NATIONAL AUDIT OFFICE

DEPARTMENT OF HEALTH

Innovation in the NHS: Local Improvement Finance Trusts

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SUMMARY

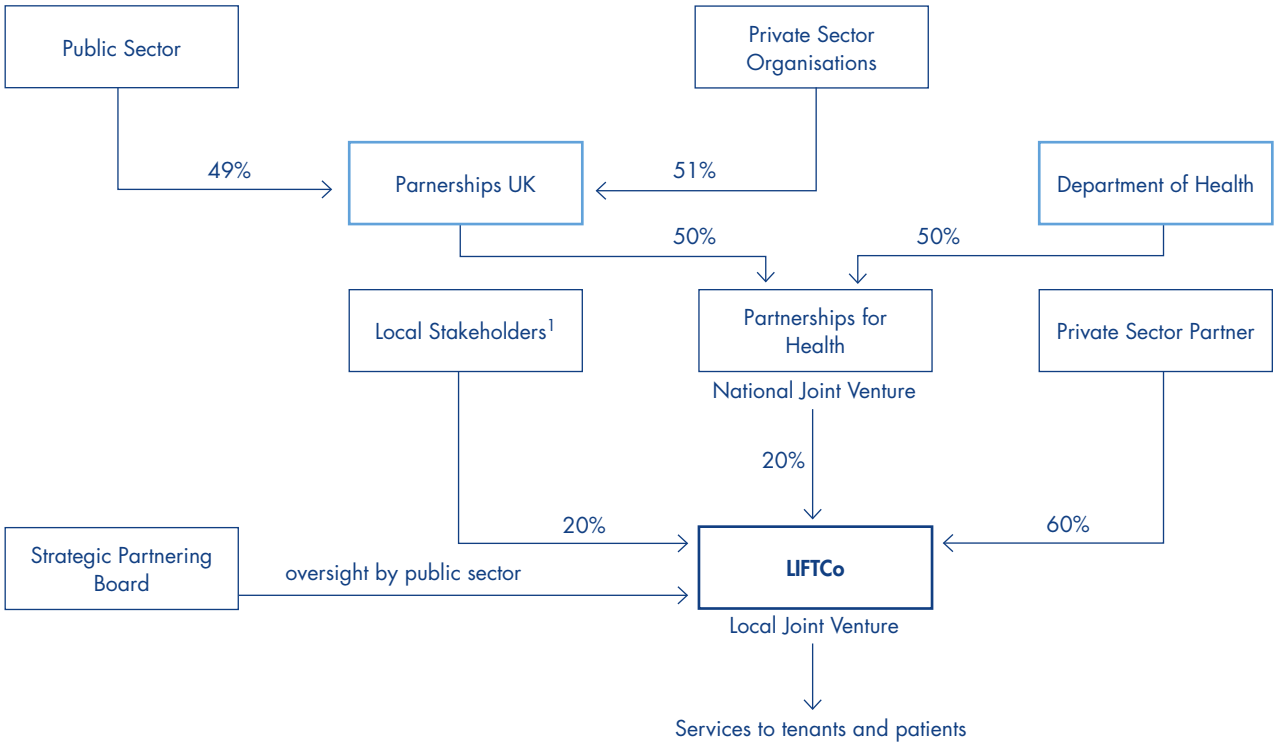

Consulting Rooms
14,15&16
Contact Room
Interview Room 2
Meeting Rooms 2&3
Treatment Room 5
Toilets
Consulting R
11, 1
Minor S
Suit
Treatment

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

2 LIFT is innovative in that it is based on long term joint ventures at national and local level. The national joint venture, Partnerships for Health, is between the Department and Partnerships UK.[2] The local joint venture company (the LIFTCo) is owned by representatives of the local health economy, Partnerships for Health and a private sector partner **(Figure 1)**. As individual primary care developments tend to be small scale – averaging around £5 million – LIFT takes a "batched" approach and promotes a standardised procurement process. Project priorities are determined in the context of a local strategic plan, developed by a Strategic Partnering Board, comprising representatives of stakeholders from the local health economy.

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

1 Structure of a LIFT Public Private Partnership



Source: National Audit Office

NOTE

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

1 Social care is the professional provision of care, support and welfare for dependent or vulnerable groups or individuals.
2 Partnerships UK, is itself a joint venture between HM Treasury, Scottish ministers and the Private Sector, HM Treasury having a substantial minority shareholding. Partnerships UK work exclusively for the public sector to improve delivery of Public Private Partnerships.

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

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

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

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

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

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

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

The National LIFT programme

10 LIFT will bring improvements in GPs' premises, support co-location of healthcare professionals and help forge links between primary and social care. Indirectly, it may help resolve GP recruitment and retention problems, help shift services away from secondary care[3], assist in achieving good chronic disease management[4] and enhance "Patient Choice" – giving patients more choice over how, when and where they receive treatment.

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

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

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

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

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

The local LIFT models

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

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

16 The financing structure and terms for LIFT are broadly similar to those achieved in PFI deals, even though LIFT deals are smaller and have novel features. The ratio of debt to equity (gearing) of the schemes examined was in the range 89 to 95 per cent, with PFI typically 90 per cent. Returns to the private sector also appear comparable. The blended equity Internal Rate of Return[5] of LIFT projects in our case studies, ranges from 14.3 to 15.9 per cent. These are not out of line with the 12.5 to 15 per cent seen on similarly sized PFI projects. The deals have been designed to offer clear long term benefits to both the public and private sector participants (see Figure 12). Requirements for benchmarking and market testing, aimed at protecting future value for money, have also been built into the contracts.

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

Outcomes and Prospects

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

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

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

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

RECOMMENDATIONS

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

Planning a new initiative

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

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

3 It is important that effective reviews of Strategic Service Development Plans for LIFT schemes are undertaken regularly, in accordance with Partnerships for Health guidance. Primary Care Trusts are responsible for the initial plan. Once the LIFTCo is established, the Strategic Partnering Board takes ownership of the plan and needs to lead on its annual review if LIFT is to meet its, wider, longer term objectives. It is important to consult with all relevant local stakeholders and determine how LIFT will contribute to issues such as premises design, organisational development, regeneration and financing whilst ensuring good strategic fit with other local initiatives in related areas – for example, in secondary, acute and social care, or in regeneration. The plan should also anticipate potential change in the long term and assess the impact that LIFT will have on the local area as a whole - not just development sites.

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

Implementing a new initiative

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

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

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

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

Evaluating a new initiative

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

9 The Department should establish a framework with which it can establish and evaluate the impact of LIFT. There are two essential components; firstly the Department should develop clear guidance about the nature and timing of Post Project Evaluation for LIFT schemes, allowing for a rigorous evaluation of implementation best practice and initial value for money. Secondly, the Department could usefully develop a basket of measures reflecting national priorities, allowing the Department to monitor the impact of LIFT over time. Working closely with the Department, LIFTCos could then track health outcomes and regeneration achievements. Local measures could be defined by LIFTCos and prioritised on the basis of the Strategic Service Development Plan. Together, these components will enable reasoned comparison of LIFT to alternative procurement models. Where developing similar initiatives it is important that Departments establish these frameworks prior to financial close.

Overseeing a new initiative

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

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

Learning from a new initiative

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