

**Does LIFT permit high social return investments in  
good quality facilities that would not otherwise be  
feasible?**

**by**

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**This thesis is submitted in partial fulfillment of the requirements for the  
degree of Master of Science in Built Environment from the University of  
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## **Abstract**

This MSc report presents a study of NHS LIFT (Local Improvement Finance Trust) which is one of the schemes of Public Private Partnerships in England, and which, in particular, focuses on procuring primary care premises. LIFT is designed to give a wide range of benefits to stakeholders, such as the Government, local primary care trusts, private sector partners, General Practitioners (GPs) and users. However, the degree to which stakeholders benefit from actual projects has not been considered properly. The aim of this report is to generate a detailed understanding of the feasibility of LIFT in terms of investments which provide a high social return in good quality facilities and in terms of benefits to stakeholders.

The research consists of three case studies on premises in different types of areas. It focuses on gathering and analysing a wide range of perceptions concerning benefits in real situations.

The research identifies some viewpoints which facilitate or undermine benefits. In particular, it is found that the current situation of GPs may undermine the effectiveness of LIFT, and thus has reduced its value for money (VFM). In other words, improvements of the system in relation to GPs have the potential to enhance the VFM of LIFT projects.

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**Keywords:** Public Private Partnerships (PPP), Local Improvement Finance Trust (LIFT), Health care premises, stakeholder approach, procurement

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## List of Abbreviations, Acronyms and Initialisations

BCR	benefit to cost ratio
BMA	British Medical Association
CABE	Commission for Architecture and the Built Environment
CHP	Community Health Partnerships
CWLB <sub>s</sub>	the society's contract whole-life benefit
CWLC <sub>c</sub>	the client's contract whole-life cost.
DoH	Department of Health
EE <sub>c</sub>	the economic efficiency of the project to the client
FundCo	Fund company
GP	General Practitioner
HM Treasury	Her Majesty's Treasury
KI	keep informed
KS	keep satisfied
KP	key players
LIFT	Local Improvement Finance Trust
LIFTCo	LIFT company
MF	minimal effort
MSc	Master of science
NAO	National Audit Office
NHS	National Health Service
PfH	Partnership for Health
PUK	Partnership UK
PCT	Primary Care Trust
PFI	Private Finance Initiative
PPP	Public Private Partnership
SCBA	Social cost-benefit analysis
SPB	Strategic Partnering Board
SPV	special purpose vehicle
SSDP	Strategic Services Development Plan
VFM	value for money
WLC	whole-life cost
3PD	third party development

## **Chapter 1 Introduction**

### **1.1 Research objectives**

According to the National Audit Office (NAO) (2005:2), “We conclude that it looks like LIFT will work”. However, it is not clear from this whether the Local Improvement Finance Trust (LIFT) actually provides sufficient benefit to society, especially to local stakeholders, because NAO takes the viewpoint from the Government’s perspective. Hence, this MSc report is mainly intended to clarify the content and the degree of benefit to stakeholders involved in this activity. As shown in the figure 2.1, there are many stakeholders involved in LIFT schemes, and, obviously, it is assumed that LIFT should attract those stakeholders who enjoy different benefits within its projects. The Department of Health (DoH) (2001) explicitly states the benefits to stakeholders in advance, however, it is not certain whether these benefits are actually realized or not. Therefore, it is significant for the research objective to take a ‘stakeholder approach’ to examine this situation.

### **1.2 Problem owner**

According to NAO (2005:1), “Although 90 per cent of patient contact with the National Health Service (NHS) is for primary care services...investment in primary care historically has been inadequate and piecemeal.” In addition, “Many of the developments tend to be focused on more affluent areas where property investment carries much less risk” (DoH, 2001:6). Thus, LIFT was devised to improve current problems.

### **1.3 Outline of the report**

This MSc report is structured into five chapters: Chapter 1 Introduction, Chapter 2 Overview of LIFT, Chapter 3 Literature review, Chapter 4 Case study, and Chapter 5

Conclusion and recommendations.

Chapter 2 focuses on an explanation of LIFT, and in particular its background, objectives, The national LIFT programme, characteristics, players, structure, changes of the new role and actors, and payment mechanism are described. Chapter 3 explores mainly three subjects: principal benefits to each stakeholder, relationships between power and interest for each stakeholder, and value for money (VFM). Chapter 4 presents and analyses benefits within three local LIFT schemes, based on interviews given to stakeholders involved in the case study schemes. These three case sites are selected as representative of different types of location, namely central London, the marginal area of London and a city other than London. Finally, Chapter 5 draws conclusions concerning the whole topic. Recommendations and further research possibilities are also stated.

## **Chapter 2 Overview of LIFT**

### **2.1 What is LIFT?**

Public Private Partnership (PPP) is one of the key ideas for providing infrastructure. The UK Government encourages the adoption of this system into a wide range of public projects. Local Improvement Finance Trust (LIFT) is one of the procurement routes provided by the DoH and implemented to deliver better primary health care services into relatively deprived areas. The DoH approved 50 LIFTs in four waves by January 2006, and 47 LIFT companies (LIFTCos) have generated over £1,500 million in developing primary care facilities. (DoH, 2008; CHP, 2008)

### **2.2 Background**

According to the DoH (2008), 90% of patients' contacts with the NHS are through general practice. General Practitioners (GPs) run their practices as a business, and either own or

lease the premises they use. However, current premises do not meet patients' expectations. A survey about the condition of primary care premises suggests that:

- only 40% of primary care premises are purpose built;
- almost half are either adapted residential buildings or converted shops;
- less than 5% of GP's premises are co-located with a pharmacy and around the same proportion are co-located with social services;
- around 80% are below the recommended size.

(DoH, 2001:7)

In addition, investment into new primary care facilities has been on a fragmented and piecemeal basis. Much of the purpose-built primary care estate was built in the 1960s and it is found that maintenance costs of the buildings have been inappropriately high. In particular the situation is much worse in deprived areas such as inner city areas because property investment in deprived areas is much more risky, and thus, there tends to be underinvestment even if the needs of local communities for health care facilities are high.

(DoH, 2001)

	% of practices within types of premises	% below required size*	% in cramped conditions	Proportion in Age band (years)		
				<10	10-30	30+
Owner occupied-national rent	33%	79%	13%	14%	24%	62%
Owner occupied-cost rent	30%	Not available, but generally never build than other premises type				
Actual commercial rent	21%	78%	19%	14%	28%	58%
Health centres	16%	88%	12%	18%	52%	30%
Total	100%	79%	14%	14%	25%	61%

\* Below current recommended size as given in premises schedule of Statement of Fees and Allowances

**Table 2.1: Condition of the primary care estate (cited from DoH (2000))**

### **2.3 Objectives**

The main purposes of LIFT are to:

- Deliver a significant change in the quality of the primary care estate;
- Remedy some of the deficiencies in the existing arrangements; and
- Contribute to the delivery of the investment targets identified within the NHS Plan.

(DoH, 2001:11)

The objectives of LIFT are based on those of NHS Plan (2000) which aims:

- to invest up to £1 billion in primary care services
- to refurbish or replace substantially 3,000 family doctors' premises by 2004
- to provide 500 one-stop primary care centres by 2004.

(DoH, 2000:45)

### **2.4 The National LIFT programme**

As briefly mentioned in 2.1, LIFT covers almost two-thirds of England with more than 210 integrated health and social care facilities being either open or under construction. The 6 schemes of the first-wave of LIFT were launched in February 2001 from Health Action Zones. Subsequently, 12 second-wave, 24 third-wave and a further 9 fourth-wave schemes were selected in November 2004.

The full list of current LIFT schemes acquired from the DoH (2008) is shown in appendix I.

(CHP, 2008; DoH, 2008)

### **2.5 Changes of role and new actors**

Under LIFT, a new set of actors is introduced: commercial property investors. Moreover,

the role of GPs is changed from often being owner-occupiers to being tenants of facilities owned by investors in the LIFT.

## **2.6 Characteristics**

According to DoH (2001:11), the main characteristics of LIFT are represented as four-fold as shown below.

- Batching approach
- Common approach
- Flexibility
- Long-term Partnerships

### **2.6.1 Batching approach**

Basically, each single premise for primary care is too small to be feasible for commercial investment. Therefore, small individual schemes are batched (or bundled) within one project. This system is expected to provide a more co-ordinated and systematic approach to investment such as saving procurement costs. According to HM Treasury (2008:19), a Private Finance Initiative (PFI) contract may only be suitable for the projects of which the capital value is above £20 million, because below that level procurement costs may be disproportionate. Thus, the batching approach enables LIFT to be viable.

### **2.6.2 Common approach**

Each scheme adopts standardised procedures, facilitating procurement process efficiency. This approach enables individual GPs and local teams to avoid having to develop an individual approach and all documentation for each scheme. Partnership for Health (PfH) (predecessor of CHP – Community Health Partnerships) established this approach for all LIFT schemes.

(DoH, 2001; DoH, 2008)

### 2.6.3 Flexibility

One of the important aims of LIFT is providing flexibility in the system. LIFT includes the concept of flexibility to meet changing requirements of primary care in the future.

(Calverley and Jago, 2005:7)

### 2.6.4 Long-term Partnerships

The principle of long-term Partnerships between the public and private sectors is a critical factor of LIFT in order to achieve successful service delivery for 25 years. LIFT aims to introduce skills and disciplines of private sector partners into the projects.

(DoH, 2001)

## 2.7 Principal players and structure

The principal players of LIFT are as follows:

### 2.7.1 Department of Health (DoH)

DoH has an essential role in the LIFT scheme as a policy maker. In addition, DoH owns 100% stake of CHP as of December 2006 which allows it to have much closer direct relationships.

### 2.7.2 Community Health Partnerships (CHP)

CHP was renamed in November 2007 as a successor of PfH, a national joint venture between Partnership UK (PUK) and the DoH, after the DoH acquired 100% share from PUK in December 2006 to meet much broader DoH policy. The goal of CHP is to become a recognized centre of excellence in:

- Efficient and effective delivery of capital projects in the health and local authority sectors
- Public-private partnerships across the NHS and local government
- Innovative and creative solutions to procure and develop assets that enhance health and social care provision

(CHP, 2008)

In addition, CHP is involved in the management of the LIFTCo by acquiring a 20% stake of each LIFT company.

### 2.7.3 Local Primary Care Trusts (PCTs)

Local PCTs play four crucial roles within LIFT, namely:

- Strategic service planner

Each local PCT is responsible for providing service and planning strategies for local primary care based on the NHS Plan. In a LIFT scheme, the local PCT makes a Strategic Partnering Agreement with LIFTCo and other stakeholders to achieve its goal by maintaining cooperative relationships during the term of the contract - see Sections 2.7.8.

- Landowner

In most cases, a PCT uses a Property Sale Agreement to sell its own land, which is to be used for the new premises of a LIFTCo, to a FundCo, the wholly owned subsidiary of a LIFTCo.

- Investor

As an investor, local PCTs usually acquire 20% shares of a LIFTCo. The aim of



being one of the shareholders is to achieve its strategic goal as designated in the NHS Plan.

- Tenant

PCTs have an agreement as a tenant with the LIFTCo (or FundCo) of the premises built by a LIFT scheme. Sometimes local PCTs are not only tenants of their own facilities, but also landlords for sub-leasing to GPs.

(Calverley and Jago, 2005:12)

#### 2.7.4 Strategic Partnering Board

A Strategic Partnering Board (SPB) is a group providing strategic input into LIFT projects. A SPB consists of representatives of each public sector participant and the board of LIFTCo, and may also include representatives of other stakeholders as sub-members who have no right to vote on board matters. SPB holds regular meetings to deal with four main issues: reviewing performance and financial information, approving new versions of the Strategic Services Development Plan (SSDP), giving guidance and approval for new scheme proposals, and managing the provision of Partnering Services.

(Calverley and Jago, 2005:17)

#### 2.7.5 Private Sector Partner

A private sector partner owns a 60% stake of a LIFTCo and thus is a principal actor. The private sector partner may be one of two main types of organisation. One is often a contractor-led group, which has its own dedicated supply chain and intends to use it in this scheme. The other type is often called an “expert procurer” which selects contractors on a project basis. There have been 19 private sector partners within waves one to three of the LIFT scheme, led by building contractors, specialist PFI providers, third party developers and property developers.

(Calverley and Jago, 2005:7)

#### 2.7.6 LIFT Company (LIFTCo)

LIFTCo is a special purpose vehicle (SPV) which provides building and facility management services, and plays a central role in the scheme. Usually, the local PCT, CHP and private sector partner acquire 20, 20 and 60% stakes respectively in the LIFTCo.

(Calverley and Jago, 2005:9)

#### 2.7.7 General Practitioners (GPs)

Traditionally, GPs own their premises or have lease agreements with a 3PD. However, LIFT has provided a completely different relationship between GPs and their premises. GPs participate in this scheme as tenants of the premises owned by the LIFTCo. Unlike when using the conventional procurement system for GP premises, they enter into a tenancy agreement with LIFTCo or with the local PCT in the case of sub-leasing.

Premises for GP surgeries require so-called high asset specificity in terms of the transaction economics. Oliver Williamson is a pioneer in this field, and Graham Winch has explored this concept within the construction industry. Asset specificity is defined as “the condition where either the buyer or supplier is limited in their choice of transaction partner due to the specific nature of the resources to be supplied” (Winch, 2002:91). If the asset specificity is low, as in commercial offices, a developer/investor does not need to consider any specification relating to a property and just provides properties within a certain range of standard specifications. On the other hand, if the asset specificity is relatively high, as in healthcare premises, and if a developer/investor is considering use by one or few main long-term tenants, tenants may specify their requirements to some extent, or risks and investments are divided by ‘shell and core’ and ‘fit out’ arrangements. In the case of LIFT, local PCTs usually have their own specifications in order to provide primary care premises

with a certain level of quality. Thus, specifications of LIFT premises are decided by local PCTs. In a sense, GPs are dealt with as tenants, in the same way as tenants of commercial offices, which is a different situation from any other current procurement routes.

### 2.7.8 Structure

The relationships among these principal players can be presented as the following model.

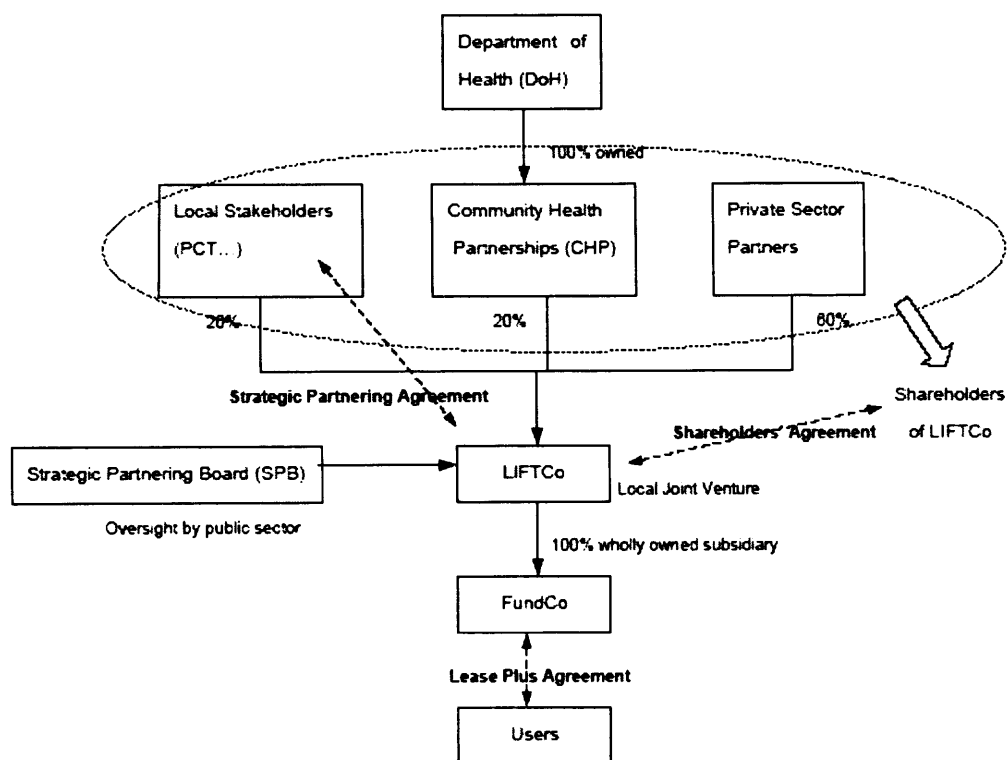


Figure 2.1: Principal players and structure (source: Calverley and Jago (2005); NAO (2005))

LIFTCo is a vehicle of a national joint venture having a central role to execute the scheme and providing buildings and services required in the agreement. LIFTCo has mainly three shareholders. The biggest shareholder is the private sector partner owning 60% shares, and

CHP and local stakeholders own 20% shares each. SPB oversees LIFTCo mainly by approving the activities of LIFTCo.

In terms of the contractual system, there are three main agreements within LIFT called Shareholders' Agreement, Strategic Partnering Agreement and Lease Plus Agreement – see Section 2.8.

Shareholders consisting of local stakeholders, CHP and the private sector partner have a Shareholders' Agreement with LIFTCo. In addition, LIFTCo and local stakeholders (i.e. PCTs, local authorities, mental health trusts, and strategic health authorities) make an agreement called a Strategic Partnering Agreement. Moreover, LIFTCo is required to have some other agreements to conduct its business, such as a Lease Plus Agreement, Loan Agreement, Supply Chain Agreement, and Sales Agreement for the site. Usually, these agreements are made through FundCo (100% wholly owned subsidiary of LIFTCo).

(Calverley and Jago, 2005)

## **2.8 Payment mechanism**

The Lease Plus Agreement is an agreement unique to LIFT. This agreement contains aspects of both a project agreement in PFI and a traditional commercial lease. It is based on a commercial lease with additional provisions to benefit the public sector tenants. These include primarily the following conditions:

- a duty to provide premises suitable for specified use
- building maintenance for the term of the lease
- a guaranteed right to buy at the end of the term, and
- a facility for making rent reductions for non-availability of specified facilities.

(CHP, 2008; Calverley and Jago, 2005)

## **Chapter 3 Literature review**

### **3.1 Principal benefits of each stakeholder within LIFT**

#### **3.1.1 Government (public sector)**

LIFT is one of the procurement routes initiated by the DoH. It is expected that LIFT would provide a variety of benefits. Possible benefits to the Government are stated as follows:

##### *3.1.1.1 The achievement of value for money*

“Value for money” is one of the most important concepts of PPP. HM Treasury (2007:2) defines the expression “value for money” as “securing the best mix of quality and effectiveness for the least outlay over the period of use of the goods or services bought. It is not about minimizing upfront prices. Whether in conventional procurement, market testing, private finance or some other form of public private partnership, value for money will improve with an appropriate allocation of risk”. Value for money attempts to keep an optimum balance between the whole-life cost (taking operation, life cycle, replacement and maintenance costs into account as well as construction costs) and quality to meet the user’s requirement. Value for money is perceived as a key to decision making on LIFT as well as on any other PPP procurement. According to NAO (2005:3), it is concluded that “The local LIFT schemes we have examined appear to be effective and offer value for money” although the difficulty of appraising value for money is also mentioned. “The value for money of a LIFT project needs to be judged on the basis of whole-life 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. ...Appraising value for money is not, therefore, straightforward or easy” (NAO, 2005:22). Moreover, Calverley and Jago (2005:27) mentions that “Although the Strategic Partnering Agreement envisages how value for money might be demonstrated, there is no

clear test or provision which establishes whether value for money has actually been demonstrated.”

The difficulties of determining value for money still exist, even though this is one of the key concepts for a PPP.

#### *3.1.1.2 Limitation of procurement cost*

LIFT is intended to limit procurement cost by offering a ‘batching’ system. LIFT is a scheme for local primary care premises which are relatively small scale developments, and requires planning and building several premises with due attention to strategic plans of local public bodies to meet the NHS Plan. This process is expected to cause significant reduction of procurement costs in each project. (DoH, 2001)

#### *3.1.1.3 Contribution to local communities and environment*

As explained, the LIFT system attempts to realize better primary care premises and environments for local communities. Buildings provided through LIFT schemes are able to provide not only several GP surgeries, but also other health related facilities such as one-stop-shops, intermediate care facilities or minor injuries units. Moreover, it is possible to include other public facilities such as local libraries or council services under one roof of a LIFT building.

In addition to the contribution towards local communities, a LIFT is able to contribute to improving the local environment. By providing high quality buildings for public use, LIFT is expected to help in enhancing the quality of the townscape. CABI has been involved in assessing the design qualities of the LIFT buildings as well as those of other public buildings. According to CABI (2008) based on results of the survey on 20 completed buildings from 80 LIFT schemes, further improvements on several points are recommended to achieve satisfactory levels of design qualities, even if it acknowledges continuous improvements through waves 1 to 3.

#### 3.1.1.4 *Private finance*

As well as the PFI, the LIFT receives several benefits from private finance. These include:

- Improved whole-of-life risk allocation and management

The optimal allocation of risk between public and private sectors as well as between the private sector company and subcontractor is a crucial aspect of PPP. Senior debt providers contributed directly to developing fair and mutually satisfactory positions of risk stances.

- Greater focus on due diligence

The existence of the senior debt enhances due diligence because any delay in the completion of projects or excess of budget causes penalties, and the situation seriously affects the financing of the private sector partner.

The study carried out by NAO (2003) clearly shows this tendency, and the research shows that PFI will deliver price certainty for departments and timely delivery of good quality goods according to an examination of the construction performance achieved in PFI projects. The study shows that PFI experience decreased cost excesses by 51% and delays by 46%. (Figure 3.1)

	Previous experience (1999 Government survey)	PFI experience (2002 NAO census)
Construction projects where cost to the public sector exceeds price agreed at contract	73%	22%
Construction projects delivered late to public sector	70%	24%

**Figure 3.1: Improved project delivery under the PFI (cited from NAO (2003))**

- Better integration of design, construction and operational skills

Potentially, it is beneficial for the government as well as for senior debt that the integration of relevant skills works consistently and creates a synergetic effect. The equity provider has long-term risk, thus better integration of relevant skills is encouraged.

(PricewaterhouseCoopers LLP, 2008)

### 3.1.2 Local health authorities and PCTs

#### 3.1.2.1 *Fit for consistent service requirements*

Local health authorities and PCTs are responsible for achieving the government plan, i.e. the NHS Plan, at local level. Before introducing LIFT, small-scale developments on primary healthcare projects tended to be on a fragmented. In terms of partnerships between the public and private sector, LIFT is able to contribute to realizing long-term government policy. Usually, the public sector holds 40% of the stake, and the private sector partner holds 60% of the stake within the LIFTCo, and this long-term close relationship helps them achieve highly coordinated outcomes in alignment with the NHS Plan.

(DoH, 2001)



### 3.1.2.2 *Common approach makes progress simpler and easier*

Common approach enhanced by the implementation of standard reusable documentation contributes to achieving economies of scale and scope within the LIFT scheme. This approach allows local stakeholders to give efficiency and, as a result, to limit transaction costs. (DoH, 2001)

### 3.1.3 Investors

#### 3.1.3.1 *Provide opportunities for investments*

LIFT is intended to attract many external investors. Nationally, LIFT is a feasible opportunity for investors as a national joint venture. Meanwhile, locally, it also offers opportunities to invest alongside partners and developers who are interested in particular local LIFT schemes.

Possible benefits to investors are stated as follows:

- Long term stable cash flow
- A portfolio investment reducing risk
- Return commensurate with risk
- Government backed revenues

(DoH, 2001)

### 3.1.4 Private sector partners (service/faculty providers)

LIFTCos are given exclusive rights over developments in the Strategic Partnering Agreement which are approved by the relevant authorities (mainly, PCTs and local governments) and LIFTCos – see Section 2.7.8. These exclusive rights are twofold:

- to provide the Partnering Services, and
- to provide Lease Plus Services (i.e., construction and “hard” facilities

management) in relation to all “Major Capital Projects”.

Major Capital Projects are defined as “all new build and other capital projects involving the enhancement of facilities or parts of premises and including all plant, equipment, fixtures and fittings therein, each such new build or capital project having a capital value in excess of £20,000 (index linked) and any other non-capital transactions for the provision of accommodation”. (Calverley and Jago, 2005:14)

In addition, the exclusivity sustains LIFTCo to achieve long-term success not only with respect to its business, but also in creating opportunities encompassing other relevant facilities such as local libraries or leisure facilities. (DoH, 2001; Calverley and Jago, 2005)

### 3.1.5 GPs (primary care providers)

The DoH (2001:22) states that potential benefits of the LIFT approach to primary care providers are as follows:

- LIFT helps to meet the provision of modern integrated healthcare services required by the local community.
- LIFT improves the working environment by providing the opportunity to develop the quality of current primary care premises which have been underinvested and outdated for a long time.
- Co-location within LIFT buildings enables the enhancement of networks among other health facilities.
- The risks of negative equity associated with property ownership are eliminated.
- GPs can mitigate risks of investment by having a share of a portfolio of properties.

- Financial support for terminating a current agreement in order to move into a LIFT building may be available on a case-by-case basis.
- Full service with maintenance is provided in LIFT buildings.
- GPs can avoid the time-consuming process of procuring and negotiating for new premises by the standardised approach.

### 3.1.6 Concluding remarks

In this chapter, the principal benefits to each stakeholder are considered. It is assumed that different stakeholders will benefit from the LIFT scheme in different ways.

## 3.2 Stakeholder mapping

Stakeholder mapping attempts to identify stakeholder expectations and power among three types of procurement routes: GP owned premises, 3PD and LIFT. According to Johnson et al. (2005:181), stakeholder mapping underlines the importance of two issues:

- How *interested* each stakeholder group is to impress its expectations on the organisation's purposes and choice of specific strategies.
- Whether stakeholders have the *power* to do so.

In addition, stakeholders are categorised in the power/interest matrix. This power/interest matrix consists of four types of groups called 'minimal effort' (MF), 'keep informed' (KI), 'keep satisfied' (KS) and 'key players' (KP), and these groups are categorized by their degree of power and level of interest.

Firstly, stakeholders are identified and categorised within a framework shown in Winch (2002:67). Then the power/interest matrix is used for implementing the stakeholder mapping for each of the three procurement routes. Subsequently, these results are analysed and lastly the findings are summarised.

### 3.2.1 Identification of stakeholders

According to Winch (2002:67), project stakeholders are divided into internal and external stakeholders. Internal stakeholders are those in a legal contract with a client, and external stakeholders are those having a direct interest in the project. Internal stakeholders can be divided into sub-categories called 'demand side' and 'supply side'. External stakeholders can be divided into private and public actors.

Similarly, potential stakeholders involved in LIFT can be categorised as follows:

#### Internal stakeholders

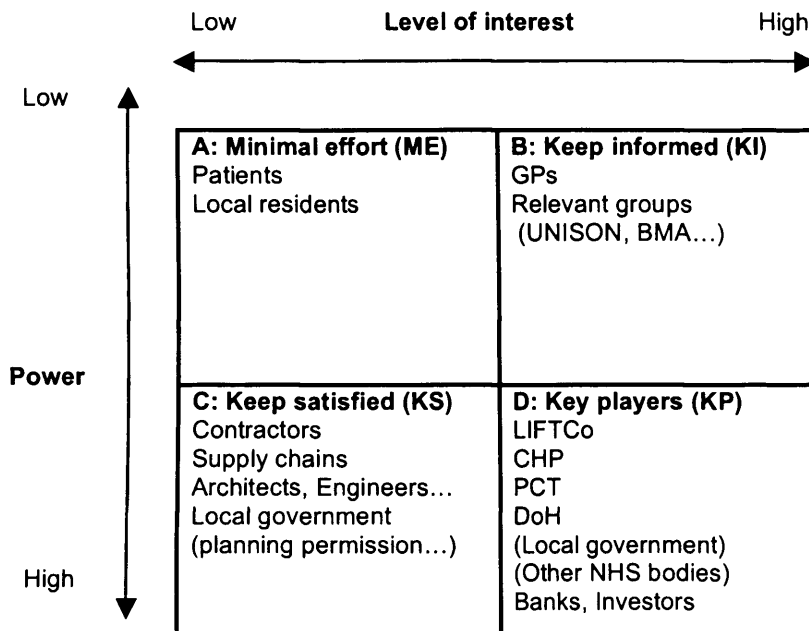
Demand side	PCTs, CHP, DoH, local governments, other relevant authorities
Supply side	LIFTCos, Architects, Engineers, Contractor, Supply chains, Material suppliers, Banks, Investors

#### External stakeholders

Private	Local residents, patients, GPs
Public	Regulatory agencies (planning permission...) Relevant groups (British Medical Association (BMA), UNISON...)

### 3.2.2 Power/ interest matrix of LIFT

The power/interest matrix of LIFT is shown as below:



**Figure 3.2: Power/ interest matrix on LIFT**

Patients and local residents belong to the category called ‘minimal effort’ (ME) which retains relatively low power and interest.

Some external stakeholders such as GPs and relevant groups, for example UNISON and the BMA among others, belong to the category called ‘keep informed’ (KI). Groups within this category do not retain strong powers that might affect the project, however, those players have a strong interest in the project. Stakeholders in this category need to be carefully managed because they may oppose the project. For example, such groups may take action leading to severe disruption through lobbying or using media publicity.

Another category called ‘keep satisfied’ (KS) contains two types of groups. One of them consists of most of the supply side internal stakeholders except LIFTCo, such as architects, contractors and supply chains. They are placed in this category for two reasons. One of them is that most of them are mobilised after the project mission is defined. The other is

that they typically have a portfolio of projects, thus they have relatively strong powers despite limited interest (Winch, 2002:72). Another group is of regulatory bodies such as the local government which is responsible for planning permission, among other issues.

The demand side internal stakeholders, such as DoH, CHP and PCT, and LIFTCo, are mainly categorised as 'key players' (KP) in this matrix. LIFTCo has a central role to provide facilities as a private sector partner. CHP and PCT participate in LIFT schemes as main public sector partners. Local governments and other NHS bodies, such as mental health trusts, Acute trusts and ambulance trusts, have been encouraged to take part in this scheme to meet local needs by providing local government facilities, such as community services or libraries within LIFT premises. Financiers, such as banks and investors are also involved in this category because LIFT adopts project finance techniques rather than corporate finance techniques.

### 3.2.3 Discussion

Johnson et al. (2005:182) mentions four points which may help in better understanding the stakeholder mapping, as follows:

- Whether the actual levels of interest and power of stakeholders are properly reflected in the corporate governance framework within which the organisation is operating.
- Who the key blockers and facilitators of a strategy are likely to be and possible responses to them.
- Whether repositioning of certain stakeholders is desirable and/or feasible.
- Maintaining the level of interest or power of some key stakeholders may be essential.

This section focuses on the second and third points above.

Regarding the second point, Johnson et al. (2005:181) mentions a possible risk in the KS category when interest in this group is underrated. In this situation, this group may reposition to KP, and prevent the adoption of new strategy. However, most groups in KS are supply side internal stakeholders and supply chains of LIFTCo, thus they are unlikely to be a threat to the project. In addition, regulatory bodies are also low risk because public bodies are involved in KP, thus regulatory bodies are likely to be cooperative towards the project. On the other hand, the threat from the KI category is much higher than that of KS. Johnson et al. (2005:182) also mentions regarding the level of threat that “These stakeholders can be crucially important ‘allies’ in influencing the attitudes of more powerful stakeholders”. In this context, GPs and relevant groups may be a risk for the project in LIFT, and thus, these groups may be blockers or facilitators.

Regarding the third point, possible repositioning routes are KS to KP and KI to KP. However, there is no merit in moving into KP from KS because the groups within KS generally need to contain a certain range of portfolios to secure their businesses. On the other hand, moving into KP from KI increases merit to GPs. The repositioning of GPs from KI to KP may result in significantly improved potential to facilitate the project if good relationships can be established and maintained, and if those groups do not create serious conflicts leading to a deterioration of outcomes among other KP groups.

#### 3.2.4 Concluding remarks

In this chapter, stakeholder mapping was used to clarify and analyse the interest and power of each stakeholder group within LIFT. LIFT can be said to be a relatively stable system in terms of interest and power because this scheme is based on partnership between the public and private sectors, and thus both sectors are included in the KP category. However, it was found that groups within the category KI such as GPs and relevant groups (BMA, UNISON...) could potentially have a strong influence within this scheme as blockers or facilitators.

### 3.3 Value for money

#### 3.3.1 Social cost-benefit analysis (SCBA)

SCBA is a procedure for:

1. measuring the gains and losses to individuals, using money as the measuring rod of those gains and losses
2. aggregating the money valuations of the gains and losses of individuals and expressing them as net social gains or losses.

(Pearce, 1983:3)

SCBA is able to analyse net gain by showing consumer surplus. The consumer surplus is shown as the area under the demand curve in figure 3.3. This area shows prices which users are willing to pay. And, from the Government's point of view, if the amount of consumer surplus exceeds the cost of providing this product, it shows that this project is still feasible.

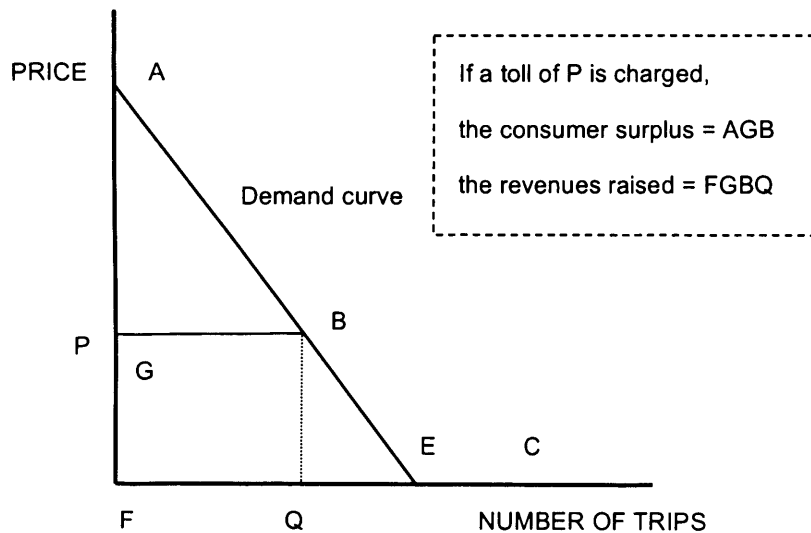


Figure 3.3: Calculation of Consumer Surplus (in the case of a bridge project) (cited from Stiglitz (2000))



Thus, the project can undertake

if  $B > C$  or  $B / C > 1$

where  $B$  is aggregated benefit (revenues plus consumer surplus) of the project and

$C$  is aggregated cost of the project.

(Stiglitz, 2000:277)

### 3.3.2 Value for money (VFM)

A definition of the term VFM has already been given in chapter 3.1.1.1. In this chapter, VFM is explained in terms of economic theory.

According to Rintala (2004:30), VFM can be defined as follows:

$$VFM = EE_c = \frac{CWLB_s}{CWLC_c}$$

Where, VFM is the value for money of the project,

$EE_c$  is the economic efficiency of the project to the client,

$CWLB_s$  is the society's contract whole-life benefit, and

$CWLC_c$  is the client's contract whole-life cost.

Thus, the VFM of a project can be shown as its benefit to cost ratio (BCR) between  $CWLB_s$  and  $CWLC_c$ . If  $CWLB_s$  becomes much higher than  $CWLC_c$ , a proportion of the VFM increases as a result.

When whole-life cost (WLC) of the project is set as a minimum, the project cannot produce any benefit. As WLC increases, a degree of benefit gradually increases. At a certain point, the degree of benefit exceeds that of WLC, and then, the difference between WLC and benefit reaches maximum at the point of the maximum VFM. The amount of the VFM then gradually decreases, and again, cost exceeds the degree of benefit after all. In

addition to maximum VFM, the constraint of affordability exists. This constraint determines the limit of possible spending on projects. Thus, the maximum VFM subject to affordability is clarified. (Figure 3.4) (Rintala, 2004)

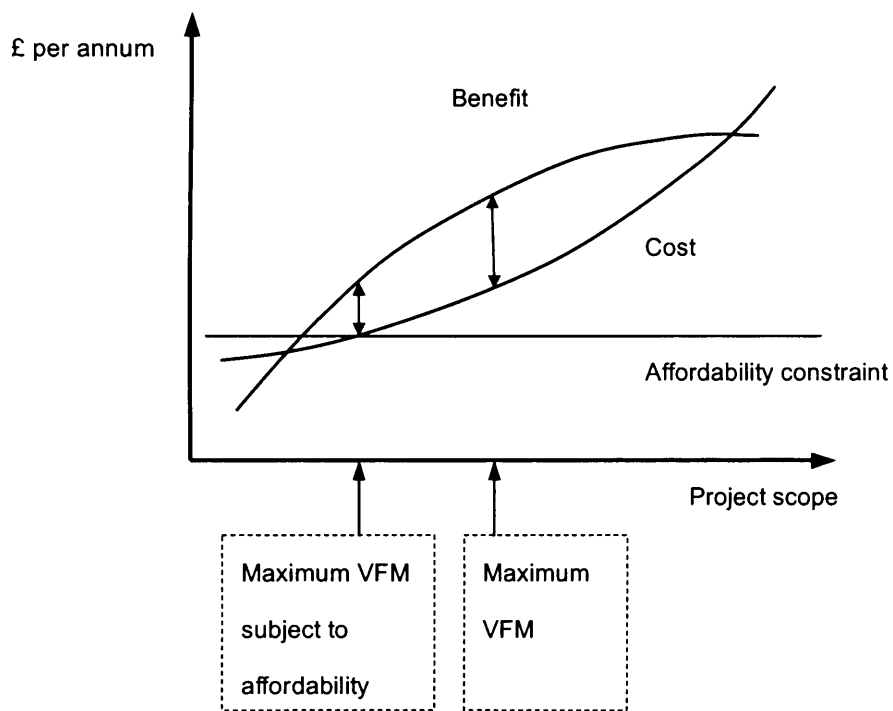


Figure 3.4: Value for money and project scope (cited from Rintala (2004))

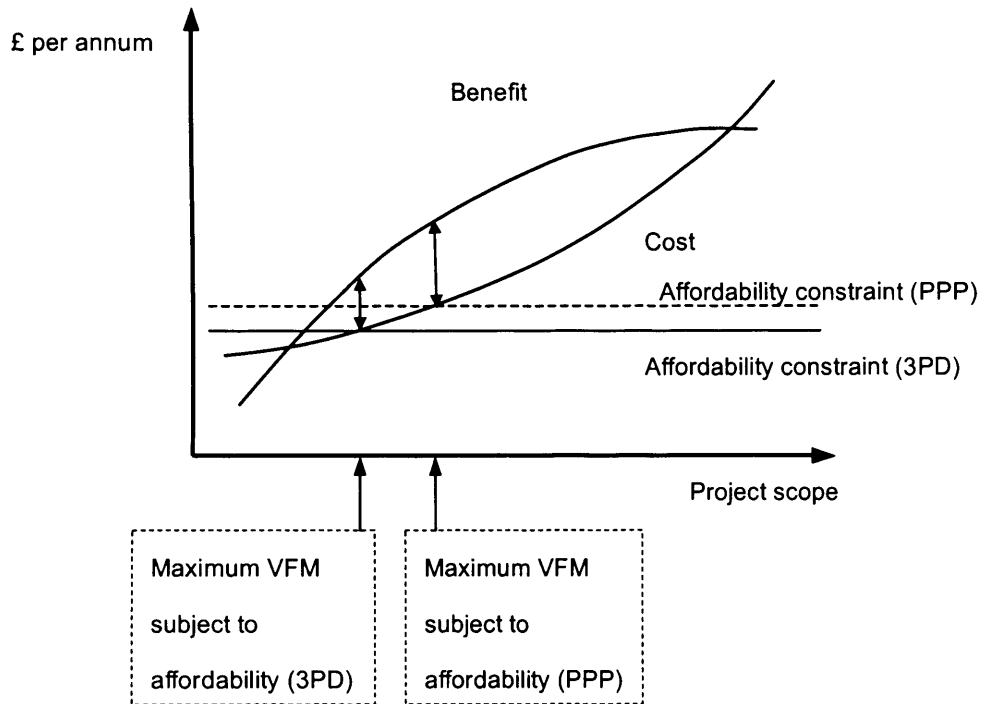
### 3.3.3 Comparison between LIFT and 3PD in terms of VFM to primary care facilities

Third party development (3PD) is one of the procurement routes of GP premises. This is the system by which GPs or PCTs have an agreement with a private sector developer, who redevelops premises for them, which he then leases to them. There are three principal differences between these procurement routes. These are:

- Ad hoc 3PD may not fit local strategic priorities, whereas LIFT is designed to meet them. In particular, location of premises by 3PD tends to be in affluent areas which provide higher rental value.
- Usually 3PD does not consider repair, maintenance and insurance of the premises, whereas LIFT is designed to take responsibility for them.
- Rent of 3PD premises tends to be lower than that of LIFT premises even if cost for repair, maintenance and insurance are subtracted, however, LIFT considers VFM for WLC, thus LIFT premises are able to provide additional value to the community which may be a crucial factor in their function as public facilities.

(NAO, 2005; Calverley and Jago, 2005)

When it is considered in terms of VFM, the affordability constraint of 3PD is set much lower than that of LIFT because additional value is not required in 3PD developments, thus charges to tenants are much lower than those made by LIFT. Therefore,  $CWLB_s$  does not exceed  $CWLC_c$ , and VFM of LIFT exceeds that of 3PD. (Figure 3.5)



**Figure 3.5: Maximum VFM for 3PD and PPP**

### 3.3.4 Comparison between LIFT and PFI in terms of VFM to primary care facilities

It can be said that LIFT is a revised version of PFI, particularly for relatively small primary care premises. The procurement system for primary care facilities needs to be differentiated from PFI to work effectively on principally four points, namely the batching approach, common approach, flexibility and long-term partnerships, as explained in 2.6. These differences are implemented to fit the specific circumstances of primary care premises, and not to improve the procurement system itself. Therefore, it is not possible to compare the VFM of these two procurement systems, nor it is possible to say that theoretically the VFM of these two procurement systems are same.

### 3.3.5 Concluding remarks

In terms of VFM, LIFT obtains much higher positive  $CWLB_s / CWLC_c$  than that of 3PD. Thus, LIFT potentially achieves higher VFM than 3PD. Nevertheless, there is no difference between LIFT and PFI in terms of VFM because the concept of these two procurement systems is basically same in terms of VFM.

### 3.4 Concluding remarks

In chapter 3, three types of literature were reviewed. Firstly, the principal benefits to each stakeholder were considered. Secondly, stakeholder mapping with regard to LIFT was undertaken to clarify the characteristics and potential of each stakeholder in terms of interest and power. Thirdly, a comparison among LIFT, PFI and 3PD was drawn in terms of VFM.

## Chapter 4 Case study

### 4.1 Outline of the case study

#### 4.1.1 Aim and objectives of the case study

As the title of this MSc report, *Does LIFT permit high social return investments in good quality facilities that would not otherwise be feasible?* implies, this report is intended to be an examination of the feasibility of LIFT as a PPP. In particular, it attempts to consider a wide range of viewpoints about VFM provided by different types of stakeholders involved in this scheme. Often individual stakeholders have diverse viewpoints and perceptions on the same situation, and this diversity may result in outcomes different from those planned by policy makers, thus the degree of VFM may be influenced either positively or negatively by these differences.

In beginning the case study, three case study objectives are set along with the main

question stated above. These are:

1. to find out whether VFM in LIFT actually works as planned by policy makers,
2. to identify whether there are any unpredicted benefits as a result of LIFT or problems which reduce or nullify the benefits, and
3. to clarify the factors required to enhance VFM.

These three objectives are designed as steps to be taken in order to reach a conclusion.

#### 4.1.2 Case study design and research methods

The three objectives set for the case study can also be perceived as research questions of the case study. Gillham (2000:6) states the verbal data dimensions regarding an interview (Table 4.1). This table explains the types of interviews in terms of their structure.

Unstructured			Structured			
Listening to Other people's conversation; a kind of verbal observation	Using 'natural' conversation to ask research questions	'Open-ended' interviews; just a few key open questions, e.g. 'elite interviewing'	Semi-structured interviews, i.e. open and closed questions	Recording schedules: In effect, verbally administered questionnaires	Semi-structured questionnaires: multiple choice and open questions	Structured questionnaires: simple, specific, closed questions

**Table 4.1: The verbal data dimension (cited from Gillham (2000))**

In order to answer the three questions of the case study, semi-structured interviews with a wide range of people involved in LIFT were adopted as the principal research method. The reasons for adopting the procedure of semi-structured interview were threefold, namely:

1. it is possible to acquire answers to particular questions,
2. it is possible to explore relevant additional information on questions, and
3. it is also possible to explore unpredicted benefits as mentioned in 4.1.1.

#### 4.1.3 Site selection

Three sites were chosen for the case study to cover significant differences among localities. Brief information about each site is given as follows.

Site A (Wave 2), located in northeast London

Site B (Wave 2), located in a city in northeast England

Site C (Wave 3), located in south-central London

#### 4.1.4 Interviews

In addition to the use of various types of interview, the fact of interviewing a wide range of people is expected to deliver different points of view among stakeholders, and thus to contribute to providing answers to research questions. 18 interviewees in total from government bodies and three local LIFT schemes participated in this research. The type of institutions and number of interviewees are shown as follows.

	Others	SiteA	SiteB	SiteC	Total
Community Health Partnerships	2				2
PCT				2	2
LIFTCo		2	1	2	5
Surgery (GP)		2	1	1	4
Surgery (Practice manager)		1	1	1	3
Surgery (others)		2			2
Total	2	7	3	6	18

**Table 4.2: Type of institutions and number of Interviewees**

These interviewees participated primarily on a one-to-one basis in in-person semi-structured interviews, however one-to-two interviews were held for interviewees in LIFTCos and receptionists in surgery. Interview instruments were implemented and used for each type of stakeholder to maintain a standard quality in each interview. (Interview instruments used for interviews are shown in appendix II.) A simple questionnaire was added in the last part of the interview instrument to check the degree of the tendency of key issues. The average, shortest and longest length of an interview was around 45 minutes, 25 minutes and 65 minutes respectively. An IC recording was made of each of the interviews.

#### 4.1.5 Documentation and other relevant sources of the case study

The Outline Business Case for each LIFT project was thought to be one of the important sources for the case study, and these documents were requested from local PCTs. However, it was not allowed to access these documents because these documents are regarded as commercially sensitive. Thus, the strategic service development plans (SSDP) of two PCTs and information from the websites regarding CHP and relevant LIFTCos were adopted as the main documentation and other relevant sources for the case study.

#### 4.1.6 Data analysis

Data collected from interviews, such as notes and recorded materials were carefully examined, and transcribed in the matrix by each site to be analysed effectively. These data are analysed not only in terms of similarities and differences among different stakeholders within the same locality, but also in terms of those among different sites. A sample of those matrices used for the analysis is shown below.



Site C	PCT	LIFTCo		Surgery (GP)
	A	A	B	
	It is necessary, but complex.	Facilitates opportunities to learn from other projects		
Batching Approach	Standardised, but not enough 3(Q5)	Beneficial, but still needs more than 200 documents 6(Q5)	2(Q5)	Complex. PCT helped GPs on this issue 2(Q5)
Common Approach	1(Q7)	In planning process, it is possible to be flexible. 4(Q7)	It is possible to change an agreement, but it is costly. 2(Q7)	Time-consuming liaison system is a problem. Costly for even small additional work. 2(Q7)
Flexibility	2(Q4)	Beneficial. Key difference with PFI. 6(Q4)	Effective for problem solving. 4(Q4)	2(Q4)
Long term partnerships	High bidding cost may be potential problem. 3(Q12)	The idea 'Whole Life Cost' enhances VFM. 6(Q12)	5(Q12)	2(Q12)
Value for money	5(Q15)	Design solution is the strength of this LIFTCo. 5(Q15)	5(Q15)	4(Q15)
Locality	It is a good deal because it is reimbursed.			Quick response is needed. (dealing with patients' needs)
GP				

Figure 4.1: A sample of matrix for the analysis

## **4.2 Sites**

### **4.2.1 Site A**

#### *4.2.1.1 Brief explanation of site A*

The Site A is one of the 12 second wave local LIFT schemes located in northeast London. The preferred bidder was appointed in May 2003, and all three proposed projects in the first tranche were already completed by 2005. The cost of each project was around £5 million. Two primary care trusts, two local governments, one local mental health NHS trust and the local strategic health authority were involved in this scheme.

#### *4.2.1.2 Case study project in site A*

One project was chosen as a case study in site A. The building includes a wide range of services, such as GP surgeries, specialist nurses, child health surveillance, immunisation, community services, nutrition & dietetics, dental services and social services, all under one roof. There was an old health centre built in the 1960's, but it was not suitable for modern health needs. The new building has an area of about 2,600m<sup>2</sup> floor, and was opened in 2005.

### **4.2.2 Site B**

#### *4.2.2.1 Brief explanation of site B*

Site B is also chosen from one of 12 wave-two approvals. This city is located in northeast England. The preferred bidder was appointed in 2003, and financial close was agreed in the middle of 2004. Currently, six projects in seven first tranche projects have already been in operation, and one project reached financial close in early 2008.

#### *4.2.2.2 Case study project in site B*

One project was selected for the case study in site B from operating six projects. These premises include a GP surgery, a pharmacy, a range of therapy services, a dental surgery, baby/child health clinics, a base for district nurses and health visitors, out-patient clinics and a public library. The building was opened to patients in 2005.

#### **4.2.3 Site C**

##### *4.2.3.1 Brief explanation of site C*

Site C is situated in south central London. The site was selected from one of the 24 wave-three schemes. The preferred bidder was appointed in 2003. The shareholders of the LIFT Co are three local PCTs (20% in total), Community Health Partnerships (20%) and a private sector partner (60%). Three projects were in operation by 2008.

##### *4.2.3.2 Case study project in site C*

One project was selected for the case study from three operating buildings. Phase 1 of the project has been completed, and phase 2 is underway. The total floor area of the building is around 5,800m<sup>2</sup>. There was an old health centre on the same site of these new premises, and that building had some problems as a health care facility.

The premises currently comprise four GP practices, community midwifery and children's services, contraception and sexual health services, dentistry, and a local PCT office. In addition to these facilities, it is planned to add some further facilities and a cafe in the near future.

### **4.3 Outcomes**

#### **4.3.1 Research outcome**

Research outcomes are analysed in terms of seven different viewpoints to meet the three objectives stated in 4.1.1. These are:

- Batching approach
- Common approach
- Flexibility
- Long term partnerships
- Issues which may affect value for money
- Locality
- LIFT as premises for GPs

The first four viewpoints are regarded as the main LIFT characteristics intended to facilitate high social returns of LIFT compared with other procurement systems. In addition, value for money is one of the core concepts underlying the *raison d'etre* for each approved LIFT scheme.

Locality is also one of the crucial issues in LIFT because LIFT is a national scheme which requires strong relationships between the national and local levels, and it does not work properly without these relationships. Lastly, LIFT as a procurement route for premises for GPs proves to be one of the most important viewpoints for research because, as mentioned in 3.2, GPs are among the most important players involved in LIFT.

#### *4.3.1.1 Batching approach*

The batching approach is implemented to make LIFT feasible as an investment. As explained in 2.6.1, PFI is not a suitable procurement method for LIFT because procurement costs may be disproportionately expensive. The batching approach was perceived as one of the crucial essences of LIFT by people in CHP, however, there is not so much interest in this approach from other stakeholders except according to comments of two interviewees, one person in LIFTCo and one in PCT. The person in LIFTCo mentioned that the batching approach facilitates opportunities to learn from other projects

and to adopt lessons learned each time because of time lags of each project. The person in PCT said that this approach is necessary, however, it increased complexity. This approach was perceived as just one of the rules of LIFT, and was not understood as a source of benefit differentiating LIFT from other procurements. Otherwise, no significant difference was found among the sites.

#### *4.3.1.2 Common approach*

The standardised documents for the LIFT scheme are intended to contribute to reducing costs for each transaction. However, various perceptions among stakeholders were found regarding this issue in all the sites. People in CHP tend to perceive that this approach works. People in LIFTCo and PCT, however, have different views. Two interviewees answered positively; chose 6 (strongly agree) and another chose 5 (agree) in question 5 of the questionnaire even if they admitted that it was still a complex system. One person answered 3 (slightly disagree), and two people answered 2 (disagree). In addition, the majority of GPs responded as disagreeing because the contracting system is too complex even if there is a standardized format. In particular, high legal costs are a heavy burden for some GPs. There was no clear difference found among the three sites.

#### *4.3.1.3 Flexibility*

It is commonly perceived that flexibility is not perfectly achieved in LIFT. People in CHP chose 4 (slightly agree) in question 7 of the questionnaire, and mentioned that this aspect needs to be improved. People in LIFTCo responded between 4 (slightly agree) and 2 (disagree). It was stated that there are sufficient opportunities to formulate plans to satisfy current local needs before reaching an agreement for each project, however, changing specifications after reaching an agreement entails high costs, if it is possible at all. Thus, changes are rarely made after an agreement is reached.

For GPs and practice managers of surgeries, flexibility is not perceived within LIFT

because they tend to participate after projects were agreed. GP surgeries directly provide services to patients, thus they have channels to get direct feedback concerning what patients really need. However, some of the interviewees mentioned that their suggestions are not properly reflected within LIFT even if these suggestions entail only small changes. This situation is the result of three issues. One of them relates to communications. There seems to be no chance to integrate ideas of GPs into LIFT premises before reaching agreements. The second issue concerns the agreements themselves. As mentioned in comments by people working in LIFTCo, it is difficult to do anything not included in an agreement even if the proposal would be beneficial, and it tends to take a long time to get a final decision. The third issue relates to the liaison system, which was stated to require a long time, even if the proposal concerns just a minor repair, and this time-consuming procedure may affect the quality of patient services. Tenants are required to give notice of problems via a certain route, and this indirect liaison system causes additional time consumption.

#### *4.3.1.4 Long term partnerships*

The building of long term partnerships between the public and private sectors is also one of the crucial factors of LIFT. These partnerships are able to allow both parties to complement each other's strengths. Data acquired from interviews did not show a clear common tendency regarding this factor, however some possible implications are evident. Firstly, the answers may show the current perception of LIFTCo on this issue in each site. One person from LIFTCo at both sites B and C answered 6 (strongly agree) to question 4 of the questionnaire and showed positive reactions, while other interviewees from LIFTCo at sites A and C answered 4 (slightly agree). This might mean that people from LIFTCo at sites B and C feel the partnerships are much more beneficial than ones at site A. Secondly, it might show the nature of relationships between public and private sector partners, in other words, it may show the degree of the distribution of difficulties experienced by each

stakeholder. For instance, at site C, it was found that one person in LIFTCo answered 6 (strongly agree) to question 4, and another person in LIFTCo put 4 (slightly agree), meanwhile one interviewee in PCT answered 2 to this question and mentioned difficulties in dealing with this issue as well as benefits. This result might indicate the current situation at site C, or it might be influenced by the position of the interviewees.

#### *4.3.1.5 Issues which may affect value for money*

Interviewees of LIFTCo at sites A and C and of PCT at site C mentioned high bidding costs. LIFTCos have to incur costs for bidding and cannot be compensated if the company fails to be selected as a preferred bidder. The costs incurred by failure of the bidding process will be a significant burden on the company. An interviewee in PCT mentioned that this cost discouraged the participation of other potential bidders and thus, reduced effectiveness in terms of VFM. As mentioned in 3.3.2, VFM can be explained as a fraction between  $CWLB_s$  and  $CWLC_c$ . Thus, this situation results in decreased  $CWLB_s / CWLC_c$ .

#### *4.3.1.6 Locality*

Different approaches embodying strengths in relation to the local community were found at two sites from the interview data of people in LIFTCo. For example, an interviewee at site B was interested in contributing to local regeneration through LIFT, and perceived LIFT as a procurement method to provide not only healthcare facilities, but also a wide range of facilities which could improve the quality of the local environment. To achieve this, this LIFTCo has acquired the services of a person who has considerable knowledge and experience in the area of urban regeneration. This approach seems to be a strength of this LIFTCo. Meanwhile, an interviewee at site C mentioned that providing strong design solutions is one of the strengths of that LIFTCo.

#### *4.3.1.7 LIFT as premises for GPs*

As mentioned in 2.7.7, the method of choosing a procurement route for GPs' premises is as unique as their business models. In effect, there is a variety of choices regarding the acquisition of premises, such as owning their own premises, or adopting the 3PD procurement route and occupying the premises as tenants. LIFT has been added as one new option among others. LIFT is also implemented as the solution to improve on the disadvantages of other current procurement methods and is one of the most feasible choices for GPs. However, many interviewees involved in surgeries did not support the feasibility of LIFT. The points of GPs' perception are summarised as follows:

1. LIFT provides higher quality buildings than ones previously used.
2. Complex procedures cause inflexibility, making it difficult to provide better healthcare services to patients.
3. GPs cannot participate in improving the quality of primary care services.

Firstly, almost all interviewees involved in surgeries agreed that premises provided through LIFT resulted in high patient satisfaction. Most of their previous premises not only did not satisfy requirements regarding suitable size and capacity, but also had maintenance problems such as rainwater leaks. However, secondly, they have experienced stress due to procedures causing disruptions to improvements of health care quality to patients. For example, it was stated that it is difficult to change the time of the automatic locking of the building even if GPs want to extend the opening time of their surgery. Moreover, GPs in all sites mentioned that it requires a long time to effect solutions to any problems. For instance, there is a problem regarding acoustic conditions in waiting rooms for patients because there is insufficient sound absorptive material used in the walls. However, it takes a long time to achieve an effective solution, and staff and patients therefore have to tolerate that situation for a considerable length of time. Thirdly, most GPs feel that in



comparison with their earlier position, they have lost initiative towards achieving better primary health care by being treated as tenants and not stakeholders in a LIFT building. As mentioned in the second point, inflexibility arose from complex procedures which undermine possible improvements for patients even if GPs receive direct feedback from patients. In a sense, there is an information gap between GPs and other authorities, especially PCT and LIFTCo, and thus, this situation has the potential to undermine the benefits of the LIFT scheme.

#### 4.3.2 Concluding remarks

In this section, case study outcomes are stated in terms of seven viewpoints based on the matrices shown in 4.1.6.

The batching approach is not perceived as of essential interest because this is primarily a tool for making LIFT feasible as an investment. However, it is perceived as a tool for utilising lessons learnt from previous projects according to the comment of one interviewee, thus the batching approach has a potential to provide a tool not only for implementing LIFT, but also for enhancing its benefits.

Regarding the common approach, standardised contractual documents help to limit costs concerning documenting agreements. However, it still entails a heavy financial burden for GPs, thus it is not perceived as a benefit by GPs.

Regarding flexibility, this works successfully before reaching agreements, however, it is difficult in practice to make changes after agreements have been reached because additional costs are incurred. Thus, further changes tend to be avoided after agreements are reached.

Regarding long term partnerships, strong tendencies are not found in relation to this viewpoint. The perception of this viewpoint seems to differ at each site.

Regarding the issues which may affect value for money, it was found that bidding costs might be heavy burden for bidders and may undermine value for money.

Regarding the locality, a unique approach according to local needs is taken by each LIFTCo. This shows that LIFTCos have a potential and a capability to effectively fulfil their roles as partnerships between public and private sectors for the benefit of local communities.

Regarding LIFT premises for GPs, three types of perceptions are noted from interviews. GPs feel that, basically, the quality of building achieves patient satisfaction, however, they also consider that the system imposed by LIFT prevents further improvements, and thus they cannot participate actively in improvements even if they have ideas supported by feedback information from direct interactions with patients.

## **Chapter 5 Conclusion and recommendation**

### **5.1 Conclusion**

This MSc report has attempted an analysis of VFM from the viewpoint of stakeholders. Three case study objectives are set in 4.1.1 as follows:

1. to find out whether or not VFM in LIFT actually works as planned by policy makers,
2. to identify whether there are any unpredicted benefits as a result of LIFT or problems which reduce or nullify the benefits, and
3. to clarify the factors required to enhance VFM.

With respect to the first objective, in general terms, it is likely to work effectively as a whole as planned by policy makers. Some points which undermine the effectiveness of benefits are found, such as the issue of complexity caused by the batching approach and high legal costs using the standardised approach. However, these points can be improved

on with the support of public sector. The issue of inflexibility after making agreements seems to be difficult to solve up to this point. There appears to be an inverse relationship; the more elaborate the contract, the less flexible the outcomes.

With respect to the second objective, the individuality of LIFTCo strategy towards each locality was found as one of the strong benefits of LIFT. On the other hand, the gap between GPs and other stakeholders seems to seriously undermine VFM. Likewise, high costs incurred at the bidding process may undermine the degree of VFM.

With respect to the third objective, the most important point involves the participation of GPs. As mentioned, GPs have ideas underpinned by direct interactions with patients as well as their strong motivation to enhance the quality of primary care. As mentioned in 3.2.2, GPs are included in KI (Keep informed) in the power/interest matrix. If GPs can participate much more actively, which means their position moves to KP (Key players), the benefits of LIFT seem to increase, and thus, VFM increases.

Therefore, it is possible to say that LIFT has a strong potential to permit high social return investments in good quality facilities that would not otherwise be feasible, and further improvements as stated above are required to enhance VFM.

## **5.2 Recommendations and further research possibilities**

The recommendations of this report are twofold. One concerns the effective participation of GPs within LIFT schemes. This may mean that GPs join shareholders of LIFT to have powers regarding management and planning issues, or it may mean that policy makers establish systems allowing them to have certain types of initiatives. The other concerns the methods for maximising flexibility within agreements. As mentioned, this is a contradictory and difficult issue, however, it might lead to a breakthrough if effective solutions are implemented.

The further research possibilities lie in understanding LIFT in a much larger context as well as these two viewpoints stated as recommendations. For example, the accountability

of PCT to the locality may affect the concepts of LIFT because the stance of PCT seems to be one of the most influential factors to LIFT. Thorby, et al (2008), mentions current issues and possibilities regarding this factor. It does not affect LIFT directly, however, LIFT may be perceived as a channel to maintain relationships between PCT and the locality. Thus, the further researches on those issues seem to be significant.

## Bibliography

- Aldred, R. (2006), *In the interests of profit at the expense of patient: An examination of the NHS Local Improvement Finance Trust (LIFT) model, analysing six key disadvantages*, London: UNISON
- Bosanquet, N. de Zoete, H. Beuhler, E. (2005), *The NHS in 2010: reform or bust*, London: REFORM.
- Calverley, M. Jago, R. (2005), NHS Lift: Current Progress, Future Growth, *PPP Bulletin*, issue 1 June/July. Surrey: City & Financial Publishing.
- Commission for Architecture and the Built Environment (2008), *LIFT Survey report*, London: CABE.
- Community Health Partnerships (2008), <http://www.communityhealthpartnerships.co.uk/>. Accessed 7.06.2008
- Construction Industry Council (1998), *Constructors' key guide to pfi*, London: Tomas Telford.
- Construction Industry Council (2000), *The Role of Cost Savings and Innovations in PFI Projects*. London: Tomas Telford.
- Department of Health (2000), *Departmental investment strategy*, London: Department of health.
- Department of Health (2001), *Public Private Partnership in the NHS: Modernising Primary Care in the NHS- NHS Local Improvement Finance Trust (NHS LIFT) Prospectus*. London: Department of Health.
- Department of Health (2008), <http://www.dh.gov.uk/en/Procurementandproposals/Publicprivatepartnership/NHSLIFT/index.htm>. Accessed 10.06.2008
- Gillham, B. (2000), *The research interview*, London: Continuum.

- HM Treasury (2003), *The Green Book: Appraisal and Evaluation in Central Government*. London: The Stationery Office.
- HM Treasury (2007), *Managing Public Money*, London: The Stationery Office.
- HM Treasury (2008), *Infrastructure procurement: delivering long-term value*. London: The Stationery Office.
- Holmes, J. Capper, G. Hudson, G. (2006), Public Private Partnerships in the provision of health care premises in the UK, *International Journal of Project Management*, 24, 566-572.
- Johnson, G. Scholes, K. Whittington, R. (2005), *Exploring corporate strategy* (7th ed), Harlow: Financial Times Prentice Hall.
- King's Fund/Commission for Architecture and the Built Environment (2002), *Primary Care – Making a Better Environment for Patients and Staff*, King's Fund/ CABE Conference, 1 May 2002.
- Mumford, M. (1998), *Public Projects Private Finance: Understanding the Principles of the Private Finance Initiative*. Griffin Multimedia, Welwyn Garden City.
- National Audit Office (2003), *PFI: Construction Performance*, London: The Stationery Office.
- National Audit Office (2005), *Innovation in the NHS: Local Improvement Finance Trusts*, London: The Stationery Office.
- National Health Service (2000), *The NHS Plan: A plan for investment, A plan for reform*. London: The Stationery Office.
- Pearce, D. W. (1983), *Cost-benefit analysis* (2nd ed), London: Macmillan.
- Pollock, A. Price, D. (2006), Privatising primary care, *British Journal of General Practice*, August, 565-566.
- PricewaterhouseCoopers LLP (2008), *The value of PFI: Hanging in the balance (sheet)?*, London: PricewaterhouseCoopers LLP.

- Rintala, K. (2004), *The economic efficiency of accommodation service PFI projects*, Tampere: VTT Technical Research Centre of Finland.
- Stiglitz, J. E. (2000), *Economics of the public sector* (3rd ed), New York, London: Norton.
- Thorlby, R. Lewis, R. Dixon, J. (2008), Should primary care trusts be made more locally accountable?, *A King's Fund discussion paper*. London: King's Fund.
- House of Commons Committee of Public Accounts (2006), *NHS Local Improvement Finance Trusts: Forty-Seventh Report of Session 2005-06*, London: The Stationery Office.
- Williamson, O. (1985), *The Economic Institutions of Capitalism*, London: Collier MacMillan.
- Winch, G. (2002), *Managing construction projects: an information processing approach*, Oxford: Blackwell Science.
- Yin, R. (2003), *Case study research: design and methods* (3rd ed), London: Sage Publications.

### Bibliography used under confidentiality

- Strategic Service Development Plan for the site A
- Strategic Service Development Plan for the site C
- LIFTCo website for the site B (Accessed 14.06.2008)
- LIFTCo website for the site C (Accessed 14.06.2008)

Appendix I All LIFT projects (cited from DoH (2008))

ALL LIFT PROJECTS – PROGRESS TO DATE - Updated 31st March 2008

LIFT Scheme	SHA	Preferred bidder date	Financial close date	LIFT Company	Capital cost of tranche			Capital cost of tranche		Buildings open to patients	Buildings under construction
					1.0m	2.0m	3.0m	4.0m			
Barnsley	Y&H	19/02/2003	30/07/2004	Barnsley Community Solutions	13.12	12.21				Worsborough - Oct 2004 Thunscrope - Nov 2004 Goatthorpe - Dec 2004	Grimethorpe - March 2008 Cudworth - August 2008 Kenshaw Town - spring 2009
Camden & Islington	LON	23/05/2003	16/07/2004	Camden & Islington Community Solutions Ltd	3.5	3.6	13			Hanley Road - June 2005 Bingfield Street - August 2005 Partnership POC - October 2006	
East London	LON	05/12/2002	01/05/2003	East London LIFT Accommodation Service Ltd	24.5	19	16.5			The Centre Manor Park - Sept 2004 Bolyrn Road, Barking Road - August 2005 Special Addiction Unit, Mile End - March 2006 Friel Elbers, East Ham - November 2006 Berkentree - December 2007	Hackney Child Development Centre - March 2008 Vicarage Lane - September 2008
Manchester, Salford & Trafford	NW	16/04/2003	01/07/2004	LIFTCo TopCo M&ST Ltd	73.9					Energygo Healthy Living Centre - Nov 2005 Parrington - January 2006 Bromley Green - January 2006 Wythenshawe - May 2006 Willow Tree - Dec 2006 Openshaw - February 2007 Brunswick - May 2007 Cheetham - August 2007 Arcoats - February 2008 Brunton Park - March 2008 Shrimmoor - March 2008 Walker - May 2008 Kenton - September 2008	Pendleton - Autumn 2008 Eccles - Autumn 2008 Walkden - Late 2008
Newcastle and North Tyneside	NE	28/05/2003	11/05/2004	NNIT LIFTCo Ltd	13.4	10.1					Dudley - March 2008
Sandwell	WM	11/04/2003	15/01/2004	Sandwell LIFT Project Company Ltd	7.4	2.4				Birmingham Rd Health Centre - March 2006 Cobury Health Centre - May 2005 Wharfedale - September 2005 Year Tree - August 2006	
<b>TOTAL CAPITAL COST - WAVE 1</b>					<b>135.92</b>	<b>47.31</b>	<b>29.5</b>	<b>0</b>			
<b>Barking &amp; Havering</b>	LON	01/05/2003	04/12/2004	Barking & Havering LIFT Ltd	46.7	19.8				Thames view - April 2005 Broad Street - June 2005 Harold Hill Centre - Oct 2005 Church Elm Lane, Dagenham - Nov 2005 Cranham - December 2005 South Hornchurch - April 2006 Marisgate, Romford - June 2006 Chadwell Heath - September 2006	Porters Avenue - November 2008 Barking Town Centre - February 2009
Birmingham & Solihull	WM	11/05/2003	21/07/2004	Birmingham & Solihull LIFT Ltd	6.3	28	8.9			Chelmsley Wood - July 2005 Woodgates Valley - July 2005 West Heath - October 2007 Finch Road - December 2007 Summertield - March 2008	Greenridge POC - April 2008 The Dove Primary Care Centre - March 2008 Stockland Green - May 2008
Bradford	Y&H	17/11/2003	19/10/2004	Bradford & Airedale Care Partnerships Ltd	14.8	14.5				Low Moor - January 2006 (partially open) Westbourne Green - March 2006 Haworth - July 06 Thornbury - October 2007 Hillsdale Bridge - January 2008 Unconediffs - January 2008	
Corwall & Isles of Scilly	S.W	22/08/2003	24/05/2004	Community 1st Corwall	3.46	4.2	16			Oak Tree Surgery, Liskeard - June 2005 The Clays, Roche - Dec 2005	Cornish Food Production - March 2008 Foster Block - December 2008 Truro Health Park





Bromley, Bexley & Greenwich	LON	24/11/2003	01/03/2005	BEG LIFT Company Ltd	54.8				Whichurch Health Centre - November 2007 Shreampton PCC - December 2007 Garland Rd - Jan 2007 Beckenham Hospital - Phase 1 Oct 07 (Phase 2 Summer 08) Cochester PCC - April 2006 Fryett Hospital & Mayflower Medical Centre - August 2006	Lakeside - December 2008
Colchester & Tendring	EOE	07/11/2003	07/07/2004	Faithful Health Ltd	35.8					
Derby	EM	30/10/2003	03/12/2004	Southern Derbyshire LIFT Company Ltd	16.8	24.8			Eden Surgery - August 2005 The Lighthouse, Chaddesden - March 2006 Long Eaton - May 2006 Swadlow PCC - Nov 06 Village Medical Centre - Feb 2007 Alfreton PCC - Feb 2007 Coleman Health Centre - June 2007	
Doncaster	Y&H	20/12/2004	28/09/2005	Doncaster Community Solutions	8.89	14.4			The Sandringham Centre - July 06 Denaby Springswell Centre - October 2006 Vermuyden Centre - November 2006	Aslern Centre - Autumn 2008 Edlington Centre - Autumn 2008 Hafield Centre - Autumn 2008 Moorlands Centre - Autumn 2008 Stratley Hill - April 2010
Dudley	WM	26/04/2004	07/10/2005	Dudley Infricare LIFT Ltd	13.2	21.4			Ridgell - October 2006 Stourbridge Health & Social Care - October 2007 Cloister Road - February 2006 Heart of Hounslow Health Centre - Feb 2007 Rowner - December 2005 Oak Park Phase 1 - March 2006 Brune Medical Centre - October 2007 Park House - January 2006 Stapleford - March 2006 Clifton Cornerstone - April 2006 Mary Potter Centre - April 2007 Keyworth - June 2007	
Ealing, Hammersmith & Hounslow	LON	15/08/2003	22/03/2005	EBH - West London Ltd	28.6				Watson PCC - 7 August 2007 (Ph 2 - Sept 08) Sunshine House - October 2007 Gravefield Gardens PCC - December 07 Armsley - November 2005 Middleton - October 2005 Woodhouse - December 2005 Parkside - January 2006 Beeston - June 2007 Yeadon - October 2007	East Leeds - June 2008 Lower Wortley - June 2008 Wetherby - June 2008
East Hampshire, Fareham & Gosport	SC	26/01/2004	09/02/2005	Soient Community Solutions	7.8				Woodside - February 2006 Mooroside - Jan 2007 Thorford - Jan 2007	
Greater Notts	EM	17/09/2003	14/06/2004	Greater Notts LIFT Company Ltd	33.5					
Lambeth, Southwark & Lewisham	LON	14/11/2003	06/12/2005	EBH - LSL Ltd	31					
Leeds	Y&H	12/12/2003	26/06/2004	Leeds LIFT Ltd	18.1	13.6	29			
Norfolk	EOE	05/12/2003	21/05/2004	Norlife Ltd	3.98	5			Plowright Medical Centre - May 05 Sheeringham HC - Aug 2005, Thorford - Jan 2007	
Oxford	NW	12/12/2003	17/11/2004	Community 1st Oxford	2.52	6	20			
Oxford	SC	20/10/2003	26/11/2004	Oxford Infricare LIFT Ltd	16					
Plymouth	SW	20/11/2003	21/10/2004	Resound Health Ltd	14.8	3.2			Ernesettle Green - September 2005 Mount Gould Local Care Centre - July 2006 Cattedown - January 2008	
St Helens, Knowsley, Halton and Warrington	NW	16/11/2003	20/10/2004	Partners 4 LIFT Ltd	12.7	16.4	13.28		Widnes Resource Centre - February 06 Longview - November 2006 Manor Farm - March 2007 Whiston - May 2007 Garswood - January 2008	North Hayton - March 2008 Newton Community Hospital - August 2008 Halewood - October 2008 Beacontfield - October 2008 Warrington Child Development Centre - August 08
Sheffield	Y&H	23/12/2003	13/10/2005	Community 1st Sheffield	5	6			Wincobank - October 2006 Dewopar - January 2007 Jordenthorpe - October 2007 Green Wytke Lane Health Centre - October 2006	
South West London	LON	22/12/2003	28/04/2005	EBH - SW London Ltd	18.48					

Tees	NE	28/01/2004	13/10/2004	Care Partnerships 25 Ltd	5.6	11.2	St John's - Feb 2007 Lawson Street, Stockton - March 06 Wyward Road - August 06 Richardson Hospital - April 2007 Phoenix Centre, Parkfields - January 2006 Gem Centre, Bentley Bridge - April 2006
Wolverhampton	WM	28/10/2003	10/11/2004	Health Improvement Partnership (Wolverhampton & Walsall) Ltd	8		
<b>TOTAL CAPITAL COST - WAVE 3</b>					<b>433.47</b>	<b>156.4</b>	<b>25.28</b>
4 <sup>th</sup> Wave							
Bolton, Rochdale, Heywood and Middleton	NW	02/11/2005	09/05/2007	BRAHM Fundroot Ltd	21.6		Alkington - April 2008 Deepdish - October 2008 Beighlimgel - March 2009
Bury, Glossop and Tameside	NW	30/08/2006	29/06/2007	Bury, Tameside & Glossop Community Solutions Ltd	25.1		Ashton - November 2008 Rabodiths - December 2008 Paddock Community Centre - Spring 2009
Southern, Castle Point, Rayleigh and Rochford	EOE	15/06/2006	10/08/2007	South East Essex	6.3		
South East Midlands	EM	27/10/2005		Preferred bidder - Guildhouse	0		
South Midlands	WM	27/10/2005		Preferred bidder -	0		
South West Hampshire	SC	01/08/2007		Preferred bidder - gbPrimaryCare	0		
<b>TOTAL CAPITAL COST - WAVE 4</b>					<b>53</b>	<b>0</b>	<b>0</b>
<b>OVERALL CAPITAL COST TOTALS</b>						<b>1341.39</b>	<b>167</b>
							<b>48</b>

POC = Primary Care Centre

Appendix II Interview Instrument

**Interview instrument** (for Community Health Partnerships)

Date: .....

Time: .....

Place: .....

Interviewee: .....

a) What are the actual benefits of LIFT to you?

Do you think that you have acquired benefits as planned?

b) How have you improved LIFT through first to fourth wave?

c) How have you changed requirements and priorities within LIFT?

Have you changed the importance of the design?

d) How do you learn from past LIFT experiences?

What have you learnt from past LIFT experiences?

e) Why was PfH changed to CHP, and why did DoH need to takeover all shares from HM Treasury?

What is the advantage to take this action?

f) What are the matters which might be revised of LIFT?

g) Is LIFT types PPP beneficial than PFI? Why?

h) How do you improve this PPP in the future?

i) Do you think this system will expand to other sectors? Why?

j) Do you think this system will expand to other areas? Why?

k) How do you deal with when agreements expire in 25 years time?

**Interview instrument** (for PCT)

Date: .....

Time: .....

Place: .....

Interviewee: .....

a) What are the benefits of LIFT to you?

b) How do these benefits affect you?

c) Which benefit is most important to you? Which is not? Why?  
Please place these benefits in order of importance and merit.

d) What kind of things are changed by LIFT?

e) Is there any problem with the current sub-lease system?

f) Do you think LIFT is cost effective? (Value for money)

g) How do you communicate with LIFT Co?

h) How do you communicate with Community Health Partnerships?

i) How do you communicate with other stakeholders?

j) What is the main relationship with the patients group?

k) What are the current disadvantages of LIFT?

l) What is the possible problem in the future of this scheme?

m) In the Outline Business Case (OBC), what were main planned benefits? How were size of these benefits estimated for the OBC?

**Interview instrument** (for LIFT Co)

Date: .....

Time: .....

Place: .....

Interviewee: .....

a) What is a difference of the benefits and risks between LIFT and PFI?

b) Do you think that LIFT is good investment?

With which other types of investment, would you say it is most comparable?

Why?

c) How do you compare investments between LIFT and other investments?

d) Is there any difficulties with current LIFT

(e.g. bundled system, hard + soft FM, minor refurbishment...)?

e) It is said that LIFT premises are more expensive to construct than ordinary ones. It may not a problem if the quality of the provided service is enhanced and whole life cycle cost is reduced. Please let me know your opinion about this.

f) How does your contract provide for flexibility?

g) Do you think the flexibility is working properly?

h) Have you ever been required to change the agreement? (Why? How?)

Do you foresee changes being required in future?

i) Do you feel stress with requirements of the Strategic Partnering Board?

j) It is said that local GPs can invest to LIFT as private sector partner.

But, it seems to be rare cases. Do you think it is possible?

k) Do you think that the requirements and interests of government have changed through wave 1 to four?

l) What are the possible problems in the future of this scheme?

m) How were you affected by the change from Partnerships for Health to Community Health Partnerships?

**Interview instrument** (for GPs)

Date: .....

Time: .....

Place: .....

Interviewee: .....

- a) Please let me know about your premises before LIFT.
- b) How is the situation changed and improved by LIFT?
- c) How has the partnership as business been affected?
- d) Do you think LIFT is the best way?  
Are you satisfied with the new premises provided by LIFT?
- e) Is your rent higher than before LIFT?
- f) Do you need to change current contract?
- g) How do you deal with if you would like to execute minor refurbishment?
- h) Do you think that cost per patient has increased with LIFT?
- i) Do you pay rent to LIFT Co or PCT?
- j) Are you subsidized by PCT?
- k) Do you think it is beneficial?
- l) Distance to premises from house seems to increase than before. Do you think this is problem for patients?
- m) Is there any problems of the location of this new premise?  
(Rent, expense, cost performance, minor refurbishment, polyclinics, commuting...)
- n) What are the obvious benefits of LIFT to you?



- o) What is the main relationship with the patients group?
- p) What are the current disadvantages of LIFT?
- q) What is the unpredicted problem within the LIFT?
- r) What is the possible problem in the future of this scheme?

An Additional questionnaire for all interviewees

Strongly agree   Agree .....   ..... Disagree   Strongly disagree  
6                    5   4                    3   2                    1

---

**Q1.LIFT is better investment than other types of procurement (PFI...)**

**(overall)**

---

**Q2.LIFT is a better investment than others**

**(as business)**

---

Q3.LIFT is better investment than others

(because of low risk)

---

Q4.LIFT is better investment than others

(because of the long term exclusive contract)

---

Q5.LIFT is better investment than others

(because of the standardized procedure)

---

Q6.LIFT is better investment than others

(because of the other reasons)

---

**Q7.LIFT is flexible enough**

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Q8.LIFT is a complex system

---

**Q9.There are risks and uncertainty within LIFT**

---

Q10. LIFT has obvious disadvantages than other systems

---

Q11. Requirement from other bodies may be a big risk for LIFT

---

**Q12. LIFT meets value for money (cost, quality)**

---

**Q13. LIFT has improved quality of healthcare service**

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**Q14. LIFT has improved quality of building design**

---

**Q15.LIFT helps improving local environment**

---

Q16. LIFT can achieve satisfaction of local people

---

Q17. Requirements of design has increased within LIFT

---

Q18. Requirements of other factors has increased/ changed within LIFT

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