and then did not do anything to them for 50 or 60 years so they either fell down, needed a big refurbishment or you just replaced them completely. LIFT is a different concept. The significant difference with LIFT is that the quality of the building delivered on day one is the quality you will get at the end of year 25."

Despite this positive view, the same informant [Fin Dir, urban NE] noted that LIFT projects could pose a challenge to affordability in the future:

"From a Finance Director's point of view LIFT is a double-edged sword. It is a fixed commitment and you cannot change it when you think money is a bit tight. But you have the high quality premises, so you just need to look at other things and get efficiency elsewhere."

This view was mirrored by the PCT's Estates Manager [Est Mgr, urban NE] who suggested that it was important to assess the long-term life costs of these facilities:

"On the face of it, LIFT buildings look expensive in terms of the cost per square meter but in terms of life cycle costs I think they probably hold their own."

Taking a different view on the long-term costs of LIFT facilities, the PCT's Assistant Director of Facilities [Asst Dir Facl, urban NE] noted that LIFT procurement was costly, but suggested that there was a strong possibility it would become cheaper over time as overhead costs declined:

"It has been an expensive process in that we were buying advice in. As we go through scheme by scheme, the amount we have to spend on this advice is reducing itself. With the legals for example just do a delta view against the previous close and if it has been accepted before, it will be accepted again. This will make an enormous impact on the amount that we are spending on each financial close."

This view was echoed by the private sector representative [CEO, urban NE] who suggested that costs of LIFT project in the area were already declining, allowing the LIFTCo to invest in additional improvements:

"Our FM costs have got cheaper because they only need so many operatives. You get to a critical mass point with buildings where the operatives that you need for the first three buildings can see you for another seven. But what we have done on every scheme, at the NHS request, we have improved the spec, like adding in green sustainability measures …"

7.2.7 Outcomes and Views on the Future - Urban North East LIFT

Despite uncertainty about costs issues, virtually all respondents judged the outcomes of their LIFT engagement positively. There is strong possibility that these views are related to the particular situation of this PCT, which was described as follows by the PCT's Director of Finance [Fin Dir, urban NE]:

"We have been fortunate to be in a financial position where we can keep that order book going, because we want to transform the healthcare landscape of our city. I know that sounds a bit grand, but that is what we need to do and that is what we are committed to doing. Then, of course, we are contributing to wider regeneration at the same time."

Despite a generally optimistic view, a number of public sector informants stressed that some of the contractual issues might have to be revisited in the future. This view was again exemplified by the PCT's Director of Finance [Fin Dir, urban NE] who suggested that changes in primary care would have to be reflected in future service agreements:

"There are a number of issues we have not come across yet. Like how do we deal with reconfiguration of buildings, when we want to continue to provide services from a set location but the services and our requirements change and we want to deliver things in a different way. … You can anticipate there will be financial and legal issues about having to renegotiate the contract or amend the contract, because no matter how good we might think we are, none of us can foresee exactly what we want in 25 years time."

Similarly, the PCT's Estates Manager [Est Mgr, urban NE] suggested that there was a possibility of future disagreements as risks materialised over time:

"It will be interesting to see how this business of risk plays out: Whose risk it is and the cost of fixing that risk, .. it will be interesting to see how that changes, because obviously as buildings age more things go wrong. Whether we get into more arguments about whose risk it is … that may happen."

7.2.8 Summary - Urban North East LIFT

Urban North LIFT presents the perhaps unusual case of a PCT which, while initially reluctant about public private partnership, enthusiastically embraced LIFT schemes as a part of a broader regeneration agenda. This regeneration agenda, together with an urgent need for primary care facilities, appears to have facilitated collaboration with a private partner, which virtually all interviewees described as a strong working relationship.

Despite these developments, it appears that a number of public sector informants remain concerned about cost issues associated with LIFT procurement in their area. These concerns appear to be temporarily ameliorated by the assumption that the costs associated with these projects will decline. From the perspective of an external observer, it stands to reason that, although this LIFT currently presents itself as a strong partnership, this situation could change rapidly if the PCT were to face serious expenditure constraints.

7.3 Case Study - Rural East Midl LIFT

Rural East Mid LIFT is a large rural county in the heart of England. The population of the county is around 730,000, with a very small Black and ethnic minority population of 1.5% that is well below the national average. The percentage of the population with long term limiting illness is around 20% and, as such, exceeds the national average. Large parts of the county are rural, and the main industries are agriculture and quarrying/mining. In the more urbanised areas of the county the main occupations are manufacturing, distribution and catering, and public sector employment. Unemployment at around 3% is below the national average.

The PCT covers the whole of the county apart from one large city which has a PCT of its own. The PCT was established on 1st October 2006, following the merger of six smaller PCTs which had each covered separate districts within the county. The PCTs in the southern part of the county had been part of LIFT prior to 2006, but the PCTs from the northern part of the county had not.

7.3.1 Methodology - Rural East Midl LIFT

Interviews in rural E Midl LIFT were conducted during the months of September to December 2008 with eight interviewees. These included the PCT's Assistant Director/LIFT Board member [Asst Dir, rural E Midl], the Director of Commissioning [Dir Com, rural E Midl], an Assistant Director of Finance [Asst Fin Dir, rural E Midl], a Project Director [Proj Dir, rural E Midl], a Project Manager [Proj Man, rural E Midl], an Estates Manager [Est Mgr, rural E Midl], a Commissioning Manager [Coms Mgr, rural E Midl], and a Director of Provider Services [Dir ProvS, rural E Midl].

Unfortunately, despite repeated requests to a number of people over a period of time, it did not prove possible to include private sector or LIFT company representatives in the fieldwork.

7.3.2 Background - Rural East Midl LIFT

The background to LIFT in the PCT in its current incarnation is quite complex. Prior to 2006, the county had six separate, small PCTs, and three of these were involved in LIFT and had schemes under way, but three had no involvement at all. Upon merger of the PCTs to create one county-wide organisation, it had been agreed that the exclusivity agreement would continue to apply to the geographical area which previously had been covered by the southernmost PCTs, but not to the north of the county. The Assistant Director of Finance [Asst Fin Dir, rural E Midl], explained the outcome thus:

"We went from 6 PCTs into one. We are now responsible for LIFT to be the preferred provider for the boundary of the south of the County for those old three PCT boundaries. North of the County we don't have any obligation. Obviously there are opportunities for LIFT itself in the north to put in a tender like any other provider, but it is only the southern half of the county where we are bound by the LIFT agreement."

This had led to some complications regarding one scheme which was well advanced in terms of planning and development, as the project manager [Proj Man, rural E Midl], who took on the scheme in the new PCT explained:

"We picked it up in the middle. … it was their flagship scheme and they were desperate that it continued. It was well advanced, the business case was done, all the LIFT bits were running alongside of it. From the new PCT's perspective, it was a case of reviewing the scheme and saying well okay that might have been top priority in [the old PCT], how does it fit within what the PCT here wants to do? There was also the politics. There

were already highly raised expectations which would have made it very difficult to shut the scheme down so it was at an advanced design stage and from a Provider perspective it was more or less done. So I don't think it was a typical kind of LIFT scheme."

This statement highlights some of the challenges and difficulties faced by this PCT which were compounded by the merger of these organisations and the implications of that for staffing.

The Assistant Director of Finance [Asst Fin Dir, rural E Midl] felt that this start to LIFT had not been helpful:

"I am not so sure whether, as a PCT, we had a co-ordinated enough approach. Still now I am not so sure whether we fully understand and recognise and identify clearly enough the benefits of it for us to want to push it and use it."

He also felt that the setting, i.e. being a large rural area, had challenges of its own, and that these applied to PCT business as a whole, not just LIFT:

"You look at the diversity of our population, and the inequalities, all that presents challenges to us as a commissioning organisation and will present the same challenges to LIFT."

This background in terms of the nature of the way LIFT was established, and the issues arising from the merger, had an impact on both the procurement process and staff attitudes. This is explored further below.

7.3.3 Procurement - Rural East Midl LIFT

On establishment, the new PCT was faced with an ongoing procurement process which was not of their choosing. It caused problems in that projects were part way through the planning and procurement process at the point of restructuring, which had an impact, as the Project Manager [Proj Man, rural E Midl] explained:

"The restructuring does cause problems because every time they restructure, basically this project was almost put on hold while they restructured in order to then reassess what they wanted to do … But the last people involved in the project wanted was yet another delay while they reassess, because every time they delay, they were adding more cost and the chances are the project becomes unaffordable."

Another tension was that the PCT had a very experienced Estates department, and some people in the PCT felt that the in-house department were more skilled than the LIFT CO, certainly when it came to building regulations and design issues that were specific to health [Proj Man, rural E Midl]:

"Our estates department has some really good people who almost can quote verbatim the requirements and building regulations because they have been dealing with it for years. The Architects and the Designers come out and say we have done this, but that does not meet the requirements. It was almost like we know what were doing and these people have no clue what they are talking about because they are not even using half the right documents to design this building. And then they are expecting us to sign it off without any arguments and we are actually saying well this needs changing, that is wrong etc. because they have not got the knowledge of our Estates department, so that was a big tension as well."

The Estates Manager [Est Mgr, rural E Midl] felt that LIFT had brought some knowledge to the PCT but that the Estates Department was still needed by the PCT to make sure that LIFT were correctly advising the PCT:

"LIFT have brought some knowledge to the projects and to the PCT, but I think probably due to their lack of experience and our probably greater experience of the requirements, there has been some added value. I think still some of the work is a compromise because it had been developed to such a stage that we could not change certain things without going back to planning consent or starting again with a different site."

He conceded that elements of the buildings were good, although he had reservations:

"The quality of the construction is quite good. I have got reservations about some of the design I think. There are some things that could be designed better and reduce the ongoing running costs."

There was quite a high degree of scepticism about the LIFT process, and whether it was really necessary, with several interviewees (who had originally been with the northern PCTs) feeling that it was a system almost foisted upon the PCT that they had to accept, whether or not it was any use or could produce anything innovative. For instance the Commissioning Manager [Coms Mgr, rural E Midl] noted:

"The LIFTCo is a mechanism to procure a building. It might be a more efficient way of doing it, but it is the only game in town though to be honest. It is about making the best fit of it with what we have got."

Similarly the Director of Commissioning [Dir Com, rural E Midl] noted:

"This constant drive for the building rather than the service existed before PFI, and was true in PFI and its true in LIFT. LIFT is just an interesting vehicle by which we make flawed decisions based upon shiny new buildings not services. If this was about co-location with the Local Authority we would have done this better and, if we had worked rationally on our estate with Local Authorities we might have found that we never needed LIFT capacity in the first place. I am not saying we won't find some fixes but they become post-hoc rationalizations."

In practice, this lack of planning led to under utilisation of buildings, which had cost implications which are discussed below [Est Mgr, rural E Midl]:

"Most of the LIFT buildings that are currently in use are under utilized. I am not sure whether that is a design for future expansion of services. It probably will work out quite well but I think that's probably not particularly planned."

7.3.4 Learning and Understanding - Rural East Midl LIFT

There was a great deal of dissatisfaction expressed with the preparation and learning that was available (or rather, not available) to staff, which was probably a function of the circumstances surrounding the introduction of LIFT to the new PCT at the time of its creation. Most interviewees felt unprepared, and noted that they had had to glean knowledge themselves, on an individual basis. An example of this was the Commissioning Manager [Coms Mgr, rural E Midl]:

"We were pretty much all dropped in it. All of us ... There was a box of paperwork that was cheerfully handed over to me, sort of "ha, you're it now", but no there wasn't anything on LIFT and how LIFT works."

Similarly the Assistant Finance Director [Asst Fin Dir, rural E Midl] noted:

"I was in at the deep end around LIFT, particularly with my first LIFT Board meeting. I had done the personal reading around LIFT's principles and what it meant, but I certainly lacked the strategic knowledge at that point over where we were going as a PCT and what LIFT would be looking for from us."

The greatest help for the Project manager [Proj Man, rural E Midl] was that coming into the new PCT from one of the old "north" PCTs, he had been able to tap into experience from people who had worked in the old "south" PCTs:

"Fortunately we had this LIFT team in place so they could guide us at the beginning, and you slowly pick it up until you eventually take over. But we're still learning what LIFT is all about and I am not even sure we understand what LIFT is actually all about anyway, even now."

He went on to say that he felt this situation mean that the LIFTCo and the private sector partners had an advantage over the public sector:

"It is very much that they had the power at the beginning because they had all the knowledge, whereas now I think we have learned from all the problems. It is the classic you learn from your mistakes and problems – had it all gone smoothly we probably would not have learned half as much, but we learned so much we are in a position to say we will do it this way, rather than say OK we will do as you say."

The PCT had relied on the LIFTCo certainly in the early stages to be the "expert", but as knowledge amongst PCT staff grew, there had been times when they had been, as the Commissioning Manager [Coms Mgr, rural E Midl] mentioned, able to challenge this LIFTCo:

"I think one of the major problems about the LIFTCo is that you kind of accept that they are the experts. We are a part of the LIFTCo. so they are working for us. I think we do hand a load of responsibility over to them and say well, if that is what you say then that must be true. But I think that was not quite the case when we squeezed another couple of million quid out of the builders."

This has implications for the relationship between the two sectors, which is discussed below.

7.3.5 Partnership - Rural East Midl LIFT

Section 5 (subsection 5.4.2) identified the cultural characteristics of the partnership underpinning rural East Midl LIFT as being positioned between *Synergy* and *Segregation* with no single organisation dominating the partnership. This is confirmed by the statements from most of the informants. However, unlike urban NE LIFT (see previous subsection), informants from rural East Midl LIFT noted that this partnership had developed only recently following a period when there had been concerns, among public sector participants, that the private sector had an advantage and dominated the relationship.

This was expressed by the Project Manager [Proj Man, rural E Midl] who suggested that the relationship between the PCT and the LIFTCo was, following initial tensions, now working well:

"We do have an overlap on the estates side, because we've got a good estates department, and that causes tensions … When it first started it was very much antagonistic but as we got through more and more problems, they started working together as a team. So now the Estates department and LIFTCo and the designers all get together around a table and talk about things and they'd often design something and then say, is this ok? So I think that process did evolve to replace all sorts of conflicts."

As we found in the previous study, the key to reaching a good working relationship revolved around individuals having good communication, and developing shared values over time. Again this commented on by the Director of Provider Services [Dir ProvS, rural E Midl]:

"I think the personalities are much of a greater issue than public v private. I think it comes down to shared vision and communication."

The challenge for some revolved around the complex nature of the relationship between the PCT and LIFT, with the PCT at times facing in two directions, one as a client of the LIFTCo, and the other as LIFTCo shareholder. The same informant [Dir ProvS, rural E Midl] highlighted this potential conflict:

"The biggest issue for me is that sometimes there is a slight real or potential conflict of interest in that this PCT is a significant partner in LIFTCo. … I sometimes feel it is very difficult to say who is absolutely safeguarding the PCTs interest as a client in this, because we are also a partner in LIFT. That is what I really struggled with."

Unfortunately, as were we unable to carry out interviews with any LIFT Co representatives, we were unable to obtain any private sector views on partnering and the relationship between the LIFT Co and the PCTs.

7.3.6 Cost Issues–Rural East Midl LIFT

The views of rural E Midl interviewees on cost issues were similar those expressed by informants from urban NE LIFT (see section 7.2.6) in that additional costs were seen as a reflection of improved maintenance and service provision. Representative for these views, the Project Manager [Proj Man, rural E Midl] noted that a balance between VfM and the quality of the development had to be achieved:

"You are going to a brand new building that is being maintained to a high standard and one of the issues is, we want it to be cheaper or as good value as the current model. But then you have to take into account that often on the current model your maintenance is basically just a lick of paint here and there, and the buildings are crumbling and you are just making it look fit, rather than keeping it up to standard."

However, several informants, including the Assistant Director of Finance [Asst Fin Dir, rural E Midl], expressed doubts about affordability and VfM:

"I am not sure if it is affordable. … There is a perception that LIFT is an expensive model and are we sure that we want to pay for that model anyway in terms of VfM, could we do with a lesser model? I am not so sure, I have not really seen any evidence of any real cost benefit analysis."

This was echoed by Director of Provider Services [Dir ProvS, rural E Midl], who was worried about the costs of the new facilities:

"Off the top of my head, affordability – the current health centres are costing me a lot of money in terms of the empty space and I can quantify what those costs are."

Overall there was evidence that informants from rural E Midl LIFT were more critical toward the affordability aspects of LIFT than those from urban NE LIFT, which might partly reflect that LIFT-related synergies are more difficult to exploit in a rural context (see also subsection 4.3.6).

7.3.7 Outcomes - Rural East Midl LIFT

Overall, the interviewees were sceptical about the benefits that LIFT had brought, and in some cases wondered whether it had been necessary at all. This view was expressed by, among others, the Project Manager [Proj Man, rural E Midl]:

"It was successful in that we got to financial close. I would not necessarily say it is better than anything else and I think you could have got to the same point without using LIFT. I am not sure what LIFT is offering other than access to funding. There must be other ways of accessing funding without tying yourself into a 25 year contract, so I am not sure LIFT is necessarily giving you great benefits."

The interesting point made earlier about this PCT, in that after the merger of the smaller PCTs in 2006 half the new PCT was tied to exclusivity whilst the other was not, seemed to be offering some evidence as to the unattractiveness of LIFT as the Director of Commissioning [Dir Comm, rural E Midl] notes:

"I tell you what it really makes stark, is that the ones in the North are not beating a path to get into LIFT. The LIFTCo did not suddenly become something that rolled out in the north with impunity. We still don't have LIFT in the North which is probably the worst condemnation I can give to LIFT in that given a free run and no great opposition; it hasn't managed to manoeuvre itself into a presence in the North."

Much of the dissatisfaction was a result of the perception that the buildings were not being well used, and that this was as a result of a flaw in the planning process, whereby the activities that were going to take place in the building had not been sufficiently thought through [Dir ProvS, rural E Midl]:

"What we've had is quite a big negative reaction to the fact that these fabulous new large facilities have opened and there doesn't seem to have been anything going on in them. There is a lot of empty space. And the population have actually picked up on that And that to me just highlights the fact that there was no clear service plan sitting behind those buildings."

It was suggested that this, again, was partly due to the reorganisation. The people who had planned the original schemes had been based in the old southern PCTs, whereas the people now working on LIFT had come from the old northern PCTs. Thus, the people making decisions about services now were not the ones who had done the original plans. This highlights one of

the key problems for PCTs generally, where reorganisation and personnel change have an ongoing impact on development and service planning.

Some of the spare capacity related to future developments, but there was some disappointment that working practices were not changing, and indeed a building per se would not bring about changes in service provision that might otherwise be desirable. This was expressed by the Estates Manager [Est Mgr, rural E Midl] as follows:

"There is a lot of spare capacity built in and because of the nature of how we use our buildings, a lot of them are sessions that they use so many hours a week. We need to be better at planning to get maximum use out of them. When you have spent £25m on a building you should not shut it up all weekend."

Similarly the Commissioning Manager [Coms Mgr, rural E Midl] noted:

"If you have got three GP practices in a new facility it does not change a thing except it smells of new paint. It does not change the way they work, or integrate them one with another and it does not integrate them with the community hospital. So the levers for change are not in the building."

On the whole, the staff who worked in the buildings and the patients who used them seemed to be satisfied with them. The concerns lay at more strategic levels, and were about decisions about use of space. It was felt that this would come about in the long term, though Assistant Director of Finance [Asst Fin Dir, rural E Midl]:

"LIFT has encouraged joined up thinking, not forcing us but encouraging and influencing us and going down a route of joining up our thinking and putting in place some sort of strategy and plan. It probably has increased cost but it comes back to the cost benefit. That's not necessarily a bad thing if it's brought more benefit, more quality, that's the equation I'm unsure of."

7.3.8 Views on the Future and Summary

Overall, the doubts about LIFT led to some scepticism about whether it was a good system and whether the PCT would want to do more with it that it had to. This was stated forcefully by the Assistant Director of Finance [Asst Fin Dir, rural E Midl]:

"I just do not think we are sufficiently positive about it to want to put ourselves in a position of wanting to say yes, we will look to LIFT to be a preferred provider, rather than go out and test the market. I don't think it has gained itself that gold badge enough for us to want to push it where we don't have to. It has worked well, we can see the benefits of it, but I think there are some questions around, not just the VfM aspect, but around the lease agreement and the lease plus agreement."

Similarly, the Project Manager [Proj Man, rural E Midl] suggested that support for the LIFTCo was limited because half of the county would be using LIFT, through no choice of their own, and half would have the option:

"There is the feeling in the PCT that if we did not already have LIFTCo we probably would not need it because our estates department covers all of the county but now we are kind of stuck with LIFTCo and anything in the South has to go through them."

Additionally, the Assistant Director of Finance [Asst Fin Dir, rural E Midl] suggested that there could be an issue in the future for the LIFT company of not having enough of a pipeline of work coming through from the PCT, which would force them to rethink their role:

"In some ways it is probably an issue more for LIFT. Is there a market out there not just for the big developments? We know there are not too many big developments on the order book, we might need to diversify."

Overall, then, there was reluctance to engage any more with LIFT than was strictly necessary, and doubts over whether there would be enough of an order book for LIFT to continue as it currently exists. Again, because we were unable to interview LIFT Co representatives, it is not possible to say whether their view matches that of the public sector.

7.4 Case Study - Mixed East Midl LIFT

Mixed East Midl LIFT is located in a mixed urban and rural area in the Midlands of England. It includes a city with a population of slightly more than 200,000 inhabitants, together with an outlying rural area. The area historically had a high level of industrial employment which centred on the aerospace and rail industries. The historical decline of industrial employment in the area has given rise to a relative high level of unemployment in excess of 6%. This is accompanied by a relatively high rate of sole occupied households which currently exceed 30%. The Black and minority ethnic population is around 15%. The percentage of

individuals with a long term limiting illness in the PCT area amount to nearly 20% and, as such, exceeds the national average.

The area is currently serviced by a single PCT which emerged from the merger of two existing PCTs. Prior to this merger, both PCTs already had an integrated management structure which jointly developed its strategic health plan. The current PCT boundaries exceed those of the local authority and include a population of nearly 300,000.

The PCT area includes two completed LIFT projects which opened in 2007 and 2008 respectively. The more recently completed project houses a range of community health services under one roof, including a GP practice, chiropody, dentistry and phlebotomy, along with a purpose-built physiotherapy gym and training kitchen.

7.4.1 Methodology - Mixed East Midl LIFT

As previously stated, the team conducted its fieldwork at Mixed East Midl LIFT from September to December 2008. In this context, the team was able to interview eight individuals who were involved in the management of LIFT projects in a number of different capacities, ranging from the Assistant Director of the PCT to Practice and Centre Managers.

Specifically, interviews were obtained with the following individuals: The Assistant Director of the PCT who was also a LIFT board member where he represents the PCT equity share [Asst Dir/Board Mem, mixed E Midl], the Assistant Director of Finance of the PCT [Asst Fin Dir, mixed E Midl], the PCT Estates Manager [Est Mgr, mixed E Midl] and the Assistant Estates Manager [Asst Est Mgr, mixed E Midl], the former Project Manager for one of the LIFT schemes [Proj Mgr, mixed E Midl], the Primary Care Manager and former project manager [PrimC Mgr, mixed E Midl], the Centre Manager of one of the LIFT buildings [Cent Mgr, mixed E Midl], and a Practice Manager working in a LIFT building [Pract Mgr, mixed E Midl]. Sadly, no private sector representative agreed to be interviewed and, therefore, the views of the Assistant Director of the PCT who also served as LIFT board member [Asst Dir/Board Mem, mixed E Midl] must be taken as a proxy for those of the private sector partner.

7.4.2 Background - Mixed East Midl LIFT

The fieldwork provided strong evidence that the involvement of mixed East Midl PCT in LIFT was driven, in part, by the perception of a number of key stakeholders that were capable of handling the potential complexities of this procurement process. This view, in turn, was based on the experience a number of PCT staff had gathered earlier in connection with the

procurement of a PFI hospital. Specifically there was an expectation that the PCT could draw on the experience of its staff members who had been involved in this hospital project in a consultative and commissioning capacity, as well as other staff who had been involved in project management. This observation closely mirrors early research into PFI uptake by Beck and Hunter-Beck (2003) which highlighted that the best predictor for the involvement of an organisation in PFI procurement was previous experience with this procurement mechanism.

The influence of the area's previous experience with PFI was highlighted, among others, by the Assistant Director of the PCT [Asst Dir/Board Mem, mixed E Midl] who noted that the PCT had become interested in LIFT soon after it was launched. The same interviewee further suggested that the PCT had taken a strategic view from the outset which saw LIFT involvement as a means of centralizing resources:

"When we concluded the PFI deal for the hospital in 1998, LIFT was something that the PCTs wanted to pursue. But they had limited resources and it was a bit of a scattergun approach. I was asked to basically pull the resources together, put it into one central place and see if we could launch the whole LIFT project, which we subsequently did."

This view was echoed by the Assistant Director of Finance [Asst Fin Dir, mixed E Midl] who suggested that the decision to engage in LIFT was aided by the participation of a staff member who had been involved in the procurement and management of the local PFI hospital:

"We decided very early on that we would like to have somebody involved who had a lot of experience of PFIs. That is why he was invited to participate because they were working on the hospital PFI at the time."

The same interviewee [Asst Fin Dir, mixed E Midl] further suggested that there was a high level of support for engagement with LIFT within the PCT. This support was primarily based on the view, by the PCT's management, that there was both a need to improve the existing building stock and to take a systematic approach to the procurement of primary care facilities:

"The feeling at the time was that we were quite excited that there was a new vehicle that was going to be available for PCTs that might potentially speed up the process of planning our buildings and trying to get some structure in terms of having a planned process that would refurbish and renew our buildings that we had got in Primary Care over a period of time."

According to the same interviewee [Asst Fin Dir, mixed E Midl], this enthusiasm for LIFT was shared widely by public sector organisations in the area and, in particular, all the local authority partners who would potentially benefit from the process:

"We had a huge participation right across the local economy so because, at that time. There were actually 13 member organisations that were going to be involved in LIFT. That included all the Local Authority partners so we had a huge interest and a lot of participants in that process to make sure we got the right partner in the end."

With regard to the issue of GP interest, the Primary Care Manager [PrimC Mgr, mixed E Midl] working at one of the LIFT buildings noted that there had been considerable demand for shared facilities which facilitated the planning process:

"One, there was very little land around for buildings and two, the actual cost was high. We were getting new GPs coming and they did not want to buy into the business, they wanted to be taken on as a salaried GP. Just by chance, we knew that just behind one of the streets there was a big plot of land … We contacted the Council and they said yes, we would love a community facility on that site. … Then we found out from the PCT that they were actually looking to build a LIFT building on that site and would we be prepared to be party to it. So a meeting was called … So that is how we got involved in the LIFT scheme initially."

Overall, there was strong evidence that this LIFT project commenced against the background of enthusiastic support by a number of stakeholders, as well as with broad support from members of the local communities. This observation stands in some contrast to research which suggested that some PCTs engaged with LIFT reluctantly, and did so solely because it was the only available means for improving primary care facilities (see e.g., Aldred, 2007).

7.4.3 Procurement - Mixed East Midl LIFT

Although there was evidence that the involvement of mixed East Midl LIFT in the LIFT procurement took place against the background of strong local support, a number of interviewees highlighted that their experience with the process had not necessarily been a positive one. Additionally, there was evidence that some of the interviewees took very different views on the

procurement and project management process and in particular the level of participation afforded to them.

This issue of differential views is perhaps best illustrated by contrasting the statement of the Assistant Director of the PCT [Asst Dir/Board Mem, mixed E Midl] and the Project Manager for one of the LIFT schemes [Proj Mgr, mixed E Midl], with those of other interviewees. Thus, the Assistant Director of the PCT noted that the project team had placed great emphasis on stakeholder involvement in order to avoid conflicts from the outset:

"It is all about communication. It is about involvement, communication and making sure there's enough actual input going into the scheme. And then the conflict and surprises are minimised."

Similarly the Project Manager for one of the LIFT schemes [Proj Mgr, mixed E Midl] suggested that the PCT had made a major effort in involving stakeholders, even though this often involved complex negotiations:

"As project manager my job was to make sure the right people were around the table. It was complicated in the sense it was a multifunctional building, so there was a GP surgery and they were out of my control in a way but I did end up picking up a lots of axes to grind! But I made sure that the people who would be actually using the building were involved in the discussions."

This view contrasted with the statements of Practice Managers [Pract Mgr, mixed E Midl], who conceded that his practice had been involved in the planning stages but noted that some representatives had been overwhelmed by this process:

"There was somebody from the Practice that went at all the planning stages, but at every meeting there were different people there from all these different departments, and it was a bit overwhelming really."

The same interviewee [Pract Mgr, mixed E Midl] further suggested that some of the consultation had been perfunctory particularly when it came to details of building design. This, in his view, had resulted in number of inappropriate arrangements:

"We work here, we know what it is like and these architects going, oh it is going to be lovely. But they do not listen to us. We need to see our

patients and you can have one of these board things that calls the patients in, but not everybody can read. You will be able to call them in then, well we cannot if we cannot see them, we would have to leapfrog onto the desk and call them over! It is not on. We've got one receptionist, she is only 4'5" or something and she really literally cannot see …"

Similarly, the Centre Manager of one of the LIFT buildings [Cent Mgr, mixed E Midl] suggested that the level of consultation had not been far reaching enough:

"There should have been more ground staff on the planning personally, especially reception staff who are in the building all the time and are running a lot of the rooms."

While taking a generally more favourable view of the procurement process, Assistant Director of the PCT [Asst Dir/Board Mem, mixed E Midl] conceded that some of the aspects of LIFT procurement were problematic. Specifically he suggested that the duration of LIFT projects could be a challenge for the private sector partner:

"I will tell you about one of the biggest areas of conflict. With the best will in the world, a LIFT scheme takes a while to dream up, to procure, to consult on, to sign a contract and to build. What will happen is the private sector will want you to give them a plan and say build this. If the whole process lasts say three years, personnel change in the NHS, thinking changes, NHS care delivery changes."

This view was echoed by the Assistant Director of Finance [Asst Fin Dir, mixed E Midl] who noted that the duration of the LIFT procurement process could create problems for private sector partners:

"You have got your strategy, and you are following that through to build up a business case for how you are going to procure a building and what that building is going to serve, and then you have got to formally sign that off. Then implementing it takes a very long time. Whether you could shorten that to any extent with the rules and regulations that are in place, I am not too sure. It is a long process but in some respects it needs to be. The private sector does not like this and I can understand why."

Lastly, a number of interviewees expressed their dissatisfaction with the signing off of one of the projects and specifically the lack of information which was provided at this stage. This view was expressed by the Assistant

Estates Manager [Asst Est Mgr, mixed E Midl] who noted that a lack of time prevented some stakeholders from fully assessing the implications of the agreements they had signed:

"One of the problems is that when the financial documents and the drawings were all signed off, I do not think the people really understood what they were doing. They were not trained enough to be able to – and that is not a criticism of them … Also there was an issue of time. The information was not there so they were not aware of what they were doing. They were not aware of how much accountability that could have."

In summary, the analysis of the procurement process at mixed East Midl LIFT provided a mixed picture. Although there had been enthusiastic participation in the scheme, a number of local stakeholders felt that levels of consultation had not been adequate. At the managerial level, there was similarly a concern that the duration and complexity of the procurement process created problems. These problems, accordingly, extended to issues of collaboration with the private sector which was adversely affected by the duration of the procurement process as well as creating uncertainty about potential future policy changes.

7.4.4 Learning and Understanding - Mixed East Midl LIFT

Apart from concerns over inadequate levels of consultation and the excessive complexity of the LIFT procurement process, a number of interviewees expressed concerns over the adequacy of skills which were available to PCTs when engaging with LIFT. These views generally touched on two areas of skilling. The first of these concerned the difficulties organisations within the NHS encountered in retaining the skills which had been gained in the context of public private partnership. The second issue concerned the problem of commercial skills within the NHS.

The issue of skill retention was addressed at some length by Assistant Director [Asst Dir/Board Mem, mixed E Midl] who argued that DoH should create special mechanisms for retention of staff and the sharing of partnership skills between PCTs:

"I think we are absolutely awful in the NHS with using expertise that we have honed and grown. Sometimes we just lose it out the NHS, sometimes the private sector take it. Once you have well trained people, next thing you know they are working for the private sector and they use us as a knowledge pool. … So I think from every active LIFT company project manager or public sector director, the DOH should actually buy out

a few days a month for those people, compensate their PCT and get them to help feed some of those knowledge successes and mistakes into areas where they have not got the knowledge. I think it would be so cost effective to do that … Also, the PFU should bear some responsibility for this in terms of not having developed this idea."

This view was mirrored by the Primary Care Manager [PrimC Mgr, mixed E Midl] who argued that there was a great need for the sharing of information and joined up thinking:

"There have been quite a number of LIFT projects happening and I think there needs to be some joined up thinking about people's experience and what they could do to improve it. LIFT needs to learn from its mistakes and try to address that in some way if they can."

While a number of interviewees felt that one of the principal difficulties with LIFT was a lack of information sharing, there was also the suggestion that organisations within the NHS lacked requisite commercial skills. This view was again expressed by the Assistant Director of the PCT [Asst Dir/Board Mem, mixed E Midl] who argued that NHS organisations often struggled with the need to make speedy decisions:

"There is a lot of quality knowledge in the NHS. What the NHS is not good at is applying it on a commercial basis. In the commercial sector they wear a watch, in the NHS we wear a calendar. We have got to be able to match them on commercial decisions, commercial options, business plans, we've got to work at their timetable. Our knowledge base is fine, we are often overawed at their speed."

Interestingly, the view of this interviewee [Asst Dir/Board Mem, mixed E Midl] that the knowledge base of NHS organisations equipped them sufficiently to engage in LIFT procurement was not shared by number of other informants. Thus, the Assistant Estates Manager [Asst Est Mgr, mixed E Midl] noted that the private sector had been more efficient in ensuring the full utilization of new projects:

"When it comes to finding the right mix of occupants, that is probably where the private sector was far more skilled, because they were able to look at it as a building as opposed to individual services. We had to learn very quickly."

Similarly, the Primary Care Manager [PrimC Mgr, mixed E Midl] suggested that the PCT lacked experience in building design and had to rely on the private partner to bring in this expertise:

"If we did not hire a Project Manager who knew all about Building Regulations and Health and Safety and Work Ergonomics and all of this, I would have had to make sure that I was up to speed on those which would have been an impossibility. On a positive side for LIFT, we did not have to worry about anything like that because you were paying for that through the scheme."

While this informant [PrimC Mgr, mixed E Midl] was generally positive about the LIFT procurement process, he, nonetheless, expressed concerns over the fact that some of the services the private sector partner had provided had come at a cost, which the PCT had not been sufficiently aware about:

"We need a lot more information about costs. With some of the difficulties, and definitely some of the costs, we need to know what to account for and bear in mind that this may inflate your cost dramatically by £XX a month ..."

Overall, there was a strong view among most informants that involvement in LIFT had presented a steep learning curve for the PCT. However, most informants felt that the PCT had coped adequately with these demands. Meanwhile a number of interviewees expressed concerns about how future changes would impact on current arrangements, and, in particular, about how the existing expertise which the PCT had developed around partnership working could be fully utilized and retained. In addition, some interviewees indicated their uncertainty over issues of cost and suggested that there was a need for a greater awareness and information sharing among PCTs.

7.4.5 Partnership - Mixed East Midl LIFT

There was a strong consensus among all interviewees that a working partnership with the private sector was essential to the success of LIFT schemes (note, no supplementary culture interviews we available for mixed E Midl LIFT, see section 5).

Speaking for a number of informants, the Assistant Director of the PCT [Asst Dir/Board Mem, mixed E Midl] noted that, in his experience, a working partnership required a close alignment of goals:

"To get a partnership to work you need people of similar status, having the same vision, usually with the same timescale and priorities."

Expanding on the issue of equality, the same informant [Asst Dir/Board Mem, mixed E Midl] suggested that a strong knowledge base within the public sector facilitated partnership working and that the NHS had to place a greater emphasis on providing pubic sector managers with these skills:

"With PCTs in particular it has not been top of the DoH's priorities and therefore they have been in the past led too much by the private sector. I think it is essential that you have intelligence on the NHS side, you have good service planners, you know what accommodation you require that's fit for purpose, and not just let a developer say well I did one down the road like this and therefore this is the one for you. They often do have templates that they want to corral you into. I do believe that a public sector Director and the project manager from the NHS needs to have the skill set to be able to work with people across the table otherwise they will be led rather than do the leading."

This view was shared by other informants, who, like the Assistant Estates Manager [Asst Est Mgr, mixed E Midl] suggested that partnership often involved a learning process where different organisations came to understand the constraints under which other organisations operated:

"The private sector could not understand that people round the table could not just make that decision and that was maybe where we clashed a little bit. But once they got their heads around how we had to work and we got our heads round how they worked, it made things a little bit easier. Also, they are employed to do that job and for the most part we are pulling it in as part of our day job and that is probably a major difference."

Lastly, the PCT Estates Manager [Est Mgr, mixed E Midl] noted that the close contacts which many staff had established with their private sector partners now made collaboration much easier:

"It always works better when you know people. You can get on the phone and start talking to them … I think we would probably still go through the same process, but that is the process we have to follow through LIFT."

Taken together, our interviewees generally felt that their LIFT was backed by a strong partnership which was based on mutual respect and understanding. However, there was also a consensus that building this

partnership had taken some time and that it was only in recent months that the PCT had been able to reap the full benefits of this collaboration.

7.4.6 Cost Issues - Mixed East Midl LIFT

Due to issues of commercial confidentiality the team was unable to obtain estimates about the capital and operating costs of LIFT facilities within mixed East Midl LIFT. As this problem had been anticipated by the research team, a special effort had been made to investigate how different LIFT users evaluated the expenses associated with these projects and how they judged their potential implications on affordability. While these subjective statements cannot replace a detailed financial analysis of cash flows (as presented in section 7), they, nonetheless, give an important indication of how satisfied users are with the financial aspects of their schemes and, more importantly, how these levels of satisfaction differ across various stakeholders.

Overall, the views of most of the senior interviewees within mixed East Midl LIFT with regard to the VfM aspects of LIFT closely mirrored those of the key informants (see subsection 4.2.6 and also subsection 4.3.6) in that this group highlighted the need to contextualise potentially higher costs in the context of improved maintenance and service delivery. This position was exemplified by the Assistant Director of the PCT [Asst Dir/Board Mem, mixed E Midl] who highlighted the fact that LIFT projects entailed more than the provision of built structures:

"I think the biggest misconception both from PCTs, Strategic Health Authority and the public is it superficially can look expensive but what you must remember is this. If you are building a development, a builder builds a house, a LIFT developer builds a home and so there are so many more things in a home than just a house, and that is why there is a difference in price."

This view was expanded on by the Assistant Director of Finance [Asst Fin Dir, mixed E Midl] who suggested that the cost of LIFT projects was justified because it was largely driven by long term maintenance:

"LIFT includes a lot more than a standard procurement. LIFT is a fully managed building. In some respects when you try to compare against other methods, you are comparing chalk and cheese … And it is getting that understanding of what exactly you are buying because on the last day that we walk away after 25 years, the building should be in the same condition as it was on day one."

By contrast, there was a tendency in those interviewees who were perhaps more closely involved with the operation of specific projects to be more critical of the costs aspects of their projects. This critical attitude was exemplified by a former Project Manager for one of the LIFT schemes [Proj Mgr, mixed E Midl] who suggested that the cost of the building he had procured was excessive:

"It is a purpose built new building which I do not think the PCT could have afforded without LIFT, whether it is worth paying over the odds over a period of years I do not know. Personally, I would not touch it with a barge pole! … Because I think it is expensive. I think it is a good building and well maintained, but a bit like hire purchase, you pay a lot more for what you get in the long run but it is a means to an end."

Similarly, a Practice Manager working in a LIFT building [Pract Mgr, mixed E Midl] suggested that he suspected the new premises to be expensive. However, his main complaint was that he had not been billed by the PCT for a lengthy time period (see also section 4.3.6 where a practice manager working in the West Midlands discusses a similar problem with regard to utility bills):

"Budget forecast: Rubbish! It has been brought up time and time again. I probably contact the PCT on a weekly basis and do not get any response. It is as though they have no idea and I am running a business here, I am accountable to the Partners of which I am one, it is my money. At the end of last year, I had to make a guesstimate of how much money I had to set aside, and I had to account for that to the accountant and the Partners who say well why are you putting that much money aside? Well, because I have no idea how much the LIFT building is going to cost. It just makes me sound like an amateur of which I am not. But it is best guess and here we are a year later and I am still at that position, pathetic."

Taken together, our interviews on the issues of cost and VfM indicated that this was less of a concern to senior management within mixed East Midl PCT who typically attributed additional costs to improved maintenance. However, as observed elsewhere, there was a tendency among those closely involved with the project management or operational side of LIFT projects to view this as a major problem.

7.4.7 Outcomes - Mixed East Midl LIFT

The previous section highlighted that LIFT users were highly divided with regard to the cost aspects of their LIFT projects. This, interestingly, was not the case when we queried our interviewees about how they viewed the overall outcome of their involvement with LIFT. Apart from a minority of

interviewees, who argued that levels of consultation had been insufficient, most informants noted that they were happy with their LIFT schemes. This included a number of informants who suggested that LIFT had brought significant improvements to service levels and patient care in East Midl PCT which, in turn, was reflected in high levels of patient satisfaction.

This pattern was exemplified by the Assistant Director of the PCT [Asst Dir/Board Mem, mixed E Midl] who expressed his satisfaction with the high level of investment his LIFT Co had brought to the area:

"I think you only have to look at the portfolio of schemes we have produced: £60 million worth of buildings; we are the now second largest property company in the area and we were nowhere 5 years ago. I think it has been highly successful. … If we exploit all the strengths of LIFT then we can make some huge differences to some really grotty accommodation … and we can deliver far better patient care."

This view was echoed by the Primary Care Manager [PrimC Mgr, mixed E Midl] who argued that LIFT had made it easier for the PCT to recruit GPs, which in turn, had positively affected levels of care in the area:

"It is now much easier to recruit GPs. Yes they may have a higher cost, but you know no-one has to find a hefty lump sum to invest in a Practice. So that was a bonus for them and is a bonus for us in terms of what our patients get."

Similarly the Centre Manager of one of the LIFT buildings [Cent Mgr, mixed E Midl] suggested that staff working in her facility were highly satisfied with their new building:

"Most people were so pleased to get into a brand new building because the majority of staff here worked in really terrible buildings, including myself, it was an atrocious building. Everybody was really pleased."

Another Practice Manager working in a LIFT building [Pract Mgr, mixed E Midl], who had been highly critical toward the financial aspects of this facility, similarly suggested that the new environment had had a positive impact on staff:

"It is a lovely building that can work very well, and the staff within the building work very well together, they gel very well which was a bit of a concern that I had."

This view was broadly echoed by the Primary Care Manager [PrimC Mgr, mixed E Midl] who argued that, although there were problems with some of the facilities, these were minor when compared with the advantages which they offered:

"The buildings are beautiful and you have got to remember that there is only a limited amount of money and you cannot have all singing and all dancing and what we had before, you know, vast improvement and fantastically so. And so although these are problems, the car park is not quite right and the air conditioning is not quite right, but you think it is going to be part and parcel of a new building."

In addition to expressing their satisfaction with their new buildings, a number of interviewees in East Midl PCT suggested that the new investments had improved patient care and satisfaction. This view was exemplified by the Centre Manager of one of the LIFT buildings [Cent Mgr, mixed E Midl] who suggested that the primary benefactors had been patients:

"The patients love it and they are very pleased, we have a comments box and we get a lot of really positive comments, because it is in a very poor area and they've had a very poor clinic before with limited services. So for the patients I think it is really good VfM, for us who pay the bill, I am not really sure. I do not think we have been in long enough to realise."

A practice Manager working in a LIFT building [Pract Mgr, mixed E Midl], meanwhile, suggested that the new facility had allowed his team to expand the quality of patient services:

"It is much better, it is cleaner so patient perception is that they are getting a better service and patient list size has grown phenomenally. I think that is also because people are coming in for other things and seeing that there is a doctor's surgery there so register while they are there for other things. We have also extended our opening hours from what we had before and so we are open until later at night on two nights, so we are catering for the additional patients. It is all good from the patient point of view."

Similarly, the Estates Manager [Est Mgr, mixed E Midl] noted that the integrated management of the new LIFT facilities had allowed the PCT to increase the utilization of available facilities and increase service provision:

"One of our new facilities is completely full. It is being used from 7–7.30 in the morning right through to 10 o'clock at night now. We have put more services in, dental, the Out of Hours service, until 10 o'clock at night so we are utilising them as much as possible."

Despite these generally positive views with regard to the facilities which had been procured through East Midl LIFT, a small number of informants felt that the procurement process could have been improved through better stakeholder involvement. This view was exemplified by a Practice Manager working in a LIFT building [Pract Mgr, mixed E Midl]:

"Our say was miniscule. Our waiting area is nowhere near the reception counter and this was pointed out and nothing was done about it, oh it will all be alright and actually it is not alright. We were completely overwhelmed by the big boys and our suggestion would have been much better."

Similarly, the Centre Manager of one of the LIFT buildings [Cent Mgr, mixed E Midl] noted that greater attention should have been paid to future users during the planning process:

"The people who are making the decision are not working in the building and do not always see the issues, no matter how much you tell them. The Centre Manager should have a little bit more say over what should be bought and paid for."

It was interesting to note that, despite a number of minor complaints, there was a broad consensus that the facilities which had been procured through LIFT in mixed East Midl PCT had brought major improvement in a number of areas including access, working conditions and the quality of patient services. This result should not be taken as self evident, since a number of past research projects tended to identify major weaknesses in facilities procured via public private partnership (see, e.g. Hudson, Capper, Holmes, 2003).

7.4.8 Views on the Future - Mixed East Midl LIFT

The final section of this case study concerns the views of staff at mixed East Midl LIFT with regard to the future of their own LIFT as well as LIFT in general.

On the whole most interviewees were optimistic about the future of their LIFT, with some informants advocating their own experiences as a model for others to follow. However, at the same time, a number of informants expressed their concerns over future uncertainties which could arise from fundamental changes in primary care and/or major political changes.

As an example of informants who saw the mixed East Midl experience as exemplary, the Assistant Director of this PCT [Asst Dir/Board Mem, mixed E Midl] noted that he would like to see LIFT expand across the whole NHS:

"I think LIFT-type approaches happen to be the best approach we currently have. This is because with LIFT, the PCT can keep some real control of it in the future through their public services Director and their equity stake. I think they should embrace it and I would like to see LIFT expand across the whole of the UK."

While being generally positive about LIFT, the same informant [Asst Dir/Board Mem, mixed E Midl], however, noted that there was a need for greater commercial awareness and closer involvement with other organisations:

"I think for it to go to the next level, we have got to be more commercially focused, we have to offer even better VfM, it has got to get slicker. PCTs have to get more involved, otherwise LIFT will just stay a very nice large property company for the next 25 years, rather than actually grow in the way that it could. LIFT could become a huge player over the next 5 years if it gets its act together, and the Strategic Authorities and PCTs give it the support they need to."

Following on from the this line of argument, the same interviewee [Asst Dir/Board Mem, mixed E Midl] argued that there could be major efficiency gains in expanding the existing LIFT into neighbouring areas:

"I would like to see us and the two neighbouring PCTs as a very minimum coming together. Although there would be less jobs for people around the table, that is the price we have to pay … So if you bring your resources together they can tackle more easily the areas that need LIFT schemes

that are currently not covered. And you would have less bureaucracy, less overheads, less AGMs, less sets of books, less sets of accounts, without necessarily compromising anything …"

In contrast to the optimistic views about the future of LIFT and PPP in general, several informants expressed their doubts as to whether these approaches would be suitable to the primary care needs of the future. This view was exemplified, among others, by former Project Manager for one of the LIFT schemes [Proj Mgr, mixed E Midl] who noted his uncertainty about the future viability of these approaches:

"Who knows what situation we are going to be in next year, let alone in 25 years' time. But you have to wonder whether PFIs and LIFT are a good thing for Health Services to be spending its money on."

Similarly, the Assistant Director of Finance of the PCT [Asst Fin Dir, mixed E Midl] expressed her doubts about the future appropriateness of the facilities which had recently been procured via LIFT in the area:

"You could say is Primary Care going to be the same in 25 years? Whether we will still need the same building in 25 years time I do not know. I suppose there is an argument that we should be looking that far ahead, or perhaps adopt more flexible solutions."

Lastly, the Estates Manager [Est Mgr, mixed E Midl] noted that there had been insufficient involvement by the Local Authority, and argued that this situation have to be remedied in the future if the LIFTCo were to expand its activities further:

"I think one thing I would do is get the City Council or the Councils on board a lot earlier as part of the planning. There have been quite a few problems, well there still are problems with the Council and getting them to understand these problems is very important."

This statement closely matched the views the earlier view of the Assistant Director of the PCT and other senior PCT officials who noted that potential synergies with local organisation had not been fully exploited on account of a lack of Local Authority involvement.

7.4.9 Summary - Mixed East Midl LIFT

Mixed East Midl LIFT present a unique case study for a number of reasons. Unlike many other PCTs, mixed East Midl LIFT appears to have entered the LIFT procurement process with a great deal of enthusiasm which was grounded primarily in what key stakeholders perceived as positive earlier experiences with a PFI project in the area. Based on these experiences, mixed East Midl PCT felt that it was well qualified to cope with the challenges posed by the LIFT procurement process. Although several members involved in the LIFT procurement process felt that this had been an unusually complex and bureaucratic process, they were generally satisfied with its outcomes. This satisfaction extended to issues such as the quality of the facilities which had been procured and their location as well as the impact which the availability of these facilities had on patient services and satisfaction.

Notwithstanding a widespread perception that the new facilities had allowed for an extension of patient services, a number of informants expressed concerns over the cost of the new buildings. These concerns focused on building cost as well as operating costs, with on of the informants voicing complaints about delayed billing. Moreover, a number of informants working in, and managing, LIFT facilities expressed their dissatisfaction with the nature and level of consultation which had accompanied the design process. This was paralleled by the perception, by PCT senior managers, that there had been insufficient involvement of, and collaboration with, the local Authority.

7.5 Case Study - Urban South West LIFT

Urban South West PCT services the largest city in its region, with a population of over 400,000. Black and minority ethnic residents make up about 11% of the population which is close to the average for England of 11.3%. One person households exceed the average for England and Wales (30.0%). This is also the case for the percentage of working age people with a long term limiting illness, which exceeds 12%. The student population in the city is unusually high, exceeding 25,000 during term time. The unemployment rate was below the national average with 4.5% for June 2007-08.

The city has deprivation 'hot spots' which are amongst some of the most deprived areas in the country, yet are adjacent to some of the least deprived areas in the country. In contrast, GDP per capita makes it one of the most affluent cities in England after London and Nottingham. With a long history as a seaport, the city is a centre for aerospace and defence industries, and the financial sector is also a major employer.

The city is services by urban South West PCT which was formed on 2006 through the merger of the two PCTs that had previously covered the city. The new PCT covers the same area as the City Council. The PCT established a LIFT company in early 2004, as part of the third wave of LIFT.

To date there have been three schemes replacing old health centres on the same or nearby land, and one refurbishment of an old hospital which had previously been used as student accommodation. This facility is now a primary care centre also housing the student medical service and offices. There are two projects at different stages of development. Two of the three new builds have been in areas of deprivation, one in a more mixed area.

Scheme 1 replaced a building that was felt to be overcrowded, extremely busy and totally inadequate for the range of primary and community care services provided there. No space was available within the building to allow for the future expansion of services and many parts of the building were in need of major repair or replacement. The centre housed two General Practices serving as well as district nurses, health visitors, speech and language therapists and community-based midwives. Services provided at the Health Centre included general medical services, ante and post natal clinics, mother and baby clinics, family planning sessions, podiatry, welfare rights advisory services and drugs counselling. These services have all now been transferred to the new building.

Scheme 2 replaced the existing Health Centre and expanded the existing site by acquiring an adjacent piece of land.

Scheme 3 was built by undertaking a land swap with an adjacent piece of land currently owned by the City Council. In addition to health facilities, a library will be built on site.

7.5.1 Methodology - Urban South West LIFT

The team conducted fieldwork in relation to 'urban South West LIFT' in November 2007 up until July 2008, making this the first area of study. As part of the case study analysis, interviews were undertaken with eight individuals, including: The PCT's Director of Strategic Planning [Dir StratP, urban SW], on two occasions with the PCT's Associate Director [Assoc Dir, urban SW], the PCT's Director of Provider Services [Dir ProvS, urban SW], the PCT's Director of Finance [Fin Dir, urban SW], the Business Manager for one of the LIFT developments [Bus Mgr, urban SW], the Project Manager for one of the LIFT developments [Proj Mgr], a Practice Manager [Pract Mgr, urban SW] and, on two occasions, with the CEO of the LIFT company [CEO, urban SW].

While the balance of informants was again skewed towards the public sector, this was in part compensated for by the fact that the private sector representative [CEO, urban SW] was available for extensive interviews on two occasions.

7.5.2 Background - Urban South West LIFT

Compared to other PCTs, a high proportion of the primary care infrastructure in urban SW was owned by the PCT. Therefore the primary focus of LIFT investment was on the replacement and refurbishment of PCT owned facilities. The private sector partner chosen to be part of the LIFTCo was a partnering organisation rather than a building company, who had a large construction firm in their supply chain.

At the outset there was a strong expectation that this arrangement would bring innovative solutions to primary care estate problems. This expectation was expressed by the PCT's Associate Director [Assoc Dir, urban SW] as follows:

"We were sold on the idea that this partnering organisation would open up possibilities that we had not thought of, particularly in our city where property is very expensive, hard to come by in the city centre. Some of the other partners in that supply chain … opened up the door to do innovative things in terms of developments … that we would not as a PCT be able to access."

This view, however, was not universally accepted by PCT stakeholders. Thus, the Project Manager for one of the LIFT developments [Proj Mgr, urban SW] expressed doubts about how innovative the LIFT company had actually been:

"My impression is that they do not come up with solutions that are that creative. I read about LIFT schemes elsewhere, and about primary care development, and I think we are coasting a bit. I think they could be more innovative."

The CEO of the LIFT Co [CEO, urban SW], meanwhile attributed a potential lack of innovation to circumstances which were outside the private sector's control, including lack of access to suitable land or development opportunities:

"We never found a site that was big enough to do anything other than put the Health Centre on with the parking it needs and put a pharmacy in there. Not because we did not want to, but because there just was no scope on the available sites."

In addition, the LIFT Co [CEO, urban SW], felt that there were aspects of working with the public sector that themselves caused delays and frustrations, but that these were outside the PCT's control:

"We are looking for the PCT to manage the impossible; policy changes, NHS design guidance, public sector approval processes, all of which are naturally subject to public accountability and scrutiny and therefore somewhat bureaucratic, slow and unwieldy."

The LIFT process itself was also felt to be a potential barrier. Thus the LIFT CEO [CEO, urban SW] expressed concerns that standardised documentation, which would lead to the more efficient development of subsequent schemes, had not materialised:

"Every tranche of schemes we have placed has been on a different version of the lease plus agreement. So that benefit has just never materialised so we are always into quite expensive and long discussions with lawyers and financial advisors.. Until that settles down, you will never actually realise that benefit which is one of the driving forces behind LIFT."

Overall there was a strong perception that the expectations of what LIFT could deliver, in terms of finding innovative solutions to estate problems, had not been matched by the reality. This view was expressed by, among others, the PCT's Associate Director [Assoc Dir, urban SW]:

"What we started to realise was that actually, the private sector doesn't necessarily have that capacity to move quickly and take risks any more than we do."

7.5.3 Procurement - Urban South West LIFT

Once the PCT had decided to form a LIFT company, the LIFT 'route' was perceived to be the only way that developments would take place, although there had been one non-LIFT development in the city during the lifetime of the LIFT company (a refurbishment of an old swimming pool, carried out by a GP practice in association with a local charity).

Speaking for one of the practices who went into Scheme 2 wanting to improve their facilities, a Practice Manager [Pract Mgr, urban SW], noted that their involvement with LIFT had not been entirely voluntary:

"We did initially look at the GPs doing the building themselves, taking out a mortgage and actually producing the building but we were told categorically by the PCT that we would not be supported because they had just signed up to LIFT for the next 25 years and therefore that was the only way to go."

Both PCT and private sector interviewees also felt that there had been difficulties in the decision-making process early on, partly because the PCT was representing several other stakeholders. This was highlight by the CEO of the LIFTCo [CEO, urban SW]:

"The difficulty is to make decisions early. This means that you have to have certainty about things that can be quite difficult to pin down, because usually they are dealing with quite a range of stakeholders and they cannot corral all these people easily and force them to make a decision and stick to it."

Similarly, the Business Manager for one of the LIFT developments [Bus Mgr, urban SW] noted that it had been difficult to reach consensus during meetings:

"I have organised several user meetings to contribute towards the footprint of the inside of the building, getting their approvals, involving various consultants to advise on various other technical aspects of the operational design, things like room weightings, soft FM planning, and involving where necessary the Health planner to look at various other services which we might have to put in to the centre and also working with other departments such as Commissioning to get some clarity around what level of activity we are projecting for the Health Centre. We have had some difficulty around that."

Other challenges in the development process revolved around finalising designs, especially for the content of the buildings, and there could be a conflict between pressure to finalise the design process in order to get to financial close, and users' desires to make changes in the design. In this context the Project Manager for one of the LIFT developments [Proj Mgr, urban SW] made the following comments:

"There were elements of the design process that had had to be compromised, and there was a point at which the design process was frozen; if the LIFT company felt they had spent enough on the design process, they froze it and said we have got to stop here, we have got to stop doing the finances, we have got to get financial close. And there had been a lot of iteration and there had been a lot of compromise. But after financial close there was still the expectation on the users side that they would be able to refine and improve this design. It was very difficult to do that after financial close."

Occasionally the need for design change could come about because of a policy change; for example, new guidance for infection control, which was issued shortly after the plans for one building had been finalised, meant that the floors needed changing. This raised a question for one interviewee [Proj Mgr, urban SW] about whose responsibility it was to make such changes in design:

"I think LIFT's supply team should have picked this up. I think the designers should have been advising us if the floor needed changing rather than us advising them."

Another potential problem concerned the decision-making chains alluded to above, where the PCT was representing a number of other stakeholders. It was felt to be vital, and very difficult, to get the details right, i.e. once the decision to build the building had been taken, most people's concerns were with the contents, the facilities, and the rooms that would be available to them. One of the Project Manager for one of the LIFT developments [Proj Mgr, urban SW] made the following comments:

"There is so much detail there were things we missed in the chain, and it is basically a chain from the architect to the tenant's rep to tenants, and back. At each stage there is a risk that someone will assume that someone else has logged the right preference and the right option, or that someone has told the users why we have chosen a particular measure."

However, several interviewees, including one of Project Managers [Proj Mgr, urban SW] commented that the building company had been very helpful and supportive:

"The contractors were absolutely fantastic, just brilliant … that relationship was excellent, they could not have done more to make it go smoothly."

Despite the difficulties, which almost always revolved around the details, staff and patients were happy with the buildings once they were opened. This was commented on by one of the Practice Manager [Pract Mgr, urban SW]:

"It is a great building and its lovely and there is going to be lots of opportunities for development but it is big and it just means that people have to walk a lot further and look at the signage a lot more deeply than they used to, and some of them, the elderly particularly, are finding it a little bit difficult."

Similarly the PCT's Director of Provider Services [Dir ProvS, urban SW] suggested that the projects had achieved a high level of satisfaction among users:

Without exception really all the people who have moved from a building into a LIFT building have gone from something which is absolutely terrible, horrible, damp, falling down, not fit for purpose, not nice to work in, to a brand new building so of course they will really like it."

7.5.4 Learning and Understanding - Urban South West LIFT

As in several of the previous case studies, a number of interviewees at urban SW LIFT commented on the process of learning about LIFT, and the challenges of dealing with an entirely new way of doing things. This was exemplified by a Practice Manager [Pract Mgr, urban SW] who made the following comment:

"I would love to go back to the beginning again because now I know so much more. … I have learnt a huge amount, you know the questions to ask, the things to look for, the way to manage it better … all that sort of thing."

For many people, LIFT had been a steep learning curve, mainly because it introduces new ways of working and new forms of partnership to the NHS, which meant that not only detailed planning processes had to be learnt, but also that the PCT had to understand how to work in partnership with the private sector. The PCT's Associate Director [Assoc Dir, urban SW] commented on this issue as follows:

"The main learning points for us are around being an informed client, making sure that we know what we are asking for, getting the right advice to help us to do that even if it takes longer and costs more.

Understanding that we are in a commercial relationship, in other words however much of a partnership it is, at the end of the day LIFT and their supply chain are in it, there is a profit to be made. There is no problem with that, I think we just need to recognise that there is that motivation out there."

The same informant [Assoc Dir, urban SW], meanwhile, noted that his concerns that organisational learning could be improved:

"I think we could have done a better job between us of formally learning. I think that in a way because there has been continuity that has stopped there being perhaps such an overt process because it would be 'well, we won't do that again.'"

Within the PCT, however, it was felt that there was neither time nor capacity to carry out this kind of evaluation and review. This view was expressed, among others, by one of the Project Managers [Proj Mgr, urban SW]:

"We do not really have the capacity to sit down and say "what are the key lessons from last time, what do we want to make sure that we learn next time?" and that is very frustrating but that's very much within the PCT."

Similarly, the Business Manager for one of the LIFT developments [Bus Mgr, urban SW] suggested that there had been little time for reflection about outcomes:

"Everyone seems to be so swamped doing their own thing, no-one has actually stopped to review after the project has been completed. Saying right, how can we make sure that someone else who may come along is better equipped from the get go to pick up a project and run with it. There is very little of that."

This organisational memory loss could be frustrating for the private sector, particularly when combined with personnel changes in the PCT; the amount of staff turnover which could sometimes be exacerbated by organisatonal changes within the NHS meant that stability tended to come from the private sector side. This issue was commented upon by the LIFT CEO [CEO, urban SW] as follows:

"One of the difficulties for our PCT is that they have quite a turnover in their estates team. So on all the four jobs we have done, there is not

anyone really who has got experience from the PCT side on delivering all four schemes. The people that have got experience are on the private sector side because I have been involved all the way through and my supply chain has been involved all the way through."

7.5.5 Partnership - Urban South West LIFT

Section 5 (subsection 5.4.3) identified the partnership of urban SW LIFT as being characterized by *Segregation* with some elements of *Synergy*. This was confirmed by most informants who described the relationship between the public and private partners as good but arm's length. Specifically, it was noted by several informants, including the that the LIFTCo CEO [CEO, urban SW], that a lack of continuity had prevented close working relationships from evolving:

"There are only a few key people who have been common to a lot of these schemes all the way through. I have a very good working relationship with them in terms of being able to share and explain detail, but there are not many of them."

For both parties there was an awareness that a partnership was a continuing process which required an effort to make it work. This was explained by the PCT's Associate Director [Assoc Dir, urban SW] as follows:

"So I think that is a lesson for any partnership scheme, particularly LIFT schemes, which is that you have to work at partnerships; there have been tensions between us, and there continue to be, and they have been resolved and continue to be resolved but you have to put time and effort into that partnership working."

Similarly, the LIFTCo CEO [CEO, urban SW] suggested that relationship development was a continuous process:

"I think we work very well in terms of our relationship with the PCT and we understand what they need. We continually work to give them a solution that meets their needs; we have to try and understand, and almost better than they understand it themselves."

7.5.6 Cost Issues - Urban South West PCT

One of the major concerns about LIFT for most respondents was cost. Specifically, at a practice/project level, there was a sense that individual

developments were, as one Practice Manager [Pract Mgr, urban SW] noted, costly for the business:

"It is costing us a lot more to be in the building, and we knew it would, we sat down and talked about it and knew we had to do it that way."

The Director of Finance [Fin Dir, urban SW], meanwhile, noted, that higher costs had to be seen in the context of the quality of the new buildings:

"For each clinic, or the health centres we are renting at the moment we are paying £600K-£700K per year. That is a lot more than the capital charges ever were. But they are great buildings."

Similarly, the PCT's Director of Strategic Planning [Dir StratP, urban SW] noted that cost issues had to be contextualized within accounting procedures:

"My gut reaction is that it does not always appear affordable. If I espouse being rational and using economic appraisal, then I have got to live by the consequences of that which say actually LIFT is good VfM. And that has to with life costs and the risk transfer."

However, the same question led the Director Finance [Fin Dir, urban SW] to reflect about whether LIFT buildings were too good:

"Where I have a problem with affordability is that I think we have almost bought too good a product. I think the health centres are excellent buildings, very well maintained, well constructed, well designed etc but we do not need that level of sophistication in primary care I don't think. You could have a building which is a bit cheaper but perhaps not quite so splendid."

There also appeared to be mixed feelings within the PCT about whether the PCT were procuring what they actually needed, or whether the buildings had been built to too high a specification, and too spacious. In this context the PCT's Associate Director [Assoc Dir, urban SW] made the following observations:

"I think we have probably got some over-designed buildings now. Beautiful and spacious. One of our emerging issues is where we have

over-specified … with the clinicians sitting around the table aspiring beyond what they had the means to do."

However, the same interviewee noted that this meant that there was flexibility in future developments and scope for putting in additional services, something which both the provider arm of the PCT and the users of the building were aware had not yet happened.

7.5.7 Outcomes - Urban South West LIFT

In general, there was a high level of satisfaction with the LIFT buildings urban SW LIFT had procured. Staff were reported to be happy to work in them, and patient satisfaction was reported to be good on the whole. Even the otherwise critical Practice Manager [Pract Mgr, urban SW] commented positively on this fact:

"It has been a very positive experience and we are very pleased to be in there I think we will manage to keep everybody and make everybody happy."

However, there was a sense that there had been missed opportunities in terms of developing new ways of providing services, or new services per se, and this links with the perceived lack of innovation mentioned above. Again it is worth quoting the aforementioned Practice Manager [Pract Mgr, urban SW]:

"One of the things we really wanted when we first started talking about the building was to have some kind of wholefood café, because we thought if we cannot teach our population how to eat healthily what are we here for if we cannot do something along those lines? There was nothing in our area, there are a couple of greasy spoons but there is nothing on the healthfood front at all and we thought if nothing else it would provide sustenance for the people working in the building, so it would be a relatively good business opportunity and that was not taken up."

Part of this was felt to be due to planning processes for the earlier schemes not being detailed enough, a problem which, according to the Director of Finance [Fin Dir, urban SW] had been resolved by the time the later schemes were being planned:

"In our first two tranches we built buildings that were too big. We did not have a good enough handle on the services that were going to be provided. And by that I mean, how is each room going to be used? Is this the way we want it to be used? I would say for the two schemes which are on the table at the moment, we are doing a much more detailed job because we have gained experience during the period."

It could be argued that many of the perceived problems with LIFT stem from inexperience early on, and a lack of organisational learning, a situation which should be resolved as more LIFT schemes are completed and experience builds up, especially in the public sector.

7.5.8 Views on the Future - Urban South West LIFT

The key issue facing this relatively small PCT and LIFTCo such as this one, was how to continue work into the future. Within the PCT there were mixed feelings about LIFT, although realistically it was unlikely that the following scenario, suggested by the Director of Strategy [[Dir StratP, urban SW], would occur:

"I think there are senior people who, if we ditched the LIFT and we did not do any more LIFT, would not be bothered."

For the CEO of the LIFTCo [CEO, urban SW] the main issues were not so much policy changes but rather the need to ensure an ongoing pipeline of work:

"What happens in a year, two years, five years time? The answer is that one expects that the pipeline is not infinite in capacity, so we would expect that there would be a slowing down of the work that the PCT will put our way. So the big question is … what happens in two years, five years time?"

Lastly, a number of informants, including the PCT's Associate Director [Assoc Dir, urban SW] raised questions remain about the value added by LIFT:

"Has LIFT added something different? Is there a value over and above decent buildings? I think so far we don't know. It's too early to say and it doesn't feel like something deeply innovative has happened."

7.5.9 Summary - Urban SW LIFT

Urban SW LIFT represents an instance in which both public and private sector stakeholders value the existing partnership without perceiving their relationship as particularly close. In line with this perception, most stakeholders viewed past projects as a success, with the proviso, that there had been no particularly innovative or novel solutions. This situation is attributed primarily to local constraints which relate to the high costs of property in this relatively compact city. Although there appears to be on the public sector side no strong commitment to LIFT, several informants felt that their experiences had been valuable and could contribute to improvement in commissioning/procurement in the future. In this context, one particularly appears to be the need to avoid the overspecification of facilities, which adversely affects affordability.

From the private sector point of view, the key concerns to relate to issues of continuity and the future deal flow in this area, which appear to be indicative of potential sustainability issues which affect smaller LIFTCo-s such as this.

7.6 Summary - Case Studies

The case studies presented in this section describe the very different experiences of four areas with LIFT. Urban North East LIFT presented the perhaps unusual case of a PCT which, while initially reluctant about public private partnership, enthusiastically embraced LIFT as a part of a broader regeneration agenda. Together with an urgent need for improvement in local primary care facilities, this regeneration agenda appears to have facilitated the creation of what virtually all interviewees described as a strong partnership which additionally benefited from buy-in by a number of Local Authority stakeholders.

This contrasted sharply with rural East Midland LIFT where several public sector informants suggested that the PCT had not benefited significantly from its involvement with LIFT. These views were based on a number of factors including the specific challenges of rurality in the area, the perception that the PCT already possessed a strong and competent estates department, the under-utilisation of new LIFT facilities and the limited impact of LIFT on working practices which appear to have highlighted issues of cost and affordability. Taking these factors together, there was some indication that the development of this LIFTCo was hampered by a lack of development opportunities which are more typical of urban areas (see also 4.3.6 which indicated a tentative urban/rural divide in term of VfM perceptions), as well as the PCTs unique administrative context, which meant that parts of the county effectively inherited LIFT on account of a PCT

merger, without having been initially involved in its creation and without being currently governed by its exclusivity agreement.

Perhaps differing from the experiences of both of these areas, mixed East Midl LIFT appears to have entered the LIFT process enthusiastically on the basis of previous experiences with a PFI hospital. This enthusiasm for LIFT seems to continue to shape the views of public sector stakeholders who expressed their belief that LIFT had, particularly in urban areas of the PCT, contributed significantly to improvements in the quality of facilities and services which would have not have otherwise been possible. Notwithstanding these positive views, a number of informants voiced concerns about insufficient levels of consultation as well as a lack of involvement from Local Authority stakeholders.

Lastly, urban South West LIFT represents the completely different set of experiences of a relatively small LIFTCo operating in a compact city with historically high property prices. While the majority of interviewees from this area viewed past LIFT projects as a success, these views were tempered by suggestions that the solutions that had been adopted had not been particularly 'joined-up' or innovative. This situation was typically attributed to the lack of available land and high land prices, which also gave rise to concerns over the sustainability of this LIFTCo. Moreover, there was a perception among senior PCT stakeholders that some of the LIFT facilities had been over-specified on account of a lack of cost-awareness among clinicians.

As a commonality, informants from all four case studies suggested that they were part of working partnerships which they had come to value as a major resource. This perception, interestingly, included both rural East Midland LIFT, which was probably the least enthusiastic LIFT participant, and urban South West LIFT, where informants described their relationship as being arm's length rather than being based on close personal contact and collaboration (as had been the case for urban NE LIFT and mixed E Midl LIFT). Moreover there was a common view that it had taken an effort to create these partnerships and that the LIFT approach to procurement, despite being bureaucratic and complex, had encouraged this type of collaboration between the public and private sectors. This finding should be given some significance, particularly in light of earlier research on PFI which indicated that these collaborations had often given rise to adversarial and litigious relationships (e.g., Asenova and Beck, 2003a).

Another common theme concerned the widespread belief, among informants from all four case studies, that LIFT had led to significant improvements in the quality of buildings and patient services as well as creating improved working conditions for staff. This view is confirmed, albeit in a limited

manner, by the survey data presented in Appendix 7, which reports high levels of patient satisfaction for two LIFT areas (which include two practices within urban NE LIFT).

Notwithstanding these positive aspects, it is important to note that public sector informants from all four locations expressed concerns over cost and affordability aspects of LIFT projects. These concerns ranged from issues of over-specification and under-utilisation to issues of short-term budgeting and long-term affordability and sustainability. Although these concerns were widespread, it was interesting to note that they rarely gave rise to fundamental objections to, or a rejection of, LIFT as a procurement mechanism. Indeed, where informants voiced a critique of LIFT, this was typically based on the belief that the PCT already possessed requisite estate skill and could have made necessary procurements without LIFT (as, e.g., in rural East Midland LIFT). Similarly, although urban NE LIFT was identified in the Financial Analysis section (section 6, subsection 6.4.3) as having created relatively high returns for the private sector partners, concerns over VfM in this LIFT were, if anything, less pronounced than in other case study areas (with several urban NE LIFT informants suggesting that costs would decline in the future). This indicates that, at least at present, stakeholder perceptions of local LIFTs are driven predominantly by views on the extent and quality of facilities procured as well as perceptions with regard to the functioning of the existing partnership. Although it is probably unreasonable to attribute these attitudes vis-à-vis the VfM aspects of LIFT to a lack of financial foresight and prudence among PCT stakeholders, it is worth noting that the financial governance of LIFT may well be suffering from a lack of financial monitoring and forecasting which may adversely affect future developments in this area.

8 Summary - Policy, Management and Research Implications

8.1 Introduction

This research project was tasked with investigating the role and effectiveness of LIFT in the development of enhanced primary care premises and services. As a procurement method which had evolved from PFI, the LIFT initiative was established in 2001 with the aim of developing a new market for investment in primary care for the regeneration of local care facilities via the creation of new surgeries, clinics and health centres (Appleby, 2001). Research by the National Audit Office (2005) suggested that LIFT was a potentially attractive means for securing value for money. However, other researchers noted that problematic issues related to the set-up, implementation and governance of LIFT Companies could adversely affect these outcomes (see, e.g. Aldred, 2007; 2008).

This design of this research project was based on a set of original policy questions specified by the SDO. These included:

- How should public-private partnerships be developed and established?
- What are the grounds or circumstances in which public-private partnerships are desirable, which stakeholders should be involved, and what are the criteria by which their performance should be measured?
- What are the organisational and behavioural factors that influence the relationship between a public organisation and its private partner(s)?
- What factors underpin the most effective working arrangements and performance of public-private partnerships?
- What are the implications of public-private partnerships for the governance of public services, and what governance arrangements should be put in place for public-private partnerships?
- What are the actual and potential conflicts of interest and problems which arise in relation to operating public-private partnerships and how should these be managed?

The aforementioned policy questions were addressed in this study through a mix of theoretical work, literature review and empirical study; with interview analysis and financial analysis playing a central role in shaping our conclusions. The following section summarises our key findings in connection with these objectives.

8.2 Summary of Key Findings and Implications for Policy and Management in the NHS

Policy Question 1

How should public-private partnerships be developed and established?

Within the limitations of our revised study design (see section 2) this report found evidence that LIFT had created the organizational and institutional framework for effective partnership working within the NHS (see sections 4, 5 and 7). Although a significant number of user informants expressed the view that LIFT posed a significant administrative burden as well as a challenge to the skills of public sector managers, there was a broad consensus that these problems were alleviated through collaboration with private sector partners within the LIFT framework. Overall, both public and private sector informants tended to view their LIFT partnerships as an effective resource and a means for clarifying and aligning potentially conflicting goals. This finding appears to contradict earlier research which highlighted problems with partnerships working in the context of PFI and, as such, lends support for the view that public private procurement and collaboration is more effective within a framework of long-term contracting and repeated purchases.

Notwithstanding these positive observations, there were indications that public private partnership within the NHS could be improved in a number of ways. These included a greater focus on knowledge sharing amongst public sector managers who had participated in LIFT projects and the creation of specific administrative mechanisms which would allow senior public sector LIFT managers to share their experiences with 'novices'. Additionally, there were some concerns among public sector informants with the ongoing loss of LIFT relevant knowledge amongst senior public managers on account of the completion of projects, retirement and/or the movement of these individuals to the private sector. Lastly, a number of public sector managers expressed the view that advice and support by organizations such as Community Health Partnership or Partnership UK was not an adequate substitute for improved lesson learning among senior public managers.

Policy Question 2

What are the grounds or circumstances in which public-private partnerships are desirable, which stakeholders should be involved, and what are the criteria by which their performance should be measured?

Both our stakeholder and our case study analysis (sections 4 and 7) highlighted a number of factors which influenced the effectiveness of LIFT partnerships. These included, above all, the development of strong commissioning and strategic planning skills among senior public sector managers, without which the joined-up and synergetic development of LIFT projects is less likely to materialize. These findings were underpinned by the fact that most public sector LIFT users reported that it was relatively easy to procure quality facilities via LIFT, while having difficulties in doing so in a joined-up and strategic manner; and even more so with a potentially valuable participation and buy-in from Local Authority stakeholder. Also, there was a suggestion that some LIFT users felt that the creation of new facilities had not resulted in changes in working practices and service improvements which these facilities would have permitted. This situation suggests that there may be a case for creating incentives for managers to pursue and implement strategic approaches to procurement which favour joined-up solutions and explicitly reward improvements in service provision.

In addition to the issue of integrating LIFT procurement in a broader service strategy, there was an indication that the effectiveness of LIFT could be hampered by circumstances beyond the immediate control of PCTs. Thus there was a strong indication that it was more difficult to achieve VfM through the co-location of services in rural areas, on account of a lack of demand in areas of limited urban density. Additionally there was an indication that the development of innovative LIFT projects could be hampered by high property prices and a lack of availability of land. Lastly, a number of informants suggested that PCT mergers (and related policy changes) could adversely affect the support for, and targeting of, LIFT facilities.

As regards stakeholder involvement in LIFT projects, there was some consensus that this issue had been adequately addressed by most PCTs. Notwithstanding these positive views, a number of informants felt that local user involvement could be improved (e.g., by involving practice managers and reception staff in the design of facilities) and that LIFT managers should attempt to secure a broader level of involvement from Local Authority and NGO stakeholders.

Policy Question 3

What are the organisational and behavioural factors that influence therelationship between a public organisation and its private partner(s)?

Our study suggested that organisational culture matters, and is seen to matter in the formation and maintenance of LIFT partnerships (see section 5). Managers at all levels in the public and private organisations recognised the significance of culture and were either actively interested in shaping it or felt constrained by its influence on inter-organisational relations. In some LIFT projects different assumed motives had created a degree of suspicion and lack of trust between partners, with public organisations being sometimes uncomfortable with the underlying profit motive of private sector organisations, and private sector organisations worried about the perceived bureaucracy, 'red tape', lack of financial acumen and political interference. However, on the whole the partners within LIFT projects appeared to be working together well and differences in culture were being managed and accommodated as partnerships matured; with partnership working being facilitated by the fact that public sector managers had gained a significant understanding of strategic and financial management issues, while some private sector managers had had prior experience in working with, or for, the NHS.

Where relationships between public and private sector partners were less amicable, this was typically due to external factors such as problems created by PCT mergers or policy changes, and/or a lack of available/affordable land for innovative developments. Also, there was some concern, both among public and private sector informants, that a future lack of deal flows and cuts in public sector funding could re-invigorate cultural tensions and organizational mistrust.

Policy Question 4

What factors underpin the most effective working arrangements and performance of public-private partnerships?

Our study noted that working arrangements around LIFT were facilitated by a number of factors including the presence of significant deal flows and opportunities for the adoption of innovative and commercially attractive solutions (which were more likely to materialize in urban areas and, in particular, in areas with significant regeneration potential). Additionally there was an indication that LIFTs schemes benefited from being paired with local regeneration activities.

Further to this, there was a suggestion that private sector participants were more likely to become involved in LIFT where PCT were able to present detailed long-term strategic plans for future improvements. Local demand for LIFT facilities, meanwhile, depended largely on the availability of alternative accommodation for GPs, with areas of population growth and high property prices being the most likely to attract GP demand.

Policy Question 5

What are the implications of public-private partnerships for the governance of public services, and what governance arrangements should be put in place for public-private partnerships?

Although our study found existing governance arrangements around LIFT to be largely to the satisfaction of both public and private sector participants, a number of public sector informants expressed concerns over the cost and affordability implications of LIFT. Given these concerns and the quantitative financial analysis presented in section 6, we would suggest that there is a potential need to strengthen the financial governance of LIFT schemes; with a view toward overcoming the current disjointed view, whereby the success of LIFT projects is seen, by both public and private sector stakeholders, largely in isolation of financial parameters. This would involve the establishment of systematic frameworks for the monitoring of LIFTCo cash flows (in line with the analysis presented in section 6) as well as improvements in the ability of PCTs to forecast future LIFT related liabilities and assess their long-term implications. Additionally, there is a potential need for PCTs to establish frameworks for the assessment of various VfM aspects of LIFT projects, which, while not neglecting potential added benefits of this projects (in terms of co-location, maintenance, etc.), analyse cost and benefits in a rigorous quantitative fashion. At this stage, the team would recommend the creation of a PCT LIFT Finance working party. This working party would aim at bringing together Finance Directors from all LIFT schemes (or their representatives) with accounting academics and representatives from professional organizations in order to establish templates for the cost benefit analysis of LIFT projects and frameworks for the continuous monitoring of LIFTCo cash flows.

As a spin-off of this study, members of this research team are already developing a specialized financial management course for senior NHS staff who are engaged in, or are planning to be engaged in, public private projects. This course will have the potential to create certificate level qualifications for these managers as well as creating the basis for future discussions within the proposed working party framework.

Policy Question 6

What are the actual and potential conflicts of interest and problems which arise in relation to operating public-private partnerships and how should these be managed?

This study found that most LIFT stakeholders felt relatively comfortable with their existing roles within LIFT schemes. These views extended to those public sector representatives who maintained a dual role within PCT management and LIFTCo boards. However, there is a possibility that these positive views of LIFT governance were based, at least partially, on a lack of understanding of the financial implications of LIFT (see previous point and section 6) and the inadequacy of existing financial auditing and monitoring requirements. It might therefore be advisable for the DoH to investigate whether additional reporting requirements could/should be imposed on private sector LIFT partners with a view toward securing a more transparent assessment of the costs and benefits of individual LIFT projects as well as the cash flows of LIFTCo-s.

8.3 Challenges to Project Delivery

The main challenges to the completion of this project arose from the multidisciplinarity of the initial research design. This multidisciplinarity was based on the recognition that the effectiveness of LIFT could not be understood from any single perspective, but rather required a bringing together of different types of qualitative and quantitative analysis (see also the PI's earlier study on PFI, Akintoye, Beck et al. 2001, which successfully employed a similar methodology). As a consequence of this approach, the research team faced two difficulties. The first of these concerned the collection and analysis of data for the different components of this study. The second challenge involved a process of triangulating these different types of information and, in particular, addressing locational mismatches which had arisen during the study on account of differential data availability.

8.3.1 Data Components

At the outset of the study, the team was able to interview a wide range of senior key informants who were willing and able to provide well informed views. Similarly, the second stage of case unspecific (or user) interviews was able to draw on a number of volunteers from the public and private sector. However, later on in the project the recruitment of LIFT projects for case study investigation proved exceedingly difficult as a number of PCTs withdrew their initial consent for collaboration within a more in depth analysis. Eventually, however, the team was able to recruit four LIFTs for this phase of the project, which, together, provided a remarkably diverse and informative cross-section of these schemes.

As regards quantitative financial data, it was clear from the outset that it would be difficult to find matching financial data for the planned case studies (see section 6.3.2 which describes how the NAO refused to provide this data because it was the commercially confidental property of its subcontractor Operis). Eventually, however, a team member was able to conduct a detailed cash flow analysis for three LIFTCo-s which included one of the case studies (urban NE LIFT).

Similarly, difficulties were encountered in securing a supplementary culture interview from mixed East Midland LIFT as well as private sector participation for the rural East Midland LIFT and the mixed East Midland LIFT case studies.

8.3.2 Data Triangulation

This study would clearly have benefited from a close match of all components of study, including cultural analysis, financial analysis and case studies. This was sadly not possible, both on account of a reluctance of PCTs to participate in the case study phase of the project and on account of the scarcity of available financial information on LIFTs.

With hindsight, however, this data mismatch created fewer information gaps than initially anticipated, predominantly because the multidisciplinary design of the study allowed the researchers to substitute and interpolate between different segments of the project. However, what became painfully clear to the team towards the end of this study was that the existing time frame of two years was too short for this undertaking and that this study should have been more realistically budgeted for three years.

Notwithstanding these observations, the authors would like to conclude that this undertaking has been a thoroughly enjoyable experience, which was enhanced by real world relevancy of the topic and the possibility of future policy relevant publications drawing on this research.

Published Papers

Fitzsimmons D., Brown S. and Beck M. 2008. Does the UK Local Finance Improvement Trust (LIFT) Initiative improve risk management in public-private procurement? *Journal of Risk and Governance* 1(2).

Fitzsimmons D., Beck M., Toms S., Brown S., Mannion R. and Lunt N. 2008. UpLIFTing PFI: does LIFT improve public-private procurement? *The Systemist* 30(2).

Brown S. and Beck M. 2009. Value for money and public-private partnerships in the UK: the Local Finance Improvement Trust (LIFT) Initiative in Primary Care. *Public Sector Management* (forthcoming)

Planned Papers

Mannion R., Lunt N., Beck M., Toms S. and Brown S. 2009. Managing cultural diversity in public-partnerships: the case of the Local Finance Improvement Trust (LIFT) initiative in Primary Care. *Public Money and Management.*

Conference Presentations

Fitzsimmons D., Beck M., Toms S., Brown S., Mannion R. and Lunt, N. "UpLIFTing PFI: does LIFT improve public-private procurement? UK Systems Society International Conference, September 2008, Oxford University.

Beck M., Fitzsimmons D. and Brown S. Does LIFT improve risk management in public-private procurement? 2008 PAC Conference, September 2008, York University.

Beck M., Toms S., Greener I., Mannion R., Brown S., Fitzsimmons D. and Lunt N. "The role and effectiveness of LIFT in the development of enhanced primary care premises and services" SDO Conference, June 2009, Birmingham.

ESRC Bid in preparation

Beck M., Toms S., Asenova D., and Bailey S. "Procurement of public sector infrastructure: the evolving plurality of methods"

8.4 Research Agenda

Although this study suggests that LIFT has brought improvements to partnership working in the NHS, it also provides evidence that the management of these public private partnerships still presents unique challenges. Specifically, there seem to be a number of gaps in the understanding of local partnerships and their economic, social and financial implications that warrant further investigation. These include:

The role of health care investment in urban and economic regeneration: This study has highlighted the potential benefits of embedding LIFT investment in a broader regeneration context (see, e.g., section 7.2), alongside the concerns of several stakeholder that these synergies have hitherto not been adequately exploited. We therefore suggest that there is case for studying in detail a small number of LIFT schemes where there is evidence of broader regeneration activities together with Local Authority buy-in, with a view to identifying the factors which have facilitated these processes. Where possible these studies should identify quantifiable gains in terms of employment generation, training and improvements in social indicators, together with an assessment of levels of investments (i.e. gauge the effectiveness of these activities along a number of indicators). It is expected that such an analysis, which could be conducted in collaboration with organizations such as CHP who already have experience in this area,

will lead to the identification of example or pathfinder projects in this field which could serve as a guidepost to other PCTs.

Effective health care investment in rural areas: This study has highlighted potential deficiencies of LIFT in terms of meeting rural investment needs (see, e.g., 7.3). In particular there was evidence that LIFTCo-s found it more difficult to provide commercially viable and joined-up solutions in these areas. Additionally, our analysis suggested that this may have led to a situation where LIFT-type investments achieve less VfM in these important and frequently 'under-doctored' locales. We would therefore suggest that there is a need to investigate, perhaps in conjunction with key policy stakeholders, alternative approaches for primary care investment for these areas. This could initially take the form of a literature review which would then branch into interviews and focus groups with key policy makers. Additionally, this analysis could investigate experiences from other European countries, and in particular Scandinavia, with a view to learning potential lessons.

Scale and value for money in primary care investment: During our interviews a number of stakeholders emphasized the importance of scale for achieving VfM in LIFT projects and PPPs in general (compare e.g., case study 7.4 with 7.5). In particular there were suggestions that a LIFTCo would benefit from operating within large PCTs and/or from operating across several PCTs. While this proposition is economically plausible, there is at this stage no evidence with regard to the optimal size of these operations. We would therefore suggest an investigation of the financial and VfM performance of LIFT schemes (possibly in conjunction with stakeholder satisfaction) across different sized undertakings with a view to identifying potential relationships. This analysis could follow the template established section 6 of this study and, like the previous two suggestions, create potentially valuable insights for the operation of Express LIFT.

Enhanced decision criteria for the procurement of PPP facilities and services (fit for purpose procurement): As one of its key findings, this study has been able to document a widespread sense of unease and uncertainty among LIFT stakeholders with regard to the VfM aspects of LIFT schemes. This uncertainty typically manifested itself in statements where informants described these facilities as costly and then highlighted potential advantages in terms of the quality of buildings, joined-up working, intangibles or improved maintenance (see, e.g., 4.2.6 and 4.3.6). Additionally several informants suggested that the VfM of LIFT projects had been adversely affected by over-specification (see 7.5.6). This situation must be considered as highly unsatisfactory from a decision-making and procurement perspective. At this stage there is a substantial literature on shadow pricing and related models which allow decision makers to quantitatively assess the benefits of such solutions vis a vis alternatives (see, e.g., Riddington, Beck and Cowie, 2004 for an application to health and safety). Similarly, such decision-making processes would benefit from

a clear understanding of what levels of maintenance are desirable and how these should be priced. We would therefore suggest that a study be undertaken which firstly surveys the literature on available pricing models, and secondly develops a template or guide which identifies how these can be applied to the LIFT and PPP context at different stages of the procurement process (see, e.g. the flowcharts developed in connection with PFI procurement by Akintoye and Beck et al. 2001). This analysis could be supplemented by a potentially more complex survey of the literature on measurable benefits of facilities and service improvements to health which, in turn, could be factored into these costing models.

Enhancing the financial transparency of LIFT/PPP: In line with the previous point, this study has highlighted an urgent need for the enhancement of the financial monitoring and governance of LIFTCo-s (see section 6). As a final suggestion, the team would therefore advocate a three-pronged research agenda. Firstly, there is, in our view, an urgent need to retroactively investigate the financial performance of all LIFTCo-s (for which such data can be obtained) with a view toward disseminating this information to PCTs and relevant DoH stakeholders. This analysis could largely follow the example set out in section 6, and although time consuming, would provide valuable insights to policy makers at various levels. Secondly, there is a case for developing a financial monitoring template which would allow individual PCTs to assess LIFTCo cash flows on an ongoing basis. Thirdly, there might be a case for a broader research agenda which would review the existing financial governance of PPPs with a view toward creating enhanced frameworks of accountability and financial control.

Addendum - Express LIFT

Following the completion of four waves of LIFT schemes in 2007 (the last project being South West Hampshire LIFT with a preferred bidder date of 1/08/2007), the DoH announced in 2008 its intention to replace LIFT by its new Express LIFT framework. This framework envisaged the creation of a list of approved private sector partners, each of whom were expected to have had a demonstrated a track-record of delivering the services required of a successful LIFT Company. Following the creation of an initial shortlist of 14 companies, the DoH announced on March 16 2009 a list of seven successful bidders.

One of the stated objectives of Express LIFT is to accelerate the procurement process and reduce costs to bidders. There is an expectation that the new process will cut the length of time for completion on bids to four to five months, with local procurements being completed within about four to six weeks rather than two years as is currently the case. The policy objective falls closely in line with statements by both key informants and user interviewees of this study that the existing LIFT process was excessively bureaucratic, complex and time consuming. It also mirrors the statements by some senior key informants (who had been interviewed in 2007) that there was an intention to simplify the procurment process and that there was a perception that the large number of companies operting within LIFT prevented the creation of a critical mass of health investors ([PUK representative], 4.2.4).

Following the format of section 4 ('Stakeholder Views'), this addendum briefly examines the views of five key informants on the creation of LIFT. Three of these informants participated in face-to-face interviews, while two of them took part in telephone interviews. All interviews were conducted towards the end of March or beginning of April 2009 and professionally transcribed. The five informants included a senior representative from Partnership UK [PUK representative], three representatives of Community Health Partnerships [CHP representative 1,2 and 3], and the CEO of a LIFTCo [LIFTCo CEO] whose parent company had been selected as Express LIFT bidder.

In terms of thematic focus these key informant interviews focused on two questions. The first of these concerned the issue as to why LIFT was introduced, and, more specifically, whether this policy measure arose from failures of the existing LIFT model. The second batch of questions sought to elicit informants' views with regard to the advantages and disadvantages of the new Express LIFT model.

With regard to the reasons for the introduction of Express LIFT, one of the CHP representatives [CHP representative 1] noted that this was largely due to the failure of some LIFT companies to develop schemes in a timely manner:

"*Historically when you set up a LIFT Company and you have gone to tender for your private sector partner through OJU process they have to present, on the back of two sample schemes. Now to be honest there are some LIFT Companies which still have not built their sample schemes. They have gone off and done other things and the sample schemes are still hanging around. But the private sector partner had to present on how they would deliver two sample schemes, real schemes. Now one of the major issues of LIFT is how long it takes to set a LIFT Company up, so you are talking up to two years to set up a LIFT Company which frankly does not suit a lot of people's agenda. What they decided therefore is to develop a new model of how you set up a LIFT Company. The LIFT entity itself is no different at all, it is exactly the same as the first four waves. But what is going to happen now is that a PCT do an independent OJU to go out to request a private sector partner to come in to facilitate the LIFT Company."*

However, when the same informant was asked further whether this should be interpreted as failure of the LIFT system, he rejected this notion and argued that Express LIFT had come about because of changes in health care and, in particular, a need to prioritise service needs and procure facilities quickly:

"Express LIFT, going back to the relationships thing, now affects where we are in terms of service needs and primary care which is where we weren't when LIFT was developed. So, and I absolutely believe in this, LIFT is not broken. LIFT has not ever been broken and Express LIFT has not come about because of the faults in LIFT. It has come about because actually Healthcare's evolved in the last 10 years."

Taking a somewhat different view, another CHP representative [CHP representative 2] agreed with the notion that the principal purpose of LIFT was to accelerate procurement, but argued further that Express LIFT was intended to shift risks to the private sector and, in so doing, make procurement easier for PCTs:

"With Express LIFT, because there are no initial schemes, the private sector has to come in with its own money. But the LIFTCo has to deliver. Therefore there is no income until delivery; unlike in LIFT where there is a definite scheme early on. This is a big risk for the private sector. … It also

shifts the front end work to the DoH, but puts the onus on the PCTs to make the selection. The private sector makes the contract with the DoH and is then able to participate in local competition."

This line of argument was further elaborate on by the third CHP representative [CHP representative 3] who suggested that Express made it easier for new and inexperienced PCTs to become LIFT partners:

"Express LIFT probably makes it easier for less experienced PCTs to come in. But I think there is still an information gap and perhaps also a management training gap. So what is coming through for us is the continued need for more information, more training of people,… benchmarking information and also just day to day hands on support."

This views were closely mirrored by the Partnership UK representative [PUK representative] who argued that the principal advantage of the new Express LIFT was not just that it made procurement faster, but that it significantly reduced the administrative burden faced by PCTs:

"If you are a PCT, you have to have an SSDP. For Express LIFT you do not need a final SSDP, but you do need a draft SSDP. This is because the first job of the LIFTCo is to finalise the SSDP with the PCT; to bring it all together, what the estate looks like now, what is the commissioning strategy going forward. LIFT should be able to pull that together once you have seen what the gap is."

Implicit to this analysis was the assumption that the joint development of the SSDP by the public and private sectors would facilitate strategic thinking which had been lacking in some LIFTs that had become overly focused on estates development. This need to refine the approach taken by PCTs to PPP was further highlighted by this informant when he explained the Pre Qualification Questionnaire requirement which now replaced requirements for a full SSDP:

"If a PCT wants to do Express LIFT, they do a Pre Qualification Questionnaire. They are asked to demonstrate that they have the capability and capacity to do LIFT. One of the problems with LIFT was PCTs not understanding or not putting resources in, so the PQQ addresses that, makes PCTs answer. Are youe capable of running a LIFTCo, do you have resources and capacity. It is not a business case, but a statement of readiness. It is not just about a £20 million building."

Needless to say there could an argument that the new PQQ requirements itself creates a new layer of bureaucracy, or, alternatively, that the absence of a full SSDP puts the private sector in an overly strong position vis a vis the public sector in determining future needs and projects.

Notwithstanding these issues, the PUK representative felt that the new Express represented a major improvement for PCTs:

"So, the PCT demonstrate readiness. They launch a competition amongst framework partners; they will get all the information. The national competition evaluated efficacy, specifically whether the private sector bidders are capable of delivering. The local competition evaluates the degree of local fit, which one do we like? Bidders then tailor their national submission, 25% is on 'We're the best for you …' where they demonstrate local fit. The end point is to select, then enter into standard documentation, and then they become a normal LIFTCo."

As far as the issue of flaws of the previous LIFT system were concerned, the same informant was remarkably frank in stating that some LIFTs had failed to deliver to expectations and that much of this was related to an excessive focus on new buildings:

"LIFT is not delivering what people want, and it is being blamed for the short-comings of buildings being delivered. There is a contradiction between where a big building = more money, small building = less money, when actually a small building = better relationship. … The idea is to get LIFTCo entwined with the PCT at an early stage, to be proactive rather than reactive. Presentationally it is a problem, administratively its not. The point is to pick companies that have demonstrated their ability so far."

While highlighting the potential advantages of Express LIFT in terms of strategic planning within a framework of reduced bureaucracy, the Partnership UK representative [PUK representative] also suggested that Express LIFT was likely to encourage novice PCT's to engage with PPPs:

"There is no mandate that PCTs will have to use Express LIFT. But we will be saying to the SHA your PCTs have five year plans. They all have building requirements, how are they going to meet that if they don't use Express LIFT?"

This view was closely aligned with the earlier statements of one of the CHP representatives [CHP representative 3] who had argued that one of the

principal advantages of Express LIFT was that it made easier for inexperienced PCTs to participate in this procurement process.

Interestingly, when asked about the key advantages of Express LIFT, the LIFTCo CEO also highlighted the possibility that the new framework would encourage a more strategic approach which would favour smaller solutions (a view which was obviously closely related to the concerns which had been expressed independently by the PUK representative):

"We have said and we continue to say, particularly in the context of Express LIFT, that we think that the LIFTCo-s, and PCTs more particularly, should be allowed to procure smaller simpler buildings and to use smaller simpler framework which again will be cheaper to the public sector."

Further to this, the same private sector informant noted that another advantage of Express LIFT was the fact that it would allow for a reduction in approval processes and, in particular, present the 'double handing' of approvals:

"There seems to be quite a big overlap in the approvals process between what the PCT are allowed to approve and what they have to put up to the SHA. There is an awful lot of double handing within the approvals process on the public sector side which takes a lot of time, unnecessarily I think. Addressing this is another advantage of Express LIFT. Those are advantages of Express LIFT."

Despite the diverging emphasis of these informants, there was an underlying consensus that Express LIFT had the potential of reducing bureaucracy and complexity around the LIFT procurement process, while at the same time creating space for strategic, and where appropriate small-scale solutions. Additionally, there was an expectation, particularly among informants advising the public sector, that Express LIFT would encourage novice PCTs to engage in this type of procurement.

These perspectives appear to fall in line with government policies vis a vis the current economic climate, which favour public spending as a means for overcoming the ongoing recession. However, both the PUK representative and the private sector representative also implied that Express LIFT made a contribution to future sustainability in that it created space for strategic, and potentially small-scale solutions, where these were appropriate. This idea was made explicit by the private sector representative [LIFTCo CEO] who noted that Express LIFT had to evolve as a flexible and fit-for-purpose means of procurement:

"The Finance Directors of the PCTs now are looking ahead and expecting tighter public finances so they are. Their own responsibilities are that they do not want to go into something unless they are absolutely sure it will help them and I honestly I genuinely think that a successful Express LIFTCo can make a major contribution to helping to rationalise PCT infrastructure in an environment where there are difficult public finances. … I think actually it is a really good format for the next few years and I just hope that people recognise that."

Although there was a possibility that, given this selection of informants, there would be a tendency to endorse rather than criticize Express LIFT, the team also enquired about the expectations informants had with regard to the future success of LIFT. Interestingly this question elicited a number of responses which suggested that the switch-over from LIFT to Express LIFT would not be unproblematic.

This view was expressed, among others, by one of the CHP representatives [CHP representative 2] who suggested that the new system would be a 'shock' to those who had become accustomed to the earlier approach:

"Initially, what the PCTs were doing was what the partner should do. They were doing all the work in terms of the spec, then evaluating the private sector to see if they could do the work they had specified. But really, we want the private sector to help do the spec. We will get that now because the design/spec will not be done until the private sector is on board. It is a shock for the market, they only get to be evaluated on methods of turning needs into a plan and then into a project. … It is lower cost but I do not think it will be any easier."

This view was echoed by the PUK representative who suggested that there was no guarantee of success for Express LIFT, particularly because the new scheme placed new demand on PCTs:

"Some of Express LIFT is utopian. There is no guarantee it will make it better. But there is good logic behind it. It is in the lap of the PCTs. It will look like this type of procurement has failed if PCTs do not do it. We need to get the SHAs to do some of the work, look at the broader questions. We need to encourage localities to do some of the thinking for themselves. We will push it through gently to make sure it works. Half the SHAs have PCTs who are interested."

Similarly the private sector representative [LIFTCo CEO] noted that there was a need for effectively communicating to potential users, the wide ranging changes which Express LIFT had brought:

> **"***All I am questioning is whether PCTs know the substantial changes that … Express LIFT brings. This is an internal communication thing throughout the NHS because without that the PCTs will not realize what is happening. They will just assume that it is the same: and oh its long drawn out, and got all these big legal documents and takes a long time and they are expensive and all that sort of stuff. … I think they have addressed all of those in the Express LIFT and I am not sure whether they have communicated that to the PCTs at large. I think they have tried but that is going to be the crux, I think."*

Following the format of section 4, these interviews were imported as text fragements into the DICTION software package where they were analysed under the under the "politics" setting with the sub-setting "political debates". While this analysis did not produce any clearly discernable patterns, the mix of positive and negative scores for non-composite variables together with two significantly negative scores for the composite variable 'uncertainty' indicated that there was significant indecision and insecurity about the subject matter among informants. This pattern is perhaps not surprising, given that the informants were asked to comment on potential failures of LIFT as a cause for the development of LIFT express.

Table A.1, DICTION output, Key informants, 'Express LIFT' text segments, standardized scores and significance

Interviewee	Praise	Satisfaction	Inspiration	Accomplishment	Certainty+
PUK representative	0.53	-0.23	-0.27	0.97	0
CHP representative 1	-0.52	1.19*	-0.51	-0.31	0
CHP representative 2	0.33	-0.31	-0.86	0.38	-*
CHP representative 3	-0.19	-0.35	-0.54	0.11	-*
LIFTCo CEO	0.08	-0.52	-0.88	-0.65	0

+ As composite variable 'certainty' produces spurious standard scores and requires varying significance thresholds, therefore only the sign and significance are recorded (0=within .05 confidence interval, +=above .05 confidence interval, -=below .05 confidence interval).

The purpose of this addendum obviously was not to assess the validity of Express LIFT as a policy instrument from the perspective of the findings of this study. Rather, the principal goal of this section was to identify the drivers which had motivated the introduction of Express LIFT and to place these into a broader context of LIFT and PPP based procurement. Based on this remit, there is ample evidence that Express LIFT presents an instance of policy learning whereby aspects of the existing policy framework have been modified in order to ensure alternative short-term and long-term outcomes (such as an increased deal flow from novice PCTs and an enhanced level of strategic partnership between the pubic and private sectors).

Notwithstanding these caveats, it can perhaps be noted that Express LIFT in its current format does not necessarily address all of the weaknesses of LIFT such as the lack of financial transparency or the fact that commercial viability of these schemes can be adversely affected by external factors such as the rurality of a location, lack of affordable land and insufficient GP demand.

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Appendix 1

Scientific Summary of the Project

Scientific summary

Background:
The NHS LIFT initiative offers PCTs and other health care providers an opportunity to develop enhanced primary care premises and services in collaboration with private sector partners. Previous research on PFI procurement in the NHS, and NHS trust performance in general, has highlighted the crucial role of a range of cultural and behavioural factors in determining organisational effectiveness, the ability to successfully cope with innovation and the ability to achieve organisational objectives.

Aim:
This project seeks to explore the key cultural, behavioural, organisational and processual aspects which influence the success, or otherwise, of a LIFT project, and to assess the extent to which LIFT provides an effective means for enhancing primary care premises and services.

Method:
The study consists of 5 interlocking strands:
1) A document analysis focussing on information relating to LIFT projects, such as business cases, planning documentation, contractual information.
2) A series of key informant interviews involving high level staff from the DoH, PFH, the 4Ps, Treasury and other decision makers that have been involved in the design, development and implementation of LIFT as a policy instrument.
3) Process focused case – unspecific interviews (ca. 30) with a broad range of participants in completed and planned LIFT projects, including public sector clients, Local Authorities and OSC representatives; private sector representatives; GPs, clinical and support staff.
4) Outcome – focused case specific interviews (ca. 10) investigating the experiences of the full range of participants in completed LIFT projects. These detailed case studies are likely to elicit a range of relevant information from interviewees and will cover early as well as recently completed LIFT projects.
5) A series of case specific user surveys which will gauge the views of patients using and staff working at LIFT facilities. These surveys are likely to focus on those facilities which are part of the detailed case studies and will be conducted face-to-face by the project researchers.

Implications for the NHS:
The completed work will provide:
1) A mapping of appropriate performance measures through the life cycle of LIFT projects.
2) An assessment of the cost effectiveness, stakeholder satisfaction and value for money achieved by LIFT projects.
3) The identification of key factors which contribute to the success or otherwise of LIFT projects.
4) Recommendations with regard to Best Practice in LIFT procurement, management, monitoring and overall governance, and with regard to desirable future developments in these areas.

Appendix 2

Original Specification of Activities

The original project proposal envisaged the following plan of work:

1) A document analysis: This part of the study will focus on two sets of information. First, it will analyse the available literature on public private partnerships with a special focus on cultural conflicts, success factors and Best Practice in governance. A comprehensive literature based search employing systematic approaches will be conducted to identify potentially relevant literature. Secondly, it will focus on document based information relating to LIFT projects, such as business cases, planning documentation and contractual information. Conceptually this part, and the consecutive parts, of the study will rely heavily on 'grounded theory'. Grounded theory uses inductive reasoning, as opposed to deductive principles, and is aimed at generating, and not proving, theory. In grounded theory, investigations do not start with a set of hypotheses, but with observations aimed at identifying existing practice. These observations are used to formulate working hypotheses that describe them. These hypotheses, in turn, are then compared with the literature. As a first step of this study, organisations involved in LIFT projects will be approached and asked to participate in this research project. They will be supplied with detailed information with regard to the purpose and methodology of this study as well as information with regard to its sponsor. Consecutively senior members of LIFTCo organisations will be asked to supply documents with regard to the financial, organisational and physical characteristics of their projects. This initial collection of information will be used to familiarise the research staff with the variety of LIFT projects which have already been implemented or are currently being implemented. As such, it will serve as basis for the key informant interviews as well as the case specific and case unspecific interviews and user surveys which will be conducted at later stages in the study. It is likely that some LIFTCo organisations will withhold some information due to issues of commercial confidentiality. However, it is expected that a close collaboration will the DoH, PFH, PCTs and LAs will ensure the success of this stage of the analysis. In any case the research team will make every effort to produce, as comprehensively as possible, a database at the early stages of the projects.

2) A series of key informant interviews involving high level staff from the Department of Health (DoH), Partnerships for Health (PfH), the 4Ps, Treasury, GP representative groups (e.g. RCGPs, MHS alliance), Unions and employer organisation representatives, senior representatives of patients and users and other decision makers that have been involved in the design and development of LIFT as a policy instrument. It is expected that access to relevant interviewees can be relatively easily gained once the goals and sponsors of this project are clearly identified. It is envisaged that approximately a total of 10 interviews will be undertaken.

3) Process focused case unspecific interviews with a broad range of participants in completed and planned LIFT projects. Previous research by the principal applicant on PFI has highlighted the usefulness of case unspecific interviews. It is envisaged that a total of approximately 30 interviews will be undertaken with a range of stakeholder who have been involved in LIFT projects and who will have been identified during the document analysis stage. Under Activity 3 interviews will be conducted with staff at all levels of the managerial

organisational hierarchy (senior, middle, junior) and across a range of professional groupings, including public sector clients, Local Authorities (LA) and OSC representatives; private sector representatives; representatives of sponsoring banks; representative of local acute trusts; GPs, clinical and support staff.

4) Outcome focused case specific interviews investigating the experiences of the full range of participants specific in completed LIFT projects. These detailed case studies are likely to draw on a mix of information from interviews and will cover early as well as recently completed LIFT projects. Based on the previous activities, a purposeful sample of ca 10 LIFTCo projects will be selected on the basis of performance for in-depth analysis. Approximately half of these will be from what appear to be 'high' performing projects and half will be from 'low' performing projects. Performance will be assessed on the basis of soft intelligence on a range of factors including LIFTCo self rating, satisfaction of leasing GPs etc. which will be gathered in activity 1. Under Activity 4 a similar range of staff to Activity 3 will be interviewed (three to four staff in each organisation). However, the interview questions will relate specifically to the selected projects with a special emphasis being placed on issues of partnership working during various stages of the project (bidding, selection, pre contract completion, post contract completion).

5) Financial document analysis. This activity will focus on: i) internal budget and financial planning documents of PCTs, published financial statements and annual returns of private sector providers (examining disclosures of the creation of special purpose vehicle companies, bond issues and investment gradings, insurance arrangements, contracts, etc.); ii) an analysis of stock market data for private sector providers to examine proportionate changes in financial risk as a result of diversification into LIFT projects; and iii) comparisons with similar investments of similar risk conducted in a purely private sector context, nationally and internationally. Where it is not possible to obtain full information due to commercial confidentiality, we will supplement our analysis with structured and semi structured interviews. A sample of ca 10 LIFTCo projects will be selected and a person (financial planner) will be interviewed in each organisation. Questions will focus on perceptions of cost and risk from the point of view of the PCT, for example through comparisons to the terms and conditions of equivalent commercial loans. Additionally, we expect that we will be able to supplement the analysis of financial documents with a broader analysis of PCT strategy documents. This analysis will focus on the role specific LIFT projects play in a PCT's long term plan, the long term financial and strategic implications of PCT involvement in LIFT and the overall strategic opportunities which the pursuit of LIFT has opened or closed for PCTs.

6a) A series of case specific user surveys which will gauge the views of patients using, and staff working at, LIFT facilities. A sample of ca 10 organisations will be selected and 40 users and 10 staff will be surveyed in each organisation. These surveys are likely to focus on those facilities which are part of the detailed case studies and will be conducted face to face by the project researchers. It is envisaged that these surveys are carried out at each of the case study sites. Separate survey instruments will developed for patients, clinical staff working at the respective LIFT site as well as non clinical staff. The survey will take the form of structured interviews using questionnaires with room for open comments. Staff will be selected from staff lists on the basis of job role. GPs will be asked to invite patients to take part in the study.

Addendum (6b): Developmental Case Studies (modification of Activities 2, 3 and 4). As a modification to the research strategies listed under Activities 2, 3, and 4, an attempt will be made to gain consent from 2 or more LIFT project groups to conduct developmental case studies of projects which are currently being established. These two developmental case studies, would take a special place among the 10 or so main case studies, in that an effort would be made to monitor, over time, the issues and problems arising for various actors, in the creation and mobilisation of the network. In order to achieve this, a number of methodological approaches would be employed, including asking relevant parties to keep written or audio diaries. In terms of phasing, there would be an obvious need for these special case studies to start early, perhaps in parallel with the initial high level staff informant interviews and the case unspecific interviews. One or two staff (programme directors/managers) will be selected in each organisation. It has to be pointed out that the inclusion of this activity will
depend entirely on the consent of research partners and that no guarantee can be given that this activity can be fully implemented.

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Appendix 3

Literature Reviewed by Type of Output

Group 1: Empirical Findings

Ref. No.	Author	Date	Title	Type of paper	Method	Location	Key findings / opinions
1	Paxton, W. and Lissauer, R.	2000	Partnerships in primary care	Book chapter	Mixed -survey and interviews, case study	National	This text describes previous premises reimbursement programme. It recognises the changes in GP view of property: premises were part of their retirement fund but ownership is now seen as a burden and there is a risk of negative equity. GP demand for part-time work and flexible career patterns now makes PPP more attractive although the inflexible contracts do not contain break-out clauses making them more problematic, especially for GPs approaching retirement. Regarding the build, the text notes that private sector developers should bring their knowledge of the local property market and expertise in designing primary care facilities. It is acknowledged that there is a good opportunity to raise revenue through part-rental of premises. Day-use only buildings have limited opportunity for hotel services characteristic of standard PFI. There is a risk of a LIFT project being driven by the profit motive of the private sector - especially in areas of high rents - rather than health needs. Case study findings – administration costs are higher. Staff report 50% of their time is spent on maintenance issues. There is a lack of alternatives to PFI and little evaluation of PFI in primary care/hospitals.

2	Aldred, R.E.	2007	Closed policy networks: broken chains of communication and the stories behind an 'entrepreneurial ploicy': The case of NHS LIFT	Journal article	Mixed - case study and interviews	Not identified	This article notes that the exclusivity clause in LIFT was demanded by the private sector. It acknowledges the duration of agreements (20 years) and the encouragement for the NHS to maximise profit. It recognises that LIFT may privatise public assets, that publicly-owned sites are easier to access, refurbishment is less attractive to investors as it is less profitable and that LIFT represents a shift in government policy. It acknowledges that LIFT provides flexibility for finance but not service provision; it is the only option, bureaucratic and excludes tenants from a slow process. Any modifications to the building are identified as being expensive. It recognises that PCTs are taking on the headlease and offering flexible terms to GPs. It also acknowledges the high rental costs associated with LIFT and a perceived inability to criticise the LIFT procurement process.
3	Aldred, R.E.	2008	Managing risk and regulation within new local health economies: The case of NHS LIFT	Journal article	Mixed: Case study, interviews, non-participant observation, document analysis	Not identified	A minority of GPs rented premises from specialist landlords before LIFT. LIFT projects are now under way in 50% of PCTs. This paper provides some description of the LIFT exclusivity clause. Civil servants are criticised for stalling service improvements through their refusal to accept risk. PPP created a market for risk which is now a tradable commodity. LIFT was designed to pass on risk. Holding companies transfer risk from the SPV to the sub-contractors or suppliers. Banks are identified as being highly risk-averse. A PCT may risk taking on headlease and thereby provide flexibility to GPs. The paper identifies that refinancing had not been considered, that there have been public protests about the closure of surgeries and

							poor transport links are creating problems. As the private sector has limited liability they can chose to walk away from a project so the public sector is placed in a weaker bargaining position. High rents in LIFT building are making it difficult to find retail tenants. It is recognised that a leisure component to a LIFT project is very popular as this provides guaranteed long-term revenue. It is suggested that NHS staff fail to feel part of LIFTCo. Private companies are viewed as having the power without any of the responsibility. It is recognised that local companies are being squeezed out of the process.
4	Andalo, D.	2003	One stop to cure all ills	Journal article	Unspecified (although included interviews)	Newcastle, Cheltenham, Eastbourne.	A review of one-stop health care centres from the perspective of academics, GPs and managers in one-stop centres, private sector companies, NHS Alliance. This paper identifies the need to incorporate the views of users, prevent repetition of past mistakes and increase the sense of community and patient benefits. It recognises the bureaucracym complexity and expense of LIFT.
5	Corney, R.	1994	Experiences of first wave general practice fundholders in South East Thames Regional Health Authority	Journal article	Postal questionnaire	South East Thames Regional Health Authority	A review of GP fund holding practices in SE Thames RHA. Several practices had developed outreach consultant, physiotherapy and audiology clinics. Patients preferred being seen in familiar surroundings, spent less time and money on travel and it facilitated communication between consultants and staff. Initial problems included antagonism and provider resistance, poor information. The paper identified the need for a VfM study of these clinics.
6	Dix, A	2001	Delayed LIFT-off	Journal article	Telephone and face-to-face	Southampton, Birmingham,	This paper identified the difficulty in finding suitable sites, the time needed to go through

					interviews	Walsall, Berkshire, Tyneside and London	the planning process (reducing time available to GPs to deliver patient care), concern about how relocation may affect patient lists, doubt whether inducements sufficient to attract allied health workers to relocate from high street and the lack of evidence to support one-stop centres being what public/health professionals want or providing better services. Respondents wanted control over sub-letting/tenancy. It was identified that 500 new health care centres equates to relocation of 10,000 of 27,000 GPs and approximately 17.5m patients in England.
7	Douglas, C.H.	2004	A prospective health impact assessment to progress the sustainable futures of a city: The case of Salford, UK	Journal article	Mixed - key informant interviews and focus group sessions, quantitative - review of published data	Salford	An assessment of the potential impact of proposed changes to health and social care in Salford. It identifies impacts from a biological, personal/family/lifestyle, social/economic, physical environment, public services and public policy perspective. Concern is voiced that the private sector may exploit project and local labour force to make excess profits which would be removed from Salford and the new health centre will generate more traffic.
8	Douglas, C.H., Higgins, A., Dabbs, C. and Walbank, M.	2004	Health impact assessment for the sustainable futures of Salford	Journal article	Mixed - qualitative: key informant interviews and focus group sessions, quantitative - review of published data	Salford	An assessment of the potential impact of proposed changes to health and social care in Salford. It identifies impacts from a biological, personal/family/lifestyle, social/economic, physical environment, public services and public policy perspective. There is a preference for investments that will affect general wellbeing rather than provision of better health care, and a view that they should consider social inclusion (by gender, culture, ethnicity), partners should identify employment opportunities and train locals to access them (construction and operational

							phases), use local supply chains, consider the range of building uses and minimise impact of road traffic.
9	Forrest, E.	2003	The generation aim	Journal article	Mixed: Case study (includes interviews)	Wythenshawe	Describes the Wythenshawe LIFT project - £20m to be spent on former theatre and community venue. Swimming pool and sports hall to be refurbished. New gym added. Library to be refurbished with more computers. GP surgery to be replaced with £4m one-stop shop incorporating health, social care and therapy. Will provide facilities for additional services (listed). Users will be given exercise 'prescriptions'. Council grant of £1.2m p.a. means prices will be comparable to other local authority facilities across Manchester.
10	Foster, M.	2003	LIFT off or left down?	Journal article	Unspecified (although includes interviews)	E. London	Description of proposed one-stop shop under LIFT from perspective of GP Committee (GPC), GPs moving into the LIFT building, Local Medical Committee, Partnerships for Health. The GPC is concerned that LIFT may become only mechanism for premises development. GPs are concerned about the lack of control and reduced time for patients. The LIFT process is acknowledged as being time consuming and may draw patients away from GPs in poor local premises leading to greater disparity. It was also recognised that many GPs invest in property for their retirement (a potential lifetime commitment).
11	Gilbert, H.	2005	Supersize me	Journal article	Mixed: Case study (includes interviews)	Wigan, Barnsley	Describes the introduction of two super-surgeries. Regular meetings held with service providers to create ownership. Layout and inclusive nature of centres creates sense of community spirit. Services being delivered locally reducing travel time for patients. llows better understanding of different services

							(between professionals). Better communication - less scope for misunderstandings.
12	Gilbert, H.	2005	From chip shop to one-stop super surgery	Journal article	Unspecified (although includes interviews)	S. Yorkshire	Suggests one-stop centre offers more GPs to provide last minute cover if locums unavailable and improved communications with other care professionals.
13	Hannay, D.R., Sunners, C.M. and Platts, M.T.	1997	Patients' perception of primary health care in an inner-city practice	Journal article	Mixed: qualitative - questionnaire surveys and interviews.	Sheffield	Primary care is increasingly being delivered in purpose-built buildings. Patients were asked to identify the services they would like at their centre. Comments included the need for a play area, an open-plan reception area without glass barriers, a pay phone and transportation. It was suggested that adding services could create a health centre rather than a medical centre.
14	Holmes, J., Capper, G. and Hudson, G.	2006	Public Private Partnerships in the provision of healthcare premises in the UK	Journal article	Qualitative - Key informant interviews	National	Article reviews PCTs requesting large one-stop premises. It recognises that planning proposals presented as 'mixed use' are more likely to gain planning consent and offers a diversified revenue stream. It is suggested that developers avoid deprived areas as they offer reduced long-term value. In prosperous areas developers must compete with residential developers. A GP practice offers a developer a pre-let development. Including residential property includes a risk of property market shift or vacant units. With LIFT, offering monopoly provider status increases interest. Bids require human and financial resources (£500k - £1m) with 1 in 3 chance of success. The paper recognises the lack of a pilot phase and evaluation. It also identifies that designs are confidential so there is frequently little community input into this part of the process. It is suggested that later

							phases of LIFT may find it hard to attract GPs. It is acknowledged that there is inherent information asymmetry in the process with attracted national companies having more experience of design and bidding processes. The high rents of LIFT buildings are acting as a disincentive to prospective tenants and it is recognised that it may be hard to demonstrate VFM. It is also identified that LIFT contractors are making higher Internal Rate of Return than traditional PFI.
15	Hudson, G., Capper, G. and Holmes, J.	2003	The implication of PFI on health care premises engineering design, durability and maintenance	Journal article	Mixed - qualitative: case study and interviews	National	GP premises are used as investment. In a poor property market it was identified that this may be disincentive for new GPs. Offering projects on a larger scale may attract investors. The bidding process is governed by European legislation which requires larger and experienced bidder. Finance is required to support unsuccessful bids. Specifying standards and requirements can stifle innovation. There is a perception of additional cost for sustainability. Having the right to review design data by a Trust does not transfer all design risk, only that related to clinical functionality. Initial capital costs take precedence over revenue (which increases uncertainty over sustainability). Smaller contractors are being squeezed out of the process. Larger companies have higher overheads which must be covered by costs.
16	Milne, R.G., Torsney, B., Gilbert, J. and Reid, L.E.	2001	Consultant outreach, 1991 to 1998. An update and extension on its distribution in Scotland	Journal article	Mixed: Review of published data on consultant activity and postal survey	Scotland	Describes the increase in consultant outreach programmes in GP locations between 1991 and 1998 (particularly general psychiatry).

17	Pollock, A.M., Player, S. and Godden, S.	2001	How private finance is moving primary care into corporate ownership	Journal article	Mixed: review of market surveys/ commercial press/ annual reports, telephone interviews, written correspondence	National	Examined companies providing primary care premises - found 8 market leaders engaged in over 300 projects. One group offer £20,000 to each GP partner as an incentive to exchange premises for lease-holding, the payment being met from the 15-20% profit margins built into the project costs. Bundling was presented as a way to integrate service but the paper claims it provides the commercial sector ways of generating revenue to underpin their investment. It claims bundling decreases access to care and services. It is identified that there is little information on planning, the implications on affordability or accessibility. If commercial outlets do not provide required income, the paper questions whether funds will be diverted from NHS to service debts at the expense of patient care.
18	Ratoff, L., Heyes, J. and Haddleton, M.	1993	Does you don't have access?	Journal article	Mixed interviews and site visits	Liverpool	Visited 114 premises belonging to 104 GP practices: 40 single handed GPs. 22 in LA health centres, 12 purpose-built/privately-owned, 61 old premises adapted for use, 19 U/K. Over 25% inaccessible to wheelchairs.
19	Rice, G. Ingram, J. and Mizan, J.	2008	Enhancing a primary care environment: a case study of effects on patients and staff in a single general practice	Journal article	Mixed: qualitative - questionnaire surveys, interviews and focus groups.	Bristol	Argues the design of premises can remove patient and staff stress and improve health care quality. 80% of health care is provided in primary care facilities. Satisfaction scores for reception, waiting and consulting rooms were all higher. The best scores were obtained by rooms with a more ‘domestic’ feel. The new buildings were perceived to be more patient-friendly, quieter, cleaner and tidier, more professional and modern with more privacy, space and light and they increased confidence in the health services provided. Health professionals had a higher level of

							satisfaction with the buildings than the administrative staff. The shared workspace and open-plan nature of the spaces were not always well received. The paper identified issues with the previous buildings and that there had been an increase in patients following move with an accompanying increased workload.
20	Simpson, V.	2007	Primary and community care: changing faces	Journal article	Mixed: Review of 2 case study sites (includes interviews)	Belfast and Burnley	A review of LIFT buildings: generally a positive experience for staff and patients. It was recognised that there was a need to ensure any policy shifts did not make the buildings redundant. It was suggested that LIFT producing mediocre buildings, that teamwork was required to overcome planning issues, rooms were designed to be flexible, local users were involved from the outset which helped improve way-finding, signage and usability and increased their sense of ownership (manifested by volunteers providing support).
21	Snell, J.	1995	Three years after Tomlinson: why millions are still unspent	Journal article	Unspecified (although includes interviews)	London	Identifies that in early phases some money was not spent wisely due to pressure to spend from politicians, bids had to be in very quickly and mechanisms not in place to spend the money. This paper recommends slowing down the process and taking it more carefully.
22	Thatcher, C., Hand, W. and Dickson, P.	2005	Primary care. The only way is up	Journal article	Mixed: Case study	Bradford	A study of 42 GP practices, 17 single-handed, found that most were in unsuitable premises, had difficulty in recruiting GPs and nursing staff, additional workload created by deprivation and a significant number of GPs approaching or past retirement age. They implemented a GP recruitment and retention scheme - a supportive personal development programme – and now have 34% of GPs on

							the scheme. A new LIFT scheme will replace 4 practices. It is claimed the others will continue to 'struggle'.
23	Lewis, R. and Williams, S.	1998	LIZ: a legacy for London	Journal article	Based on third party study - semi-structured interviews	London	65% of £400m LIZ funding was spent on improving premises, extra staff and computers. 1992 750 GP premises (62%) fell below acceptable standard. This fell to 42% by December 1997 and will fall to 32% by April 1999. The paper recognises that many patients prefer single-handed GPs which provided better continuity of care.
24	Mahmood, A.	2004	NHS LIFT: Appraisal and Evaluation of Public Private Partnerships in Primary Health Care	Masters thesis	Mixed: Analysis of quantitative financial data received from the NAO, site visits	Site of 6 Phase I LIFT projects	Describes the context, aims and characteristics of LIFT and a literature review of PPP. It identifies the financial models developed by individual LIFTCos. No two financial models found to be alike but this thesis identifies similar key assumptions regarding development costs, revenues, cash in- and out-flows and financial models. It identified Nominal Internal Rates of Return of 14.5 - 16.13%. It also identifies that each LIFTCo specified the residual value of their estate. This thesis provides funding analysis for 6 LIFTCos and P&L accounts and a balance sheet for one LIFTCo.
25	British Medical Association	2006	Survey of GP practice premises: report	Study report	Postal survey questionnaire	National	Reports on a survey issued to 973 GP practices across the UK 251 (26%) response rate. Found that 60% of GPs were in purpose built premises. 55.9% of the premises were less than 25 years old. 64% were owned by the practice. 44% had received funding to improve premises in last 5 years from grants, practice savings, loans, PFI, cost rent schemes or combination of these. 59% felt their premises were unsuitable for their current needs being too small or unable to expand further due to site restrictions

							meaning relocation was required. 72% GPs have a mortgage and 25% of these are in negative equity.
26	Commission for Architecture and the Built Environment	2008	LIFT survey report	Study report	Mixed: Site visits and interviews	National	A review of 20 LIFT projects. 40% of design criteria were found to be rated either good or excellent, the rest were classed as mediocre, poor or very poor. There was no systematic approach to shared learning. Space provision was often short of the required standards (including in consulting and exam rooms). There was a significant amount of unused space and little evidence of out-of-hours use. 7/20 scored mediocre for wheelchair access. There were frequent problems with environmental conditions - temperatures were too high, there was poor air flow which was distressing to ill patients, windows un-openable, poor ventilation creating a risk of cross-infection, a lack of staff training on how to use buildings. It was thought that maintenance had been considered over comfort. Many planned cafes were found not to be in use as they had been unable to find operators for them. Clients had not been taught how to prepare design briefs. Many selected sites were felt to be too small or in inaccessible locations. Some of the designs were felt to be poor with layouts restricted air flow and long corridors creating disorientation.

27	Hines, C.	2003	How LIFT is helping Cornwall experience a taste of Eden	Journal article	Based on experience within project	Cornwall	Identifies LIFT as time-consuming and consequently reducing the hours available for other initiatives. Identified that it required specialist resources. The process was only believed to be quicker in the second wave due to staff enthusiasm rather than organisational learning. The paper identifies that the guidance and rules were prone to change. It also identifies the large work volume and short timescales. The paper describes the use of enabling funds. Sites will belong to LIFTCo but slow set-up meant they were owned by PCT short-term and it is unclear who will be liable for capital charges. GPs were involved throughout process but the paper identifies the need for broader involvement (local authority, local council etc) and that the project team must be adequately resourced.
28	Aizlewood, K.	2002	How our LIFT scheme will help us to speed up service improvement	Journal article	Based on experience within project	Sandwell	Description of Sandwell LIFT project (£15-20m). The main problem encountered was convincing new PCT boards of benefits of the project.
29	Rassell, C.	2008	LIFT Review for Department of Health	Report for Department of Health	Mixed: Site visits and interviews	National	Review of 16 LIFTCos. Most stakeholders are happy that developments had been delivered. In the main the projects have been delivered on time and on budget. LIFT has not been found to be as innovative and risk taking as hoped. The promised order book from the public sector never materialised in some cases (usually because the order book was revised). It was recognised that the reorganisation of PCT affected corporate memory of LIFT. There was uncertainty about how LIFT will be treated financially. PCTs

							have rationalised their estates and now have funds to consider other options. It has also proved hard to find LIFT Chief Executive Officers. The report identifies the lack of required skills in some PCTs and that the private sector had not provided skills or support required.
30	Capita Advisory Services	2007	Swindon PCT: Wiltshire and Swindon LIFT VfM study	Review	VfM study	Swindon	Compares estimated Third Party Development (TPD) derived from data from District Valuer to LIFT based on shadow figures provided by PCT financial advisers. Risk assessed at 15%. Limited financial analysis provided.

Group 2: Guidance material

Ref. No.	Author	Date	Title	Type of paper	Method	Location	Key findings / opinions
31	Department of Health	2001	Briefing note on the .55m capital for GP premises improvements	Guidance		National	Briefing note
32	Department of Health	2003	Enabling funds for LIFT	Guidance		National	Guidance on the use of enabling funds
33	Department of Health	1999	General medical practice premises: a commentary: a guide to the size, design and construction of GP premises	Guidance		National	Guide to assist health authorities, general practitioners, developers and their respective advisers considering the provision or re-provision of practice premises
34	Department of Health	2003	Guidance to PCTs on taking a shareholding in a local LIFT company	Guidance		National	Guidance note explaining development of policy recommending the formation of a number of joint venture companies to develop primary care facilities.
35	Department of Health	2003	New GMS contract and changes to the GP premises funding arrangements	Guidance		National	Briefly describes new unified funding stream to meet all GP practice costs, including payments for GP premises
36	Department of Health	2005	NHS LIFT business case approval process: establishing a LIFT company	Guidance		National	Guidance for SHA staff establishing their first LIFTCo
37	Department of Health	2003	NHS LIFT starter pack	Guidance		National	Documents: MOI, exemplar, project management paper, strategic service

							development plan
38	Department of Health	2001	NHS LIFT: Q and A	Guidance		National	Answers to FAQ about LIFT
39	Department of Health	2001	PPP in the NHS: modernising primary care in the NHS: NHS LIFT prospectus	Guidance		National	Prospectus
40	Harrison, A.	2001	LIFT briefing	Guidance		National	Briefing outlining high level view of LIFT presented to Royal Pharmaceutical Society
41	Health Development Agency	2001	New primary care premises: design to support workplace health	Guidance		National	Guide to principles and processes of primary care premises development. Identifies key design considerations for non-clinical areas. Identifies difficulties in obtaining sites, need for early involvement, good communication, need to be a functional working environment yet have capacity and flexibility of build
42	NAO	2006	A framework for evaluating the implementation of PFI projects	Guidance		National	Presents evaluation framework to be used by evaluators when determining VFM of PFI projects.
43	Partnerships for Health	2007	LIFT: Planning Toolkit for Primary and Social Care	Guidance		National	Guidance for GPs, LAs and PCTs considering premises development. Includes explanations of the process, describes examples.
44	Cawthra, L.	2006	NHS LIFT	Guidance - presentation		National	Power-point slides giving high-level summary of PFI in the NHS
45	Jones, T.	2006	Proven strategies for long term partnering	Guidance - Presentation		Manchester	Presentation about MAST LIFT projects by Trevor Jones, Director of Facilities, South and Central Manchester PCTs.

46	Commission, S.D.	2004	Progress in practice: LIFT and sustainable development in East Lancashire	Guidance - website		E. Lancashire	Overview of LIFT development in E. Lancashire
47	Department of Health	2006	Investment guidance routemap	Guidance - website		National	Department of Health website providing guidance on PFI investment
48	Department of Health	2006	LIFT guidance	Guidance - website		National	Department of Health website providing documentation and accounting advice about LIFT
49	Colin-Thome, D.	2004	NHS LIFT - enabling social regeneration	Letter		National	Letter from Chair of Partnerships for Health. Identifies reasons for supporting LIFT (current premises prevent adoption of modern service practices, facilitating joint working, innovative way of working with private sector, will deliver new primary care centres. Describes first LIFT project successes.
50	Department of Health	2004	2004/05 and 2005/06 primary care premises funding	Letter		National	Letter from Richard Armstrong confirming allocations of an additional £108m for primary care premises over the next two years
51	Stubbings, A.	2008	Business case approval guidance for PCTs with existing LIFTS: stakeholder consultation	Letter		National	Consultation document containing survey soliciting views on draft business case approval guidelines for PCTs with existing LIFT projects.
52	Department of Health	2007	Examples of NHS LIFT in practice	Report	Case studies	East London, Barnsley, Newcastle and North Tyneside	Describes schemes in East London, Barnsley, Newcastle and North Tyneside. London LIFT - described as positive. GPs didn't have stress associated with build or gaining finance. Build quality very good and delivered on schedule. Barnsley - premises may encourage more GPs/staff

							and facilitate extended range of services.
53	NAO	2005	Innovation in the NHS: LIFT	Report		National	No framework to evaluate LIFT. No pilot scheme/evaluation. GPs become shareholders in LIFT to retain investment in property. Generally GPs lose capital asset and control of development. Little staff continuity at Partnerships for Health, slow process and high fees charged. No enabling funds paid back to Department of Health. Slow progress initially. Lack of shared learning. Analysis of LIFT required. PCTs find process complex and time-consuming. Difficult for some Local Authorities and Health Authorities to become involved. Shortage of suitable sites and human resources. GP buy-in patchy. High GP rents. Subsidised rents to attract tenants (pharmacies have to pay full rents). VfM must be determined. Potential conflict of interest identified. Financial analysis outsourced to Operis and a MSC student. IRR
54	NHS Information Centre	2008	Investment in General Practice 2003/04 to 2006/07: England, Wales, Northern Ireland and Scotland	Report		National	Identifies NHS expenditure on GP premises in 4 fiscal periods. In England: 2003/4 - £5,810.589m, 2004/5 - £6,914.440m, 2005/6 - £7,746.920m, 2006/7 - £7,757.015m. Breakdown of expenditure provided.

55	NHS confederation	2001	Getting the best out of future capital investment in health: building future-proof healthcare for local communities	Report		National	Critiques PFI/LIFT process: do not invest in good design/health care planning (leads to increased staff costs), social/environmental benefits excluded from VfM review, inflexible long term contracts, more expensive to modify buildings, inadequate cross-sector consideration, bidding costs too high (later passed to NHS), need to reduce bureaucracy, end of capital/revenue flexibility (staging, phasing of costs), strong incentive to discard existing buildings (may be inappropriate, unaffordable).
56	Aldred, R.E.	2006	In the interests of profit at the expense of patients: an examination of the NHS LIFT model, analysing six key disadvantages	Report commissioned by UNISON		National	Identifies six reasons why LIFT may be a "bad deal" - bureaucracy, profit, inflexibility, conflicts of interest, VfM and staff outsourcing. No pilot study. Bureaucracy - not local solution as small local companies lack resources, top-down with consultation late in the process. Profit - investment vs. area of need, may draw GPs from where they are needed, planning control shifts to private sector. Inflexibility - 30 year leases, money could be used to refurbish more GP surgeries, unable to make changes to buildings, PCTs bear risk of providing flexible leases to GPs. Conflicts of interest - PCT/LIFTCo/GP. VfM - 15.1% IRR vs. 8-9% IRR from traditional build, affordability gap. Staff - may be outsourced. Services may be privatised - support services; engage private companies to provide GP/other clinical services.

57	UNISON	2003	LIFT: what you need to know and what you need to ask: a briefing for non-experts	Report commissioned by UNISON		National	LIFT untested. Long-term legal obligations. Premises always owned by LIFTCo. Conflict of interest - LIFTCo public sector members - duty to keep costs down but duty to make profit for shareholders. Staff will be outsourced. PCTs make have to take over lease if GP lease expires. Alternatives to LIFT may be more affordable (if they do not have a profit component). Costs more for private sector to borrow money. All costs/profit will be reflected in the rental fees. Revenue implication. VfM assessment does not compare LIFT scheme to alternatives in the real world. Re-financing gains not passed back to public sector. PCTs must take head leases (with inherent risk). Can public sector afford to purchase the facility/land at the end of their contract?
58	House of Commons	2006	Treasury minutes on the 47th to 51st reports from the Committee of Public Accounts 2005-2006	Report to Parliament		National	Limited development via conventional public finance - alternatives not always feasible. LIFT more expensive than existing estate but latter not always suited to modern services. Extra cost/high lease payments reflect additional service provision, full maintenance, and quality. Need for comparative costs and detailed explanation. Risk of affordability gap. All LIFT projects over £20m to include public sector comparator for more rigorous assessment of VfM. PCT subsidies for tenants to be explicit and short-term. Mechanism for evaluating LIFT still in development - required urgently. Supply chain must be benchmarked /market-tested for all new projects to ensure VfM. Lease payments to be assessed for

							fairness. Department of Health commissioned benchmarking of cost of LIFT schemes and VfM of design. LIFT contract revised in Aug 06 to "ensure" maximum VfM of LIFT projects. Building costs likely to increase at rate above inflation partly due to demand on construction industry arising from Olympic Games. Problems undertaking minor alterations within LIFT buildings. Centralising services causing access problems (less convenient locations).
59	House of Commons	2006	NHS LIFT: 47th report of session 2005-06	Report with formal minutes, oral and written evidence		National	LIFT is identified as the only mechanism for PCT premises development. The report recognises that new premises are more expensive than continuing in existing buildings (up to 8x higher) and this higher cost could displace other primary care spending. Subsidies are being used to encourage new tenants. There is no mechanism developed to evaluate LIFT. There is no explicit provision to target cost reduction. It is recognised that it is difficult and/or expensive to obtain repairs and/or changes to LIFT buildings. It is also acknowledged that there are patient access issues due to centralisation of services. It was recognised that there was a need to determine the effectiveness of LIFTCo Boards. It was recognised that a constant flow of projects is required to achieve VfM. In effect a LIFTCo has been granted monopoly status in a region. Internal rate of return of approximately 15% seem high compared to the level of risk transferred. Other issues identified with LIFT included local companies being

							discouraged from seeing tenancies or involvement in the construction; the lack of a pilot study or evaluation, the risk of GPs moving to LIFT buildings leaving more deprived areas without doctors, enabling funds not being reclaimed by the Department of Health for reuse in future projects and financial analysis of LIFT being outsourced to Operis who are involved in LIFT schemes and a Masters student. The PAC commented on the lack of financial data provided to them.

Group 3: News Releases

Ref. No.	Author	Date	Title	Type of paper	Method	Location	Key findings / opinions
60	Department of Health	2004	Hutton announces plans for more super surgeries: trusts invited to bid for new LIFT schemes	News release		National	NHS LIFT will "pump £1 billion of private investment into primary care". PCTs invited to bid for new one-stop health centres funded under LIFT - estimated additional investment of £150 - £225m.
61	Department of Health	2004	Lift off for first 'super surgery'	News release		National	Opening of first £4.9m one-stop super surgery built under LIFT initiative. Confirmed total of 42 LIFT projects in progress across 120 PCTs. One third of these in health action zones (deprived areas of the country). Wave 1 (Feb 2001) - 6 projects. Wave 2 (Jan 2002) - 12 projects. Wave 3 (Aug 2002) - 24 projects.£195 million in enabling funds made available to date
62	Department of Health	2006	Lift off for more doctor's surgeries and health centres	News release		National	NHS plans to open 60 new GP surgeries (one per week) during 2006 under LIFT offering services previously only found in hospitals. In excess of £700m set aside for LIFT. 54 new buildings open by end of 2005. Claims 3,000 GP premises improved and over 500 one-stop health centres opened since 2001.
63	Department of Health	2003	New 4.9 million health centre for East London is first for LIFT	News release		National	E. London chosen as one of first areas for LIFT due to challenge in attracting investment. High number of sub-standard primary care premises.
64	Department of Health	2000	New initiatives to modernise GP premises	News release		National	Recognises areas of deprivation offer poor return on investment acting as disincentive to investment for private sector and GPs. GP current investment locked-in - poor patient access/inability to integrate services
65	Department of Health	2001	PFI extended into primary care into poorest parts of England	News release		National	Announcement of £55m package for GP investment - £30m capital to enable premises to train more doctors, £15m capital to accommodate expanding numbers of primary care staff and £10m for 6 first

							wave LIFT projects
66	Department of Health	2000	Radical reform will put patients at the centre of the NHS: .1 billion for GP premises in Health and Social Care Bill	News release		National	Announcement of £1billion for GP premises in Health and Social Care Bill through LIFT
67	Department of Health	2002	Speech by John Hutton MP, Minister of State for Health, to NHS LIFT Conference, London	News release		National	Transcript of speech describing progress with LIFT to date
68	Guillochon, R.	2006	MPs say government scheme for GP's premises threatens other primary care needs	News release		National	Review of the Public Accounts Committee (PAC) report – it identifies that it cannot be determined whether LIFT will provide VfM. PAC has requested that an evaluation mechanism be developed urgently. The report identifies that providing new buildings will be more expensive, that there should be some form of demonstration of benefits to justify subsidies provided to tenants, that there is currently no minimum cost for building alterations, that the location of new LIFT buildings make create transport problems for patients and that LIFT may divert funds from other needs including the amendment of premises where LIFT does not apply.
69	Roumeliotis, G	2007	DH boasts younger NHS estates	News release		National	Presentation of Department of Health statement – the age of NHS estate has reduced from 50% over 60 years old to 20% and capital expenditure has increased from £1.1b in 1997 to £5.5b in 2007.

Group 4: Opinion pieces

Ref. No.	Author	Date	Title	Type of paper	Method	Location	Key findings / opinions
70	Devereux, G. and Sutton, P.	2004	PPP in urban health development: NHS: fit for purpose	Conference paper - based on opinion		Manchester, Salford and Trafford	Descriptive report of the MAST LIFT project including the role of the Joint Health Unit and PCTs.
71	Dawson, D.	2001	The Private Finance Initiative: a public finance illusion?	Guest editorial - journal		National	Identifies that the level of risk transferred to the private sector must be high enough to justify belief of VfM. The paper identifies the lack of transparency in the PFI process and the lack of evidence that buildings have been constructed in such a way as to minimise maintenance costs (given that consortiums sell on their interest after construction). It is recognised that the bundling of all maintenance restricts the NHS bodies that are unable to delay, restrict or phase investment and/or maintenance expenditure. The paper discusses the commercial confidentiality around PFI internal rates of return, that the NHS is tied to these assets for a period of 30-50 years and that they are unable to change PFI contracts if new NHS policy is introduced. PFI is identified as the only finance mechanism available.

72	Pollock, A and Price, D.	2006	Privatising primary care	Guest editorial - journal		National	This paper describes the anxiety over the commercial take-over of general practice and other NHS clinical services. A private company will provide elective surgery for one LIFT project. This article claims PCTs could stand against this by arguing against practice-based commissioning and for population-based planning. It is argued that GPs could force their PCT to protect services and could demand a repeal of the legislation.
73	Aldred, R.E.	2005	Challenges of private provision in the NHS: Real story is beginning to emerge	Journal - Letter		National	This article sees LIFT as a way for private health companies to make money from primary care, creating monopolies, complex sub-contracting chains and complex long-term contracts. It recognises a lack of transparency created by commercial confidentiality and acknowledges that health care planning may become fragmented.
74	Ballantyne, N	2005	Getting LIFT of the ground	Opinion piece		National	Identifies some of the benefits of LIFT - adaptability, potential bid savings, ability to attract bidders to small projects. It also identifies some of the issues - lack of VfM assessment or dedicated resources and rationalisation of PCTs affecting their commitment to LIFT.
75	Black, A.	2002	Reconfiguring health systems	Opinion piece		National	Discusses the reconfiguration of health care. The paper questions whether the whole systems approach in reality is merely a project-based investment (typically a new building). 75% of health expenditure pays for staff but the redesign of employment and

							remuneration has largely been ignored as a driver for change. The article claims the current configuration of 1 GP per 2000 citizens is probably unsustainable.
76	Bunce. C.	1997	Laying the foundations for a GP-led study	Opinion piece		National	Claims that young GPs are unable to invest in premises and bureaucracy slows private sector investment. It describes one partnership between a local and health authority redeveloping an old community centre and renting space to GPs (pre-LIFT).
77	Burrell, R.	2004	Improving the practice	Opinion piece		National	Historically GPs have been owner occupiers and this article identifies that retirees want to extract their equity. Younger GPs have different work patterns to their predecessors. A higher level of investment required to buy and/or improve premises which increases the financial risk, increases involvement in management and reduces the time available for clinical work.
78	Burton, R.	2004	Regeneration game	Opinion piece		Liverpool	Anticipates 30 LIFT schemes worth over £100m in Merseyside. This article compares the 'hub and spoke' design to 'stem and leaf' models with their improved flexibility, functionality, fit on urban sites and expansion capability. It describes two LIFT schemes and their impact based on urban regeneration, including the release of prior publicly – owned sites.
79	Comerford, C.	2004	Is .108m of premises funding just	Opinion piece		National	Suggest that new LIFT money fails to address maintenance costs, GP rents have increased and premises costs

			papering over the cracks?				have increased further by the need to comply with disability legislation. This paper recognises opportunity cost – that one large project may consume all available funding. LIFT is considered to be expensive to set up for a PCT as it can include buy-out of previous premises, but there is no option other than LIFT. The paper also identifies the issue of the affordability gap.
80	Cooper, G.	2006	Bright lights: London health care	Opinion piece		London	Describes three new developments and highlights two previous "future-proof" buildings marked for demolition.
81	Cumberledge, J.	1996	Primary care premises. Owners and occupiers	Opinion piece		London	Paper discusses tenancy arrangements including how the cost of community space in building must be covered by tenants, adding flexibility to contracts creates additional problems and the possibility that lack of consideration of terms of leases may result in polyclinics being put to more profitable purposes in the future.
82	Davis, K.	2002	Primary concerns	Opinion piece		National	Report on CABE/King's Fund seminar. Identifies that a lack of innovation and quality in design is creating submissive architecture and that the aim of LIFT is not to produce “genius designs" but to "prevent the worst" ones.
83	Douglas, M. and Naru, A.	2005	Partnership for health	Opinion piece		Newcastle case study, national commentary	Discusses a partnership approach (in ProCure 21 by a private sector company who is also working on LIFT). It identifies the benefits of early involvement for familiarisation and education. It encourages openness and the sharing of information in meetings, the use of risk management to allow parties to raise concerns/obstacles, the

							early integration of specialist suppliers to bring specialist knowledge, reduce risk and improve quality and cost certainty.
84	Dudman, J.	2003	Ready for lift-off	Opinion piece		National	First six LIFT projects took over a year to select preferred provider. Identifies one aim of LIFT is to free GPs from property ownership and the risk of negative equity by buying out leases and providing and maintaining new premises. The process is described as "horrendously complicated". Identifies how one LIFT team delayed discussing rents with GPs and there was concern over the transfer of equity from the public to the private sector.
85	Forrest, E.	2004	Look lively	Opinion piece		St. Helens	Describes how a private sector partner selected a new site creating a more ambitious project (housing/shops/leisure development plus possible hotel) with the aim of developing an urban village. The concentration of GPs was intended to counteract the fragmentation of existing health care service. It was recognised that residents had moved away from area so they would still need to travel to visit their GP.

86	Godden, S., Pollock, A.M. and Player, S.	2001	Capital investment in primary care. The funding and ownership of primary care premises	Opinion piece		National	Describes the history of GP premises funding and ownership. Recognises GPs as independent contractors who could build own premises but had no separate income stream available for this. Conversely there were 3 rental reimbursement schemes (cost rent, notional and actual). In 1998-9 the expenditure on practice premises was over £319m. The article provides a description of LIFT. Part-time GP employment rose from 5% in 1990 to 17% in 1999. Complexity, risk, and scale of investment and change in working practice are all identified as being likely to accelerate the trend for companies buying out and owning GP premises.
87	Hellowell, M.	2004	PPPs in perspective - Uplifting experience	Opinion piece		E. London	Describes how run-down facilities are encouraging some GPs to leave. Describes the new LIFT scheme and recognises that a LIFTCo may be expected to deliver clinical services or procure services as part of their remit, although it was felt that this may put some investors off.
88	Hospital Development	2007	£10m 'super surgery' contract for Morgan Ashurst	Opinion piece		Camden	Describes 'state of the art' super surgery to be built in Camden
89	Hospital Development	2006	CABE's community exemplars	Opinion piece		National	Announces CABEs "Designed with Care" campaign aimed at encouraging better design in health care buildings.
90	Hospital Development	2006	CABE's LIFT favourites	Opinion piece		Birmingham and Solihull	Two LIFT projects praised by CABE for their design and attention to detail.

91	Hospital Development	2006	Design improved under PFI	Opinion piece		National	Comments on a survey of facilities managers commissioned by a health care consultancy company. LIFT is believed to be effective but costly and slow, however a lower approval rating was received for NHS Estates replacement.
92	Hospital Development	2003	East London LIFT raises questions	Opinion piece		London	Questions the procurement process for the first LIFT project - workload for bidders considered to be onerous and lengthy. It acknowledges that medium-sized organisations face resource issues. It is suggested that there should be a change in the process so that the selection of the winning bidder is based on approach and track record rather than on a specific design.
93	Hospital Development	2007	Europe's largest health care centre nears completion	Opinion piece		Hounslow	Describes a new super surgery being built in Hounslow
94	Hospital Development	2006	Forum report: Information for Health design Part Two: What should the future hold?	Opinion piece	Presentation of discussions at Hospital Development Forum	National	Identifies that written guidance is no guarantee that the final building will be what users either wanted or needed. Some issues may be caused by staffing rather than premises. One architect undertook a study of the factors affecting local residents' satisfaction and buildings came 11th. The discussants argue that this was incorrect as quality of environment affects health, performance, recruitment and retention of staff. It is identified that there are few real health care architects - some claim to have developed 200 buildings, others feel it to be 200 repetitions of the same

							building. Guidance can remove 'technical drudgery' but it is recognised that this can also stifle innovation. Often the same architects may be used as they have portfolio to show prospective clients. It is recognised that there is often poor interaction between architects and planners as they "wander into areas which are about architecture and planning buildings".
95	Hospital Development	2003	GP advocate suspicious of LIFT	Opinion piece		National	Chair of NHS Alliance is reported as doubting that private firms will be given charge of PCT facilities under LIFT in the same way as occurred for PFI projects as it would raise problems for GPs by taking services out of their hands.
96	Hospital Development	2005	LIFT bidding period increased	Opinion piece		National	Identifies that the bidding period was extended from 12 to 15 months after the publication of the NAO report. It cites the report as claiming that funds were not routinely monitored and some schemes did not utilise funds in a timely manner.
97	Hospital Development	2006	LIFT health centres now more than 100	Opinion piece		National	LIFT offers super surgeries with services only previously available in hospital e.g. x-rays, medical tests, Speech and language therapy, chiropody, physiotherapy and dentistry. It is claimed that LIFT buildings are more convenient for patients (especially the elderly and patients with chronic conditions).
98	Hospital Development	2006	New £3 million health centre for Knowsley	Opinion piece		Knowsley	Identifies that the 100th LIFT centre has opened. Describes the project and services provided.

99	Hospital Development	2007	NHS reaches LIFT milestone	Opinion piece		Dudley	200th health centre under LIFT completed bringing total capital value to over £1.1bn. Identifies that the new building includes new services, attracts GPs to the area and improves staff morale. Describes the services at the centre.
100	Hospital Development	2003	Triple LIFT whammy for Galliford Try	Opinion piece		Liverpool, Barnet / Enfield / Haringey and Coventry	One private company announced as preferred bidder for 3 LIFT projects in Liverpool (£60m), Barnet/Enfield/Haringey (£32m) and Coventry (£45m)
101	Hospital Development	2006	Ulrich's view from the inside	Opinion piece		National	Reflections by Professor Roger Ulrich (former advisor to NHS Estates). This paper identified the limited experience of trusts in developing development briefs.
102	Hospital Development	2002	Winning design chosen for London LIFT pilot	Opinion piece		N. London	Describes how the design was result of Royal Institute of British Architects competition. 76 expressions of interest short listed to 4 for final designs. The winning design encompassed 'unlimited flexibility' and the paper articulates the 'hope' that LIFTCo will use the design.
103	Hospital Development	2006	WYG supports £124m LIFT project	Opinion piece		St. Helens	Describes St Helens LIFT scheme - 40 health centres / £125m.
104	King's Fund and N. Alliance	2001	PPP and Primary care	Opinion piece		National	PFI is identified as the only game in town and that there is little evidence that it offers value for money. Contracts cannot be specified rigidly enough. No enterprise should be privatised unless it could be allowed to fail (threat of subsidies). Lack of definition of mVfM. In effect the LIFTCo becomes a monopoly. There is also

							acknowledgement that there is a risk of a conflict of interest between public and private sector partners. The author also questions why the existing stock of premises is in such poor condition.
105	Kmietowics, Z.	2001	Evidence that PPP can increase funding is 'paltry'	Opinion piece		National	The author feels that it is unclear whether LIFT will offer VfM and encourage investment in deprived areas however it frees GPs from maintaining premises and adds flexibility to GP careers.
106	Kmietowics, Z.	2002	Relations between NHS and private sector are 'not a one night stand' says Milburn	Opinion piece		National	Reports on the announcement by Health Secretary Alan Milburn (including 12 second wave LIFT projects)
107	Little, W	2006	Primary care. Settle for super	Opinion piece		West Bromwich, Burnley, London case studies with national commentary	Review of the white paper on health care outside hospitals. Describes how new super centres are to be opened in most deprived areas and how grouping practitioners under one roof increases shared learning. It recognises that there is no specific commitment from Department of Health on polyclinics, that it is up to local PCTs to do what they think will meet the needs of their local population. It recognises that planning for first super-surgery took years and suggests that services will be more integrated. It identifies that the LIFT process means that additional projects do not need to start fresh. It also argues that super-centres may go against ethos of family medicine that patients want.

108	Mathieson, S.	2002	LIFT doors still open (special report: buildings)	Opinion piece		Manchester, London with national commentary	Identifies that LIFT removes GP dependence on the value of the property and passes responsibility for maintenance to a dedicated company. Space is being rented out to other companies including local authorities, health care practitioners and private shops (although the LIFTCo hold a right of veto over selection of the tenants) providing a long term income prospect. The cost of purpose-built premises could be prohibitive for individual GPs. GPs only benefit from property value increases if they become shareholders in the LIFTCo, although it is recognised that this may increase the risk of a conflict of interest. It is suggested that LIFT provides easier entry into market and the ability to relocate for new GPs. It identifies that negative equity a risk for a LIFTCo in the same way it is a risk for individual GP owner occupiers.
109	Mathieson, S.	2003	LIFT-long learning	Opinion piece		London, Salford, Norfolk	Outlines lessons from some second and third wave LIFT projects. Some schemes are described as unimaginative. It recognises the challenging timetable of LIFT and the workload for the PCTs. It recognises that it may still be difficult to attract funding if in areas away from large cities where it is more difficult to make money from property (e.g. Norfolk LIFT project).
110	Meara, R.	2001	Do we have lift off?	Opinion piece		National	This article reviews LIFT and identifies drivers for change and a number of key questions: are the projects in areas of

							need? Will bundling of schemes be acceptable to GPs? Will LIFT result in better / competitively priced buildings? How will rents compare? Will it include option for privately-managed care centres?
111	Montague, A.	2004	A LIFT for local communities	Opinion piece		London	Identifies most of existing stock of premises are out of date or unsuited to primary care delivery. Before LIFT, only 40% of premises were purpose built with almost 50% being shops or adapted residential buildings. It describes one new health centre in Hainault describing how care has been taken over the design features. It recognises how some LIFT projects are being seen as urban regeneration tools.
112	Neal, J	2005	LIFT consumes all premises funding	Opinion piece		National	Claims LIFT is using all premises funding. The bias is now towards large private providers who are able to raise funds for new buildings.
113	Parker, J.	2006	Street life	Opinion piece		N. London	Provides a review of an early LIFT project. Designed in collaboration with the PCT and community leaders, the building has maintained a strong place in the community like the community hall that used to be on the site. Setting up the LIFTCo proved difficult and took two years; six months to get the preferred bidder and a year until financial close. The paper recognises that site selection may be difficult and can impact on the final building. It also acknowledges a lack of design flair in this building.
114	Parker, J.	2005	Urban uplift	Opinion		E. London	Provides a review of an early LIFT

				piece			project. Winner of 2004 NHS Estates Best Designed Primary Care Facility award. Developed in a demanding location in an area of widespread deprivation with special health needs, a low GP-Patient ratio and difficult staff recruitment. The high quality build helped attract, retain and integrate staff. It was recognised that there was a balance to be struck between the need for openness yet provision of security. This has been a positive experience for staff and patients. The building was developed with flexibility and adaptability to help maintain residual value.
115	Parker, J. and Davis, K.	2001	A LIFT for primary care	Opinion piece	Presentation of discussions at Hospital Development Forum	National	LIFT partnering is described as poor due to the long term agreement. The paper identifies that the NHS will not own the primary care property as it will all be leased. It suggests that the role of Local Authority has been underestimated. NHS Estates is under pressure to deliver projects from LIFTCo's and there are concerns that not all projects are providing the right building in the right place.
116	Parley, M.	2006	LIFT effectiveness questioned	Opinion piece		National	One MP comments that Department of Health and Partnerships for Health must speed up development of a tool to evaluate LIFT. This paper also asks whether funds are being diverted to LIFT which could be better sent elsewhere.

117	Pollock, A.M.	2001	Will primary care trusts lead to US-style health care?	Opinion piece		National	Identifies that the Government has not published the revenue implications of using private finance. It recognises that there is a reliance on new income streams from provision of other services and commercial/retail outlets. Currently there are no restrictions on setting up business ventures. It is claimed that some PCTs may enter into joint ventures with private insurers and health companies to sell insurance products such as long term care and private healthcare cover to patients. This paper recommends that the government should reaffirm the principle of universal coverage and provide funding based on geographic population rather than practice and that it should prohibit sale of private services and health insurance from premises in which the NHS pays for care.
118	Pope, N.	1988	Brightening up the inner city	Opinion piece		E. London	Describes pre-LIFT health centre - two GP practice partnership. Chose new site in centre of practice area. Found mechanism to fund multi-purpose room excluded under cost-rent scheme (cash payment from DHA). Charging DHA rental fee for use of space to cover cost rent deficit.
119	Richer, G.	2007	Building a better NHS	Opinion piece		National	Identifies that LIFT is perceived to be an expensive process. PCTs had pre-existing deficits which have slowed LIFT projects considerably. The 4th wave of LIFT includes delivery of clinical services within contractual remit. Once completed the

							procurement/set-up costs for LIFT projects may be forgotten.
120	Robinson, F.	2005	The trouble with LIFT…	Opinion piece		National	Provides a review of the NAO report. The authors feel that LIFT will improve recruitment/retention of GPs, improve care for patients (having multiple providers in the same building). Some GPs are unhappy as they are unable to gain money from their PCT for basic improvements to their premises. Consequently GP buy-in has been patchy, independent practitioners have not been convinced about co-location, the benefit of the new build would not seem to be outweighed by high rents. It was recognised that one LIFT project may use all PCT funds and the notional rent scheme used to provide cost-efficient way of improving premises has now stopped.
121	Sansom, A.	2007	London LIFT projects: Meeting of minds	Opinion piece		London	This paper dismissed the issue of conflict of interest. It is argued that the issue is one of the private sector making money (vs. public sector wasting it). It is recognised that the private sector must deliver. Gaining sign-off for the proposals was seen as difficult. To improve the process it is suggested that there must be a reduction in changes, time delays and financial instability. It describes PCT taking on the headlease sp GPs are not tied to long-term contracts, thereby allowing for different practice patterns.

							This also creates opportunities for GPs, easier referrals and communication. A LIFT project can include housing and this paper describes one example with 72 apartments, 24 classed as affordable and 8 allocated for PCT staff. Their buildings are designed to incorporate some flexibility. The paper argues that buildings must be affordable, efficient and good-quality as well as civic landmarks.
122	Slingsby, C.	2004	10 things to know about premises	Opinion piece		National	Identifies a number of issues about renting premises including considering what may happen if a practice outgrows their space building, the lease rent review and lease terms.
123	Slingsby, C.	1992	Escape the GP premises trap	Opinion piece		National	Identifies that a lack of development money preventing the expansion of outgrown/ageing surgeries and that it is hard to find suitable sites and/or get planning permission. Barking and Havering FHSA identify that the area has problems with depreciation, small practices with substandard premises and fewer health centres but that they are prepared to liaise with GPs to identify ways to bring premises up to higher standard but these must fit with the services the FHSA want to develop. It also identifies alternate ways to obtain new premises (conversion of new property, developer willing to build premises in new development and lease it to GP, repurpose former hospital).
124	Spinks, J.	2002	Heartened by headlines	Opinion piece		Medway	Describes the Medway PCT LIFT scheme. The process started in March

							2002. They were ready to find a private sector partner six months later and proposals for 17 centres will be completed by 2006. It recognises that the centralisation of services will impact GPs still in their own premises.
125	Tredinnick, B.	1993	Getting into practice: part 1: Backdrop for change	Opinion piece		Watford, Denbigh, Liverpool, Cheltenham, London, Ely, Epsom, Reading	Identifies that 46% of premises in inner London are below minimum standards (compared to 7% in the rest of England). A lack of space is blamed for the inability to expand staff/services. The cost rent scheme is blamed as it only funds the basic unit of consulting/waiting/treatment and reception rooms based on number of GPs. The paper describes projects completed by GPs using a variety of other funding methods (pre-LIFT)
126	Tynedale Biscoe, Julian	2003	Why LIFT isn't hitting the mark	Opinion piece		National	Identifies that here has been a £175m Government investment in LIFT over 4 years. Having a standard lease means lower legal costs for GPs. It is claimed that it is impossible to say if LIFT provides VfM (especially given cost of tendering process). The paper recognises the lack of a pilot scheme and the complicated funding system. The cost of preparing bids is estimated at between £500k - £1m. LIFT rents evaluated by a District Valuer but these are affected by the cost of the scheme itself. The paper also claims that bureaucracy adds to the cost of LIFT projects.
127	Ward, S.	2003	Cash dash	Opinion piece		National	Identifies that the process behind LIFT makes it unable to take advantage of unforeseen opportunities and that the

							lead PCT may get majority of funding. The paper recognises that there is some potential for the reconfiguration of existing NHS estate and that there are revenue implications of LIFT.
128	Watson, J.	2002	Take the LIFT	Opinion piece		National	Provides an outline of the LIFT initiative
129	Bosanquet, N., Haldenby, A. and de Zoete, H.	2006	Investment in the NHS - facing up to the reform agenda	Opinion piece - report		National	Describes how some private providers are building cheap/modern builds with 5 year life, their argument being that as you cannot estimate practice requirements in 20 years time there is no need for all long term build/high capital investment. It identifiers that delays cost an average of £2.4m per PFI scheme. It argues that VfM is the key for future procurement and that local responsibility for investment must be placed with local managers to increase local freedom and flexibility. It recognises that it is unlikely that there will be any new funding from public sector and that improvements in infrastructure in next decade will be via PPP. It recommends use of amended form of PFI/LIFT which must be affordable, relate depreciation periods to useful life rather than fixed rule, provide a range of finance options including PFI with an emphasis on smaller projects which must be related to specific income streams.
130	Banyard, R	2004	Funding GP premises: a constant challenge for PCTs?	Opinion piece		National	Describes the issues faced by PCTs trying to allocate resources for GP premises equitably with no central guidance re: criteria. Recognises that PCT staff will require technical estate

							and planning skills and information. It also recognises that a substantial proportion of staff time is likely to be spent upon LIFT projects and that GPs are unaccustomed to bureaucratic procedures when planning their premises.
131	Wall, A.	2007	LIFT/PFI: will the NHS survive with further deals?	Opinion piece		National	Provides a synopsis of UNISON report (2006). It identifies that GP practices require additional space for new services although the needs and designs may change with demography in the future. It also recognises the need for a VfM review of LIFT.

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Appendix 4

Requests for Collaboration

[University headed paper] [date]

Dear <x>,

The Role and Effectiveness of Public-Private Partnerships (NHS LIFT) in the Development of Enhanced Primary Care Premises and Services

The Management School at the University of York has recently been awarded a grant from the NHS Service Delivery and Organisation Programme (SDO) to examine the effectiveness of Public Private Partnerships in the development of enhanced primary care premises. The study is entitled ***The Role and Effectiveness of Public – Private Partnerships (NHS LIFT) in the Development of Enhanced Primary Care Premises and Services,*** and a detailed description of the project can be found on the SDO webpage at http://www.sdo.lshtm.ac.uk/sdo1562006.html.

Part of the project involves conducting interviews with a variety of staff who have been involved in LIFT projects, and subsequently carrying out in-depth case studies across a range of PCTs, chosen to provide a broad spread both geographically and across the different waves of the LIFT programme.

I am writing to you to ask whether you would be willing for your PCT to take part in the interview round of the project, with a view to possibly becoming one of our case study sites. Initially, we would like to interview a selection of people including managers, finance directors, health care professionals and Board members from the public sector, plus representatives from private sector partners.

Should you wish to discuss this further before making a commitment, please do not hesitate to contact me, or my Research Fellow, Dr Sally Brown. I can be reached via email at mb541@york.ac.uk, and Dr Brown can be reached at sb616@york.ac.uk or on 01904 434894.

I look forward to hearing from

you. Yours sincerely,

Professor Matthias Beck

[University headed
paper] [date]

Dear <x>,

The Role and Effectiveness of Public-Private Partnerships (NHS LIFT) in the Development of Enhanced Primary Care Premises and Services

Over the last year the Management School at the University of York has been carrying out a research project entitled ***The Role and Effectiveness of Public – Private Partnerships (NHS LIFT) in the Development of Enhanced Primary Care Premises and Services.*** This has been funded by the NHS Service Delivery and Organisation Programme (SDO)**,** and a detailed description of the project can be found on the SDO webpage at http://www.sdo.lshtm.ac.uk/sdo1562006.html.

Following the development of Express LIFT, and the announcement of the private sector framework partners, we should like to include some analysis of Express LIFT in our work. Therefore I am writing to you to ask whether it would be possible to interview people in your organisation who could contribute to our research. We would ideally like to speak to CEOs, Directors of Finance, Directors with responsibility for planning, strategy and business, and anyone else in your organisation whom you think would be relevant.

Should you wish to discuss this further before making a commitment, please do not hesitate to contact me, or my Research Fellow, Dr Sally Brown. I can be reached via email at mb541@york.ac.uk, and Dr Brown can be reached at sb616@york.ac.uk or on
01904 434894.

I look forward to hearing from

you. Yours sincerely,

Professor Matthias Beck

Appendix 5

Expanded Version of Child & Faulkner's Model

The Meeting of Cultures: Achieving a Cultural Fit

	The Four Possible Bases for Accommodating Cultural Diversity within Health Care Organisations	
No	1) Synergy The objective is to meld both partners' cultures and to achieve the best possible fit between the two. The best elements are combined with the objective of making the whole greater than the sum of its parts. Th e combination of management and clinical roles by clinical directors is an example of this.	2) Se gregation Here the aim is to strike an acceptable balance between different subcultures by virtue of maintaining separation rather than seeking integration. In many health systems inter-professional alliances may be seen to be of this type. For example, accommodation between the nursing profession and doctors
Yes	3) D omination This is based on recognition that integrating subcultures may prove impossible and accepts the right of dominance of one sub-group's culture. Clinicians have traditionally assumed this role and have until recently been largely self-regulating rather than being the subject to external monitoring and assessment.	4) Br eakdown This occurs when a sub-group seeks domination, integration or mutually acceptable segregation but fails to secure the acquiescence of the other group. For example, failed attempts in advanced health systems over many years to usurp the dominance of the medical profession.

Domination By One Subculture

Integration

Yes No

Derived and expanded from a classificatory scheme on strategic alliances developed by Child & Faulkner, 1998.

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Appendix 6

Tables 6.1 to 6.4, Financial Analysis

1. East Lancs Base Case

Input assumptions	
Inflation rate	0.025
senior debt amortisation rate	0.96
subordinated debt amortisation	0.93
tax rate	0.27

Model Outputs	
Nominal Pre-Tax Project IRR no RV	7.60%
Nominal Pre-Tax Project IRR no RV	8.07%
Nominal Pre-Tax Blended Equity IRR no RV	15.69%
Nominal Pre-Tax Blended Equity IRR (RV)	16.47%
Nominal Post-Tax Blended Equity IRR no RV	**13.90%**
Nominal Post-Tax Blended Equity IRR with RV	**15.10%**

Detailed forecast

	total	30/9/04	30/9/05	30/9/06	30/9/07	30/9/08	30/9/09	30/9/10	30/9/11	30/9/12	30/9/13	30/9/14	30/9/15	30/9/16	30/9/17	30/9/18	30/9/19	30/9/20	30/9/21	30/9/22	30/9/23	30/9/24	30/9/25	30/9/26	30/9/27	30/9/28	30/9/29	30/9/30
Proforma P&L a/c																											
Lease plus payments	85703.12		98.00	2274.00	2576.00	2640.40	2706.41	2774.07	2843.42	2914.51	2987.37	3062.05	3138.61	3217.07	3297.50	3379.94	3464.43	3551.04	3639.82	3730.82	3824.09	3919.69	4017.68	4118.12	4221.08	4326.60	4434.77	4545.64
third party revenues	1823.85		24.00	53.00	54.00	55.35	56.73	58.15	59.61	61.10	62.62	64.19	65.79	67.44	69.12	70.85	72.62	74.44	76.30	78.21	80.16	82.17	84.22	86.33	88.49	90.70	92.96	95.29
Recovery of pass through costs	6278.92		80.00	182.00	186.00	190.65	195.42	200.30	205.31	210.44	215.70	221.10	226.62	232.29	238.10	244.05	250.15	256.40	262.81	269.38	276.12	283.02	290.10	297.35	304.78	312.40	320.21	328.22
Recovery of utilities costs	3307.21		42.00	95.00	98.00	100.45	102.96	105.54	108.17	110.88	113.65	116.49	119.40	122.39	125.45	128.58	131.80	135.09	138.47	141.93	145.48	149.12	152.85	156.67	160.58	164.60	168.71	172.93
Total revenue	**97113.10**		**244.00**	**2604.00**	**2914.00**	**2986.85**	**3061.52**	**3138.06**	**3216.51**	**3296.92**	**3379.35**	**3463.83**	**3550.43**	**3639.19**	**3730.17**	**3823.42**	**3919.01**	**4016.98**	**4117.41**	**4220.34**	**4325.85**	**4434.00**	**4544.85**	**4658.47**	**4774.93**	**4894.30**	**5016.66**	**5142.08**
admin and secretarial	5038.91		274.00	139.00	143.00	146.58	150.24	154.00	157.85	161.79	165.84	169.98	174.23	178.59	183.05	187.63	192.32	197.13	202.06	207.11	212.28	217.59	223.03	228.61	234.32	240.18	246.18	252.34
SPV Management	1687.45		21.00	49.00	50.00	51.25	52.53	53.84	55.19	56.57	57.98	59.43	60.92	62.44	64.00	65.60	67.24	68.93	70.65	72.41	74.23	76.08	77.98	79.93	81.93	83.98	86.08	88.23
External fees	337.49		4.00	10.00	10.00	10.25	10.51	10.77	11.04	11.31	11.60	11.89	12.18	12.49	12.80	13.12	13.45	13.79	14.13	14.48	14.85	15.22	15.60	15.99	16.39	16.80	17.22	17.65
Bank fees and charges	67.70		1.00	2.00	2.00	2.05	2.10	2.15	2.21	2.26	2.32	2.38	2.44	2.50	2.56	2.62	2.69	2.76	2.83	2.90	2.97	3.04	3.12	3.20	3.28	3.36	3.44	3.53
Insurance	3036.41		38.00	87.00	90.00	92.25	94.56	96.92	99.34	101.83	104.37	106.98	109.66	112.40	115.21	118.09	121.04	124.07	127.17	130.35	133.61	136.95	140.37	143.88	147.48	151.16	154.94	158.81
Hard FM Operating Costs	12878.98		174.00	380.00	381.00	390.53	400.29	410.30	420.55	431.07	441.84	452.89	464.21	475.82	487.71	499.91	512.40	525.21	538.34	551.80	565.60	579.74	594.23	609.09	624.31	639.92	655.92	672.32
Pass through costs	4590.47		58.00	133.00	136.00	139.40	142.89	146.46	150.12	153.87	157.72	161.66	165.70	169.85	174.09	178.44	182.90	187.48	192.16	196.97	201.89	206.94	212.11	217.42	222.85	228.42	234.13	239.99
Utilities costs	3307.21		42.00	95.00	98.00	100.45	102.96	105.54	108.17	110.88	113.65	116.49	119.40	122.39	125.45	128.58	131.80	135.09	138.47	141.93	145.48	149.12	152.85	156.67	160.58	164.60	168.71	172.93
Total life cycle costs	4456.76					197.00	291.00	146.00	149.65	153.39	157.23	161.16	165.19	169.32	173.55	177.89	182.33	186.89	191.56	196.35	201.26	206.29	211.45	216.74	222.16	227.71	233.40	239.24
balancing																												
Total costs	35401.38		612.00	895.00	910.00	1129.75	1247.07	1125.97	1154.12	1182.97	1212.55	1242.86	1273.93	1305.78	1338.43	1371.89	1406.18	1441.34	1477.37	1514.31	1552.16	1590.97	1630.74	1671.51	1713.30	1756.13	1800.03	1845.03
Gross profit	**61711.71**		**-368.00**	**1709.00**	**2004.00**	**1857.10**	**1814.45**	**2012.09**	**2062.39**	**2113.95**	**2166.80**	**2220.97**	**2276.49**	**2333.41**	**2391.74**	**2451.53**	**2512.82**	**2575.64**	**2640.03**	**2706.04**	**2773.69**	**2843.03**	**2914.10**	**2986.96**	**3061.63**	**3138.17**	**3216.63**	**3297.04**
Depreciation	17940.00		690.00	690.00	690.00	690.00	690.00	690.00	690.00	690.00	690.00	690.00	690.00	690.00	690.00	690.00	690.00	690.00	690.00	690.00	690.00	690.00	690.00	690.00	690.00	690.00	690.00	690.00
Operating profit			**-1058.00**	**1019.00**	**1314.00**	**1167.10**	**1124.45**	**1322.09**	**1372.39**	**1423.95**	**1476.80**	**1530.97**	**1586.49**	**1643.41**	**1701.74**	**1761.53**	**1822.82**	**1885.64**	**1950.03**	**2016.04**	**2083.69**	**2153.03**	**2224.10**	**2296.96**	**2371.63**	**2448.17**	**2526.63**	**2607.04**
stamp duty																												
interest on senior debt 2 bullet	3500.00			140.00	140.00	140.00	140.00	140.00	140.00	140.00	140.00	140.00	140.00	140.00	140.00	140.00	140.00	140.00	140.00	140.00	140.00	140.00	140.00	140.00	140.00	140.00	140.00
interest on senior debt 1amortising	20543.10			1222.00	1205.00	1190.00	1142.40	1096.70	1052.84	1010.72	970.29	931.48	894.22	858.45	824.12	791.15	759.50	729.12	699.96	671.96	645.08	619.28	594.51	570.73	547.90	525.98	504.94	484.75
interest on subordinated debt	3640.04			285.00	271.00	266.00	247.38	230.06	213.96	198.98	185.05	172.10	160.05	148.85	138.43	128.74	119.73	111.35	103.55	96.30	89.56	83.29	77.46	72.04	67.00	62.31	57.95	53.89
interest receivable	-1524.05			-28.00	-28.00	-48.00	-49.20	-50.43	-51.69	-52.98	-54.31	-55.67	-57.06	-58.48	-59.95	-61.44	-62.98	-64.55	-66.17	-67.82	-69.52	-71.26	-73.04	-74.86	-76.74	-78.65	-80.62	-82.64
balance																												
total financing costs			0.00	1619.00	1588.00	1548.00	1480.58	1416.34	1355.10	1296.72	1241.04	1187.92	1137.22	1088.82	1042.60	998.45	956.25	915.92	877.34	840.44	805.13	771.32	738.93	707.90	678.16	649.64	622.27	596.00
Profit before tax			**-1058.00**	**-600.00**	**-274.00**	**-380.90**	**-356.13**	**-94.25**	**17.29**	**127.23**	**235.76**	**343.05**	**449.28**	**554.59**	**659.14**	**763.09**	**866.57**	**969.73**	**1072.69**	**1175.59**	**1278.56**	**1381.71**	**1485.17**	**1589.05**	**1693.47**	**1798.54**	**1904.36**	**2011.04**
tax	7445.94															28.15	91.32	162.02	240.22	325.92	419.12	519.85	628.12	743.96	867.42	998.53	1137.36	1283.96
Profit after tax			**-1058.00**	**-600.00**	**-274.00**	**-380.90**	**-356.13**	**-94.25**	**17.29**	**127.23**	**235.76**	**343.05**	**449.28**	**554.59**	**659.14**	**734.94**	**775.25**	**807.71**	**832.48**	**849.68**	**859.44**	**861.86**	**857.05**	**845.09**	**826.06**	**800.01**	**767.00**	**727.08**
Deferred tax			-285.66	-447.66	-521.64	-624.48	-720.64	-746.08	-741.42	-707.07	-643.41	-550.79	-429.48	-279.74	-101.77	104.26	338.23	600.06	889.69	1207.10	1552.31	1925.37	2326.37	2755.41	3212.65	3698.25	4212.43	4755.41
Balance sheet cash flows																												
Fixed assets		-14666.00	-8835.00																									
Senior debt 2 bullet		1355.00	817.00																									
Senior debt amortising	2020.10	12200.00	6977.00	-286.00	-303.00	-318.00	-365.60	-411.30	-455.16	-497.28	-537.71	-576.52	-613.78	-649.55	-683.88	-716.85	-748.50	-778.88	-808.04	-836.04	-862.92	-888.72	-913.49	-937.27	-960.10	-982.02	-1003.06	-1023.25
sub debt	0.00	1737.00	667.00	41.00	-43.00	-48.00	-107.00	-107.00	-107.00	-107.00	-107.00	-107.00	-107.00	-107.00	-107.00	-107.00	-107.00	-107.00	-107.00	-107.00	-107.00	-107.00	-107.00	-107.00	-107.00	-107.00	-107.00	-107.00
	-19560.90	626.00	-374.00	-245.00	-346.00	-366.00	-472.60	-518.30	-562.16	-604.28	-644.71	-683.52	-720.78	-756.55	-790.88	-823.85	-855.50	-885.88	-915.04	-943.04	-969.92	-995.72	-1020.49	-1044.27	-1067.10	-1089.02	-1110.06	-1130.25
Residual values																												
Fixed assets																												8250.00
Senior debt 2 bullet																												-2172.00
Senior debt amortising																												-2020.10
sub debt																												
Operating pre tax cash flow			-368.00	1709.00	2004.00	1857.10	1814.45	2012.09	2062.39	2113.95	2166.80	2220.97	2276.49	2333.41	2391.74	2451.53	2512.82	2575.64	2640.03	2706.04	2773.69	2843.03	2914.10	2986.96	3061.63	3138.17	3216.63	3297.04
Project pre tax cash flows (no RV)		-14666.00	-9203.00	1709.00	2004.00	1857.10	1814.45	2012.09	2062.39	2113.95	2166.80	2220.97	2276.49	2333.41	2391.74	2451.53	2512.82	2575.64	2640.03	2706.04	2773.69	2843.03	2914.10	2986.96	3061.63	3138.17	3216.63	3297.04
Project pre tax cash flows (RV)		-14666.00	-9203.00	1709.00	2004.00	1857.10	1814.45	2012.09	2062.39	2113.95	2166.80	2220.97	2276.49	2333.41	2391.74	2451.53	2512.82	2575.64	2640.03	2706.04	2773.69	2843.03	2914.10	2986.96	3061.63	3138.17	3216.63	11547.04
Senior debt 2 cash flows		1355.00	817.00	-140.00	-140.00	-140.00	-140.00	-140.00	-140.00	-140.00	-140.00	-140.00	-140.00	-140.00	-140.00	-140.00	-140.00	-140.00	-140.00	-140.00	-140.00	-140.00	-140.00	-140.00	-140.00	-140.00	-140.00	-2312.00
Senior debt 1 cash flows		12200.00	6977.00	-1508.00	-1508.00	-1508.00	-1508.00	-1508.00	-1508.00	-1508.00	-1508.00	-1508.00	-1508.00	-1508.00	-1508.00	-1508.00	-1508.00	-1508.00	-1508.00	-1508.00	-1508.00	-1508.00	-1508.00	-1508.00	-1508.00	-1508.00	-1508.00	-3528.10
Post senior debt pre tax cash no RV		-1111.00	-1409.00	61.00	356.00	209.10	166.45	364.09	414.39	465.95	518.80	572.97	628.49	685.41	743.74	803.53	864.82	927.64	992.03	1058.04	1125.69	1195.03	1266.10	1338.96	1413.63	1490.17	1568.63	-2543.06
Post senior debt pre tax cash (RV)		-1111.00	-1409.00	61.00	356.00	209.10	166.45	364.09	414.39	465.95	518.80	572.97	628.49	685.41	743.74	803.53	864.82	927.64	992.03	1058.04	1125.69	1195.03	1266.10	1338.96	1413.63	1490.17	1568.63	5706.94
Post senior debt post tax cash no RV		-1111.00	-1409.00	61.00	356.00	209.10	166.45	364.09	414.39	465.95	518.80	572.97	628.49	685.41	743.74	775.38	773.50	765.63	751.82	732.12	706.56	675.18	637.99	595.00	546.22	491.64	431.27	-3827.02
Post senior debt post tax cash (RV)		-1111.00	-1409.00	61.00	356.00	209.10	166.45	364.09	414.39	465.95	518.80	572.97	628.49	685.41	743.74	775.38	773.50	765.63	751.82	732.12	706.56	675.18	637.99	595.00	546.22	491.64	431.27	4422.98

2. East Lancs: Adjusted 3 years ex post data

Detailed forecast	total	30/9/04	30/9/05	30/9/06	30/9/07	30/9/08	30/9/09	30/9/10	30/9/11	30/9/12	30/9/13	30/9/14	30/9/15	30/9/16	30/9/17	30/9/18	30/9/19	30/9/20	30/9/21	30/9/22	30/9/23	30/9/24	30/9/25	30/9/26	30/9/27	30/9/28	30/9/29	30/9/30
Proforma P&L a/c																											
Lease plus payments	85703.12		98.00	2274.00	2576.00	2640.40	2706.41	2774.07	2843.42	2914.51	2987.37	3062.05	3138.61	3217.07	3297.50	3379.94	3464.43	3551.04	3639.82	3730.82	3824.09	3919.69	4017.68	4118.12	4221.08	4326.60	4434.77	4545.64
third party revenues	1823.85		24.00	53.00	54.00	55.35	56.73	58.15	59.61	61.10	62.62	64.19	65.79	67.44	69.12	70.85	72.62	74.44	76.30	78.21	80.16	82.17	84.22	86.33	88.49	90.70	92.96	95.29
Recovery of pass through costs	6278.92		80.00	182.00	186.00	190.65	195.42	200.30	205.31	210.44	215.70	221.10	226.62	232.29	238.10	244.05	250.15	256.40	262.81	269.38	276.12	283.02	290.10	297.35	304.78	312.40	320.21	328.22
Recovery of utilities costs	3307.21		42.00	95.00	98.00	100.45	102.96	105.54	108.17	110.88	113.65	116.49	119.40	122.39	125.45	128.58	131.80	135.09	138.47	141.93	145.48	149.12	152.85	156.67	160.58	164.60	168.71	172.93
Total revenue	**97113.10**		**1890.00**	**2862.00**	**2914.00**	**2986.85**	**3061.52**	**3138.06**	**3216.51**	**3296.92**	**3379.35**	**3463.83**	**3550.43**	**3639.19**	**3730.17**	**3823.42**	**3919.01**	**4016.98**	**4117.41**	**4220.34**	**4325.85**	**4434.00**	**4544.85**	**4658.47**	**4774.93**	**4894.30**	**5016.66**	**5142.08**
admin and secretarial	4085.93		274.00	111.20	114.40	117.26	120.19	123.20	126.28	129.43	132.67	135.99	139.39	142.87	146.44	150.10	153.86	157.70	161.64	165.69	169.83	174.07	178.42	182.89	187.46	192.14	196.95	201.87
SPV Management	1354.16		21.00	39.20	40.00	41.00	42.03	43.08	44.15	45.26	46.39	47.55	48.74	49.95	51.20	52.48	53.80	55.14	56.52	57.93	59.38	60.86	62.39	63.95	65.54	67.18	68.86	70.58
External fees	270.79		4.00	8.00	8.00	8.20	8.41	8.62	8.83	9.05	9.28	9.51	9.75	9.99	10.24	10.50	10.76	11.03	11.30	11.59	11.88	12.17	12.48	12.79	13.11	13.44	13.77	14.12
Bank fees and charges	54.36		1.00	1.60	1.60	1.64	1.68	1.72	1.77	1.81	1.86	1.90	1.95	2.00	2.05	2.10	2.15	2.21	2.26	2.32	2.38	2.43	2.50	2.56	2.62	2.69	2.75	2.82
Insurance	2436.73		38.00	69.60	72.00	73.80	75.65	77.54	79.47	81.46	83.50	85.59	87.73	89.92	92.17	94.47	96.83	99.25	101.73	104.28	106.88	109.56	112.30	115.10	117.98	120.93	123.95	127.05
Hard FM Operating Costs	10337.99		174.00	304.00	304.80	312.42	320.23	328.24	336.44	344.85	353.47	362.31	371.37	380.65	390.17	399.92	409.92	420.17	430.67	441.44	452.48	463.79	475.38	487.27	499.45	511.94	524.73	537.85
Pass through costs	3683.98		58.00	106.40	108.80	111.52	114.31	117.17	120.09	123.10	126.17	129.33	132.56	135.88	139.27	142.76	146.32	149.98	153.73	157.57	161.51	165.55	169.69	173.93	178.28	182.74	187.31	191.99
Utilities costs	2654.16		42.00	76.00	78.40	80.36	82.37	84.43	86.54	88.70	90.92	93.19	95.52	97.91	100.36	102.87	105.44	108.08	110.78	113.55	116.39	119.29	122.28	125.33	128.47	131.68	134.97	138.35
Total life cycle costs	4456.76					197.00	291.00	146.00	149.65	153.39	157.23	161.16	165.19	169.32	173.55	177.89	182.33	186.89	191.56	196.35	201.26	206.29	211.45	216.74	222.16	227.71	233.40	239.24
balancing																												
Total costs	29334.86		419.00	716.00	728.00	943.20	1055.86	929.98	953.23	977.06	1001.48	1026.52	1052.18	1078.49	1105.45	1133.09	1161.41	1190.45	1220.21	1250.71	1281.98	1314.03	1346.88	1380.56	1415.07	1450.45	1486.71	1523.87
Gross profit	**67778.24**		**1471.00**	**2146.00**	**2186.00**	**2043.65**	**2005.67**	**2208.08**	**2263.28**	**2319.87**	**2377.86**	**2437.31**	**2498.24**	**2560.70**	**2624.72**	**2690.33**	**2757.59**	**2826.53**	**2897.20**	**2969.63**	**3043.87**	**3119.96**	**3197.96**	**3277.91**	**3359.86**	**3443.86**	**3529.95**	**3618.20**
Depreciation	17940.00		690.00	690.00	690.00	690.00	690.00	690.00	690.00	690.00	690.00	690.00	690.00	690.00	690.00	690.00	690.00	690.00	690.00	690.00	690.00	690.00	690.00	690.00	690.00	690.00	690.00	690.00
Operating profit			**781.00**	**1456.00**	**1496.00**	**1353.65**	**1315.67**	**1518.08**	**1573.28**	**1629.87**	**1687.86**	**1747.31**	**1808.24**	**1870.70**	**1934.72**	**2000.33**	**2067.59**	**2136.53**	**2207.20**	**2279.63**	**2353.87**	**2429.96**	**2507.96**	**2587.91**	**2669.86**	**2753.86**	**2839.95**	**2928.20**
stamp duty																												
interest on senior debt 2 bullet	3500.00			140.00	140.00	140.00	140.00	140.00	140.00	140.00	140.00	140.00	140.00	140.00	140.00	140.00	140.00	140.00	140.00	140.00	140.00	140.00	140.00	140.00	140.00	140.00	140.00	140.00
interest on senior debt 1amortising	20543.10			1222.00	1205.00	1190.00	1142.40	1096.70	1052.84	1010.72	970.29	931.48	894.22	858.45	824.12	791.15	759.50	729.12	699.96	671.96	645.08	619.28	594.51	570.73	547.90	525.98	504.94	484.75
interest on subordinated debt	3640.04			285.00	271.00	266.00	247.38	230.06	213.96	198.98	185.05	172.10	160.05	148.85	138.43	128.74	119.73	111.35	103.55	96.30	89.56	83.29	77.46	72.04	67.00	62.31	57.95	53.89
interest receivable	-1531.05		-7.00	-28.00	-28.00	-48.00	-49.20	-50.43	-51.69	-52.98	-54.31	-55.67	-57.06	-58.48	-59.95	-61.44	-62.98	-64.55	-66.17	-67.82	-69.52	-71.26	-73.04	-74.86	-76.74	-78.65	-80.62	-82.64
balance																												
total financing costs			1048.00	1590.00	1555.00	1548.00	1480.58	1416.34	1355.10	1296.72	1241.04	1187.92	1137.22	1088.82	1042.60	998.45	956.25	915.92	877.34	840.44	805.13	771.32	738.93	707.90	678.16	649.64	622.27	596.00
Profit before tax			**-267.00**	**-134.00**	**-59.00**	**-194.35**	**-164.91**	**101.75**	**218.18**	**333.15**	**446.82**	**559.39**	**671.03**	**781.88**	**892.12**	**1001.89**	**1111.34**	**1220.62**	**1329.85**	**1439.18**	**1548.74**	**1658.65**	**1769.03**	**1880.01**	**1991.70**	**2104.22**	**2217.68**	**2332.20**
tax	14618.84															443.32	526.67	618.22	717.96	825.89	942.05	1066.45	1199.13	1340.13	1489.50	1647.32	1813.65	1988.56
Profit after tax			**-267.00**	**-134.00**	**-59.00**	**-194.35**	**-164.91**	**101.75**	**218.18**	**333.15**	**446.82**	**559.39**	**671.03**	**781.88**	**892.12**	**1001.89**	**1111.34**	**1220.62**	**1329.85**	**1439.18**	**1548.74**	**1658.65**	**1769.03**	**1880.01**	**1991.70**	**2104.22**	**2217.68**	**2332.20**
Deferred tax			-66.75	330.75	316.00	267.41	226.18	251.62	306.17	389.45	501.16	641.01	808.76	1004.23	1227.26	1477.73	1755.57	2060.72	2393.19	2752.98	3140.17	3554.83	3997.09	4467.09	4965.01	5491.07	6045.49	6628.54
Balance sheet cash flows																											
Fixed assets		-14666.00	-8835.00																								
Senior debt 2 bullet		1355.00	817.00																								
Senior debt amortising	2020.10	12200.00	6977.00	-286.00	-303.00	-318.00	-365.60	-411.30	-455.16	-497.28	-537.71	-576.52	-613.78	-649.55	-683.88	-716.85	-748.50	-778.88	-808.04	-836.04	-862.92	-888.72	-913.49	-937.27	-960.10	-982.02	-1003.06	-1023.25
sub debt	0.00	1737.00	667.00	41.00	-43.00	-48.00	-107.00	-107.00	-107.00	-107.00	-107.00	-107.00	-107.00	-107.00	-107.00	-107.00	-107.00	-107.00	-107.00	-107.00	-107.00	-107.00	-107.00	-107.00	-107.00	-107.00	-107.00	-107.00
	-19560.90	626.00	-374.00	-245.00	-346.00	-366.00	-472.60	-518.30	-562.16	-604.28	-644.71	-683.52	-720.78	-756.55	-790.88	-823.85	-855.50	-885.88	-915.04	-943.04	-969.92	-995.72	-1020.49	-1044.27	-1067.10	-1089.02	-1110.06	-1130.25
Residual values																											
Fixed assets																											8250.00
Senior debt 2 bullet																											-2172.00
Senior debt amortising																											-2020.10
sub debt																											
Operating pre tax cash flow			1471.00	2146.00	2186.00	2043.65	2005.67	2208.08	2263.28	2319.87	2377.86	2437.31	2498.24	2560.70	2624.72	2690.33	2757.59	2826.53	2897.20	2969.63	3043.87	3119.96	3197.96	3277.91	3359.86	3443.86	3529.95	3618.20
Project pre tax cash flows (no RV)		-14666.00	-7364.00	2146.00	2186.00	2043.65	2005.67	2208.08	2263.28	2319.87	2377.86	2437.31	2498.24	2560.70	2624.72	2690.33	2757.59	2826.53	2897.20	2969.63	3043.87	3119.96	3197.96	3277.91	3359.86	3443.86	3529.95	3618.20
Project pre tax cash flows (RV)		-14666.00	-7364.00	2146.00	2186.00	2043.65	2005.67	2208.08	2263.28	2319.87	2377.86	2437.31	2498.24	2560.70	2624.72	2690.33	2757.59	2826.53	2897.20	2969.63	3043.87	3119.96	3197.96	3277.91	3359.86	3443.86	3529.95	11868.20
Senior debt 2 cash flows		1355.00	817.00	-140.00	-140.00	-140.00	-140.00	-140.00	-140.00	-140.00	-140.00	-140.00	-140.00	-140.00	-140.00	-140.00	-140.00	-140.00	-140.00	-140.00	-140.00	-140.00	-140.00	-140.00	-140.00	-140.00	-140.00	-2032.00
Senior debt 1 cash flows		12200.00	6977.00	-1508.00	-1508.00	-1508.00	-1508.00	-1508.00	-1508.00	-1508.00	-1508.00	-1508.00	-1508.00	-1508.00	-1508.00	-1508.00	-1508.00	-1508.00	-1508.00	-1508.00	-1508.00	-1508.00	-1508.00	-1508.00	-1508.00	-1508.00	-1508.00	-3528.10
Post senior debt pre tax cash no RV		-1111.00	430.00	498.00	538.00	395.65	357.67	560.08	615.28	671.87	729.86	789.31	850.24	912.70	976.72	1042.33	1109.59	1178.53	1249.20	1321.63	1395.87	1471.96	1549.96	1629.91	1711.86	1795.86	1881.95	-1941.90
Post senior debt pre tax cash (RV)		-1111.00	430.00	498.00	538.00	395.65	357.67	560.08	615.28	671.87	729.86	789.31	850.24	912.70	976.72	1042.33	1109.59	1178.53	1249.20	1321.63	1395.87	1471.96	1549.96	1629.91	1711.86	1795.86	1881.95	6308.10
Post senior debt post tax cash no RV		-1111.00	430.00	498.00	538.00	395.65	357.67	560.08	615.28	671.87	729.86	789.31	850.24	912.70	976.72	599.01	582.92	560.32	531.24	495.73	453.82	405.51	350.84	289.78	222.36	148.54	68.31	-3930.46
Post senior debt post tax cash (RV)		-1111.00	430.00	498.00	538.00	395.65	357.67	560.08	615.28	671.87	729.86	789.31	850.24	912.70	976.72	599.01	582.92	560.32	531.24	495.73	453.82	405.51	350.84	289.78	222.36	148.54	68.31	4319.54

Nominal Pre-Tax Project IRR no RV	9.40%
Nominal Pre-Tax Project IRR no RV	9.77%
Nominal Pre-Tax Blended Equity IRR no RV	44.39%
Nominal Pre-Tax Blended Equity IRR (RV)	44.41%
Nominal Post-Tax Blended Equity IRR no RV	43.95%
Nominal Post-Tax Blended Equity IRR with RV	43.97%

3. Mixed West Midlands: Adjusted 3 years ex post data

Profit and loss account			**31/03/06**	**31/03/07**	**31/03/08**	**31/03/09**	**31/03/10**	**31/03/11**	**31/03/12**	**31/03/13**	**31/03/14**	**31/03/15**	**31/03/16**	**31/03/17**	**31/03/18**	**31/03/19**	**31/03/20**	**31/03/21**	**31/03/22**	**31/03/23**	**31/03/24**	**31/03/25**	**31/03/26**	**31/03/27**	**31/03/28**	**31/03/29**	**31/03/30**	**31/03/31**
Total revenue	54618.74		839	1439	1618	1658.45	1699.911	1742.409	1785.969	1830.618	1876.384	1923.294	1971.376	2020.66	2071.177	2122.956	2176.03	2230.431	2286.192	2343.346	2401.93	2461.978	2523.528	2586.616	2651.281	2717.563	2785.503	2855.14008
Cost of sales	5054.96		146	186	146	149.65	153.3913	157.226	161.1567	165.1856	169.3152	173.5481	177.8868	182.334	186.8923	191.5647	196.3538	201.2626	206.2942	211.4515	216.7378	222.1563	227.7102	233.4029	239.238	245.219	251.3494	257.63316
Gross profit	49563.78		693	1253	1472	1508.8	1546.52	1585.183	1624.813	1665.433	1707.069	1749.745	1793.489	1838.326	1884.284	1931.392	1979.676	2029.168	2079.897	2131.895	2185.192	2239.822	2295.818	2353.213	2412.043	2472.344	2534.153	2597.50692
Depreciation	8548.8		328.80	328.80	328.80	328.80	328.80	328.80	328.80	328.80	328.80	328.80	328.80	328.80	328.80	328.80	328.80	328.80	328.80	328.80	328.80	328.80	328.80	328.80	328.80	328.80	328.80	328.80
Operating profit	41014.98		364.20	924.20	1143.20	1180.00	1217.72	1256.38	1296.01	1336.63	1378.27	1420.95	1464.69	1509.53	1555.48	1602.59	1650.88	1700.37	1751.10	1803.09	1856.39	1911.02	1967.02	2024.41	2083.24	2143.54	2205.35	2268.71
Financing costs				1117.13	1072.73	1018.55	970.72	925.28	882.10	841.04	802.00	764.85	729.48	695.80	663.71	633.12	603.95	576.12	549.54	524.16	499.91	476.72	454.53	433.28	412.93	393.43	374.72	356.76
Profit before tax			364.20	-192.93	70.47	161.45	247.00	331.10	413.91	495.59	576.27	656.10	735.21	813.73	891.77	969.47	1046.93	1124.25	1201.55	1278.93	1356.48	1434.31	1512.49	1591.13	1670.31	1750.12	1830.63	1911.95
tax	13764.74															476.28	552.60	634.56	722.15	815.39	914.27	1018.84	1129.10	1245.09	1366.86	1494.44	1627.89	1767.27
Profit after tax				**-192.93**	**70.47**	**161.45**	**247.00**	**331.10**	**413.91**	**495.59**	**576.27**	**656.10**	**735.21**	**813.73**	**891.77**	**493.19**	**494.32**	**489.69**	**479.40**	**463.54**	**442.21**	**415.47**	**383.40**	**346.04**	**303.45**	**255.68**	**202.74**	**144.67**
Deferred tax			98.33	46.24	65.27	108.86	175.55	264.95	376.71	510.52	666.11	843.25	1041.76	1261.47	1502.25	1764.00	2046.67	2350.22	2674.64	3019.95	3386.20	3773.47	4181.84	4611.44	5062.43	5534.96	6029.23	6545.45
Financing cash flows																												
interest on senior debt 2 bullet	2505.75			100.23	100.23	100.23	100.23	100.23	100.23	100.23	100.23	100.23	100.23	100.23	100.23	100.23	100.23	100.23	100.23	100.23	100.23	100.23	100.23	100.23	100.23	100.23	100.23	100.23
interest on senior debt 1amortising	12150.82			759.90	729.50	700.32	672.31	645.42	619.60	594.82	571.02	548.18	526.25	505.20	485.00	465.60	446.97	429.09	411.93	395.45	379.63	364.45	349.87	335.88	322.44	309.54	297.16	285.28
interest on subordinated debt	3640.04			285.00	271.00	266.00	247.38	230.06	213.96	198.98	185.05	172.10	160.05	148.85	138.43	128.74	119.73	111.35	103.55	96.30	89.56	83.29	77.46	72.04	67.00	62.31	57.95	53.89
interest receivable	-1524.05			-28.00	-28.00	-48.00	-49.20	-50.43	-51.69	-52.98	-54.31	-55.67	-57.06	-58.48	-59.95	-61.44	-62.98	-64.55	-66.17	-67.82	-69.52	-71.26	-73.04	-74.86	-76.74	-78.65	-80.62	-82.64
				1117.13	1072.73	1018.55	970.72	925.28	882.10	841.04	802.00	764.85	729.48	695.80	663.71	633.12	603.95	576.12	549.54	524.16	499.91	476.72	454.53	433.28	412.93	393.43	374.72	356.76
Balance sheet cash flows																												
Fixed assets	-15420	-15420	0																									
Senior amort	11873	11873	0	-286.00	-316.40	-345.58	-373.59	-400.48	-426.30	-451.08	-474.87	-497.72	-519.64	-540.69	-560.90	-580.30	-598.92	-616.80	-633.97	-650.44	-666.26	-681.45	-696.03	-710.02	-723.46	-736.35	-748.74	-760.62
Senior debt bullet	1542	1542	0																									
sub debt	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	-13996.62	-2005	0	-286.00	-316.40	-345.58	-373.59	-400.48	-426.30	-451.08	-474.87	-497.72	-519.64	-540.69	-560.90	-580.30	-598.92	-616.80	-633.97	-650.44	-666.26	-681.45	-696.03	-710.02	-723.46	-736.35	-748.74	-760.62
Total senior amortisation payment				-1045.90																								
Residual values																												
Fixed assets																												7200.00
Senior debt 2 bullet																												-1542.00
Senior debt amortising																												-1542.00
sub debt																												
Operating pre tax cash flow			693.00	1253.00	1472.00	1508.80	1546.52	1585.18	1624.81	1665.43	1707.07	1749.75	1793.49	1838.33	1884.28	1931.39	1979.68	2029.17	2079.90	2131.89	2185.19	2239.82	2295.82	2353.21	2412.04	2472.34	2534.15	2597.51
Project pre tax cash flows (no RV)		-15420.00	693.00	1253.00	1472.00	1508.80	1546.52	1585.18	1624.81	1665.43	1707.07	1749.75	1793.49	1838.33	1884.28	1931.39	1979.68	2029.17	2079.90	2131.89	2185.19	2239.82	2295.82	2353.21	2412.04	2472.34	2534.15	2597.51
Project pre tax cash flows (RV)		-15420.00	693.00	1253.00	1472.00	1508.80	1546.52	1585.18	1624.81	1665.43	1707.07	1749.75	1793.49	1838.33	1884.28	1931.39	1979.68	2029.17	2079.90	2131.89	2185.19	2239.82	2295.82	2353.21	2412.04	2472.34	2534.15	9797.51
Senior debt amort cash flows		11873.40	0.00	-1045.90	-1045.90	-1045.90	-1045.90	-1045.90	-1045.90	-1045.90	-1045.90	-1045.90	-1045.90	-1045.90	-1045.90	-1045.90	-1045.90	-1045.90	-1045.90	-1045.90	-1045.90	-1045.90	-1045.90	-1045.90	-1045.90	-1045.90	-1045.90	-2587.90
Senior debt 1 cash flows		1542.00	0.00	-100.23	-100.23	-100.23	-100.23	-100.23	-100.23	-100.23	-100.23	-100.23	-100.23	-100.23	-100.23	-100.23	-100.23	-100.23	-100.23	-100.23	-100.23	-100.23	-100.23	-100.23	-100.23	-100.23	-100.23	-1642.23
Post senior debt pre tax cash no RV		-2004.60	693.00	106.87	325.87	362.67	400.39	439.06	478.68	519.31	560.94	603.62	647.36	692.20	738.16	785.26	833.55	883.04	933.77	985.77	1039.06	1093.69	1149.69	1207.09	1265.92	1326.22	1388.03	-1632.62
Post senior debt pre tax cash (RV)		-2004.60	693.00	106.87	325.87	362.67	400.39	439.06	478.68	519.31	560.94	603.62	647.36	692.20	738.16	785.26	833.55	883.04	933.77	985.77	1039.06	1093.69	1149.69	1207.09	1265.92	1326.22	1388.03	5567.38
Post senior debt post tax cash no RV		-2004.60	693.00	106.87	325.87	362.67	400.39	439.06	478.68	519.31	560.94	603.62	647.36	692.20	738.16	308.98	280.95	248.48	211.62	170.38	124.79	74.86	20.59	-38.00	-100.94	-168.22	-239.87	-3399.89
Post senior debt post tax cash (RV)		-2004.60	693.00	106.87	325.87	362.67	400.39	439.06	478.68	519.31	560.94	603.62	647.36	692.20	738.16	308.98	280.95	248.48	211.62	170.38	124.79	74.86	20.59	-38.00	-100.94	-168.22	-239.87	3800.11
		-1111	-1409	61	356	209.1	166.4525	364.0888	414.391	465.9508	518.7996	572.9696	628.4938	685.4062	743.7413	775.3846	773.5	765.6274	751.8193	732.1194	706.5633	675.1786	637.9854	594.996	546.216	491.6436	431.2703	4422.9811

Nominal Pre-Tax Project IRR no RV	9.64%
Nominal Pre-Tax Project IRR no RV	10.06%
Nominal Pre-Tax Blended Equity IRR no RV	23.30%
Nominal Pre-Tax Blended Equity IRR (RV)	23.59%
Nominal Post-Tax Blended Equity IRR no RV	20.63%
Nominal Post-Tax Blended Equity IRR with RV	21.21%

4. Urban NE: Adjusted 3 years ex post data

Profit and loss account																													
Total revenue	76,154.6		70	776	2328	2386.2	2445.855	2507.001	2569.676	2633.918	2699.766	2767.26	2836.442	2907.353	2980.037	3054.538	3130.901	3209.174	3289.403	3371.638	3455.929	3542.327	3630.885	3721.658	3814.699	3910.067	4007.818	4108.01367
Cost of sales	9,150.0		18	139	278	284.95	292.0738	299.3756	306.86	314.5315	322.3948	330.4546	338.716	347.1839	355.8635	364.7601	373.8791	383.2261	392.8067	402.6269	412.6926	423.0099	433.5851	444.4248	455.5354	466.9238	478.5968	490.56177
Gross profit	67,004.5		52	637	2050	2101.25	2153.781	2207.626	2262.816	2319.387	2377.372	2436.806	2497.726	2560.169	2624.173	2689.778	2757.022	2825.948	2896.596	2969.011	3043.237	3119.317	3197.3	3277.233	3359.164	3443.143	3529.221	3617.4519
Depreciation	12,707.5			508.30	508.30	508.30	508.30	508.30	508.30	508.30	508.30	508.30	508.30	508.30	508.30	508.30	508.30	508.30	508.30	508.30	508.30	508.30	508.30	508.30	508.30	508.30	508.30	508.30	508.30
Operating profit	54,297.0		52.00	128.70	1541.70	1592.95	1645.48	1699.33	1754.52	1811.09	1869.07	1928.51	1989.43	2051.87	2115.87	2181.48	2248.72	2317.65	2388.30	2460.71	2534.94	2611.02	2689.00	2768.93	2850.86	2934.84	3020.92	3109.15
Financing costs				1191.67	1143.32	1085.34	1033.86	984.92	938.38	894.10	851.95	811.83	773.61	737.19	702.47	669.35	637.76	607.59	578.79	551.26	524.95	499.78	475.69	452.63	430.53	409.34	389.02	369.52
Profit before tax			52.00	-1062.97	398.38	507.61	611.62	714.41	816.14	916.99	1017.12	1116.68	1215.82	1314.68	1413.41	1512.13	1610.97	1710.05	1809.51	1909.45	2009.99	2111.24	2213.31	2316.31	2420.34	2525.50	2631.90	2739.64
tax	21248.58															768.66	886.10	1010.76	1142.67	1281.87	1428.40	1582.31	1743.66	1912.52	2088.96	2273.07	2464.94	2664.66
Profit after tax				**-1062.97**	**398.38**	**507.61**	**611.62**	**714.41**	**816.14**	**916.99**	**1017.12**	**1116.68**	**1215.82**	**1314.68**	**1413.41**	**743.47**	**724.87**	**699.29**	**666.83**	**627.58**	**581.59**	**528.93**	**469.65**	**403.79**	**331.37**	**252.43**	**166.96**	**74.98**
Deferred tax			14.04	-272.96	-165.40	-28.34	136.79	329.68	550.04	797.63	1072.25	1373.75	1702.02	2056.99	2438.61	2846.88	3281.84	3743.56	4232.13	4747.68	5290.37	5860.41	6458.00	7083.40	7736.89	8418.78	9129.39	9869.09
Financing cash flows																													
interest on senior debt 2 bullet	1896.18			75.85	75.85	75.85	75.85	75.85	75.85	75.85	75.85	75.85	75.85	75.85	75.85	75.85	75.85	75.85	75.85	75.85	75.85	75.85	75.85	75.85	75.85	75.85	75.85	75.85	75.85
interest on senior debt 1amortising	13732.66			858.82	824.47	791.49	759.83	729.44	700.26	672.25	645.36	619.55	594.76	570.97	548.14	526.21	505.16	484.95	465.56	446.93	429.06	411.89	395.42	379.60	364.42	349.84	335.85	322.41
interest on subordinated debt	3640.04			285.00	271.00	266.00	247.38	230.06	213.96	198.98	185.05	172.10	160.05	148.85	138.43	128.74	119.73	111.35	103.55	96.30	89.56	83.29	77.46	72.04	67.00	62.31	57.95	53.89
interest receivable	-1524.05			-28.00	-28.00	-48.00	-49.20	-50.43	-51.69	-52.98	-54.31	-55.67	-57.06	-58.48	-59.95	-61.44	-62.98	-64.55	-66.17	-67.82	-69.52	-71.26	-73.04	-74.86	-76.74	-78.65	-80.62	-82.64
				1191.67	1143.32	1085.34	1033.86	984.92	938.38	894.10	851.95	811.83	773.61	737.19	702.47	669.35	637.76	607.59	578.79	551.26	524.95	499.78	475.69	452.63	430.53	409.34	389.02	369.52
Balance sheet cash flows																													
Fixed assets	-14586	-7293	-7293																										
Senior amort	13419	6710	6710	-286.00	-320.35	-353.33	-384.99	-415.38	-444.56	-472.57	-499.46	-525.28	-550.06	-573.85	-596.69	-618.61	-639.66	-659.87	-679.27	-697.89	-715.77	-732.93	-749.40	-765.22	-780.41	-794.98	-808.98	-822.41
Senior debt bullet	1167	583	583																										
sub debt	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	-14887.93	0	0	-286.00	-320.35	-353.33	-384.99	-415.38	-444.56	-472.57	-499.46	-525.28	-550.06	-573.85	-596.69	-618.61	-639.66	-659.87	-679.27	-697.89	-715.77	-732.93	-749.40	-765.22	-780.41	-794.98	-808.98	-822.41
Total senior amortisation payment				-1144.82																									
Residual values																													
Fixed assets																													9392.50
Senior debt 2 bullet																													-1166.88
Senior debt amortising																													-1166.88
sub debt																													
Operating pre tax cash flow			52.00	637.00	2050.00	2101.25	2153.78	2207.63	2262.82	2319.39	2377.37	2436.81	2497.73	2560.17	2624.17	2689.78	2757.02	2825.95	2896.60	2969.01	3043.24	3119.32	3197.30	3277.23	3359.16	3443.14	3529.22	3617.45
Project pre tax cash flows (no RV)		-7293.00	-7241.00	637.00	2050.00	2101.25	2153.78	2207.63	2262.82	2319.39	2377.37	2436.81	2497.73	2560.17	2624.17	2689.78	2757.02	2825.95	2896.60	2969.01	3043.24	3119.32	3197.30	3277.23	3359.16	3443.14	3529.22	3617.45
Project pre tax cash flows (RV)		-7293.00	-7241.00	637.00	2050.00	2101.25	2153.78	2207.63	2262.82	2319.39	2377.37	2436.81	2497.73	2560.17	2624.17	2689.78	2757.02	2825.95	2896.60	2969.01	3043.24	3119.32	3197.30	3277.23	3359.16	3443.14	3529.22	13009.95
Senior debt amort cash flows		6709.56	6709.56	-1144.82	-1144.82	-1144.82	-1144.82	-1144.82	-1144.82	-1144.82	-1144.82	-1144.82	-1144.82	-1144.82	-1144.82	-1144.82	-1144.82	-1144.82	-1144.82	-1144.82	-1144.82	-1144.82	-1144.82	-1144.82	-1144.82	-1144.82	-1144.82	-1144.82	-2311.70
Senior debt 1 cash flows		583.44	583.44	-75.85	-75.85	-75.85	-75.85	-75.85	-75.85	-75.85	-75.85	-75.85	-75.85	-75.85	-75.85	-75.85	-75.85	-75.85	-75.85	-75.85	-75.85	-75.85	-75.85	-75.85	-75.85	-75.85	-75.85	-75.85	-1242.73
Post senior debt pre tax cash no RV		0.00	52.00	-583.67	829.33	880.58	933.11	986.95	1042.15	1098.72	1156.70	1216.13	1277.06	1339.50	1403.50	1469.11	1536.35	1605.28	1675.93	1748.34	1822.57	1898.65	1976.63	2056.56	2138.49	2222.47	2308.55	63.02
Post senior debt pre tax cash (RV)		0.00	52.00	-583.67	829.33	880.58	933.11	986.95	1042.15	1098.72	1156.70	1216.13	1277.06	1339.50	1403.50	1469.11	1536.35	1605.28	1675.93	1748.34	1822.57	1898.65	1976.63	2056.56	2138.49	2222.47	2308.55	9455.52
Post senior debt post tax cash no RV		0.00	52.00	-583.67	829.33	880.58	933.11	986.95	1042.15	1098.72	1156.70	1216.13	1277.06	1339.50	1403.50	700.45	650.25	594.52	533.25	466.47	394.16	316.34	232.97	144.04	49.53	-50.60	-156.39	-2601.63
Post senior debt post tax cash (RV)		0.00	52.00	-583.67	829.33	880.58	933.11	986.95	1042.15	1098.72	1156.70	1216.13	1277.06	1339.50	1403.50	700.45	650.25	594.52	533.25	466.47	394.16	316.34	232.97	144.04	49.53	-50.60	-156.39	6790.87

Nominal Pre-Tax Project IRR no RV	13.53%	
Nominal Pre-Tax Project IRR no RV	13.83%	
Nominal Pre-Tax Blended Equity IRR no RV	199.98%	
Nominal Pre-Tax Blended Equity IRR (RV)	199.98%	
Nominal Post-Tax Blended Equity IRR no RV	199.98%	12.92
Nominal Post-Tax Blended Equity IRR with RV	199.98%	14.966667

Appendix 7

Survey Analysis and Questionnaire

This appendix summarises the findings of patient surveys carried out by the research team in March 2009. Despite earlier promises of collaboration from all four case study areas, eventually only three health centres collaborated with this part of the study. All participating health centres were mailed an initial batch of 100 questionnaires together with envelopes, which were to be distributed by the practice receptionist, allowing respondents to return their questionnaires in a sealed envelope. All sealed envelopes were to be returned unopened to the research team by the practice managers after a period of one month via post (in a large sealed self-addressed envelope). As additional incentives, all participating practices were offered a donation to a charity of their choice for each returned envelope.

The participants included one practice which was the sole practice occupying a health centre in rural West Midlands LIFT (rural West Midlands LIFT was not part of the case study
analysis of section 7, but contributed to the user interviews of section 4.3). This practice returned seventy completed questionnaires. The other participants included two practices operating in two different health centres which were part of urban North East LIFT (which was part of both the financial analysis of section 5 and the case study analysis of section 7). Since one of these practices returned only 17 questionnaires and the other 9 questionnaires, it was decided to analyse the questionnaires from urban NE LIFT together.

Overall, the number of questionnaires returned byrural West Midlands LIFT and urban NE LIFT were indicative of a low response. In addition, the demographic profile of respondents at both locations indicated the possibility of response bias with a large number of respondents being elderly, female and white.

Table A7) Demographic Profile of Respondents

	Rural West Midl LIFT	Urban NE LIFT
Male	27.1% (19)	38.4% (10)
Female	72.8% (51)	61.5% (16)
Median Age	1953	1957.5
Average Age	1954.6	1961.2
Percentage White	100.0% (70)	96.1% (25)
Percentage Asian	0.0% (0)	3.8% (1) is not part

However, despite these limitations, there was strong evidence of a high degree of satisfaction among patients with their facilities. This was demonstrated by a number of indicators which will be discussed below.

With regard to patient awareness that the facility had been procured via a public private partnership, there was evidence that only a small number of respondents knew about this.

Table A7a) Patient Knowledge of Partnership

	Rural West Midl LIFT		Urban NE LIFT	
	Yes	No	Yes	No
Did you know that this Surgery/Health Centre was a partnership between the public and private sector?	37.5% 24	62.5% 42	20.0% 3	80.0% 12

With regard to accessibility by different means of transport, all locations were generally rated favourably by the respondents. One possible exception to this were the car parking facilities at the rural West Midl LIFT practice, which 30.9% of the respondents rated as not convenient.

Table A7b) Patient Views on Accessibility

	Rural West Midl Lift			Urban NE LIFT		
	Yes	Unsure	No	Yes	Unsure	No
Do you think the location of this Surgery/Health Centre is convenient for						
walking	93.9% 62	6.0% 4	0.0% 0	100.0% 25	0.0% 0	0.0% 0
public transport	84.3% 59	14.3% 10	1.4% 1	96.0% 24	4.0% 0	0.0% 1
driving by car	97.1% 67	1.4% 1	1.4% 1	100.0% 24	0.0% 0	0.0% 0
car parking	57.3% 39	11.8% 8	30.9% 21	100.0% 22	0.0% 0	0.0% 0

All locations were overwhelmingly rated as ‘safe’, with only a very small percentage of rural West Midl LIFT respondents expressing uncertainty over this matter.

Table A7c) Patient Views on Location Safety

	Rural West Midl LIFT			Urban NE LIFT		
	Yes	Unsure	No	Yes	Unsure	No
Do you feel this is a Safe location?	97.1% 67	1.4% 1	1.4% 1	100.0% 26	0.0% 0	0.0% 0

This was mirrored by generally positive views which respondents from all locations expressed with regard to buggy and wheelchair access.

Table A7d) Patient Views on Special Access

	Rural West Midl LIFT			Urban NE		
	LIFT Yes	Unsure	No	Yes	Unsure	No
Is this Health Centre accessible with a buggy	98.5% 67	1.5% 1	0.0% 0	96.0% 24	4.0% 1	0.0% 0
with a wheelchair	95.5% 64	4.5% 3	0.0% 0	96.0% 24	4.0% 1	0.0% 0

When asked about recent (over the past year) changes to the practice, most respondents expressed positive views. One possible exception to this was the issue of 'getting appointments' and 'waiting times', where slightly more than 10% of respondents at the rural West Midl LIFT practice expressed that this had become worse (a similar pattern was
visible for the urban NE practices, where 8% of respondents indicated that waiting time had become worse at their practice).

Table A7e) Patient Views on Changes to this Building

	Rural West Midl LIFT			Urban NE LIFT		
	Better	Unsure	Worse	Better	Unsure	Worse
Have you noticed changes to this building in general	60.6% 40	39.4% 26	0.0% 0	50.0% 12	50.0% 12	0.0% 0
the furniture	56.7% 38	43.3% 29	0.0% 0	40.0% 10	60.0% 15	0.0% 0
cleanliness	63.6% 42	36.4% 24	0.0% 0	56.0% 14	44.0% 11	0.0% 0
the reception area	66.6% 44	33.3% 22	0.0% 0	44.0% 11	56.0% 14	0.0% 0
Staffing	57.3% 39	42.6% 29	0.0% 0	32.0% 8	68.0% 17	0.0% 0
getting appointments	67.1% 47	21.4% 15	11.4% 8	80.0% 20	20.0% 5	0.0% 0
waiting times	58.5% 41	31.4% 22	10.0% 7	56.0% 14	36.0% 9	8.0% 2
facilities for children	45.3% 29	50.0% 32	4.7% 3	52.0% 13	48.0% 10	0.0% 0

When asked to compare the current building with previous accommodation, the majority of respondents indicated that there had been improvements. Again, these views were less pronounced when it came to the issue of 'getting appointments' and waiting times'.

Table A7f) Patient Views on Changes from Previous Building

	Rural West Midl LIFT			Urban NE LIFT		
	Better	Unsure	Worse	Better	Unsure	Worse
Have you noticed changes to						
the furniture	85.2%	10.3%	4.4%	88.4%	7.7%	3.8%
	58	7	3	23	2	1
cleanliness	81.1%	17.4%	1.4%	84.6%	11.5%	3.8%
	56	12	1	22	3	1
the reception area	88.4%	8.6%	2.9%	88.4%	7.7%	3.8%
	61	6	2	23	2	1
staffing	68.1%	31.9%	0.0%	68.0%	32.0%	0.0%
	47	22	0	17	8	0
staff attitudes	66.6%	33.3%	0.0%	80.7%	19.2%	0.0%
	44	24	0	21	5	0
getting appointments	69.6%	24.6%	5.8%	80.0%	12.0%	8.0%
	48	17	4	20	3	2
waiting times	69.6%	27.5%	2.9%	76.9%	15.4%	7.7%
	48	19	2	20	4	2
facilities for children	51.4%	44.1%	4.4%	69.2%	26.9%	3.8%
	35	30	3	18	7	1

As regards overall patient perception with regard to the quality of services, this was overwhelmingly rated as either very good or good with respondents from the rural west Midl practice giving, interestingly, an even more positive picture than those form the urban NE LIFT practice.

Table A7a) Patient Views on Overall Quality of Service at their Health Centre

	Rural West Midlands					Urban NE LIFT				
	Vgd	gd	adeq	poor	vpoor	Vgd	gd	adeq	poor	vpoor

Table A7g) Patient Views on Overall Quality of Service at their Health Centre

	Rural West Midlands					Urban NE LIFT				
	Vgd	gd	adeq	poor	vpoor	Vgd	gd	adeq	poor	vpoor
How would you rate the Quality of service at this health centre?	62.3% 43	34.7% 24	2.9% 2	0.0% 0	0.0% 0	50.0% 12	50.0% 12	0.0% 0	0.0% 0	0.0% 0

These results were closely mirrored by the respondents' views on the quality of the building which was rated as either 'very good' or 'good' by respondents in all locations.

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Table A7h) Patient Views on Building Quality at Present

	Rural West Midlands					Urban NE LIFT				
	Vgood	gd	adeq	poor	vpoor	Vgood	gd	adeq	poor	vpoor
How would you rate the 0.0% Quality of this Building at present?	82.8% 58	17.1% 12	0.0% 0	0.0% 0	0.0% 0	72.0% 18	18.0% 7	0.0% 0	0.0% 0	0

Similarly positive results were detected for the questions as to how patients thought services in their practice and their practice building compared with other practices.

Table A7i) Patient Views on Services Compared to other Practices

	Rural West Midlands			Urban NE LIFT		
	Better	Unsure	Worse	Better	Unsure	Worse
Overall, do you think the services here are better or worse than in other practices in the area?	71.4% 50	28.6% 20	0.0% 0	68.0% 17	28.0% 7	0.0% 0

Table A7j) Patient Views on Building Compared to other Practices

	Rural West Midlands			Urban NE LIFT		
	Better	Unsure	Worse	Better	Unsure	Worse
Overall, do you think this Building is better or worse than in other practices in the area?	74.2% 52	25.7% 18	0.0% 0	76.0% 19	24.0% 6	0.0% 0

Overall this, albeit flawed and limited survey, gave considerable support to the statements by virtually all case study informants, that patients benefited from new LIFT premises in terms of the quality of the buildings and services delivered.

THE UNIVERSITY of York

Health Centre ……

GP practice ……

Thank you for taking the time to complete this questionnaire. Please answer the questions by circling the answer which you agree with for each question.

Once you have answered all the questions, please return the completed questionnaire to Reception in the envelope provided. You do not have to write your name anywhere on the form, and the answers you give will remain confidential.

1. Did you know that this GP's surgery/health centre is a partnership between the public and private sector?

Yes No

2. Do you think the location of this surgery/health centre is convenient for:

a) people walking here?	Yes	Not sure	No
b) getting here by public transport?	Yes	Not sure	No
c) driving here by car?	Yes	Not sure	No
d) car parking?	Yes	Not sure	No

3. Do you feel this is a safe location? Yes Not sure No

4. Is this health centre accessible?

a) with a buggy?	Yes	Not sure	No
b) with a wheelchair	Yes	Not sure	No

For the next set of questions, please think about your visits to this building over the last year.

5. Have you noticed any changes in the building in general?

Better Don't know Worse

6. Have you noticed any changes in the furniture?

Better Don't know Worse

7. Have you noticed any changes in cleanliness?

Better Don't know Worse

8. Have you noticed any changes in the reception area?

Better Don't know Worse

9. Have you noticed any changes in the staffing?

Better Don't know Worse

10. Have you noticed any changes in the time it takes to get an appointment?

Better Don't know Worse

11. Have you noticed any changes in waiting times once you're here?

Better Don't know Worse

12. Have you noticed any changes in facilities for children (e.g.toys)?

Better Don't know Worse

For the next set of questions, please think about the building you went to before this health centre opened, and how it compares to here.

13. Have you noticed any differences in the furniture?

Better Don't know Worse

14. Have you noticed any differences in cleanliness?

Better Don't know Worse

16. Have you noticed any differences in the reception area?

Better Don't know Worse

17. Have you noticed any differences in the staff numbers?

Better Don't know Worse

18. Have you noticed any differences in staff attitudes?

Better Don't know Worse

19. Have you noticed any differences in the time it takes to get an appointment?

Better Don't know Worse

20. Have you noticed any changes in waiting times once you're here?

Better Don't know Worse

21. Have you noticed any differences in facilities for children (e.g.toys)?

Better Don't know Worse

22. Overall, how would you rate the quality of service at this health centre at present?

Very good Good Adequate Poor Very poor

23. Overall, how would you rate the quality of this building at present?

Very good Good Adequate Poor Very poor

24. Overall, do you think services here are better or worse than other practices in the area?

Better Don't know Worse

25. Overall, do you think this building is better or worse than other practices in the area?

Better Don't know Worse

26. Do you have any other comments about this health centre?

It would help us if you could answer a few questions about yourself now.

27. Are you: male female

28. In what year were you born? ……

29. Which ethnic group do you belong to?
White
Mixed
Asian or Asian British
Black or Black British
Chinese
Other ethnic group

Thank you very much for completing this questionnaire. Please return it to Reception in the envelope provided.

Appendix 8

Glossary of Abbreviations

CABE - Commission for Architecture and the Built Environment

CABE is a statutory body, sponsored by the Department for Culture, Media and Sport but also funded by Communities and Local Government. Its goal is to promote design and architecture to raise the standard of the built environment (source: cabe.org.uk).

CEO - Chief Executive Officer (CEO) or Chief Executive

A CEO is one of the highest-ranking corporate officers (executives) or administrators in charge of total management. An individual selected as president and CEO of a corporation, company, organization, or agency, reports to the board of directors (source: Wikipedia).

CHP - Community Health Partnership

Community Health Partnerships (CHP) creates investment in, and helps deliver, innovative ways to improve health and local authority services. Its main activity has been to deliver the Local Improvement Finance Trust (LIFT) Initiative which provides modern, purpose-built premises for health and local authority services in England. CHP is an independent company, wholly owned by the Department of Health (source: www.communityhealthpartnerships.co.uk).

CINAHL - Cumulative Index to Nursing and Allied Health Literature

CINAHL is a comprehensive resource for nursing and allied health literature. While starting out as a single bibliographic database, CINAHL has expanded to offer four databases including two full-text versions. CINAHL is owned and operated by EBSCO Publishing, with the Cinahl editorial team continuing to work out of the offices in Glendale, California (source: www.Ebescohost.com).

CIPFA - Chartered Institute of Public Finance and Accountancy

CIPFA a professional accountancy bodies in the UK that specialises in the public services (source: www.cipfa.org.uk).

CRD - Centre for Reviews and Dissemination

CRD is a department of the University of York and is part of the National Institute for Health Research. CRD undertakes systematic reviews that evaluate the effects of health and social care interventions and the delivery and organisation of health care (source: www.york.ac.uk/inst/crd/).

DETR/EPSRC MCNS – Programme Department of the Environment, Transport and the Regions and Engineering and Physical Sciences Research Council, Meeting Clients' Needs Through Standardisation Programme

DETR/EPSRC MCSN was a grant funding programme sponsored by the EPSRC and DETR which aimed at improving the competitive performance of UK industries such as construction.

DoH - Department of Health (also DH)

DoH is a department of the United Kingdom government but with responsibility for government policy for England alone on health, social care and the National Health Service (NHS). It is led by the Secretary of State for Health with two Ministers of State and three Parliamentary Under-Secretaries of State (source: Wikipedia).

ESRC - Economic and Social Research Council

ESRC funds research and training in social and economic issues. It is an independent organisation, established by Royal Charter, but recieve most of our funding through the UK Department for Business, Innovation and Skills. Our planned expenditure for 2009/10 is £204 million, which funds over 2,500 researchers in academic institutions and policy research institutes throughout the UK. We also support more than 2,000 postgraduate students (source: esrc.ac.uk).

FHSA - Family Health Service Authority

FHSAs were set up in the early 1990s by the government to provide common services, making payments and providing administrative support to GPs, practice nurses, dentists, pharmacists and opticians (source: www.amazon.co.uk/Practices-Make-Perfect-Services-Authority/dp/0118860852).

GMS contract - General Medical Services (GMS) contract

The GMS contract has evolved in partnership between the NHS Confederation and the General Practitioners Committee (GPC) of the British Medical Association (BMA). It creates greater flexibility for GPs and represents an unprecedented level of investment in primary care (source www.dh.gov.uk).

GP - General Practitioner

A GP is a medical practitioner who provides primary care and specializes in family medicine. A general practitioner treats acute and chronic illnesses and provides preventive care and health education for all ages and both sexes. They have particular skills in treating people with multiple health issues and co morbidities (source: Wikipedia).

HELMIS - Health Management Information Service

HELMIS was established to provide access to information sources on health and social care management and policy in the UK and internationally and is located in the Nuffield Institute for Health Information Resource Centre (IRC), University of Leeds (source: www.ovid.com).

HM Treasury - Her Majesty's Treasury (also The Treasury)

HM Treasury is the United Kingdom government department responsible for developing and executing the British government's public finance policy and economic policy (source: Wikipedia).

HMIC - Health Management Information Consortium

HMIC's database brings together the bibliographic database of two UK health and social care management organizations: the Department of Health's Library and Information Services (DH-Data) and King's Fund Information and Library Service (source: www.ovid.com).

HMSO - Her Majesty's Stationery Office

HMSO is responsible for the publication of legislation and the management of Crown copyright (source: www.opsi.gov.uk).

IRR - Internal Rate of Return

The internal rate of return (IRR) is a rate of return used in capital budgeting to measure and compare the profitability of investments. It is also called the discounted cash flow rate of return (DCFROR) or simply the rate of return (ROR). In the context of savings and loans the IRR is also called the effective interest rate. The term internal refers to the fact that its calculation does not incorporate environmental factors (source: Wikipedia).

LA - Local Authority

LA is collective term used for lower levels of governments including Historic counties still exist with adapted boundaries, although in the 1990s some of the districts within the counties became separate unitary authorities and a few counties have been disbanded completely. There are also metropolitan districts in some areas which are similar to unitary authorities. In Greater London there are 32 London boroughs which are a similar concept (source: Wikipedia).

LIFT - Local Improvement Finance Trust (also NHS LIFT)

LIFT is a major initiative by the Department of Health (DoH) in a national joint venture with Community Health Partnerships (CHP), to develop and encourage new markets for investment in primary care, social care and community based facilities and services. The NHS Plan published in July 2000 first announced the planned introduction of NHS LIFT and the formation of public-private joint venture companies. To enable PCTs to take part in forming joint venture companies the Department of Health enacted changes in primary legislation to clarify the powers of PCTs to take shares in joint ventures (clause 4 of the Health and Social Care Act 2001 as incorporated into the NHS Act 1977). The partnering arrangements for NHS LIFT are supported by the provisions of a Strategic Partnering Agreement ("SPA"), which is entered into by the participants (such as local authorities and PCTs in the area) and the local LIFT Company. The SPA sets out how the parties will act together in a collaborative, partnering, non-adversarial and open manner with a view to achieving the objectives of the local LIFT. The SPA establishes the Strategic Partnering Board (SPB) and LIFT Co. The local health economy supervises the performance of the LIFT Co through a SPB which also approves new projects from the Strategic Service Development Plan (SSDP) which it reviews on an annual basis. Each LIFT Co is a joint venture company with 60% of its shareholding held by a private sector partner. Together the local PCTs and CHP hold the remaining 40% and local authorities may also take an equity stake. Shareholders in LIFT Co, are entitled to dividend payments in accordance with an agreed dividend policy. This is governed by a Shareholders Agreement (SHA) (source: Mersey Care NHS Trust).

LIFTCo see LIFT

LIZ - London Initiative Zone

LIZ, encompasses an area of about 16 km radius from Piccadilly Circus, which was set up by the Department of Health in 1993 "to concentrate attention and resources on developing primary care in the inner city" (source www.bmj.bmjjournals.com).

LMC - Local Medical Committee

LMCs are professional organisations representing the interests of GPs (source: www.lmc.org.uk).

MaST LIFT - Manchester, Salford and Trafford NHS LIFT Initiative

The long term private sector partner for MaST is Primary Plus Ltd. As well as MaST they are the private sector partner in five other LIFT companies with a total property portfolio of £280 million (source: www.mastlift.co.uk/).

MP - Member of Parliament

A Member of Parliament is a representative of the voters to a parliament (source: wikipedia).

NAO - National Audit Office

NAO audits central government accounts and reports to Parliament on the value for money achieved by government projects and programmes (source: Nao.org.uk).

NCCSDO - National Co-ordinating Centre for NHS Service Delivery and Organisation Research and Development also
NIHRSDO - National Institute for Health Research Service Delivery and Organisation

NCCSDO/NIHRSDO is The National Institute for Health Research Service Delivery and Organisation (NIHR SDO) programme was established in 1999. It aims to improve health outcomes for people by commissioning research evidence that improves practice in relation to the organisation and delivery of healthcare and Building research capability and capacity amongst those who manage, organise and deliver services - improving their understanding of the research literature and how to use research evidence (source: NIHR SDO).

NHS - National Health Service

NHS is the name commonly used to refer to the three publicly funded healthcare systems in Great Britain, collectively or individually, although only the health service in England uses the name 'National Health Service' without further qualification. The publicly-funded healthcare organisation in Northern Ireland does not use the term 'National Health Service', though is still sometimes referred to as the 'NHS' as well. Each system operates independently, and is politically accountable to the relevant devolved government of Scotland (Scottish Government), Wales (Welsh Assembly Government) and Northern Ireland (Northern Ireland Executive), and to the UK government for England (source: Wikipedia).

NHS Conf - NHS Confederation

The NHS Confederation is an independent membership body for the full range of organisations that make up today's NHS. We represent over 95 per cent of NHS organisations and a growing number of independent healthcare providers (source: www.nhsconfed.org).

PAC - Public Accounts Committee, strictly, the Committee of Public Accounts

PAC is a select committee of the British House of Commons. It is responsible for overseeing government expenditures to ensure they are effective and honest. The PAC is seen as a crucial mechanism for ensuring transparency and accountability in government financial operations (source: Wikipedia).

PCG - Primary Care Groups, see PCT

In 1998, primary care groups and trusts became the new purchasers. The key difference between the primary care group and trust was that the former operated as a subcommittee of the health authority, whilst the later was self-

governing. A primary care group was converted into a trust when it demonstrated its ability to manage budgets and services. (source: www.econ.qmul.ac.uk).

PCT - Primary Care Trust

Healthcare in the UK is divided into 'primary' and 'secondary' services. Primary care services are provided by the people you normally see first when you have a health problem. It might be a visit to your doctor or dentist, to your optician for an eye test, or a trip to your pharmacist. NHS walk-in centres and the NHS Direct phone service are also part of primary care. All of these primary care services are managed by Primary Care Trusts (PCTs). There are about 147 Primary Care Trusts in England, each one covering a separate local area. PCTs are a very important part of the NHS, and they get about 80% of the total NHS budget. PCTs decide what health services a local community needs, and they are responsible for providing them. They must ensure that there are enough services for people within their local area, and that the services are accessible. These services include: GPs, Dentists, Pharmacists, Opticians, NHS Direct, and NHS walk-in centres. PCTs make decisions about the type of services that hospitals provide and are responsible for making sure that the quality of service is high enough. They also control funding for hospitals (source: www.NHS.uk).

PfH - Partnership for Health (see also Community Health Partnerships)

PfH was renamed in Autumn 2007 as Community Health Partnerships. PfH/CHP is an independent company, wholly owned by the Department of Health (source: communityhealthpartnerships.co.uk).

PFI - Private Finance Initiative

PFI is a form of PPP (Public Private Partnership) which involves joint working between the public and private sector. In the broadest sense, PPPs can cover all types of collaboration across the interface between the public and private sectors to deliver policies, services and infrastructure. Where delivery of public services involves private sector investment in infrastructure, the most common form of PPP is the Private finance initiative (source: HM treasury).

PFU - Public Finance Unit

Several government departments including the NHS and MoD maintain a Private Finance Unit which advises on PFI procurement.

P+L Accounts - Profit and Loss Accounts

P+L accounts also referred as profit and loss statement (P&L), earnings statement, operating statement or statement of operations, is a company's financial statement that indicates how the revenue (money received from the sale of products and services before expenses are taken out, also known as the "top line") is transformed into the net income (the result after all revenues and expenses have been accounted for, also known as the "bottom line"). It displays the revenues recognized for a specific period, and the cost and expenses charged against these revenues, including write-offs (e.g., depreciation and amortization of various assets) and taxes. The purpose of the income statement is to show managers and investors whether the company made or lost money during the period being reported (source: Wikipedia).

PPP - Public Private Partnership

PPP involves joint working between the public and private sector. In the broadest sense, PPPs can cover all types of collaboration across the interface between the public and private sectors to deliver policies, services and infrastructure. Where delivery of public services involves private sector investment in infrastructure, the most common form of PPP is the Private finance initiative (source: HM Treasury).

PSC - Public Sector Comparator

The PSC is a costing of a conventionally financed project delivering the same outputs as those of the PFI deal under examination. It is just one of a number of ways of evaluating a proposed PFI deal. It is directly relevant only when the publicly financed option on which it is based is a genuine alternative to the PFI deal. This is most likely to arise at the outset of a project (source: www.parliament.uk).

PUK - Partnership UK (also P-UK)

Partnerships UK (PUK) is a public private partnership which has a unique public sector mission: to support and accelerate the delivery of infrastructure renewal, high quality public services and the efficient use of public assets through better and stronger partnerships between the public and private sectors (source: www.partnershipsuk.org.uk).

Q and A - Question and Answer

R + D - Research and Development (also R and D or, more often, R&D)

R + D according to the Organization for Economic Co-operation and Development, refers to "creative work undertaken on a systematic basis in order to increase the stock of knowledge, including knowledge of man, culture and society, and the use of this stock of knowledge to devise new applications" (source: Wikipedia).

SHA - Strategic Health Authority

SHAs were created by the Government in 2002 to manage the local NHS on behalf of the secretary of state, there were originally 28 strategic health authorities (SHAs). On July 1 2006, this number was reduced to 10. Strategic health authorities are responsible for: developing plans for improving health services in their local area, making sure local health services are of a high quality and are performing well, increasing the capacity of local health services - so they can provide more services, and making sure national priorities - for example, programmes for improving cancer services - are integrated into local health service plans. Strategic health authorities manage the NHS locally and are a key link between the Department of Health and the NHS (source: www.nhs.uk).

SPA - Strategic Partnering Arrangement

In a NHS LIFT venture, the SPA sets out how the parties will act together in a collaborative, partnering, non-adversarial and open manner with a view to achieving the objectives of the local LIFT. The SPA establishes the Strategic Partnering Board (SPB) and LIFT Co. The local health economy supervises the performance of the LIFT Co through a SPB which also approves new projects from the Strategic Service Development Plan (SSDP) which it reviews on an annual basis (source: cmis.derby.gov.uk).

SPV - Special Purpose Vehicle

A SPV is a legal entity (usually a limited company of some type or, sometimes, a limited partnership) created to fulfil narrow, specific or temporary objectives. SPE's are typically used by companies to isolate the firm from financial risk. A company will transfer assets to the SPE for management or use the SPE to finance a large project thereby achieving a narrow set of goals without putting the entire firm at risk. SPEs are also commonly used in complex financings to separate different layers of equity infusion. In addition, they are commonly used to own a single asset and associated permits and contract rights (such as an

apartment building or a power plant), to allow for easier transfer of that asset (source: Wikipedia).

TPD - Third Party Development

TPD is a development that is not directly tied to the primary product that a client is procuring (source Wikipedia).

TTF - Treasury Task Force

TTF was created by the Government l Taskforce as an operational taskforce acting on behalf of HM Treasury, based in Partnerships UK. The Taskforce maintains a helpdesk to assist public sector partners with operational PFI issues (source: HM Treasury).

UNISON

UNISON is Britain's biggest public sector trade union with more than 1.3 million members (source: Unison.org.uk).

VfM - Value for Money

VFM is the term used to assess whether or not an organisation has obtained the maximum benefit from the goods and services it acquires and/ or provides, within the resources available to it. It not only measures the cost of goods and services, but also takes account of the mix of quality, cost, resource use, fitness for purpose, timeliness and convenience to judge whether or not, when taken together, they constitute good value. Achieving VfM may be described in terms of the 'three Es' - economy, efficiency and effectiveness (source: Imperial College London).

WYG Group - White Young Green Company

WYG is a private consulting firm.

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Addendum:

This document is an output from a research project that was commissioned by the Service Delivery and Organisation (SDO) programme whilst it was managed by the National Coordinating Centre for the Service Delivery and Organisation (NCCSDO) at the London School of Hygiene & Tropical Medicine. The NIHR SDO programme is now managed by the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton.

Although NETSCC, SDO has managed the project and conducted the editorial review of this document, we had no involvement in the commissioning, and therefore may not be able to comment on the background of this document. Should you have any queries please contact sdo@southampton.ac.uk.