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UpLIFTing PFI: Does LIFT improve public-private procurement?

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Abstract

The Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) were both introduced by the UK government as part of a drive to improve public service provision. Both PFI and LIFT focus on leveraging the key strengths of the public and private sectors when developing new facilities. This paper does not seek to question the need for new infrastructure, but rather discusses the difficulties encountered when trying to analyse LIFT as a system and when evaluating whether it can address earlier concerns about the PFI procurement process. Our analysis suggests that it is difficult to predict whether LIFT will be capable of delivering on its promise of providing cost-effective, bespoke Primary Care facilities.

Key words: PFI, LIFT, public private partnerships, finance.

Introduction

For over twenty years the UK government has recognised the need to improve health care infrastructure, initially focusing on hospitals but more recently turning its attention to the needs of the primary care sector. With this change in focus came the recognition that primary care estates would provide a different investment parameter to potential private sector partners. Consequently, a change to the Public Finance Initiative (PFI) system that had been used to purchase and manage the earlier flagship hospitals was required; and in 2001 the Department of Health introduced the Local Improvement Finance Trust (LIFT).

In 2007, researchers at The York Management School received funding from the National Institute for Health Research Service Delivery and Organisation Programme to examine the role and effectiveness of Public – Private Partnerships (NHS LIFT) in the development of enhanced primary care premises and services. One year on, the researchers have gained a greater understanding of the nature and environment in which this system is expected to operate. The aim of this paper is to discuss how LIFT differs from PFI and, using Soft Systems Methodology, identify why this system is proving to be extremely complex to unravel.

The evolution of Public Private Partnerships in the NHS

In the early 1990's, the UK government sought to address inefficiencies it believed existed in the National Health Service (NHS). With the introduction of hospital trusts and the quasi-market for hospital-based health care and the introduction of GP Fund-Holders (GPFHs), making them the gatekeepers of funding for their patients and ensuring that funding followed service provision, the government needed to ensure that any improvements to NHS estates were provided in an efficient manner. It was believed that Public Private Partnerships (PPP) could achieve this by attracting sources of funding previously unavailable to the NHS. Since the government struggled to find adequate funding for basic maintenance, "let alone large scale investment without infringing Treasury limits on the PSBR and financial markets' expectations regarding the long term sustainability of government expenditures" (Clark & Root, 1999), PFI was seen by many as a way of providing desperately needed upgrades. This was based on the underlying assumption that the government did not have the required capital resources and that alternative systems would allow for delivery with far lower financial outlay (Clark & Root, 1999; Spackman, 2002).

Following the introduction of the Public Finance Initiative (PFI) in 1992, by November 1994 it had become mandatory that all capital projects in the public sector requiring Treasury approval should explore the use of private finance options (Private Finance Panel, 1995) unless it was absurd or unrealistic to do so (Private Finance Panel, 1996; Akintoye et al, 2003). Whilst strongly criticised by the opposition at the time, PFI in various guises eventually became the lynchpin for capital estates reform for the subsequent labour governments and facilitated an increased commitment to the "buy now pay later" approach which characterises much of the development and management of NHS estates (Clark & Root, 1999).

PFI Issues

Among PFI supporters there was an expectation that the new approach would attract private sector funds, resources, management skills, expertise and innovation to the provision of public sector infrastructure (Mustafa, 1999). It was also hoped that PFI would prevent many of the issues prevalent in public sector managed capital projects, including over-spend, delays, poor design, high operational and maintenance costs and low residual values (Forshaw, 1999) while introducing more commercial discipline and encouraging value for money (Birnle, 1999).

However, whilst the government hoped that PFI would see private sector investment in the public sector increase significantly, in reality this failed to be the case (Clark & Root, 1999). Initially PFI failed to produce the levels of investment expected when it was announced, with targets for PFI investment being on average 50 per cent less than planned (Daily Telegraph, 1995). This was in part due to a feeling among public sector clients that they would be overwhelmed by this process. Many issues inherent in the PFI process came to the fore during the various waves of consecutive infrastructure development. The key issues that prevented PFI from being an optimal system for infrastructure procurement and management are discussed below.

Lack of required skills in the public sector (PFI)

Over the years it has become evident that local authorities and other public sector bodies struggle to become equal partners in PFI projects (Clark & Root, 1999). This appears to stem from a number of factors. Firstly, the PFI process inherently suffers from asymmetry of information (Asenova et al, 2002). The private sector partners already have all the technical skills required to complete the design,

negotiations, construction and management of a new building as they are required to do this on a frequent basis. For the public sector partners, involvement in PFI is often a unique experience that challenges their commercial capabilities. In theory public sector clients must lead the entire process if they do not wish to be at the mercy of the contractors; but in reality many clients feel as though they are “walking in the dark” (Akintoye et al, 2003). Asenova et al quote one NHS Manager as saying that “building a hospital is a once in a lifetime experience” (Asenova et al, 2002). Similarly, HM Treasury publications note that skill shortages occurred in the healthcare sector, particularly in areas such as contract negotiation and project risk management (HM Treasury, 1999). These skill shortages continue to be apparent many years after PFI has been introduced, which is surprising given that the budget of some of these projects exceeded £100 million (Spackman, 2002).

Lengthy negotiations and complex contracts (PFI)

One particular point of criticism of traditional PFI procurement concerns the length and complexity of negotiations. Where projects have involved multiple partners and funding streams, PFI negotiations were renowned for being exceedingly long (Asenova et al, 2002; Akintoye et al, 2003), slow (Asenova et al, 2002) and complex (Akintoye et al, 2003). This has again been attributed to a lack of experience on the part of public sector staff who appear to have required lengthy discussions with consultants in order to gain the required degree of understanding of the PFI process (Asenova et al, 2002; Akintoye et al, 2003) and/or lengthy time periods for arriving at decisions among multiple stakeholders (Asenova et al, 2002). Notwithstanding these problems, some research suggests that consultants may have exacerbated this by providing excessive levels of technical detail (Asenova et al, 2002; Akintoye et al, 2003), while some private sector partners were less forthcoming with detail, preferring a ‘black box’ approach (Akintoye et al, 2003).

Researchers continue to attribute the slow pace of the negotiations typical of PFI projects to the public sector’s bureaucratic attitudes” (Asenova et al, 2002; Akintoye et al, 2003; Stewart & Butler, 1996), prolific regulations (Stewart & Butler, 1996) as well as a (lack of) efficiency and validity of procedures (Clark & Root, 1999). This is aggravated by the fact that the purchase of full-service contracts poses further problems as it requires clients to define the quality of service they expected which can give rise to post-contract disputes (Akintoye et al, 2003).

For a whole variety of reasons therefore, the resultant PFI contracts continue to be seen as highly complex, and being shrouded in secrecy and ‘opacity’ (Clark & Root, 1999).

Poor risk management (PFI)

Part of the rationale for PFI was that appropriate risks would be transferred to the private sector if it was better placed to handle them. However, PFI procurement has been criticised on the grounds of inappropriate risk transfer (Clark & Root, 1999). Whilst it was apparent that it was not always possible to specify the precise nature and distribution of risk (Clark & Root, 1999), it would seem that the public sector had particular difficulty understanding risk assessment and management, particularly with regard to risk associated specifically with PFI, or even with finding consultants who could help them with this process (Private Finance Panel, 1995; Akintoye et al, 2003). Additionally, there was a lack of central guidance that resulted in public sector organisations trying to develop their own evaluation criteria. This has been both time consuming and costly as it incurs a significant amount of professional fees (Akintoye et al, 2003). As regards specific projects, it was recognised that some risks were transferred to the private sector that the public sector was better placed to take. Some of

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this could have been avoided through an improved knowledge of PFI risks within client teams and a more standardised approach to project and risk management (Akintoye et al, 2003; Asenova et al, 2002)

Cost (PFI)

When compared to projects purchased via traditional procurement methods many PFI projects involved higher purchase costs (Akintoye et al, 2003; Akintoye et al, 2003). This applies to the health sector in particular, where, in a 1996 survey of 202 NHS Trust Chief Executives, only 17 per cent believed that PFI would be cost-effective in the long term (UNISON, 1996). The same survey noted that even where a PFI project was shown to provide value for money, there was still a question of affordability as the hospital trust had to pay rent for the new facilities for the entire tenure of the contract which could give rise to long-term affordability gaps (UNISON, 2002).

Interestingly, concerns over costs were also voiced by private sector PFI parties in connection with the high bidding costs they faced when competing for PFI contracts. A series of interviews with private sector partners noted that these costs arose from upfront payments for consultancy and legal services which the private sector saw as part of a mounting budding risk (Akintoye et al, 2003; Asenova et al, 2002). In addition, private sector consortia noted that establishing and maintaining a consortia added cost and effort to the undertakings (Akintoye et al, 2003). The PFI process also required private sector partners to price their facilities management services in a vacuum during the bidding process, which proved to be difficult (Akintoye et al, 2003). For the private sector, PFI projects therefore came with a high opportunity cost, since bidding for these contracts required greater efforts and resources to improve the chance of success, which could have been utilised for smaller and more numerous projects (Akintoye et al, 2003). When queried about the cost of PFI, private sector partners therefore noted that PFI bids placed a significant financial burden on them, which had to be recouped on consecutive projects (Asenova et al, 2002).

Further concerns about the cost of traditional PFI projects have arisen in connection with the issue of project refinancing. After a project has been commissioned, banks may be willing to refinance for a longer term at a lower rate. Refinancing increases the expected dividends which will accrue to the shareholders. This has raised concerns about fairness to the taxpayer and in particular the need for refinancing gains to be shared fairly with the public sector client (Asenova et al, 2007; Spackman, 2002)

Responsiveness to local needs (PFI)

Whilst it was hoped that PFI investment in the NHS would improve the capabilities of the health service for the foreseeable future, the King's Fund has claimed that the government "rushed into a massive capital building programme without any collective or central reflection as to precisely what type of facilities it ought to be investing in" (The King's Fund, 2000) . They went on to state that "Hospitals are being built under the Private Finance Initiative (PFI) without taking the needs of local people into account". Despite a lack of further and detailed studies, there remains a concern that PFI projects are not built where they are most needed, but rather where the public sector is most able to progress the procurement process (Beck and Hunter-Beck, 2003).

Building quality (PFI)

One of the expectations associated with the involvement of private sector partners in PFI projects was an improvement in both the design and quality of buildings in the NHS estate. The Commission for Architecture and the Built Environment, the Government's architectural watchdog, however, has raised concerns about the quality of design in PFI schemes (UNISON, 2002). Sunand Prasad, Commissioner at the Commission for Architecture and the Built Environment) claimed that "There is a legacy of sub-standard buildings in primary care and we are still, tragically, constructing buildings in PFI that are not buildings to be proud of in the future" (Davis, 2002).

Whilst some of the issues stem from the designs put forward by the architects, some blame has been laid with the public sector who, the private sector partners claim, have put forward either unclear or unreasonable demands which subsequently lead to delays and mistakes (Asenova et al, 2002; Akin-toye et al, 2003).

LIFT – a new system for PPP infrastructure development

Whilst PFI in the health service was initially conceived as a way to procure new hospital infrastructure for the health service, it was recognised that similar improvements were required in the primary care sector. However, it was clear that much of this would merely involve the refurbishment or redevelopment of relatively small GP-led premises. As Aldred (2007) identifies, GP-owned premises are usually small and therefore their refurbishment would not typically be the type of project that would appeal to the private sector investor. In response to this dilemma, in 2001 the Department of Health (DoH) introduced its new Local Improvement Finance Trust (LIFT). Inherent in LIFT is an exclusivity clause giving the successful LIFTCo the right to build primary care premises for Primary Care Trusts (PCTs) (Aldred, 2007). By grouping a number of projects together and including the long-term operation and management of these facilities, the scale of each initiative is increased considerably, making them viable and attractive to private investors (Hudson et al, 2003; Holmes et al, 2006; National Audit Office, 2005). One example of this is a project where a company is providing design services on a range of schemes forming part of a £125 million programme to deliver over 40 health care centres (Hospital Development, 2006a). Another project will provide nine new healthcare centres, a 72-bed care home for the elderly, a new HQ for the lead primary care trust as well as additional facilities in the first 18 months (Hospital Development, 2006a).

The question for the research team is whether there is evidence that LIFT, as a system, can address the shortcomings of PFI. The project started by The York Management School seeks to examine the role and effectiveness of LIFT in the development of enhanced primary care premises and services. In order to do so, it is necessary to have a clear understanding of the steps involved in LIFT and the environment in which it operates. As soft systems analysis can be used to ensure understanding of the various aspects of a system in order to develop a root definition, it is believed that this approach may assist in gaining a clearer perception of LIFT (Checkland, 1990a). A review of the elements and parties involved in LIFT using Checkland's CATWOE mnemonic (1999a) assists in understanding some of the complexity. However, as the driver is the transformation process, this will be considered first.

Transformation

Transformation is the "means by which defined inputs are transformed into defined outputs" (Checkland, 1999b). For LIFT, the final output is a bespoke building capable of supporting the delivery of primary care services in the more deprived areas of England and the ongoing management of these

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facilities. A review of the literature would suggest that not only have there been similar issues encountered when using LIFT as a system for the delivery of these outputs to those found with PFI, LIFT would appear to have created additional problems, all of which are discussed below.

Building quality (LIFT)

The implementation of LIFT has kick-started the regeneration of primary care premises on a major scale. For example, in Merseyside alone it is envisaged that there will be 30 schemes with a total value of £100 million (Burton, 2004). Given that many GP practices were housed in poor accommodation with only 40% of premises purpose built, and almost 50% in either converted shops or former residential buildings (Montague, 2004), the government has high hopes for LIFT-built premises. However, in the main, there is no evidence that this has been the case. One author goes so far as to state that “LIFT as a vehicle, is not necessarily producing very much better buildings. Generally speaking, they are mediocre at best” (Simpson, 2007). Peter Wearmouth, chief executive of NHS Estates, identified a lack of innovation in design and said

We are still designing buildings that look the same as they did 30-40 years ago. We still have waiting rooms and consulting rooms, but society has changed. Patients are no longer submissive yet we build architecture that is submissive

(Davis, 2002)

Mathieson (2003) confirms this view by describing one proposed centre with five stand-alone GP surgeries, each with their own waiting room. Even Lord Hunt, Ministerial Design Champion is quoted as saying “It is striking how unambitious the health service has been in the quality of the design of what it produces” (Davis, 2002). Prasad supported the aims of the “NHS Achieving Excellence in Design” evaluation Toolkit, intended by NHS Estates to raise the general standards of design in the NHS building programme, but conceded that it would not ‘produce genius designs’ (Davis, 2002). Whilst this lack of “flair” was perhaps understandable during the first wave where the impetus was to get the first projects completed (Parker, 2006), it is less acceptable for these issues to characterise later projects.

Designing for a health care market was something new for most architects / design companies (Holmes et al, 2006) and seems to have posed some challenges. These challenges included the need to take into account the “unique aspects of each centre such as the acoustic features for those which had audiology departments, the need to develop bespoke characteristic entrances to each site” (HD, 2006) as well as the security concerns of staff (Holmes et al, 2006). Whilst it was recognised that the health service did not “want to make the same mistakes as we did in the 1950s and 1960s” when “we built health centres, which are now unloved buildings surrounded by security fences and covered in graffiti” (Andalo, 2003), some initial designs were likened to ‘car show-rooms’ or ‘prisons’ by lay stakeholders (Holmes et al, 2006).

Whilst the multi-disciplinary, open-layout approach to working in some new LIFT buildings has created a “sense of community spirit” that has been well received by some (Gilbert, 2005), it has also created problems. For example, in one location the creation of a centralised reception area for four physician practices has reduced patient privacy as any discussion with the medical secretaries can be easily overheard (Gilbert, 2005). There have also been basic oversights, such as the lack of a patient call system so doctors must leave their rooms to call in their next patient, insufficient car parking

spaces and a common alarm system that prevents GPs from calling in to their practice to work out of hours are some of the “teething problems” encountered (Gilbert, 2005).

The LIFT process is credited with attracting national construction and design teams (Holmes et al, 2006.), and for facilitating attention to detail, such as the creation of a design with features to maximise light and ventilation (Montague, 2004). However, bringing this “sophisticated design expertise” into the procurement process also brought negotiation teams into the bidding process who “used this experience to drive a hard bargain with the PCT teams for whom each negotiation was a first” (Holmes et al, 2006). Today private sector partners claim that they are “on the hook” to deliver “decent buildings” that are “affordable”, “efficient” and “good-quality” whilst being “architecturally-striking civic landmarks” (Sansom, 2007). At the same time there are economic incentives for the private partner to design and build in a way that will minimise maintenance costs (Dawson, 2001). However, there is a worry that LIFT has the potential for inadvertently locking the health service may into inflexible contracts for poorly constructed building with high operating costs for the next 25 years (Paxton and Lissauer, 2000).

Lengthy negotiations and complex contracts (LIFT)

Given the scale of the combined LIFT projects, companies bidding for the work must go through a detailed procurement process governed by European legislation. The scale of the projects means that a bidding company must have the requisite skills and adequate resources not only to complete the job, but to develop and fund expensive, and potentially unsuccessful, bids (Hudson et al, 2003; Holmes et al, 2006). Holmes et al (2006) suggest that submitting a bid may cost an organisation between “£500,000 and £1 million, with only a one-in-three chance of success”. Consequently, some smaller developers are unable to compete and are squeezed out by the large development companies (Hudson et al, 2003). However, these larger, often national, companies often have higher overheads which can be a significant factor in the overall construction costs of the schemes (Hudson et al, 2003; Holmes et al, 2006).

Some private partners consider the pressure of the bidding process as “too onerous”, with one company Managing Director stating that “I think that the selection process is asking too much. Originally we had been asked to develop 11 schemes over two months. We managed to compromise and agreed on six, but this is still a huge amount of work bearing in mind that one scheme alone was worth £12m” (Hospital Development, 2003). This Managing Director believes that the selection process should be refined so that the preferred bidder is chosen on the design approach and track record rather than the actual design (Hospital Development, 2003). Another developer is quoted as saying “the process is very lengthy and it puts pressure on medium-sized organisations. You can’t go forward to the next bid” (Hospital Development, 2003).

Cost (LIFT)

The LIFT process removes the need to go out to tender for construction projects in the future as all facilities can be delivered by the same local LIFTCo (Ballantyne, 2005; Little, 2006). It is assumed that this ensures good quality bids for relatively small capital schemes and can save on bid costs (Ballantyne, 2005). However, the House of Commons Committee of Public Accounts identified that

For the LIFT model to work efficiently there needs to be a continuous flow of developments. The LIFTCo is intended to operate as a local property development business with overhead costs spread over a number of projects. Given the cost to the local health economy of developing LIFT buildings, and

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the long term funding requirements, there is a risk that a continuous flow of projects may not be taken forward. If so, the model may not achieve the expected benefits

(House of Commons, 2006)

In addition, the funding mechanism behind LIFT has been described as “very complicated” (Tyndale-Biscoe, 2003). With the current lack of any form of evaluation, it is understandable that costs associated with the LIFT process are being questioned, from initial set-up (Tyndale-Biscoe, 2003), fees payable to Partnerships for Health (National Audit Office, 2005), and operating costs (Comerford, 2004) to the rents being charged to tenants (Holmes et al, 2006). The House of Commons (House of Commons) Public Accounts Committee has stated that “Primary Care Trust accommodation spending on patients registered with GPs in a LIFT development is up to eight times higher than total primary care spending on accommodation. The difference mainly reflects the cost of providing new, high quality and purpose built buildings” (House of Commons, 2006). Given this analysis, it is understandable that the Chairman of this committee argued that

“What we really need to know is whether the expected benefits to patients justify the cost of using LIFT to provide the new facilities. Providing new, purpose-built buildings for GPs and other primary care services is obviously going to be more expensive than carrying on with older premises”

(Guillochon, 2006)

These views are shared by others who perceive LIFT as being effective but costly and drawn out (Hospital Development, 2006b).

In the past the NHS, and individual GPs, could choose to reduce immediate expenditure by deciding to postpone building maintenance, or the replacement of equipment. With the advent of LIFT this no longer remains an option as all maintenance now falls under the remit of the LIFTCo contract and the PCT will automatically have a share of these charges routinely included in their fees (Dawson, 2001). Similarly, whilst PCTs and GPs may have chosen to expand or refurbish premises on a piecemeal basis, with LIFT new buildings are delivered in entirety committing the PCT, and their tenants, to their maximum rent immediately with no potential for any phasing (Dawson, 2001). Both factors are likely to raise overall costs but there is also a possibility that they will contribute to higher levels of maintenance and higher residual values.

Use of enabling funds

To facilitate the start of LIFT projects, the Government made ‘enabling funds’ available to the projects to “remove obstacles to a project going ahead by, for example, purchasing sites or releasing GP practices from negative equity” (Hines, 2003). These funds could also be used to reconvert primary care premises back into residential premises in order to make them more attractive to the market and easier to sell if the GPs were prepared to relocate into LIFT premises (Department of Health, 2000). These funds are “not automatically refundable”. However, in the limited guidance provided by the Government, it was stated that “there may be circumstances in which the Department would be keen to reclaim funding to enable it to be recycled into further LIFT developments” (National Audit Office, 2005). The NAO go on to state that one third of project managers were uncertain as to how to use the enabling funds, leading to “variation” in usage (National Audit Office, 2005). The NAO also notes that, as of January 2005, “no funds have been paid back to the Department. This has prompted a re-

view of the efficiency of how funds are used and recycled". Hardly surprising since for one project the funds have been disclosed at £5 million (Hines, 2003).

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

Refinancing

Concerns have also been raised about refinancing packages where the private sector consortiums have managed to re-negotiate lower rates of interest but have not passed any benefits on to their local authority partner. According to UNISON (2003) "The Government has now said that there has to be a public sector clawback on such-refinancing packages in PFI schemes. It is not clear whether this will apply to LIFT schemes or, if it does, whether it would be the local public sector partners or the national partners who would benefit". As of yet there is no guidance as to how LIFT refinancing should be approached.

Revenue

Rental income has, understandably, been a consideration of developers given the significant opportunities for revenue raising (Paxton and Lissauer, 2000). Some have designed and built more traditional GP surgeries, preferring GP stability and steady rental income over multi-use facilities with "more risky tenants" (Mathieson, 2002). It is interesting to note that at one LIFT project, the LIFT coordinator has chosen not to discuss rents with its GPs as:

It does not want them to become alarmed over figures that are still being discussed: the bidders have put indicative rental figures in their bids and we are in negotiation with them over those figures

(Dudman, 2003)

This suggests that the rent could be considerably higher than the GPs would anticipate. Holmes et al (2006) describe the major concern over rents to be paid by tenants of LIFT buildings by stating that "there is a perception that the higher costs of LIFT, compared to current rent payments, outweighs the benefits of new, purpose-built premises".

UNISON (2003) notes that the LIFTCos have to pay back the capital borrowed to fund the development, pay to maintain the buildings and must still make a profit for investors; and that all of these costs must be reflected in the rents charged to the PCT and other tenants. Holmes et al (2006) note that there are hidden costs associated with unsuccessful bidders which need to be "built into other rounds". It is therefore not surprising that there are instances where PCTs are being charged a higher rent than their previous market-rate cost-rents which, according to Comerford (2004), amounts to an eight to ten per cent increase.

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

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of GPs either leaving or defaulting (Aldred, 2007) or coming to the end of their lease and the PCT being unable to find a replacement tenant (Unison, 2003).

These concerns have been examined by Aldred (2007) who interviewed a number of dentists, pharmacists and local authorities representatives and noted that LIFT premises do not always represent an attractive option to these professionals. Holmes (2006) goes on to say that “In the case study area the rent charged for the new LIFT premises is in the order of £210/m². Similar, if not superior accommodation provided by the third party procurement is in the region of £160/m². When a comparable facility management package is added the rent from a third party developer will be approximately 175-190/m². In real terms, the facilities provided are expensive when compared to market rents in the locality”. For this reason some local authorities and allied health practices, including pharmacies and dentists, have chosen not to rent spaces in the LIFT buildings, preferring in some cases to rent retail premises adjacent to the doctor’s practice at a “considerably” lower rent (Holmes et al, 2006). The reason pharmacies in particular may not wish to relocate into a LIFT building was identified by the NAO (2005) who stated that, whilst primary care providers such as dentists and doctors receive some automatic reimbursement for the rent paid for primary care premises, the PCT determines whether a pharmacy is similarly classified. In the main pharmacies tend to be considered a business and as such will be expected to pay full rent for their space. As the NAO (2005) identifies that pharmacies are “likely to be the most significant source of third party income” which can be used to “plug funding gaps and reduce the rent levels paid by other tenants”, pricing them out of the market would seem to be a short-sighted approach. This may be why alternatives such as cafes, vending machines, internet training facilities and complementary therapists are now being encouraged to locate within the space. There is evidence that in order to encourage healthcare professionals to relocate into LIFT premises, some PCTs have now even agreed to subsidise rents (National Audit Office, 2005).

Transformation summary

LIFT has many facets, from building provision and facilities management to health care and other service delivery. This is making the determination of the various steps time consuming and complicated to extract. It can be difficult to identify the customers, actors and owners of each distinct element and many of the processes seem vague, even to those directly involved. Furthermore, many of the steps making up LIFT procurement and operational phases would seem to be veiled in ‘commercial confidentiality’ creating a further challenge.

Customers

Customers are described by Checkland (1999b) as “beneficiaries or victims affected by the system’s activities”. So who are the customers of LIFT? Typically in health care it can be challenging to identify customers – are they the patients who receive care, their families who may receive support services or their physician who arranges hospital care and pays for it out of their practice funds? With LIFT it becomes even more complex as this may now include the PCT, GPs, other health care professionals as well as non-healthcare providers as tenants of the LIFT building. What is evident is that there is a government expectation that the LIFT system should provide appropriate, economical and efficient health care to ensure the improved health and well-being of the local population.

LIFTCo contracts group non-clinical services under the heading of “partnering and leaseplus services” (UNISON, 2006, pp.12) and can include a large range of support and facilities management services. Furthermore, the terms of the contracts state that these services may be provided not only for the LIFT buildings but also to “other buildings within the contracting authorities’ estate” which may

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“not just mean PCT buildings; potentially this could include staff in local authority buildings and hospitals, as councils and acute NHS trusts are normally additional ‘contracting authorities’ in the LIFT process” (UNISON, 2006, pp.12). In reassigning some activities to the LIFTCo, affected former public sector employees will be transferred from customer organisations to the privately operated LIFT-Cos, whilst others remain employed by the public sector PCTs. This has been seen to represent that start of privatisation of primary care (UNISON, 2006, pp.12).

As new positions within the LIFTCo are subject to different terms and conditions, UNISON (2003) claims:

One of the ways in which operators of PFI schemes and private providers of public services have tried to cut costs and increase profits is through worsening pay, terms of employment and career opportunities for new staff, creating a two-tier workforce.

As public sector bodies employ significant numbers of women and ethnic minorities in low paid employment, groups that are frequently cited as marginalised in the work force, there are concerns that these are the sorts of positions which are at greatest risk from reclassification. Consequently, it is suggested that policy on equality should form part of the selection process for the private sector partners (UNISON, 2003).

Additionally, some GPs may be close to retirement and therefore financially unable to afford to relocate their practice into the new building, so they may be considered to be victims of the system if their patients transfer allegiance. Similarly, if the new location is inaccessible by public transport, or further from people’s homes, these residents may also perceive themselves as victims of LIFT who are forced to change physician due to transportation restrictions. In any case, it is obvious that the notion of ‘customers’ in the context of LFT involves a complex mix of parties, whose actions are determined by unpredictable and, at times, incompatible incentives.

Actors

Actors are the agents who “carry out or cause to be carried out the main activities of the system, especially its main transformation” (Checkland, 1999b). What has become evident from the literature is that there are three major issues with the actors involved in LIFT:

1. The inequity of skills in the public and private sector actors;
2. Control issues; and
3. Conflicts of interest.

Each of these is discussed below.

Inequity of skills in the public and private sector actors

By its nature, PPP requires the agents to come from both the public and private sector, each bringing their particular skills and experience. Whilst the Primary Care Trusts have little, if any, experience of property (re)development and management, the consultants required to assist them with those critical skill sets (Hines, 2003) have little, if any, experience of health care and special requirements in terms of design and specifications. In their study, the NAO (2005) reported that PCTs found the development of plans understandably “complex and time consuming”. According to Holmes et al (2006) this “inequality in the size and expertise of the negotiating parties has given the upper hand to the contrac-

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tors when discussing technical specifications and operational arrangements”. To try to overcome this, the PCT requires a project team that is adequately resourced with the appropriate skills and management/leadership support (Hines, 2003). Although this may seem a basic requirement, according to the NAO (2005), 56 per cent of PCTs felt that they did not have sufficient resources to complete their project efficiently. Whilst some authorities provided centralised resources to assist with this process where they had several concurrent LIFT projects, other authorities were slower in providing this support (Ballantyne, 2005). Overall there is no evidence that significant measures have been undertaken to fill skill gaps in this area.

Control

Whilst with PFI the public sector retains responsibility for deciding on the public sector services to be provided, the quality and performance standards of these services, and taking corrective action if performance falls below expectation” (Akintoye et al, 2003) the same is not true for all LIFT projects. New language in LIFT contracts authorises them to “privatise clinical services in LIFT and non-LIFT buildings” by getting them to “engage private medical companies to provide GP services, or agencies to provide district nursing services” (UNISON, 2006). Assuming that the LIFT companies do engage others to provide these services, there are fears that such deals would be “shrouded in ‘commercial confidentiality’” and embedded in highly complex, long-term contracts making it impossible for others to intercede, even if public safety was at stake (Aldred, 2005). There are also concerns that the planning function of the NHS will be further eroded and allowing the LIFTCos to determine how, and by whom, service will be delivered (Aldred, 2005). Hellowell (2004) quotes Brian Johns, chief executive for Partnerships for Health, as saying:

The department is not yet clear on the best way to take this forward. It could be that a new-wave LIFT company would be expected to build clinical services into its delivery model – perhaps even taking financial risk on clinical outcomes as in the elective care programme. More likely, LIFT companies would be expected to procure clinical services such as diagnostics and out-of-hours services as part of the supply chain. Interestingly, this is not an innovation that existing private sector players in LIFT are keen on.

Similarly David Toplas, Chief Executive of Mill Group, a prominent investor in the LIFT programme, believes this would “make many people think again about their involvement in LIFT” (Hellowell, 2004).

Under current contractual arrangements, LIFT companies can determine which private businesses are able to move into their buildings. This is of some concern to the GPs. As one GP noted in an interview with Dix (2001), they did not want to see a “McDonald’s next to the waiting room” as had already appeared in some NHS hospitals (UNISON, 2006). Some LIFT project managers have negotiated the right of veto to ensure that the public sector partner can determine who is allocated a tenancy agreement. In one such project the co-ordinator explained that other complementary shops and services can rent spaces on the site, such as social housing related activities, opticians, dentists and pharmacies. They may also allow third party revenue generation from private businesses such as “a veterinary practice, but not a tobacconist. We wouldn’t have betting shops, but retail outlets complementary to health might be accepted such as health food outlets” (Mathieson, 2002).

It is recognised that the public sector will be forced to consider how the profitability of new premises can be maximised whilst enhancing the services available to the local population (Aldred, 2007).

However, it may be hard to ignore the fact that “The more professionals you cram into a one-stop shop, the more profitable the site” (Andalo, 2003).

Conflicts of interest

In an NAO study, two thirds of Primary Care Trust Chief Executives or Finance Directors had been appointed to act as public sector directors on their LIFTCo (National Audit Office, 2005). In their employment contracts these individuals have a duty to protect the interests of the PCT, such as minimising the costs of purchasing services from the LIFTCo. However, their new roles with the LIFTCo would require them to act in the interest of the LIFTCo board, including maximising profits for the shareholders. This could create a potential for conflict of interest (Unison, 2006; National Audit Office, 2005). There are similar concerns over potential conflict of interest for GPs who become members of a local LIFT Company and who are required to act in the best interest of their patients (Mathieson, 2002). The King’s Fund (2001) notes that whilst the private sector will be “seeking to develop sites with profitable complementary uses... the public shareholders will be seeking to ensure good locations and a good mix of (non-profit making) users”.

Similarly, the recruitment of independent non executives to Chair the PCT and strategic Partnering Boards has proved difficult for many LIFT areas (National Audit Office, 2005). Whilst it is recognised that there is a need for the board to have the requisite skills to protect public interests, in practice this has resulted in the recruitment of individuals with conflicting interests. In one third of the NAO case studies the Chair of the Strategic Partnering Board was a local stakeholder in LIFT (National Audit Office, 2005) who could clearly have an influence on the bidding process (Tyndale- Biscoe, 2003).

Actors - summary

Whilst these types of issues are typical where individuals switch roles from that of customer, to agent, to owner, in LIFT this comes with a pecuniary interest attached making this a greater consideration. This complicates the analysis of LIFT as a system as well as the incentive structures that operate within it.

Owners

Checkland (1999b) states that there is “some agency having a prime concern for the system and the ultimate power to cause the system to cease to exist”. While the LIFT companies will claim ownership of the project, having provided the finance for it, it could be equally claimed that the project falls under the jurisdiction of the Department of Health. For this reason, specific legislation had to be created to provide some comfort to the LIFT companies that at some stage in the future, the government would not seize the buildings as a public asset (making their investment worthless).

As many of the PCTs have taken on the headlease for the new building, they could, if they were to default on the lease, close the LIFT project down. For smaller projects, GPs have taken the main leases within the building and they too could end the project if so desired. Furthermore, as the public sector must invest in the LIFT company financially, the public can also claim that this funding has been drawn from their taxes and that they are therefore legitimate part-owners. If they believed their needs could be better met elsewhere, there is the possibility that they will abandon the project causing it to fail (although this would be an extreme case).

Weltanschauung

Weltanschauung is the “outlook, framework or image which makes this particular root definition meaningful” (Checkland, 199b). From the public perspective, for LIFT, this hinges on the transfer of risk from the public to the private sector. The Public Accounts Committee (PAC) recognised that the returns for LIFT were perceived to be very high in relation to the level of risk assumed by the private sector partners, a fact confirmed by Holmes et al (2006) who felt that “contractors involved in the LIFT process are making a greater return on their investment than the much-criticised PFI schemes”. However the PAC argues that this may have been the case in the early schemes “because of perceived greater risk associated with the newness of the schemes, and uncertainty over the pace of future developments” (House of Commons, 2006). This view has been confirmed by the NAO (2005) who noted that the returns should reduce over time as learning curves are overcome. Notwithstanding this expectation, criticisms are still being voiced, with UNISON (2006) claiming that “the projected LIFT rate of return of 15.1% on average compares with 8-9% for traditional third party development – a lot of extra profit given that a PCT may pay around £1 million per year or more to lease each LIFT health centre”. Others, like Dawson (2001) would argue that a 15% return is considered standard for a low-risk, privately financed project. Perhaps one of the greater risks of focusing solely on rates of return is that “future schemes may actually draw GPs away from where they are needed...” (UNISON, 2006).

Checkland argues that there will be more than one possible Weltanschauung, and a new root definition should be developed for each, whether this is done by the analyst or expressed by the people in the problem situation (Checkland, 1999b). For LIFT there will be many views: from the property developer who seeks to use the process to increase their possible returns from the project; the GP who may use LIFT as a means to escape from a position of negative equity, or to relocate from the converted house where they previously practiced and could not afford to update; the patient who may have to travel further to sit in a group medical practice waiting room who does not really care about the architect's view of light and ambiance as they think it is an inconvenient waste of money; to the government minister who is now able to claim that his local constituents are able to receive care in a state of the art building that was made possible by his party. Unravelling each of these views will provide an interesting insight into LIFT and may identify why some of the issues have come about.

Environment

Clearly any project that involves public and private sector partnerships will be operating in a complex environment. LIFT operates at the uneasy juncture of corporate finance, health care and government and is therefore operating within one of the most complex political, legal, economic, social, demographic and ethical environments. Added to this, the changes in health care provision also make this an area subject to rapid technological change.

Whilst the general roll-out of the Department of Health's LIFT programme has been quicker than many anticipated, LIFT-based procurement has been slow, with the first projects taking over a year to select their preferred private sector supplier before being able to proceed with subsequent stages (Dudman, 2003). Whilst the prospectus for the program was released in July 2001, by the end of 2004, only four new buildings were open to the public (National Audit Office, 2005).

Although the introduction of any new scheme requires a certain amount of administration, the literature would suggest that for LIFT, it is perceived as excessive and questions have been raised about the significant proportion of money that has been consumed in administration costs (Tyndale-Biscoe, 2003). Like PFI, bureaucratic procedures were perceived as being largely responsible for delays, in-

creasing costs and the marginalisation of local people and their organisations (UNISON, 2006). UNISON (2006) believes that the latter is evidenced by “organised opposition to LIFT schemes”. Rather than “freeing up enterprise”, it has been claimed that LIFT creates large, legalistic, and bureaucratic systems “locking the NHS into the use of certain buildings and services for a long period (Aldred, 2007). Whilst private developers have shown an interest in developing and owning primary care premises, Bunce (1997) claims that the “speed of their involvement has been slowed by the bureaucracy”. In part, this has been blamed on Partnerships for Health (now known as Community Health Partnerships, an independent company owned by the DoH and tasked with developing and creating investment and delivering innovative ways to improve health and local authority services) which has been slow to allocate advisers to LIFT projects (National Audit Office, 2005).

This perception of complex bureaucracy is shared among nearly all stakeholders. Aldred (2007) cites some GPs as stating that they believe it to be “a very, very bureaucratic process” which is “significantly and heavily management-led”. Similarly, trust management staff have commented that they feel LIFT has been “a lot more complex” (Aldred, 2007) and others have stated they feel the process is “horrendously complicated” (Dudman, 2003).

In this context the bidding process seems to pose particular difficult to all parties. The Managing Director of one development company is quoted as saying that this phase is “overly complicated and can often be a waste of time” (Andalo, 2003). Andalo (2003) noted that detailed plans must be submitted very early in the process which significantly increases costs for potential bidders. Gaining sign-off is also perceived to be “a pretty painful process” (Sansom, 2007). Little (2006) identifies that for one super surgery “the planning took several years” and for one LIFT project Parker (2006) claimed that the process lasted for two years:

Three consortia were picked to bid, one dropped out halfway through. It took six months for the LIFT to get a preferred bidder, then a year until financial close

Consequently, some individuals involved in the process have queried whether the process could be streamlined and whether the front-end planning costs could be reduced as they current act as a deterrent (Meara, 2001).

LIFT “represents a shift in the way governments contract with private firms: from short-term, discrete contracts, to long-term, complex and open-ended contracts” (Aldred, 2007). Such contracts are inherently complex and require extensive negotiations..

Overall LIFT related negotiations with local health care providers seems to have taken longer than expected with varying degrees of success in gaining buy-in to the process (National Audit Office, 2005). Even when the buildings are occupied, health care professionals working within LIFT buildings have noted that the terms of the contracts make it difficult and expensive to undertake minor alterations to the property once it has been completed (House of Commons, 2006) as “the lease agreement states that tenants can only do so with prior consent of the LIFTCo, but the time delay and bureaucracy involved in getting LIFTCo approval often causes frustration”.

Patching (1990) describes the environment as “the world that surrounds and influences the system, but has no control over it”. LIFT was supposed to provide access to care and improved services in areas of high deprivation: but are these projects attractive to developers? Is such targeting compatible with the profit maximisation imperatives of the private sector? And what of the GPs that were expected to

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become involved? Given the high proportion of GPs approaching retirement age, has this had an impact on the ability of the projects to gain support and attract the key professionals they need? An understanding of this complex arena will be critical to gaining insight into LIFT.

Project progress to date and next steps

Elite interviews have already been completed with officials from the Department of Health, Partnership UK, the NHS Confederation, LIFT companies and Community Health Partnerships (formerly Partnerships for Health).

Over the next twelve months the research group is planning to undertake detailed case studies with a number of LIFT companies that have completed their construction phase in an attempt to gain a retrospective view of the process and an understanding as to whether LIFT is perceived as a successful mechanism by the LIFT company, its partners and the people using the resultant facilities. The group will also be undertaking a case study with one LIFT company during the early stages of construction in order to gain a current view of the process and identify any issues as they arise during these key phases.

Conclusions

Whilst PFI was used as a vehicle for the development of large projects, including flagship hospitals, LIFT is an adaptation of this original system, designed to facilitate the procurement and management of smaller scale projects. Recognising that such projects can be less profitable, LIFT was developed as a way to group projects in order to make them more attractive to investors. However, the question is whether they are being developed at a quality level appropriate for the market and at a price they can afford.

Using SSM to review each of the elements in order to develop a root definition of LIFT, it is evident that this scheme it has not fully addressed the problems associated with earlier PFI procurement. If the literature is correct, LIFT would seem to have created additional problems on top of those created by standard public private partnership. The lengthy, complex negotiations between customer and actor is seen as placing an onerous burden on both parties, and it is argued that the public sector does not have all the skills and experience required to undertake these tasks effectively or economically. Moreover, as a LIFT project is seen as a 'once in a lifetime opportunity', this would suggest that the customers will never obtain these skills and will continue to require the support of some central agency.

Allowing the LIFTCos to determine who will be allowed to occupy their buildings and be offered a tenancy agreement, whilst ensuring their revenue may be maximised, effectively removes control for health care planning from the organisations best placed, and still with a statutory duty, to perform these functions. Consequently, it is being questioned whether it is appropriate to place this function in the hands of the private sector.

In the early phases of LIFT infrastructure development, it would seem that some designs were not of the high standard anticipated, and 'teething troubles' were repeated in various locations due to a lack of shared learning. There also seems to be a common concern that the tenancy costs in the new buildings are significantly higher than market rents, and some health care providers are questioning whether they can afford to relocate from their current, less than ideal accommodation. Conversely, if the local population is attracted to the 'one stop shopping' approach to health care that LIFT can offer, these providers must question whether they can afford to remain where they are and lose their patient

census. This creates a dilemma, particularly for those independently operating physicians approaching retirement age who may not be in a position to commit themselves to a long tenancy agreement.

Notwithstanding these concerns, it must be remembered that LIFT has been designed as a deliberately open-ended approach to the procurement of primary care facilities. As such, LIFT gives key local policy makers considerable leeway in adjusting their project to local needs and constraints. These adaptive processes can take many forms, ranging from a bundling of LIFT projects among different PCTs to the involvement of PCTs, the shared use of facilities, to the modification of Strategic Partnering Agreement to include Lease Plus and other arrangements. Much of the success of LIFT as a policy tool will depend on the ability of local decision makers to make use of the innovative potential of this scheme in overcoming potential barriers.

LIFT is the mechanism used by many organisations seeking to improve their primary care premises. Indeed, there is a claim that it is the “only game in town” (Aldred, 2007) for many PCTs. Consequently, regardless of its shortcomings, PCTs must work within its rules and ways must be found to improve its efficiency and effectiveness together with avenues for the improvement of future infrastructure development. In the coming months it is hoped that this project will assist with this process.

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