

**Briefing note for the House of Commons Public
Accounts Committee on the National Audit
Office report: *Innovation in the NHS: Local
Improvement Finance Trusts***

**Produced by The Centre for International
Public Health Policy, School of Health in Social
Science, University of Edinburgh, October 2005**

Conclusions and recommendations

Conclusions

1. The methodology used by the National Audit Office is fundamentally flawed, being based on surveys of informants who have an interest in LIFT schemes.
2. Other than these biased interviews, there is no evaluation of value for money or the factors that underpin it. Specifically:
 - There is no comparison of the LIFT proposals against other current or potential financing methods;
 - There is no examination of risk transfer despite the unusually high levels of return to equity providers;
 - The analysis of the financial models was contracted out to Operis, a PFI/PPP consultancy, and neither the models nor the evaluation are in the report; and
 - There is strong evidence that affordability (the capacity of the public sector to meet the cost of the unitary charge) may be a problem, but there is no analysis.

As such, the report marks a new phase in the NAO's problematic shift away from quantitative to qualitative analysis in its evaluation of PFI/PPP projects.

3. The NAO make clear that the new governance structures for the delivery of health and other public services could be problematic, but there is no attempt at evaluation.

Recommendations

We recommend:

- (1) that the Public Accounts Committee ensure that a proper, in-depth evaluation of NHS LIFT is undertaken, with due regard to quantitative data, and with respect to:

- value for money (as compared with other financing options, whether these are real or theoretical);
- the quantum of risk transferred to the private sector;
- the rate of return to private sector investors;
- affordability; and
- the effect of joint venture companies on public sector governance.

(2) that the Committee request from the NAO the financial models from the Department of Health that were given to Operis as part of its inquiry, and that these should be published. Included in the models we would expect to see:

- affordability calculations;
- income streams;
- anticipated sources of income (revenue-sharing arrangements);
- risk premium;
- rates of return;
- value for money calculations (Net Present Value and cash); and
- the apportionment of risk and liabilities in the event of project failure.

Background to LIFT

The Local Improvement Finance Trust (LIFT) initiative is being used to develop new primary and social care facilities for the NHS. LIFT involves the creation of a joint venture company within each LIFT locality in which representatives of central government and the local public sector own shares along with a private sector partner.

These vehicles raise private finance in order to develop a succession of projects over the 20-year life of the partnering agreement. They charge rents to primary care providers to service this debt - and provide profits for investors and contractors. This is repaid through NHS subsidy to GPs, primary care trusts and/or other health providers. Investment through LIFT, therefore, is ultimately paid for by the NHS.

A total of 42 schemes across England were approved by the DoH in August 2002, followed by a further nine schemes in November 2004. Building work has so far schemes valued at £866m. This number will grow as more LIFT contracts are signed.

The NAO report's terms of reference

The NAO sought to assess whether LIFT has proved to be successful so far through attempting to answer four 'high-level' questions. These were:

1. Will LIFT contribute to the better long-term delivery of local health services?
2. Does the LIFT structure include appropriate governance arrangements, incentives and accountability?
3. Have LIFTCos sufficient public and private skills and capacity to deliver and operate their programmes?
4. Will LIFT deliver the expected benefits in a way conducive to value for money?

These questions were together used to answer a general question: is LIFT a suitable vehicle to support improved primary and community care services that meet local needs while improving value for money? (page 36). However, the report is not structured around the four questions, but around the NAO's 'Dinner Party' approach

(p.36), the aim of which is “to produce crisp, interesting report conclusions that can each be stated in 10-15 seconds.”

The conclusions that the NAO reached through this process were (page 36):

- The National LIFT programme appears an attractive way of securing improvements in Primary and Community Care
- The local LIFT models appear to be an effective mechanism clearly demonstrating value for money; however, local management frameworks could be strengthened.

The NAO report’s methodology

The NAO studied the national picture through two large surveys. One was sent to the private sector bidders who had competed for LIFT schemes; the other was sent to Project Directors from the public sector side. The NAO consulted frequently with the Department of Health and Partnerships for Health, and used these two bodies to provide details of potential interviewees.

The NAO also carried out case studies of the six LIFT schemes that had been signed at this stage of their fieldwork. They also carried out in-depth interviews with ‘key stakeholders’, including Project Directors, private sector bidders, clinicians, Primary Care Trusts, Strategic Health Authorities and local authorities.

A survey was sent to Local Pharmaceutical Committees in each of the six case study areas following a request by the National Pharmaceutical Association, which had expressed concerns that pharmacists felt they had not been fully included in the LIFT process.

Evaluation of the financial models of the six case studies was provided by Operis, a management consultancy.

Our critique of the methodology

i. Project Sampling

The NAO sample was restricted to the first projects to close. As such, the NAO's sample may not represent the full picture of the procurement. Looking only at the projects that were most successful in terms of the procurement process makes it hard to assess how well LIFT projects are progressing generally. The report might have been more representative had it included analysis of LIFTs where organised opposition had started to develop.

The NAO did receive letters from people complaining about their local LIFT schemes but the report did not include these cases in its evaluation.

ii. Selection of Informants

The NAO's choice of informants could lead to biased results. In the two national surveys, it only contacted private sector bidders and LIFT project directors. The experiences and views of staff and service users were not incorporated. Both private sector bidders and project directors have an obvious interest in providing the NHS with a positive account of their projects. This is also, of course, the case with PFI and indeed public procurement processes. However, unlike PFI and public procurement, LIFT involves the promise of future projects, and it may therefore be particularly difficult for those involved to provide objective evidence.

iii. The contracting out of the financial analysis: The Committee may question the legitimacy of outsourcing the review of the financial models to Operis, a consultancy company which advises private sector bidders and banks involved in PPPs.

iv. Evaluation of performance

The NAO notes that all of the LIFT schemes it studied have failed to conduct proper post-project evaluations. Of the six LIFT projects examined by the NAO, just one had developed a post-project evaluation plan. However, the NAO fails to point out that

these LIFT schemes - and the DoH itself - are consequently in breach of published guidance. The NAO seems not to be aware of this guidance. Of evaluation, it says there is “no clear guidance recommending either its nature or timing” (p.30, par. 3.8).

But this is wrong. In January 2002, the DoH published guidance to assist NHS bodies involved in capital schemes in the process of evaluating their completed projects. This guidance, *The Good Practice Guide: Learning Lessons from Post-Project Evaluation*, states that such evaluations are “an essential aid to improving project performance, achieving best value for money from public resources, improving decision-making and learning lessons” (p.1).

This guidance sets out a four-stage process of evaluation and a number of technical considerations. In addition, it advises NHS bodies to carry out an initial post-project evaluation of project outcomes *six months after the facility has been commissioned*.

It would appear that the LIFT schemes studied in this report are in breach of this guidance, since in most cases some buildings have been operational for more than six months. In addition, since all LIFTs involve Partnership for Health - a representative of the DoH - arguably the DoH is itself in breach of its own published guidance.

While the details of this guidance have the status of ‘advice’ to NHS bodies, the requirement to evaluate and learn from projects is in fact mandatory for all DoH projects with a cost in excess of £1m. Further, guidance specific to LIFT states that LIFTCos should “regularly monitor and report the standard of performance” of the services they provide (Standard Strategic Partnering Agreement, version 4, Section 2).

v. Value for money comparison

The NAO does not produce direct quantitative comparisons with public sector finance or with GP-managed developments. The NAO takes the DoH line that value for money can be demonstrated through the running of a competitive procurement, in addition to some benchmarking and an assessment of rents by a district valuer.

We would question this proposition, which runs against the process operating under PFI, in which a public sector comparator is used to test the value of the PFI proposal against a theoretical publicly financed scheme.

It could be argued that the PSC system is not appropriate for LIFT schemes, since public finance is rarely available for large-scale capital investment in primary care. Instead, investment has primarily been through debt-financing in the form of interest-free loans from the General Practice Finance Corporation (GPFC). These loans are paid back by the NHS in the form of a number of different types of subsidies to GPs.

However, there is no reason why the government could not produce comparators, based either on public financing or financing through the GPFC in order to provide information about base costs. The production of a fully costed 'theoretical' publicly financed project has taken place within the mainstream PFI programme since the initiative's conception.

In addition, it seems the NAO is unaware of recent examples of public sector funded health centres, such as those built with London Implementation Zone grants. Anecdotal evidence suggests that these projects have been very successful. For example, Greenwich's Fairfield Grove Health Centre was highly commended by the Commission for Architecture and the Built Environment (CABE 2002).

vi. Risk Transfer and the Rate of Return

The NAO presents little data with which we might make inferences about the value for money of LIFT projects. This is despite the fact that local NHS bodies were sceptical. For example, some of the Strategic Health Authority representatives in the NAO's case study areas expressed concerns that initial business cases did not sufficiently explore the risks of LIFT, and that it was hard to have complete assurance about value for money for an untried initiative.

Meanwhile, the quantum of risk transfer is not explored by the NAO, despite the higher rates of return in LIFT (case study range is from 14.3% to 15.9%) compared to the average in PFI schemes (12.5% to 15% in the NAO's comparator PFI schemes).

Despite this, the NAO agrees with the government that LIFT is “clearly value for money”.

vii. Affordability

Affordability refers to the income required from the public sector to pay the unitary charge to the LIFTCo. The NAO report does not produce any affordability calculations, despite the fact that GPs have expressed concerns that smaller GP premises may lose funding because the higher lease costs of LIFT schemes within the locality are tying up resources (*Pulse* magazine, 30th April 2005).

In addition, representatives from the National Pharmaceutical Association, the British Dental Association and local authorities told the NAO that they had concerns about rental costs. Indeed, the NAO comments that “there is a common perception from these groups of prospective tenants that the higher cost of LIFT, compared to current rent payments, outweighs the benefits of new, purpose built premises” (p.21, par.2.14). The report makes no final conclusion on affordability.

viii. Conflicts of Interest:

The NAO makes some criticisms in this area and recommends stronger management arrangements. Its report expresses concern about the potential conflicts of interest, in particular the issue of PCT directors sitting on the LIFTCo Board. It comments (p.32): “if the LIFTCo was in financial difficulties, as a LIFTCo director a Primary Care Trust employee might have conflicting pressures between helping the LIFTCo and protecting the interests of the Primary Care Trust” (par. 3.13).

The NAO points out (p.32. par.3.13): “the public sector director, in the role as a LIFCo Board Member, has a fiduciary duty to act in the interests of the LIFTCo and not for the Primary Care Trust.” The NAO provides no evaluation of how these difficulties have impacted on issues such as accountability, transparency and the avoidance of conflict in the governance procedures of the six LIFT areas studies.

Our conclusions and recommendations:

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Supplementary note on LIFT's move into clinical services:

The NAO comments that in the fourth wave of LIFT, LIFTCos will be encouraged to “expand the range of services provided” (p.32, par. 3.16). What the NAO is referring to here is the delivery, through the private sector, of clinical primary care services.

In a document from Partnerships for Health that was circulated to private sector bidders, healthcare companies and their advisers described how clinical services will be delivered through LIFT under the alternative provider medical services route.

The clinical services which may be included in LIFT's fourth wave are as follows:

1. Essential Medical Services: including care for those who are ill, or believe themselves to be ill, but recovery is expected
2. Replacement Additional Services: These services include Cervical Screening, Contraceptive Services, Vaccinations and Immunisations – excluding childhood immunisations and certain travel vaccinations, Childhood Vaccinations and Immunisations, Child Health Surveillance Services, Maternity Medical Services and Minor Surgery
3. Enhanced Services: These include Intrapartum Care, IUCD Fitting, More Specialised Services for patients with Multiple Sclerosis, More Specialised Sexual Health Services, Alcohol and Drug Misuse Services, Provision of Near-patient Testing – shared care drug monitoring service, Provision of Intermediate Care and First Response Care, Specialised Care of Patients with Depression, Care of the Homeless and Anticoagulation Services
4. Out-of-Hours Services
5. A combination of any of the above

This proposal will dramatically reduce the public sector role in primary care services.

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Parts of this memo were based upon a forthcoming UNISON report; Aldred, R. (2006): In the interests of profit, at the expense of patients: An examination of the NHS Local Improvement Finance Trust model, analysing six key disadvantages.'