

# The LIFT PPP Model

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Providing an estate for the 21<sup>st</sup> century NHS



A research review prepared by The LIFT Council  
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## List of abbreviations

BREEAM - Building Research Establishment Environmental Assessment Method

CHP - Community Health Partnerships

CHPI - Centre for Health and Public Interest

CCG - Clinical Commissioning Group

DHSC - Department of Health and Social Care

LIFT - Local Improvement Finance Trust

LIFTCos - LIFT Companies

MCP - Multi-specialty community provider

NAO - National Audit Office

NIHR - National Institute for Health Research

PAC - Public Accounts Committee

PACS - Primary and acute care systems

PFI - Private Finance Initiative

PF2 - Private Finance 2

PPP - Public-private partnership

3PD - Third-party development

STP - Sustainability and Transformation Partnership

VfM - Value for money

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## Introduction to the LIFT Council

The LIFT Council is the representative body for the non-public sector partners within the Local Improvement Financial Trust (LIFT) initiative. Following the introduction of the LIFT public private partnership model by the Department of Health in 2004, the Council was established in 2005 as a forum for discussion and a vehicle for action as the clear industry voice of the LIFT community in dialogue both with political and policy stakeholders and with the media. The Council is a thought leader in debates around the provision of primary and community care premises in the National Health Service in England.

The LIFT Council's eight members have significant experience of managing health and social care facilities across England, with responsibility for nearly 300 buildings, representing over 80% of all LIFT buildings nationally. In addition to much-needed investment in these facilities, LIFT companies (LIFTCos) offer extensive strategic knowledge and expertise in local health care economies, the lack of which has otherwise been recognised as a shortcoming preventing improvements to the NHS estate. LIFT has a proven track record of investing in primary care infrastructure to move services out of hospitals and into community settings. Now is a crucial time for NHS facilities, and LIFTCos are well placed to continue working with their public sector partners to ensure that NHS properties are equipped to deliver the ambitions of the Five Year Forward View.

LIFT Council members are the private sector partners in LIFT, working closely with Community Health Partnerships: a wholly government owned subsidiary company of the Department for Health and Social Care, which holds a 40% stake in all LIFTCos. The LIFT Council acknowledges the support given for this research by its members:



## Summary

### The need for investment: a 21st century NHS estate

There is an urgent need for investment in the NHS estate across England to improve patient experiences and ensure our healthcare infrastructure is fit to deliver new models of integrated care. The Naylor Review of NHS property and estates in 2017 found that much of the estate is outdated with some healthcare buildings pre-dating the formation of the NHS 70 years ago. The Government endorsed Sir Robert Naylor's assessment, admitting that many buildings across acute, primary and community care "would not meet the demands of a modern health service". The medical profession agrees, with seven in ten GPs viewing their practices as too small to offer additional services, and the British Medical Association calling for an immediate review of the primary care estate as part of its 2018 contractual negotiations with the Government.

The Department of Health and Social Care has stepped up its efforts to tackle this issue, with the recent Budget and its formal response to the Naylor Review pledging a £10 billion investment package for NHS infrastructure over the next five years. However, the Government has made it clear that it will need to find funding from a range of sources, and call on the capacity and expertise of the private sector to enable the transformation needed to design and deliver a healthcare estate fit for the 21<sup>st</sup> century.

### The benefits of LIFT

LIFT companies have a track record of developing high quality primary and community care buildings to suit local health needs. Evidence from several surveys during the 15-year life-span of LIFT, demonstrates that the PPP model delivers benefits including:

- **A proven partnership approach to primary care estates development**, mandating close collaboration between public and private sector stakeholders. Unlike other private procurement models, LIFT requires that both public and private sector investors retain an equity share in LIFT schemes, and evaluations of LIFT have found this approach leads to effective risk transfer and alleviation of administrative burdens; inter-agency cooperation and co-location of previously separated bodies; and the transfer of skills and experience between stakeholders, including an improved understanding of financial and strategic management issues among all parties.

- **A long-term community focused approach to local estate needs**, with contracts offering 25-year agreements backed by a government indemnity covenant. LIFT agreements offer well-balanced incentives to both private sector investors and the public sector equity holder Community Health Partnerships which is mandated to reinvest profits into local estates and healthcare services. As part of its enduring commitment, LIFT companies are in continuous dialogue with a wide range of NHS stakeholders, including through local estates forums, while simultaneously providing a range of partnering services to improve broader strategic estates planning and delivery.

### Delivering new care models for the NHS

The current nature of healthcare infrastructure presents a barrier to health and care transformation demanded by the Five Year Forward View. The vision of NHS England Chief Executive, Simon Stevens, focused on creating new models of care that would enable an efficient and effective integration of primary, acute, mental health, social care and community services. LIFT can help to enable the modernisation of the estate by offering:

- **A development model which has successfully shifted additional services into primary and community care.** LIFT buildings have, in many cases, provided access to treatments previously only available in hospitals through award winning designs facilitating the integration of services. LIFT supports the hubs model and implementation of multi-speciality community provider (MCP) and primary and acute care systems (PACS) structures which bring together a wide range of healthcare staff to better care for patients closer to their homes.
- **A modern, flexible approach to development to ensure quality**, which will be equally as important as models of development for a 21st century healthcare estate. LIFT has been specifically credited for raising the bar for quality in healthcare infrastructure development, by attracting national construction and design teams and bringing more sophisticated expertise to the development of purpose built primary and community care buildings. LIFTCos also seek to incorporate flexibility into designs to meet changes required by the evolution of local estates and service planning, while maintaining premises to avoid the significant backlog maintenance issues seen in other parts of the NHS.

## A role for private finance

Sir Robert Naylor has emphasised the need to embrace private investment in NHS estates development, particularly in primary care. The Government's 5-year programme of investment in healthcare infrastructure outlines an ask for over £3 billion of capital from the private sector, though it is crucial this investment is carefully scrutinised and does not recreate the problems of the past. Primary care estates development through LIFT will enable this as:

- **LIFT differs significantly from traditional PFI arrangements.** The PPP model offers a value for money estates procurement option at lower capital values than PFI builds, and unlike these controversial PFI deals, significant public sector shareholding in LIFT projects ensures local buy-in from all stakeholders, as LIFTCos own, build, maintain and refurbish the premises. While PFI is being reimagined as PF2 under stricter scrutiny of value to the taxpayer, LIFT has been successful in delivering projects under set affordability caps, with every proposal forced to demonstrate value for money prior to gaining approval.
- **The LIFT Council supports the call for greater transparency and more data on the value and utilisation of private capital** in NHS estates development. Critics of LIFT sometimes cite project costs and repayment rates as a reason not to utilise the model, but value for money standards through the appraisals process are designed to ensure good outcomes for patients and the taxpayer. A lack of information on cost, value and utilisation of the estate reflects a broader issue facing the primary care sector in particular, for which detailed data is rarely produced or shared publicly. Public and private partners in LIFT are constantly innovating to reduce under-used building space and these efforts need to be supported by a broader discussion on the many factors influencing utilisation of local healthcare buildings.

## LIFT: a local partnership approach

The NHS LIFT model has provided a successful long-term approach towards planning, investment, development and maintenance of the primary care estate across England since its introduction in 2004. A key feature of this success has been the establishment of an effective partnership between public and private shareholders in LIFT companies. Unlike in other private procurement models, LIFT requires that both public and private sector investors retain an equity share in LIFT schemes, with the government owning a 40% stake in each LIFTCo through Community Health Partnerships (CHP). A key lesson from the experience of LIFT over the past 15 years has been the positive impact the partnership approach can provide, not only for the benefit of public and private sector officials closely involved in LIFT projects, but also for the benefit of local healthcare communities as a whole.

### Progress through PPPs

Multiple evaluations of the LIFT programme over the past decade have highlighted the positive impact of its partnership approach to local healthcare estates improvement. [The National Audit Office in 2005](#) found that LIFTCos were demonstrating the ability “to build strong local partnerships with key stakeholders”<sup>1</sup> and stated that “the structure of LIFT is designed to foster a spirit of partnership with stakeholders working together to achieve mutual goals”. The report also noted specific benefits to the NHS, including risk transfer to the private sector which enables “public sector healthcare professionals to focus on delivery of a good quality service.”<sup>2</sup>

In its [10-year progress report on LIFT](#) - developed through independent research by Amion Consulting - CHP highlighted LIFT’s record of facilitating “broader linkages and a more holistic approach to the delivery of health and community services” within localities. This is supported by “inter-agency co-operation” and the “co-location of previously separated bodies.”<sup>3</sup>

Another independent investigation on the value of LIFT, carried out by the [National Institute for Health Research](#) (NIHR) in 2010, repeatedly emphasised the benefits of the partnership approach. The NIHR report “found evidence that LIFT had created the organisational and institutional framework for effective partnership

<sup>1</sup> National Audit Office AO (2005), *Innovation in the NHS: Local Improvement Finance Trust*, page 3.

<sup>2</sup> NAO, page 10.

<sup>3</sup> Amion Consulting (2014), *The Impact of the Local Improvement Finance Trust Programme, Community Health Partnerships*, page 6.



working within the NHS.”<sup>4</sup> While interaction between various stakeholders working within NHS frameworks is often accompanied by ‘cultural clash’, LIFT has been effective in promoting joint-working systems. NIHR stated that partners within LIFT projects were “working together well” while “differences in culture were being managed and accommodated as partnerships matured”.

At an operational level, LIFT partnerships provide the opportunity for a transfer of skills and experience between the public and private sectors. Working with private sector LIFT investors and managers who specialise in healthcare estates development has allowed public sector officials to gain “a significant understanding of strategic and financial management issues”<sup>5</sup>; develop strong commissioning and planning skills<sup>6</sup>; and alleviate significant administrative burdens.<sup>7</sup>

### **An enduring commitment**

The LIFT model provides the value of a stable, long-term partnership, with contracts typically offering 25-year agreements backed by a government indemnity covenant. The length of contractual arrangements between LIFT companies and local health economies ensure a commitment to the community and its shifting healthcare needs. The positive effect of this commitment is evident in research on LIFT, with the NAO stating that contracts offer long-term “well-balanced”<sup>8</sup> incentives to both public and private sector partners. In its [only review of the LIFT model in 2006](#), the Public Accounts Committee endorsed the NAO’s finding that LIFT provides an enduring strategic approach to local health estates planning<sup>9</sup>, and this is further supported by NIHR’s assertion that “public private procurement and collaboration is more effective within a framework of long-term contracting and repeat purchases.”<sup>10</sup>

A key element of LIFT’s offer is in the strategic approach it provides for local health economies or the regions covered by LIFT development. Both public and private sector LIFT partners engage frequently with local NHS stakeholders, including commissioners, providers and local authorities, including through formal collaborative working groups via local estates forums/groups. In the early stages of LIFT this took place through the Strategic Partnering Boards<sup>11</sup> and in recent years,

<sup>4</sup> National Institute for Health Research (2010), *The Role and Effectiveness of Public Private Partnerships (NHS LIFT) in the Development of Enhanced Primary Care Premises and Services*, page 236.

<sup>5</sup> NIHR (2010), page 238.

<sup>6</sup> NIHR (2010), page 237.

<sup>7</sup> NIHR (2010), page 238.

<sup>8</sup> NAO (2010), page 26.

<sup>9</sup> House of Commons Committee of Public Accounts (2006), *NHS Local Improvement Finance Trusts*, Forty-seventh report of Session 2005-06, page 23.

<sup>10</sup> NIHR (2010), page 236.

<sup>11</sup> Public Accounts Committee (2006), *Public Accounts (2006), NHS Local Improvement Finance Trusts*, page 4.

some LIFTCos have become more closely involved in the development of Sustainability and Transformation Partnership (STP) estates plans, by providing capability and capacity through ‘partnering services’. This includes the offer of strategic estate planning and guidance on infrastructure programmes/reconfiguration and development across the STP footprint area. This service has answered the call of [the Naylor Review](#), highlighting the need for the health service to “improve capability and capacity to support national strategic planning and local delivery.”<sup>12</sup>

### Community impact and reinvestment

While LIFTCos are for-profit enterprises, returns from investment flow both to public and private sector partners. This delivers the clear benefit of enabling public-sector reinvestment to meet local health needs. Indeed, the Government has recently re-affirmed its mandate that “all dividends received by CHP are re-invested exclusively into the NHS.”<sup>13</sup> In addition, value for money for LIFT schemes needs to be secured at business case approval on the terms of both public and private sector partners, providing a level of transparency and oversight not consistently seen through other procurement routes. Finally, LIFT developments have often made a positive impact on more deprived communities. In 2014, Amion found that close to 90% of LIFT projects are situated in areas with above average health needs.<sup>14</sup> The buildings are also typically in areas where there are few other employers and will often provide the main source of local employment.<sup>15</sup>

## Delivering new models of care

The NHS in England is undergoing a step change in its approach to providing care. Simon Stevens’ Five Year Forward View strategy, first published in 2014, was an overdue attempt to modernise the delivery of services by better integrating hospital, primary, community, mental health and social care to ensure better outcomes for patients across the country. More recently, this national strategy has been taken forward through the development of STPs and the amalgamation of service providers through accountable care, though it is clear that the pace of change needs to increase. There are very few stakeholders across the NHS who would argue against the need to bring services together ‘under one roof’, but the practicalities of providing that physical environment are a challenge. Estates transformation has been identified - both at a national and local level - as a key enabler of integration

<sup>12</sup> Naylor, Sir Robert (2017), *NHS property and estates: why the estate matters for patients*, page 4.

<sup>13</sup> Hansard (2018). Answer to parliamentary written question, Stephen Barclay MP, 8 February, 2018.

<sup>14</sup> CHP (2014), page 5.

<sup>15</sup> CHP (2014), page 11.

through new care models, with the development of new buildings providing the opportunity to shift care into the community. LIFT has a key part to play in this transformation, as providers and commissioners across the country seek to make significant changes to their health and care infrastructure.

### Developing the 21<sup>st</sup> century estate

There is an acknowledgement across the NHS that the current state of England's healthcare infrastructure presents an obstacle to transformation. In its response to the Naylor Review, the Department of Health and Social Care agreed with Sir Robert's findings, admitting that "some of the estate is old, in parts even older than the NHS itself", contending that these buildings "would not meet the demands of a modern health service".<sup>16</sup> The non-party think-tank *Reform* published a review of the primary care estate in January 2018 which added that "infrastructure is a barrier"<sup>17</sup> to the transformation of health and care services, noting the British Medical Association's finding that seven in ten general practitioners regard their buildings as too small to deliver the additional services demanded by the Five Year Forward View.<sup>18</sup>



LIFT provides a solution to the 'state of the estate', offering a development model which has consistently designed buildings to provide more than just traditional primary care services. NIHR found evidence that "LIFT projects have extended primary care delivery, providing services, previously only available in hospital"<sup>19</sup> and DHSC has endorsed the expansion of LIFT for this purpose, stating that the model is a "critical part of (its) primary care strategy" given its aim to "integrate health, community and local authority services like gyms and libraries."<sup>20</sup>

Quality will be equally as important as procurement type in the development of a 21<sup>st</sup> century healthcare estate. Senior NHS officials have told the LIFT Council that premises designed through LIFT are considered to be of a very high quality. All new health buildings in the UK are required to meet a high sustainability standard under

<sup>16</sup> Department of Health and Social Care (2018), *The Government Response to the Naylor Review*, page 5.

<sup>17</sup> Reform (2018), *A design diagnosis: reinvigorating the primary care estate*, page 2.

<sup>18</sup> Reform (2018), page 3.

<sup>19</sup> NIHR (2014), page 49.

<sup>20</sup> DHSC (2018) Naylor Review response, page 16.

the Building Research Establishment Environmental Assessment Method (BREEAM)<sup>21</sup>, but LIFT has been specifically credited for raising the bar for quality in healthcare infrastructure development, by “attracting national construction and design teams and bringing more sophisticated expertise to the development of purpose built primary care projects.”<sup>22</sup> The LIFT model also mandates ongoing maintenance to a high standard throughout its buildings and for the duration of each lease, essentially eliminating the potential for critical backlog maintenance concerns. This is particularly relevant given the Department of Health and Social Care currently faces an estimated backlog maintenance bill of £5 billion across the English healthcare estate<sup>23</sup>, with much of the early rounds of STP capital funding being directed towards alleviating this substantial challenge.

### **The community hubs solution**

The Government has outlined a new vision for primary care premises, which calls for the introduction of hubs or “super-hubs” in primary care to enable considerably greater collaboration between all types of primary care staff and the delivery of a wider range of services within a single location.<sup>24</sup> Evidence suggests that larger GP practices with more staff and a greater number of patients produce better outcomes.<sup>25</sup> “Super-hubs” will not be appropriate for every community and, in particular, may not necessarily help to serve more isolated areas effectively. However, the move away from the model of small, single-handed GP partnerships - often accommodated in old converted houses - is both inevitable and necessary to ensure high quality, timely treatment for patients close to their homes.<sup>26</sup>

There is emerging proof that new care models will reduce demand for accident and emergency services in hospital by providing a more complete service which focuses on the preventative impact of primary care. NHS England's 50 new care model vanguards have been in operation across the breadth of the country since September 2015 to create a blueprint for the modern delivery of services.<sup>27</sup> Two types of vanguards, focused specifically on integrating primary and community care with acute services, have proved to be successful at pilot stage. The integrated primary and acute care systems (PACS) and multi-specialty community provider (MCP) pilots have reduced relative demand for Accident & Emergency services, as

<sup>21</sup> BREEAM (2013), “BREEAM Healthcare FAQs”, June 2013.

<sup>22</sup> NIHR (2010), page 48.

<sup>23</sup> The Naylor Review (2017), page 2.

<sup>24</sup> Hansard (2017), “Debate on GP indemnity costs”, 15 March 2017.

<sup>25</sup> Reform (2018), page 2.

<sup>26</sup> GP Online (2016), “Days of single-handed GPs are over, says CQC chief inspector”, 25 October 2016.

<sup>27</sup> NHS England, “About vanguards”.

growth in emergency admissions has increased by 2.6% and 0.9% under these models, respectively, against 6.3% for the rest of England.

LIFT developments across the country provide best-in-class examples of premises design for integrated services through these models. For example, the Kentish Town Health Centre - which won awards for “Best Primary Care Design” and “Best Public Building” in 2009 and 2010<sup>28</sup> - houses a GP practice complemented by children’s services, screening and diagnostic imaging facilities, a library, gym and rentable community space. In February 2018, the Birmingham Dental Hospital and School of Dentistry was highlighted at the King’s Fund’s conference on NHS partnerships. The LIFT scheme is the first combined dental hospital and dental school to be built in the UK for 40 years, created through a partnership between the local LIFT company (BAS LIFT), Birmingham Community Healthcare Foundation Trust and the University of Birmingham.



Kentish Town

This project was built as part of the Edgbaston Medical Quarter health and care hub, which will bring together 180 medical organisations - including 80 hospitals and specialist care centres and 44 GP clinics and routine care facilities - within walking distance in Edgbaston.<sup>29</sup> The project also shows how LIFT can provide a solution to ongoing local estates issues: prior to the new development, the Community Trust had been operating within dangerous physical conditions, and the outcome not only ensured the creating of a safe, best-in-class building, but also provided a considerable benefit to the University of Birmingham by allowing for co-location with the Dental Hospital within the premises.



Birmingham Dental Hospital and School of Dentistry

These are just two of the many examples of LIFT schemes supporting the national NHS primary care estates investment strategy. In January 2018, the Department of Health and Social Care called for the development of a “clinically fit-for-purpose estate... equal to delivering the Five Year Forward View and new models of care”. The Department emphasised the need for local strategic estates planning to reflect “changing delivery models, in particular the planned shifts of activity into primary care”.<sup>30</sup>

In its response to the Naylor Review, the Department identified LIFT as a “critical part” of this strategic vision from 2018 onwards. In order to realise the benefits of new care models and ensure the shift towards enhanced delivery of primary care services is designed to suit community needs, local health organisations would

<sup>28</sup> Camden & Islington Community Solutions (2009), “Kentish Town wins Building Better Healthcare 2009 Awards”.

<sup>29</sup> Edgbaston Medical Quarter Birmingham website.

<sup>30</sup> DHSC (2018), Naylor Review response, page 7.

benefit from LIFT companies bespoke approach to premises development, which enables the effective integration of health, social care and community services.

## Private finance in NHS estates

The use of private finance in the development of public sector infrastructure has recently come under the microscope in the UK. The current Government, DHSC, and NHS organisations have been subject to increased scrutiny over their partnerships with private companies through Private Finance Initiatives (PFI). The vast majority of PFI developments - used primarily in the design and construction of healthcare and education buildings - were completed during the 1990s and the first decade of this century, but the issue regained its prominence in public debate during 2017, following the Labour Party's announcement of a PFI "buy-out" policy at its annual conference.<sup>31</sup>

### Contrasting procurement models: LIFT and PFI

The LIFT PPP model is not an iteration of the Private Finance Initiative. LIFTCos have attempted to outline the variances when engaging with local stakeholders since NHS LIFT was first launched in 2004, while several publications have emphasised the distinctions between PFI and LIFT procurement for NHS estates. The NAO's report in 2005 stated that LIFT schemes have much smaller capital values than most PFI projects<sup>32</sup> and that tenants are subject to comparatively low levels of repayment during the lease term.<sup>33</sup>

Unlike PFI deals, LIFT projects ensure local buy-in from all stakeholders, as local LIFTCos own, build, maintain and refurbish the premises.<sup>34</sup> The LIFT model provides for an enduring partnership between public and private sector investors in the local healthcare estate and it can only be successful where board members from the private companies and CHP engage productively to meet the requirements of tenants and local health systems as a whole. The NIHR's 2010 review found that the LIFT initiative has "differed significantly from traditional PFI procurement in a number of ways". The report again emphasises the contrast with LIFT involving "significant public sector shareholding", and mandating much closer, ongoing collaboration between public and private partners in healthcare estates development.<sup>35</sup> The Department of Health - through CHP - has both the incentive

<sup>31</sup> BBC (2017), "John McDonnell 'would bring existing PFI contracts in-house'".

<sup>32</sup> NAO (2005), page 14.

<sup>33</sup> NAO (2005), page 24.

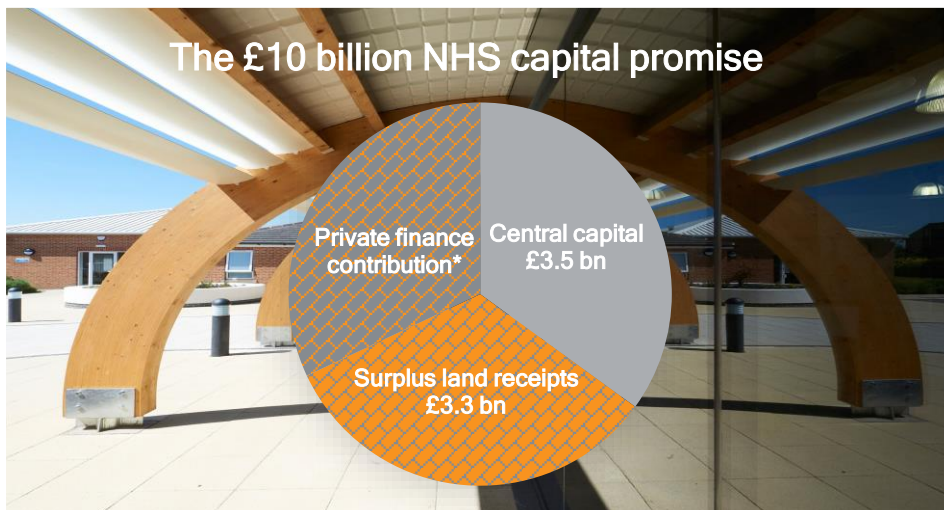
<sup>34</sup> NAO (2005), page 2.

<sup>35</sup> NIHR (2010), page 14.

and the necessary oversight to ensure LIFT companies develop and maintain premises which facilitate the needs of patients across England.

### Private investment in primary care

LIFT is sometimes inaccurately linked to PFI in discussions around improving the NHS estate. However, recent reviews and reports on private finance deals in healthcare have not highlighted the PPP model, in contrast to the PFI model, in their analyses of the impact on government finances. In its [critique of PFI in 2017, Profiting from infirmaries](#), the Centre for Health and Public Finance (CHPI) highlighted 13 PFI schemes where total profits reached over 20% of total NHS payments.<sup>36</sup> None of these schemes had any relationship to LIFT, and only one of the deals was agreed to complete the development of primary care buildings. An NAO review on PFI and PF2 in early 2018<sup>37</sup> preceded a Public Accounts Committee hearing where MPs questioned Treasury witnesses on problems caused by large “traditional” PFI deals stemming from the first wave of investment under the Major and Blair governments.<sup>38</sup> Neither LIFT, GP premises, nor primary care in general were mentioned at any stage within the NAO report or during the PAC hearing.



The omission of the primary care PPP model within these reports and formal inquiries underlines the irrelevance of traditional large private financing deals for hospital construction within discussion on the value of LIFT. While the NAO concluded in January 2018 that there is “still a lack of data available on the benefits”<sup>39</sup> of PFI, the case for LIFT is much clearer. With less than 10% of

<sup>36</sup> Centre for Health and Public Interest (2017), *Profiting from Infirmaries*, page 12.

<sup>37</sup> National Audit Office (2018), *PFI and PF2*, report by the Comptroller and Auditor General, HM Treasury, HC 718 Session 2017-2019.

<sup>38</sup> Public Accounts Committee (2018), “Oral evidence: Private Finance Initiatives, HC 894”.

<sup>39</sup> National Audit Office (2018), *PFI and PF2*, page 5.

healthcare spend dedicated towards primary care<sup>40</sup>, and the NHS capital budget repeatedly raided to meet service shortfalls<sup>41</sup>, the Naylor Review made it clear that private investment was especially important in the sector.<sup>42</sup> DHSC has endorsed Sir Robert's recommendation and LIFT companies' role in providing private finance for estates transformation "where this provides value for money".<sup>43</sup>

## Criticism of the LIFT model

While many commentators see the LIFT model as an effective means of utilising private investment to improve the local healthcare estate, some stakeholders have cited concerns around the cost and utilisation of LIFT facilities. Some complaints surrounding LIFT are exacerbated by the lack of data available on comparative costs and utilisation levels for other development routes, while other challenges raise legitimate concerns around the lack of public transparency in the process for development approvals generally. However, when they occur, such negative views of LIFT are often borne out of a misunderstanding of the factors influencing underutilisation of buildings and the value provided by the model.

### Value for money

Value for money measurements (VfM) have been adapted in the years since private finance was first utilised in the development of UK healthcare infrastructure. In evidence provided to the Public Accounts Committee in March 2018, officials from HM Treasury confirmed they have adopted a "much more rigorous approach" to VfM considerations in the new wave of PF2 deals, when compared to the level of evaluation involved in the initial PFI agreements.<sup>44</sup>

LIFT has been subject to similar value for money objections as traditional large PFI deals. NIHR said in its 2010 review that there is a "lack of evidence of whether LIFT projects provide VfM"<sup>45</sup>, while complaints have often more crudely focused on the notion of cost by highlighting the impact of ongoing financing and facilities payments, and labelling LIFT as an 'expensive' option. However, since the model's introduction in 2004, LIFT schemes have been subject to progressively higher thresholds at project appraisal stage. VfM must be demonstrated within proposals for every LIFT development<sup>46</sup>, which also need to reach the stringent quality and sustainability ratings (BREEAM) noted earlier in this report.

<sup>40</sup> British Medical Association (2017), "Investment in general practice in England".

<sup>41</sup> The Health Foundation (2017), "NHS Capital spending falls for third year in a row".

<sup>42</sup> The Naylor Review (2017), page 25.

<sup>43</sup> DHSC (2018) Naylor Review response, page 16.

<sup>44</sup> PAC (2018), "Oral evidence: Private Finance Initiatives".

<sup>45</sup> NIHR (2010), page 50.

<sup>46</sup> NHS England, Estates and Technology Transformation Fund Q&As.



Part of the reason LIFT has been labelled as ‘expensive’ is due to an inappropriate comparison of affordability, VfM and lifecycle costs. Concerns can arise when the cost of LIFT buildings, via a “lease plus” contractual agreement which fully maintains a building’s services and fabric, is crudely compared to the cost of developing through other routes which do not provide facilities management and lifecycle cost (for the whole 25-year life of the contract) as part of the annualised rent, and which do not transfer the same level of liabilities and risks as the LIFT model. It is fair to conclude that some smaller developments may lend themselves to alternative procurements routes, for example third-party development (3PD). LIFT Companies are well placed to explore these alternatives and are able to give examples where affordability issues (limited revenue) have led to alternatives being delivered for NHS partners, including through 3PD.

In terms of affordability, LIFT has been consistently successful in delivering projects under stated thresholds. The programme has delivered £2.5 billion for capital development within affordability caps set at outline business case stage, supported by only £100 million of public sector funding. [The 2006 PAC report](#) on out-of-hours care in England, confirmed that no LIFT projects had exceeded planned costs by the date of the related inquiry.<sup>47</sup>

### Utilisation concerns

Both the Naylor Review and Lord Carter’s report on NHS *Operational productivity and performance* in 2016 highlighted poor utilisation of substantial amounts of the estate. This was particularly underlined within the acute sector, for which comprehensive data is much more readily available, but it is also a significant problem within primary and community care, and has been an issue within some LIFT buildings. Under-utilisation is sometimes presented as a reason not to develop estates through the LIFT model, though this reflects an overly simplistic diagnosis of the problem. Levels of utilisation of all healthcare buildings reflect a range of interrelated factors, including commissioning patterns and decisions; land ownership status; organisational silos within local health economies; treatment incentives; shifting patient demand and NHS structural reorganisation.

Premises development through LIFT has stalled in some areas recently, in part due to the impact of structural changes within the NHS. The abolition of Primary Care Trusts through the Health and Social Care Act of 2012 particularly affected LIFTCos

<sup>47</sup> House of Commons Committee of Public Accounts (2007), *The Provision of Out-of-Hours Care in England*, HC 360 Session 2005-06, page 23.

- not simply due to the lack of direct local involvement by those trusts in LIFTCos in which they owned a stake - but also by the manner in which the major structural overhaul created new lines of reporting, new stakeholders, new targets, and new decision-making procedures for all areas including primary care estates development. Decisions which reflected commissioning strategies before this change were not necessarily carried to fruition under new management, and there is a risk that a similar pattern will emerge with the move from localised commissioning (CCGs) towards merged, regional (STP) or integrated (accountable care structures) health and care management frameworks.

LIFTCos are supportive of the move towards new care models, given the key role they can play in delivering more care in the community. However, it is important for all NHS stakeholders to recognise how frequent structural change can impact long-term strategic planning, and how the process can cause a logical decision over the deployment of resources to look misguided once these changes have begun to take effect. LIFTCos have, where necessary, attempted to incorporate flexibility into designs to meet changes required in the future,<sup>48</sup> while CHP has introduced a new centre management service and tenant access portal to improve bookable services and reduce void space in LIFT buildings.<sup>49</sup>

<sup>48</sup> NIHR (2010), page 49.

<sup>49</sup> CHP, "Making the Most of Buildings and Land".

## Conclusion

LIFT companies across England have provided £2.5 billion of investment in primary and community care buildings, establishing the model as an effective vehicle for developing the healthcare estate. The overarching strength of LIFT over the past 15 years has been its ability to create strong, enduring partnerships between key local stakeholders and to ensure close collaboration among public and private partners at board level and beyond. LIFTCos have developed high quality, multi-purpose buildings throughout the country over the past decade and a half, but they are eager to look to the future and play a central role in the transformation of the NHS through new care models. The Government in 2018 has committed to implementing the “most ambitious programme of investment” in healthcare buildings “the NHS has ever seen”<sup>50</sup>, and while there will be central funding to support this aim, there is a clear need for value for money private investment to support the expansion of the primary care estate.

LIFT buildings have been developed to provide the integrated service offer demanded by the Five Year Forward View, and LIFTCos provide the benefit of both a model to facilitate the community hubs approach to primary care, and the expertise to assist NHS partners in their broader reconfigurations of local NHS estate. LIFT is not perfect, but it has proven to be adaptable amidst ever shifting organisational structures within the NHS, providing benefits not easily attained through more traditional models of private finance procurement. Public and private partners in LIFT are continuously innovating to improve the utilisation of their buildings, while being subject to fixed quality standards and value for money tests on all developments.

This report has provided evidence on the benefits of LIFT and has addressed concerns about the procurement model held by some stakeholders. It has gathered the most relevant and up to date pieces of literature which explore NHS LIFT in detail and the wider debate around the ‘state of the estate’. Few would argue against the urgent need for significant improvement of NHS infrastructure, particularly in primary care, and the conclusions of this report prompt a number of necessary actions to reach that goal.

<sup>50</sup> The Conservative and Unionist Party (2017), *Forward Together: Our Plan for a Stronger Britain and a Prosperous Future - The Conservative and Unionist Party Manifesto*, page 67.

## Recommendations

### 1. Greater central government - local NHS alignment on evaluating

**PPPs** - The Department of Health and Social Care has endorsed the use of private finance for the development of the NHS estate, where it provides value for money. However, procurement options such as LIFT are sometimes ignored by local NHS organisations due to misperceptions over the cost and value of the model. Regional officials tasked with providing guidance on strategic estates planning and implementation must ensure PPPs are considered without prejudice by commissioners and providers, particularly given the limited availability of central capital.

### 2. A long-term revenue commitment to support the Department's 5-year capital plan

- The Government's welcome commitment to improving NHS buildings and technology must be supported by an appropriate uplift in the revenue budget to enable rent repayments. While LIFTCos are willing and able to provide billions of pounds in capital investment, progress will be limited if prospective tenants are not given the financial headroom for development in the long-term NHS plan to be released by the end of 2018.

### 3. Clarification on the business case approvals process between the NHS and investors

- LIFTCos have consistently met affordability caps at the outline business case approval stage for new schemes, but the overall decision-making process towards approvals has provided confusion for some time and appears to differ across the country. The LIFT Council is eager to work with NHS England, and other national and local stakeholders to ensure the healthcare estates community is aligned on its understanding of approvals process.

### 4. Greater transparency and more data on cost, value and utilisation

- The LIFT Council recognises that the lack of clear data on various procurement options presents difficulties to local and regional NHS officials tasked with transforming their estate. We are eager to work closely with CHP, the Department of Health and Social Care and the Treasury to ensure greater access to data on cost and value, as well as utilisation rates within buildings developed through LIFT and other procurement routes available to NHS organisations.

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