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A PFI REPORT FOR UNISON

# IN THE INTERESTS OF PROFIT AT THE EXPENSE OF PATIENTS

An examination of the NHS Local Improvement Finance Trust (LIFT) model, analysing six key disadvantages.

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# IN THE INTERESTS OF PROFIT AT THE EXPENSE OF PATIENTS

An examination of the NHS Local Improvement Finance Trust (LIFT) model, analysing six key disadvantages.

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# 1. Introduction

## 1.1 Background

This report has been commissioned by UNISON to examine the NHS Local Improvement Finance Trust (LIFT) initiative. There are LIFT schemes in 26 out of the 28 English strategic health authority areas, and the model is being transferred to other public services[1]. UNISON believes that primary care trusts (PCTs) and LIFT companies should be held to account for their use of public money, and that trade unions and service users should play an active role in this process.

## 1.2 Executive summary

This report gives six reasons why LIFT may be a bad deal for the NHS, patients, staff and taxpayers.

- Bureaucracy. LIFT, like PFI, puts extra layers of bureaucracy between managers, staff, and service users. The complex networks of contracting and subcontracting may make it harder for patients and public sector staff to influence the future direction of primary health care. The LIFT structure works in a top-down manner, setting strategy through high level meetings which are closed to the public.
- Profit. The LIFT structure risks putting private profit before health care needs. Schemes have to be attractive to the private sector partners, which means that they must be profitable. This may come to threaten health care provision in needier areas, where it is harder to charge high rents for pharmacies, cafés and other 'third party income streams'.
- Inflexibility. LIFT is flexible for private investors, as it allows them to treat primary health care buildings as a property portfolio. However, this creates an inflexibility for the NHS, which is locked into long-term contracts in order to guarantee the private sector's cashflow. If the NHS wants to alter buildings (as frequently happens in primary care), the LIFT company has a monopoly over such work.
- Conflicts of interest. LIFT institutionalises conflicts of interests, creating new organisations which sit uneasily between the public and private sector. The programme is run nationally by Partnerships for Health, itself a public-private partnership, which is both an investor and a regulator. PCTs both purchase services from LIFTCo and invest in it.
- Value for money. The National Audit Office has failed to demonstrate that LIFT provides value for money. There are many examples of public sector excellence which have been bypassed in favour of this new variant of PFI. LIFT may also be unaffordable – the Public Accounts Committee[2] heard that in one area, LIFT buildings cost four times more per patient than the average for that area.
- Staff. LIFT will lead to outsourcing of NHS jobs, which may threaten pay, conditions and the coherence of the NHS team. Fourth wave (and perhaps other) LIFT companies may also be asked to tender for clinical services, allowing these private entities to take control of more and more parts of the NHS.

The report examines the future for LIFT, and how PCTs and LIFTCo may be held to account. It also contains a brief analysis of the National Audit Office report on LIFT, which was seen to give LIFT a clean bill of health, but which has been severely criticised by MPs on the House of Commons Select Committee for Public Accounts.

1 Such as Building Schools for the Future

2 References to the Public Accounts Committee meeting on LIFT are based on the uncorrected transcript of oral evidence, available at http://www.publications.parliament.uk/pa/cm200506/cmselect/cmpubacc/uc562-i/uc56202.htm. This is not yet a formal record of proceedings – neither witnesses nor MPs have had the opportunity to correct it.

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# 2. What is NHS LIFT?

## 2.1 A new form of PPP to build and develop health centres and surgeries

NHS LIFT is a public-private partnership (PPP) to redevelop and replace primary care facilities (buildings like health centres and GP surgeries). LIFT was launched in 2001 and there are now 51 LIFT schemes in England, involving 155 out of 303 PCTs. There have been four 'waves' and the most recent of these (nine schemes) was announced in November 2004.

The LIFT schemes are at various stages – a small number have built one or more surgeries, while some have not yet issued tender advertisements[3]. However, the 2004 NHS Improvement Plan estimated that 50% of people in England would be using LIFT buildings by 2008. The Scottish Executive are considering the model, and there are plans to introduce it in Wales and Northern Ireland.

LIFT involves several PCTs[4] coming together to select a 'private sector partner' and form a local LIFT company (LIFTCo), which will build, own and maintain the new buildings. Mental health trusts (MHTs) and local authorities may also be involved. LIFTCos are companies limited by share capital – i.e. private companies run to make a profit, but not publicly traded on the stock exchange.

Many health centres and surgeries are currently inadequate – cramped, lacking disabled access, dilapidated or badly designed. Prior to LIFT, these buildings have been provided in a range of ways. Some are NHS owned, others are GP owned, and others owned by private landlords. Many initial LIFT buildings are replacing NHS owned centres and/or building on NHS land.

The government decided to roll out LIFT throughout England without pausing to scrutinise and evaluate the first wave of schemes. The only official evaluation of LIFT so far has been the National Audit Office's Value for Money report entitled Innovation in the NHS: Local Improvement Finance Trusts, produced in May 2005.

3 The process of finding a private sector partner starts with Trusts placing an advert in the Official Journal of the European Union to ask companies for expressions of interest.

4 Although a small minority of schemes have only involved one PCT.

## 2.2 Each LIFT company has a complex structure

Each LIFTCo will buy land, and build or redevelop primary care centres on it, making money by renting out space to tenants. The main tenant is usually the local PCT, which may sublet to GPs and others, although there will also often be 'retail units' which LIFTCo would lease directly to pharmacists and others.

A LIFTCo has a complex structure. Individual buildings (or groups of buildings) will actually be owned by 'FundCos', shell companies within the LIFT financing structure. Each of these FundCos will carry heavy debts to banks and financiers.

LIFT has a similar 'procurement process' (the way in which the public sector select private companies) to PFI. First, a notice is placed in the Official Journal of the European Union (OJEU), asking companies for expressions of interest. Then the firms complete a Pre-Qualification Questionnaire. Potential bidders are interviewed, and whittled down to a shortlist of around three. They go into the Invitation to Negotiate stage, where they work on plans for several buildings. Then the trusts choose a 'Preferred Bidder' and enter detailed negotiations, until they reach 'financial close', sign the legal documents and set up the LIFT company.

After this there will be no further competitive tendering, although there is supposed to be five-yearly benchmarking at least against other LIFT schemes. Like PFI, LIFT involves private companies maintaining the premises they build – this is part of the 'leaseplus agreement' between a LIFTCo and its tenants. But there are also differences between LIFT and PFI.

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## 2.3 LIFT has some important differences from PFI

1 LIFT involves a public sector shareholding. Local NHS bodies hold 20% of LIFTCo shares, and the national PPP Partnerships for Health holds another 20%. By contrast, in PFI the Special Purpose Vehicle created to manage the project is 100% owned by the private sector.

2 Under LIFT, health centres will remain owned by the LIFT company at the end of the lease period unless purchased by the NHS, whereas under PFI, hospitals can revert to the public sector at the end of the lease period.

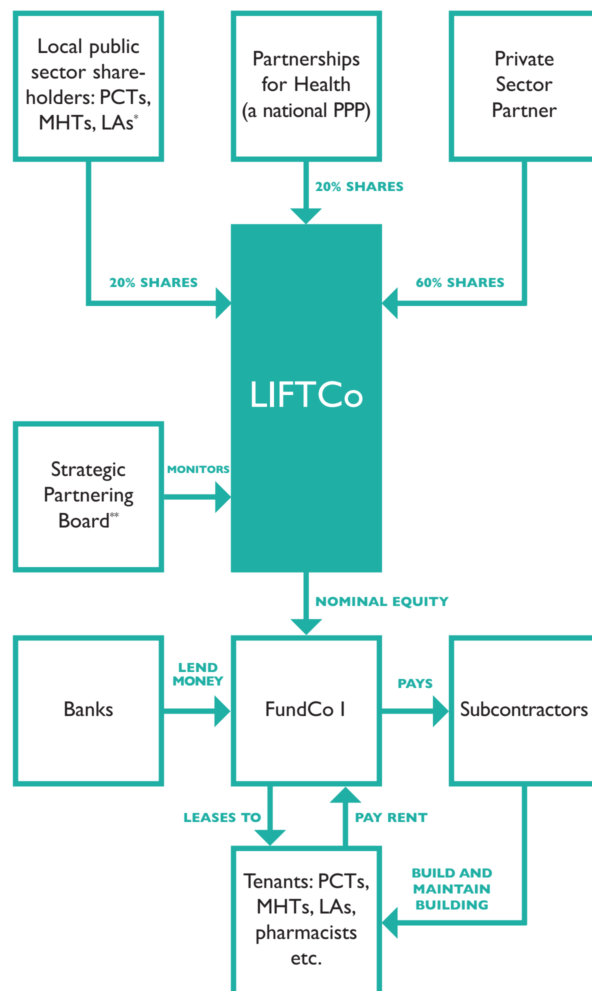
3 LIFT involves an exclusivity clause: over the period of the 'Strategic Partnering Agreement' (20 years), a LIFTCo has exclusive rights to develop primary care facilities in its area. PFI projects only cover specific, named buildings.

4 LIFT brings the public and the private sector closer together. There is a 'public sector director' on the LIFTCo board, and LIFTCo directors attend the local NHS Strategic Partnering Board. By contrast, under PFI the special purpose vehicle is relatively separate from NHS management.

## 2.4 The LIFT model is still changing

There are plans to include more services within LIFT. Firstly, 'soft FM' – i.e. support services such as cleaning and catering, and secondly, clinical services – which in theory could mean anyone from GPs, to PCT employed community nurses, to radiographers. See Section 5.

## LIFTCo structure




* May include GPs but this does not seem to be happening as yet.

** Includes PCTs, MHTs, LAs. Representatives of Strategic Health Authority, Private Sector Partners and clinicians are also invited.

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# 3. The LIFT model: six key issues of concern

5 http://www.dh.gov.uk/ProcurementAndProposals/PublicPrivatePartnership/NHSLIFT/AboutNHSLIFT/fs/en?CONTENT_ID=4076707&chk=iVdaOG
6 http://www.dh.gov.uk/assetRoot/04/07/05/39/04070539.PDF

7 http://www.dh.gov.uk/ProcurementAndProposals/PublicPrivatePartnership/NHSLIFT/AboutNHSLIFT/fs/en?CONTENT_ID=4076707&chk=iVdaOG

8 For example, in Oxford and Holland-on-Sea. See Oxford Mail 13th November 2004, and Colchester Evening Gazette 10th May 2004

9 http://society.guardian.co.uk/nhsreforms/story/0,15919,1480744,00.html

Many primary health care buildings do need renewal or replacement, and in many areas clinicians have been asking for this for some time. The Department of Health has said that 'NHS LIFT and public capital will lever £1 billion into reinvigorating the primary care estate [in England]'[5]. (PCTs have limited access to public capital, so most of this funding is likely to come through LIFT.)

The Department of Health acknowledges that LIFT is likely to cost PCTs more than other ways of building and refurbishing surgeries.[6] It claims that LIFT has benefits that outweigh this extra expense. However, this report outlines six key areas where the LIFT model may create problems for the NHS.

## 3.1 Bureaucracy

The Department of Health states that a key benefit of LIFT is that it will 'empower and assist the regeneration of local communities by providing better healthcare facilities, involving local businesses to deliver local solutions.'[7]

But community regeneration involves more than simply providing buildings; it needs to include meaningful participation by local people. The danger is that as LIFT involves large private sector companies in planning primary healthcare across the country, local people and their organisations are marginalised by excessively bureaucratic structures. This can be seen most clearly in those areas where organised opposition to LIFT schemes has started to develop. As the NAO report comments, 'some proposals have provoked local opposition' (page 8) and sometimes 'groups of stakeholders felt that LIFT did not fulfil their aspirations' (page 19). In some LIFT areas, service users raising concerns about Trust plans have complained that they feel left out of decision-making processes.[8]

The Department of Health and Partnerships for Health have little to say on the role of patient forums and local authority health overview and scrutiny committees with respect to LIFT. Yet the public and their elected representatives should have a key role in ensuring that LIFT delivers what people need, and that community involvement is at the centre of the planning process. The role of such organisations needs to be examined urgently, given that critics have recently argued that patient forums are under-resourced and often unable to represent patients' interests effectively.[9]

The claim that LIFT involves 'local businesses' to deliver 'local solutions' can also be queried. In the majority of LIFT schemes, the private sector partners are multinational service companies and finance companies, as smaller organisations generally do not have the resources to bid for such complex contracts. There is no guarantee that these large companies will select local businesses as part of their supply chain. They are likely to use their existing, centralised subcontracting networks, which will be cheaper and help support their profit margins – but which will not be 'local'. These complex networks may also be difficult for service users and their representatives to scrutinise: information may be labelled 'commercially confidential', and kept out of the public domain. They may also make maintaining buildings more difficult as regional call centres may replace on-site staff.

**The LIFT structure risks reinforcing top-down decision-making**
The decision-making structures of LIFT are managerially focused, and staff and service users are often only consulted at a relatively late stage. The LIFT process involves NHS and private sector managers writing a medium term 'Strategic Service Development Plan' (SSDP), which should include all buildings planned for the next few years. This process is driven by high-level management meetings held in private. The Strategic Partnering Board, which oversees the SSDP, is dominated by senior managers at the expense of clinicians and patients' representatives, and is not open to the public. It may be hard for patients and staff to find out what is actually being discussed.

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LIFT, like PFI, introduces extra levels of bureaucracy into the public sector, and imports private sector practices of subcontracting and complex contractual relationships. During October's safety crisis on the Northern Line, London Underground had to employ an army of lawyers to read the two million words of the PPP agreement and check that it was allowed to impose emergency measures.[10] As with the tube PPP, LIFT buildings involve lengthy contractual documents, which are far more complex than if the public sector was directly paying a builder to construct a surgery. The worry is that these extra layers of bureaucracy diminish the ability of NHS directors and managers to control the services provided, and make it still harder for patients and staff to make their voices heard.

## 3.2 Profit

The Department of Health argues that 'as a shareholder the NHS will be better placed to direct investment to the areas of greatest need'. It claims that a company is a relatively simple and efficient way to structure a Public Private Partnership and that with this structure, 'The NHS (and GPs) will have the key role in determining where investments are made'.[11] However, there is a danger that instead, the search for profit will distort health care provision.

It is not clear why having a shareholding in a LIFT company should make it easier for the NHS to invest in the neediest areas. The danger is that the opposite may happen: if trusts are encouraged to think of primary care buildings as 'investments', they may tailor their plans according to what is profitable. One reason given for developing LIFT is that it can remedy past 'market failures' – the relative lack of interest shown by GPs and developers in investing in schemes in deprived areas. Yet if trusts begin to think of the primary care estate in terms of rates of return, future schemes may actually draw GPs away from where they are needed. Kitty Ussher MP has expressed her fear that this will happen in her constituency, and that GPs may leave practices in deprived estates to move to brand new LIFT centres in the middle of town.[12]

LIFT gives more control over service planning to unaccountable private sector companies, at the expense of NHS organisations, which must ensure that projects are financially attractive to LIFT companies. By contrast, public funding could ensure that the NHS and clinicians determine where investments are made. There are recent precedents for this: London Implementation Zone grant funding in the 1990s allowed the NHS to build many health centres in deprived areas. Even where buildings are developed by GPs rather than the NHS itself, the local NHS has the ultimate say over whether the project goes ahead. If it indicates unwillingness to reimburse the GPs involved, banks are unlikely to give the GPs a mortgage for the development.

The Department of Health argues that one of LIFT's aims is to bring different services together on the same site. While this may be desirable, there needs to be proper scrutiny to ensure that service integration puts the needs of local people first, before LIFT company profits. In particular, to ensure that 'retail units' developed within LIFT sites are appropriate to health care facilities, rather than (for example) the burger franchises which appear out of place in NHS hospitals.

**Oxford: critics argue that profit is being put before health care need**
Oxford City PCT wants to relocate GP facilities for some 40,000 patients from different localities to one giant clinic on the Radcliffe Infirmary site. Members of the patients forum – despite pressure – opposed the scheme. Critics such as NHS expert Professor Charles Webster argue that the plan is driven by profit, not health need, and that it will actually reduce access to health services for many, while costing over £3 million per year. To make the scheme affordable, Oxford City PCT plans to raise £1 million a year in 'third party revenue'. The worry is that these other parties will be given the best accommodation, leaving the PCT paying over the odds for cramped conditions, despite the large site.[13]

10 http://www.guardian.co.uk/transport/Story/0,,1594718,00.html

11 http://www.dh.gov.uk/ProcurementAndProposals/PublicPrivatePartnership/NHSLIFT/AboutNHSLIFT/fs/en?CONTENT_ID=4076707&chk=iVdaOG

12 At the meeting of the Select Committee on Public Accounts which discussed LIFT on 17th October 2005.

13 See reports published in the Oxford Mail.

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## 3.3 Inflexibility

The issue of flexibility was raised by Dr. Kohli, a GP who works in a LIFT centre, at the Public Accounts Committee meeting. He described the need for alterations as 'inevitable in general practice', which constantly changes. Traditionally, owner-occupier GPs would go to the open market for alterations, and the NHS would reimburse them to the cost of the cheapest of three quotes. However, LIFT companies are monopoly providers of such services to LIFT buildings. Earlier this year Bob Ricketts, the Department of Health's head of capacity planning, said that the NHS was building unwanted and inflexible 'monuments' on 30-year hospital contracts through PFI. Many of these, he said, would be redundant within five years.[14] LIFT is in danger of replicating this expensive mistake in primary care centres across the country.

LIFT has imposed PFI-style financing on half the PCTs in England, with its associated complex and costly legal documentation. More bills are in store as PCTs are amalgamated and must take legal advice on what will happen to LIFT schemes. The worry is that LIFT will create expensive white elephants, while using money that could have paid for cheaper – but less profitable – refurbishments of other GP surgeries. If GPs want to redevelop premises themselves, PCTs may not allow them to: firstly because it may conflict with the exclusivity agreement with LIFTCo, and secondly because PCTs may not be able to afford to reimburse the GPs.

The Department of Health and the NAO seem to assume that a flexible structure for business investment will translate into flexibility for the NHS. But it is hard to see what flexibility is provided for NHS services when trusts sign up to a long-term contract with a private monopoly provider. LIFT may be flexible for the private sector, by offering them the opportunity to 'grow their business' and to sell on different parts of it. But for the public sector, the danger is that LIFT is not just expensive but also inflexible. Following Jamie Oliver's school meals campaign, schools with long-term PFI contracts have found that they are locked into serving processed 'junk food' to children, unless they want to pay substantial financial compensation to contractors for ending contracts early.[15] PFI hospitals are having similar problems, as companies build them without cooking kitchens. Mike Duckett, catering manager at the Royal Brompton Hospital, told The Caterer: 'Patients and staff in PFI hospitals will have to rely on pre-prepared, frozen and reheated meals – almost always less tasty, less healthy and worse for the environment and jobs.'[16]

**PCTs are bearing the risks – and costs – of providing flexible leases for GPs**

Originally the plan was for LIFTCos themselves to provide GPs with flexible lease terms[17], but this proved unattractive to the private sector, because of the risks it entailed. So – to make sure LIFT goes ahead – PCTs have decided to lease GPs' space themselves from LIFT companies ('headleasing'), then subletting it to the GPs. But headleasing means that PCTs bear the risks of GPs leaving, and – contrary to the NAO's claim that headleases and LIFT in general are simpler for PCTs – surely makes the documentation more complex as PCTs have multiple sets of leases to negotiate. Medical solicitors Hempsons say that LIFT leases are extremely complicated compared to traditional leases.[18]

With LIFT, as with PFI, the NHS will bear the risks of service change, or changes in requirements. This makes the public sector very vulnerable and means that it may not be able to implement plans for improvements in health care services. If an aspect of a LIFT building (from picture hooks or fire doors to an X-ray suite) has not been mentioned in the original contractual specification, the PCT will have to negotiate with LIFTCo to provide it. As LIFTCo is then in a monopoly position, the cost could be high, and this could make significant changes or improvements impossible. By contrast, publicly owned and run buildings can be far more flexible if large-scale alterations become necessary, as there is no long-term contract with a private monopoly provider that has to be renegotiated before any changes can be made.

14 Health Service Journal June 9th 2005.

15 http://education.guardian.co.uk/schoolmeals/story/0,15643,1469550,00.html

16 http://www.caterersearch.com/Articles/2005/10/17/302968/PFI+hospital+food+comes+under+fire.htm

17 http://www.dh.gov.uk/ProcurementAndProposals/PublicPrivatePartnership/NHSLIFT/AboutNHSLIFT/fs/en?CONTENT_ID=4076707&chk=iVdaOG

18 Pulse magazine, 9th August 2004.

## 3.4 Conflicts of interest

The LIFT model creates overlapping roles and responsibilities, within a framework that closely links public and private sector organisations. Even the generally positive NAO report expressed some unease about conflicts of interest that may result from this.

**Public sector LIFTCo directors: between the private and the public sector**
The PCTs nominate a 'public sector director' to sit on the LIFTCo board. In four of the six NAO case study areas, the public sector LIFTCo director was a PCT chief executive or finance director. The NAO suggests that this means '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 PCT' (page 32).

As the NAO points out 'the public sector director, in the role as a LIFTCo board member, has a fiduciary duty to act in the interests of the LIFTCo and not for the PCT' (page 32).

Partnerships for Health believes that conflicts of interest are not a serious problem for LIFT. Its history, and that of its joint owner Partnerships UK, is worth examining more closely. In 2000, the Treasury Taskforce which promoted PFI was part-privatised: 51% was sold and the organisation became Partnerships UK.

## Partnerships UK Shareholder List

| Company | % |
|---|---|
| HM Treasury | 44.6% |
| Uberior Infrastructure Investments Limited | 8.8% |
| The Prudential Assurance Company Ltd | 8.8% |
| Abbey National Treasury Services plc | 6.7% |
| Sun Life Assurance Society plc | 6.7% |
| Barclays Industrial Investments Ltd | 6.1% |
| The Royal Bank of Scotland plc | 6.1% |
| The Scottish Ministers | 4.4% |
| Serco Ltd | 3.3% |
| GSL Joint Ventures Limited | 2.2% |
| Boldswitch Ltd (The British Land Company) | 2.2% |

*Source: Partnerships UK*

In 2001, Partnerships UK and the Department of Health created the jointly-owned Partnerships for Health (PfH), which was set up to develop the LIFT programme – both to advise the public sector, and to take shares in LIFT companies. So there is a potential conflict of interest between what is good for the public sector, and what is good for the LIFT company's shareholders. PfH has now decided to offer advice in managing operational LIFT schemes. Still a 20% shareholder in the LIFT companies, it is trying to benchmark LIFT companies and compare them. It is currently promoting the inclusion of more services, including clinical services, in LIFT. Some of the winners from this would be the banks that make money out of lending to LIFT companies, perhaps including those, like the Royal Bank of Scotland, who are shareholders in Partnerships UK.

It could be argued that the LIFT structure institutionalises the potential for conflicts of interest, with the public sector having a stake in a profit-making company and yet also deciding if the company provides value for money. Local authorities' direct service organisations, NHS Trusts' cleaning departments and other in-house organisations have had to face not just five yearly benchmarking, but full competitive tendering, and sometimes they have not been allowed to compete with private providers. The Probation Service is currently having to demonstrate 'contestability' (services are being put out to tender). The argument for this is that public sector 'provider

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interest' stops the public getting a good deal, and competition will ensure value for money. The LIFTCo exclusivity deal seems to go against this main plank of government policy, as it creates long-term monopolies, which are frowned upon if the provider is the public sector.

## 3.5 Value for money

While the Department of Health portrays LIFT as an additional investment, the exclusivity agreement and the high cost of LIFT rentals encourage PCTs to use LIFT instead of other funding routes. Giving evidence to the House of Commons Select Committee on Public Accounts, Dr. Kohli stated that in Newham, two LIFT buildings serve 8% of the population while using 33% of the premises budget. If LIFT quadruples the average premises spend per patient, this money must come from somewhere. Spending on the NHS has greatly increased since 2000; however, the NHS Confederation argues that most of this has had to be used to 'compensate past wrongs' and make up for decades of underfunding.[19] Research organisation and NHS support group Health Emergency has described a '£1.6 billion crisis' in the English NHS.[20] Given this financial pressure, patients may be concerned that the extra cost of LIFT rentals will ultimately be paid for by cuts in services. At the very least, there must be a serious attempt to measure the additional costs LIFT will impose upon the NHS.

Yet the NAO, despite criticising the lack of a proper framework to evaluate LIFT, decided not to produce direct quantitative comparisons with public sector funded developments and only to compare LIFT to PFI, despite recent 'live' comparators that could easily be used to compare LIFT with public funding.

**Public sector excellence: the untold story**
The NAO ignores recent examples of public sector funded health centres, such as those built with NHS grant funding as part of the London Implementation Zone (LIZ), some of which were excellent.

Greenwich's Fairfield Grove Health Centre, funded as part of LIZ, was highly commended by the Commission for Architecture and the Built Environment. North Croydon Medical Centre, also a LIZ building, was given a Royal Institute of British Architects (RIBA) award. The publicly funded Hammersmith Bridge Road Surgery, also given an award, was described by RIBA judges as 'extraordinary, in the real sense of the word; it creates something extra over and above the ordinary, from an unpromising set of circumstances. The Hammersmith surgery is a shining example of the way that good architecture can and should operate at all levels of society…'

There should be a comparison between LIFT and such examples of what the public sector alone can do.

However, instead of drawing upon these experiences of public sector excellence, the government has chosen to launch an untested PFI variant across half of all English PCTs (and soon, Scotland and Northern Ireland too).

The projected LIFT rate of return of 15.1% on average compares with 8-9% for traditional third party development[21] – a lot of extra profit given that a PCT may pay around £1million per year or more to lease each LIFT health centre. There are no plans to analyse the actual rates of return that the LIFT companies receive. If, as the NAO suggests, LIFT companies expand by refinancing parts of their portfolio, this may increase their profit rate and the public may never know. There have been many PFI projects where the public sector has ended up paying far more than the predicted yearly charge, such as the Inland Revenue's deal with Mapeley Steps where an

19 http://www.nhsconfed.org/docs/briefing122.pdf/SHAlist.pdf

20 http://home.btconnect.com/london-health/pdf/SHAlist.pdf

21 UNISON/Democratic Health Network, LIFT: a briefing for non-experts, 2003, available at http://www.unison.org.uk/acrobat/13620.pdf

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'average annual charge' of £170 million turned into payments of over £300 million per year[22]. So actual LIFT profit rates may far outstrip 15% in some areas, especially given the complicated structure of LIFT businesses and the potential for refinancing buildings, as has happened with PFI.

**Many people involved with LIFT worry whether it will provide value for money**
'Representatives from the National Pharmaceutical Association, the British Dental Association and local authorities told us they had concerns about rental costs. 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.' (NAO page 21)

'Some of the strategic health authority representatives in our case study areas were anxious 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.' (NAO page 26)

Even if LIFT projects are good value for money, the NHS might still be unable to afford them. It would be self-defeating and inequitable if PCTs allocate much of their revenue to pay for a small number of state of the art health centres, and then have to cut back on key services in other areas. If projects are too expensive, other services suffer. Yet in its report, the NAO does not produce any affordability calculations. It is possible that LIFT may mean smaller GP premises will eventually lose funding, because their PCT has no money left to pay them[23]. PCTs might face pressure to outsource additional services (perhaps to LIFTCo) if LIFT, like PFI, creates an 'affordability gap'.

## 3.6 Staff

In the first three waves of LIFT, estates and maintenance staff are likely to transfer to a subcontractor to the LIFT company at some point. Fourth wave LIFT schemes explicitly include other support staff, such as cleaning and catering workers, and those LIFT companies may also be given responsibility for tendering for clinical services. Research has shown the damaging impact of contracting out public services[24]. When the pay and conditions of healthcare staff are cut, patient care is threatened. While the recent agreement extending Agenda for Change to contracted-out employees is very welcome, it currently only applies to 'soft facilities management' staff in the NHS in England. Estates and maintenance staff ('hard FM'), clinical staff, and staff in the rest of the UK are currently not covered by the agreement. However, discussions are taking place to persuade the Department of Health to extend the agreement.

Considering all this, it is very worrying that the NAO report gives no attention at all to workforce issues and their relation to the quality of health services. In contrast, the NAO report actually characterises outsourcing as positive. It argues that outsourcing will allow PCTs to concentrate on 'core functions', without considering the impact on outsourced staff or, indeed, on those 'core' functions themselves. The implication is that staff providing essential services such as keeping clinics clean, or making sure that therapeutic gardens are tended, are again seen as peripheral.

As the UNISON report Cleaners' Voices[25] shows, front-line domestic staff are the real experts on hygiene, and their expertise and professionalism must be recognised, if services are to be improved and dangerous infections prevented. Instead, to talk about subcontracting 'non-core' employees sends the message the contribution of support staff to the patient environment is not important. If – as seems likely – different groups of staff are increasingly hived off to different subcontractors, LIFT risks fragmenting NHS teams in a similar way, and damaging the attempt to create a holistic, patient-focused service.

22 In 2003-04, £63 million of this was for additional expenditure, so the basic price seems to have jumped to £246 million. See http://www.publications.parliament.uk/pa/cm200304/cmselect/cmtreasy/835/4063011.htm and http://www.publications.parliament.uk/pa/cm200304/cmhansrd/vo040719/text/40719w13.htm

23 Pulse Magazine 30th April 2005.

24 E.g. Steve Davies, Hospital contract cleaning and infection control, available from http://www.unison.org.uk/acrobat/14564.pdf; Steve Davies, School meals, markets and quality, available from http://www.unison.org.uk/acrobat/B1985.pdf; John Lister, The PFI experience: voices from the frontline, available from http://www.unison.org.uk/acrobat/13383.pdf. See also Labour Research August 2005.

25 Written and researched by John Lister. Available from http://www.unison.org.uk/acrobat/14565.pdf

# 4. LIFT in the future

*The Department of Health and Partnerships for Health are planning to extend LIFT to Scotland and Northern Ireland, and the LIFT model is undergoing some changes.*

## 4.1 Clinical and support services

### 4.11 Fourth wave LIFT schemes

Partnerships for Health is encouraging PCTs to privatise more services as part of fourth wave LIFT schemes. A Partnerships for Health conference on 'Taking the LIFT Concept Forward' in March 2005 included 'a major session on the inclusion of clinical services in the LIFT model and the issues that this will raise' since 'many of the fourth wave LIFT schemes are likely to include clinical provision in some way'[26]. There are currently nine fourth wave schemes going out to tender from Autumn 2005. Tenders can be viewed online for free at http://ted.publications.eu.int/official/.

As this report went to press (January 2006) eight fourth wave schemes had gone out to tender: South West Hants LIFT, Wiltshire and Swindon LIFT, South East Essex LIFT, Sustainable Communities Kent LIFT, Bury, Tameside and Glossop LIFT, South East Midlands LIFT, South Midlands LIFT, and Bolton, Rochdale and Heywood & Middleston LIFT.[27] They closely resemble each other, and the other fourth wave tender (Kensington and Chelsea LIFT) may well be similar.

All the tenders explicitly include 'building cleaning services and security services'. This marks a change from the first three LIFT waves, which have not included such 'soft FM'[28] services. Although the tenders do not mention other ancillary services like catering, these may be included, as the list of 'partnering and leaseplus services' to be provided or procured by a LIFT company begins 'included but not limited to…'. So a large range of support services could be automatically privatised in LIFT buildings.

LIFT may also be used to privatise ancillary services in non-LIFT buildings. All tender documents state that 'The PPP vehicle [LIFTCo] may also provide facilities management services (such as building maintenance and repair services, grounds maintenance services, building cleaning services and security services) to other buildings within the contracting authorities' estate.' This does not just mean PCT buildings; potentially it could include staff in local authority buildings and hospitals, as councils and acute NHS trusts are normally additional 'contracting authorities' in the LIFT process.

The tenders also include clinical services, again in a way which permits widespread privatisation. Contracting authorities 'may require the PPP vehicle [LIFTCo] to advise on and/or manage and oversee separate competitive tender processes for the provision of services which may include clinical services from the Relevant Facilities or other buildings within the contracting authorities' estate'. This means that PCTs can ask LIFT companies to privatise clinical services in LIFT and non-LIFT buildings. LIFT companies could engage private medical companies to provide GP services, or agencies to provide district nursing services.

South East Essex's LIFT tender goes further and may also use LIFT to privatise 'the provision of sports and leisure facilities, libraries, museums and/or community centre facilities'. Similarly, South East Midlands' tender stipulates 'sports and leisure facilities and libraries'. A vast range of clinical and social services in these areas could be handed over to the private LIFT companies. GP practices have always been private organisations. But there are many differences between small groups of self-employed doctors providing GP services, and multinational private companies running a full range of health and social services in an area.

The eight tender documents point the way towards greater privatisation of services under LIFT. The Trusts have chosen the most radical option – to include clinical services generally under LIFT, rather than specifying individual services such as diagnostics. Fourth wave LIFT companies may take on much of the PCTs' commissioning role, contracting for a range of privatised services, with little remaining of publicly provided primary health care services.

26 http://www.partnershipuk.org.uk/newsAttachments/documents/doc_57_3-3-2005-10-18-59.pdf. The conference cost £250+VAT for public sector participants and £495+VAT for private sector participants.

27 Contract numbers 2005/S 249-246444 (South West Hants). 2005/S 151-151107 (Wiltshire), 2005/S 162-162003 (Essex), 2005/S 191-188521 (Bury), 2005/S 189-186540 (Kent), 2005/S 210-207126 (South East Midlands), 2005/S 2005-208871 (South Midlands), 2005/S 213-210634 (Bolton, Rochdale and Heywood & Middleston).

28 'Soft FM' can include cleaning, catering, caretaking, security, waste and reception services, whereas 'Hard FM' refers to buildings and grounds maintenance.

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**4.12 Earlier LIFT schemes**

If the fourth wave LIFT contains such radical changes, Partnerships for Health may decide to adapt earlier LIFTs to increase the opportunities for privatisation. Earlier LIFT companies might be encouraged to go through another tendering process to establish a 'ClinicCo' to provide clinical services, which might or might not be the existing LIFT company. Or possibly legal advice may indicate that a tendering process can be avoided, and clinical services could be offered to the LIFT company already involved (subject to a value for money test). The position will become clearer as LIFT develops and as the government's policies for PCTs unfold. But other waves may well include clinical services.

It is less clear whether additional support services will begin to be included in earlier LIFT waves. The private sector is keen for them to be included, so it is possible that this will also happen, particularly if the LIFT market becomes consolidated and dominated by an even smaller number of companies. Again, how this is done would depend on whether these services could be held to fall within the current specification – many of the earlier LIFT tenders mention the provision of 'building and facilities management services', without naming particular services. And if PCTs are encouraged to cease providing services, support services are likely to be privatised, whether to LIFT companies or not.

# 5. Holding PCTs and LIFTCos to account: what branches can do

## 5.1 Finding out information

Although LIFT companies are not subject to the Freedom of Information Act, you have the right to ask PCTs for information that LIFTCo has provided to them[29], although PCTs may argue that some information is commercially confidential. They would have to be able to show that the potential prejudice to commercial interests outweighs the public interest in accessing the information. Members of the public can also attend PCTs' board meetings, which will be held every one or two months, and ask the directors questions about LIFT. You may also be able to attend regular meetings of the trust's patient and public involvement forum, and encourage forum members to scrutinise LIFT developments and to take a position on any schemes that put profit before need, or which appear not to be value for money.

## 5.2 Local authorities and the local press: potential allies

You can put pressure on local authorities to scrutinise LIFT. PCTs have to apply for planning permission for LIFT developments, and local authorities will take objections and comments into account when deciding whether to grant permission. Members of the public can attend local authority health overview and scrutiny committee (OSC) meetings and ask questions. You can contact your local councillor, or councillors who sit on the health OSC, and encourage them to ask questions for you. MPs may also be interested.

Often LIFT schemes involve the sale of local authority land. Local authorities (unlike PCTs) are elected, and may find the sale of public assets politically embarrassing. If a local authority decides not to sell its land to LIFTCo, LIFT may not be a viable route (rents become much more expensive without the land transfer). The PCT and local authority could then look for alternative ways to develop the site.

Local newspapers will also often be interested in LIFT, and may run stories or letters about local GP surgeries closing or high LIFTCo rents, for example.

## 5.3 The limits of exclusivity and alternatives

Although PCTs have little capital funding and are signed up to exclusivity, there are potential alternatives that campaigners can argue for. The NAO says 'If LIFTCo cannot demonstrate through either benchmarking or market testing that value for money criteria have been satisfied, the participants have the right to go elsewhere for the services required.' (page 26).

So if a LIFT company is not interested in a scheme or if its plans can be shown to be poor value for money, PCTs may be able to go elsewhere for buildings. Even if a PCT thinks that it does not have this right, it might still be able to get around the exclusivity clause – for example, by getting an organisation which hasn't signed up to exclusivity (like a mental health trust) to commission a building and lease some of it to the PCT.

New health centres can still be built and owned publicly. Under the Local Government Act 2003, local authorities can borrow to finance capital spending[30] providing they can pay for it – which would certainly be possible with a guaranteed revenue stream from a PCT.[31] Other public or voluntary sector organisations may have resources available too and such routes may well be better value for money than LIFT.

In some areas, local GPs may want to build and redevelop their own premises rather than going through LIFT, and it may be possible to demonstrate that this would provide better value for money than the LIFT route. In many areas there will be good recent examples of NHS funded (or GP funded) buildings that can be compared to any new LIFT proposals, such as Greenwich's Fairfield Grove Health Centre, North Croydon Medical Centre and Hammersmith Bridge Road Surgery (see section 3.5).

29 See two useful guides to using the act, available at http://www.unison.org.uk/acrobat/B1803.pdf and http://www.cfoi.org.uk/pdf/foi_guide.pdf

30 Capital spending is money to build buildings; the local authority could then charge the PCT rent.

31 Local authorities also have general powers to spend to promote local well-being.

## 5.4 Campaigning works

It is early days, but public campaigns have encouraged PCTs to take account of the public's wishes. Often people are not happy if they hear their local GP practice will be closed and relocated further away. In Colchester and Tendring, the persistent pressure by Holland-on-Sea Residents' Action Group resulted in the PCT agreeing to retain 'satellite' practices in two locations. Opposition to the LIFT plans in Oxford have forced the PCT there to consider other options. The exclusion of support services from LIFT in waves 1-3 was probably due to vocal trade union campaigns.

## 5.5 National demands

As MPs John Trickett and Richard Bacon argued in the Select Committee on Public Accounts, the NAO report on LIFT is inadequate (see section 6) and campaigners should demand that a proper investigation is carried out. There needs to be a proper independent review of LIFT, comparing it to publicly built health centres, and providing detailed statistics on how much LIFT is costing us. How much is the NHS paying per patient for LIFT buildings, and what could we get for this money through other means? Allied to this, we need not just predictions of future profit levels, but detailed figures on how much profits are actually being made, including through refinancing. Finally, national scrutiny of LIFT developments must ensure that the search for profit is not distorting the provision of health care services, particularly in poorer areas.

# 6. The National Audit Office report on LIFT

## 6.1 About the NAO report

The NAO report aimed to evaluate the LIFT programme. It is a 'Value for Money' audit, which assesses public spending programmes with respect to the criteria of economy (whether costs have been minimised), efficiency (whether the resources used have produced the greatest possible output) and effectiveness (whether the intended results have been achieved).[32] This NAO report has received unprecedented criticism from MPs on the House of Commons Public Accounts Committee, for whom it was produced (see 6.5 below). The following sections outline the NAO report and assess its shortcomings.

## 6.2 The national research

The NAO report was researched using a range of methods. The main way the NAO studied the national picture was through two large surveys. One was sent to private sector bidders who had competed for LIFT schemes; the other was sent to project directors from the public sector side. 66% of the private sector bidders responded to the survey; 95% of the project directors (who have a statutory responsibility to reply) did.

These surveys mainly covered progress up to financial close, as at this time only six LIFTs had actually passed this stage. The NAO consulted frequently with the Department of Health and Partnerships for Health, and used these two bodies to provide details of potential interviewees. It had a panel of 10 experts to give advice on the research methodology and the structure of the report. Three of the 10 were clinicians or representatives of professional associations.[33]

## 6.3 The case study research

The NAO report also used a selection of case studies, which are the six LIFTs that had actually passed financial close at this stage in their fieldwork: East London and the City, Barnsley, and Sandwell from Wave One; East Lancashire and Barking and Havering from Wave Two, and Ashton, Leigh and Wigan from Wave Three. Auditors spent a week with each of the case studies. They looked at documents (such as business cases), visited building sites and attended meetings. They also carried out in-depth interviews with 'key stakeholders' including project directors, private sector bidders, clinicians, PCTs, strategic health authorities and local authorities.

A survey was sent to local pharmaceutical committees in each of the six case study areas (two-thirds of these responded). This was suggested by the National Pharmaceutical Association, which was concerned that pharmacists did not feel fully included in LIFT. The NAO followed up on other areas of interest or where they had been alerted to problems with particular LIFT schemes.

## 6.4 The report's conclusions

The conclusions the NAO reached 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.

## 6.5 The Public Accounts Committee's criticism of the NAO

The National Audit Office report is the only official study of LIFT, so it is vitally important that its conclusions can be trusted. However, when the Select Committee on Public Accounts met to discuss LIFT, there was a great deal of unease. Usually, the Select Committee uses the data in NAO reports to ask questions of witnesses. In this case, the witnesses were Peter Coates from the Department of Health, James Stewart from Partnerships UK, Brian Johns from Partnerships for Health and Dr. Bhupinder Kohli, a GP working in a LIFT centre.

But this time, two MPs on the panel (Jon Trickett and Richard Bacon) raised serious questions about the NAO report itself, especially its failure to provide comparative data and statistical analysis.

32 http://www.nao.org.uk/about/role.htm

33 It was made up of one NAO director, one NHS Confederation representative, one person from the Commission for Arhitecture and the Built Environment (CABE), one PCT chief executive, one LIFT project director, one director of 4ps (a body giving local authorities advice on private finance deals), one project management consultant, a representative of the National Pharmaceutical Association, a Fellow of the Royal College of GPs, and a dental practitioner.

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Faced with these, Auditor General Sir John Bourn agreed that the NAO will come back with a supplementary report containing more statistical data, and comparing public funding directly with LIFT.

## 6.6 Some potential problems with the NAO report's methodology

Firstly, the six case studies chosen may not be representative of all 42 (now 51) LIFT schemes. As the first to reach financial close, they were the most successful in each of their 'waves' (although none of them met Partnerships for Health's target of 12 months from finalising an SSDP to financial close). Looking at the best cases makes it hard to assess how quickly LIFT schemes are progressing generally. The report might have been more representative if it had included analysis of LIFTs where problems and/or opposition have developed. The NAO did receive letters from people complaining about their local LIFT schemes, but chose not to discuss these cases.

The NAO's choice of key informants may have helped to prioritise the views of the privatisation lobby. In the two national surveys, it only contacted private sector bidders and LIFT project directors. But these are the groups one would expect to be most likely to give positive accounts, as they are so closely involved with LIFT. It would have been useful to compare their responses with the way that other staff (nurses, GPs, maintenance staff, non-executive directors, other PCT managers, heads of service etc.) and service users have experienced the LIFT process so far. The choice of bidders and project directors as key informants reinforces the report's managerial focus.[34] When the researchers found opposing views, they downplayed them: local authorities, mental health trusts and pharmacists all told the NAO they thought LIFT's costs exceeded its benefits.

Finally, how is it possible to judge LIFT a success for health care at a point when (page 15) 'LIFT has yet to contribute significantly to targets for investment in primary care'? The NAO says that the value for money of a building should be measured 'on the basis of whole life costs and how well it meets objectives, including local health priorities, delivery to time and budget, the quality of the building in structural and functional terms and flexibility of use over time' (page 22). So it is worrying that the NAO felt able to conclude that LIFT clearly shows value for money so early in the process. Others have drawn different conclusions. A report by Professor Chris Drinkwater for the NHS Alliance predicts trouble ahead, saying that some initial LIFT sites 'had been chosen hastily, were in the wrong area and had to be 'fortified' against vandalism.'[35]

34 There may have been added reluctance on the part of project directors to be critical of their LIFT schemes, as up to half of the project directors have moved on to become general managers of the new LIFT companies.

35 Pulse Magazine 29th July 2005

# 7. List of NHS LIFT schemes

## 7.1 Fourth wave

- Bury, Tameside & Glossop (Bury PCT and Tameside PCT)
- Kensington and Chelsea (Kensington and Chelsea PCT)
- Rochdale, Bolton, Heywood & Middleton (Heywood & Middleton PCT, Bolton PCT, Rochdale PCT)
- South East Midlands (Bedfordshire Heartlands PCT, Milton Keynes PCT, North Hertfordshire and Stevenage PCT, Bedford PCT)
- South Essex (Southend PCT and Castle Point & Rochford PCT)
- South Midlands (Northamptonshire Heartlands PCT, Northampton PCT, Melton, Rutland & Harborough PCT, Daventry & South Northants PCT)
- South West Hants (Southampton City PCT, Eastleigh & Team Valley South PCT, New Forest PCT, Mid Hampshire PCT)
- Sustainable Communities in Kent (Dartford, Gravesham & Swanley PCT, Maidstone Weald PCT, Ashford PCT)
- Wiltshire (South Wiltshire PCT, Kennet & North Wiltshire PCT, West Wiltshire PCT, Swindon PCT)

## 7.2 Third wave

- Ashfield (Bassetlaw PCT, Mansfield District PCT, Newark & Sherwood PCT, Ashfield PCT)
- Ashton, Leigh & Wigan (Ashton, Leigh & Wigan PCT)
- Barnet, Enfield & Haringey (Haringey PCT, Enfield PCT, Barnet PCT)
- Brent & Harrow (Brent PCT, Harrow PCT, Hillingdon PCT)
- Bristol (Bristol South and West PCT, Bristol North PCT)
- Bromley, Bexley & Greenwich (Bromley PCT, Bexley PCT, Greenwich PCT)
- Colchester & Tendring (Colchester PCT, Tendring PCT)
- Derby (Derby Dales & South Derbyshire PCT, Amber Valley PCT, Erewash PCT, Greater Derby PCT, Central Derby PCT)
- Doncaster (Doncaster West PCT, Doncaster Central PCT, Doncaster East PCT
- Dudley (Dudley South PCT, Dudley Beacon and Castle PCT)
- Ealing, Hammersmith & Hounslow (Ealing PCT, Hammersmith & Fulham PCT, Hounslow PCT)
- East Hampshire, Fareham & Gosport (East Hampshire PCT, Fareham & Gosport PCT)
- Gedling (Gedling PCT, Nottingham City PCT, Broxtowe & Hucknall PCT, Rushcliffe PCT)
- Lambeth, Southwark & Lewisham (Lambeth PCT, Lewisham PCT, Southwark PCT)
- Leeds (Leeds West PCT, Leeds North West PCT, Leeds North East PCT, East Leeds PCT, South Leeds PCT)
- Norfolk West/South/North (North Norfolk PCT, Southern Norfolk PCT, West Norfolk PCT, Suffolk West PCT)
- Oldham (Oldham PCT)
- Oxford (Oxford City PCT)
- Plymouth (Plymouth PCT)
- Sheffield (North Sheffield PCT, Sheffield West PCT, Sheffield South West PCT)
- South West London (Kingston PCT, Richmond & Twickenham PCT, Wandsworth PCT, Croydon PCT, Sutton & Merton PCT)
- St Helens, Knowsley, Halton & Warrington (St Helens PCT, Knowsley PCT, Halton PCT, Warrington PCT)
- Tees Valley (Middlesbrough PCT, Hartlepool PCT, North Tees PCT, Easington PCT, Durham Dales PCT, Sedgefield PCT)
- Wolverhampton/Walsall (Wolverhampton PCT, Walsall PCT)

## 7.3 Second wave

- Barking and Havering (Barking and Dagenham PCT, Havering PCT)
- Birmingham (Eastern Birmingham PCT, Heart of Birmingham PCT, North Birmingham PCT, South Birmingham PCT, Solihull PCT)
- Bradford (Bradford City PCT, Airedale PCT, Bradford South and West PCT)
- Cornwall and Isles of Scilly (West of Cornwall PCT, Central Cornwall PCT, North and East Cornwall PCT)
- Coventry (Coventry PCT, Hillfields PCT, Longford PCT, Cheylesmore PCT, Canley PCT)
- East Lancashire (Blackburn with Darwen PCT, Hynburn and Ribble Valley PCT, Burnley PCT)

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- Hull (East Hull PCT, West Hull PCT, Hull & East Riding PCT)
- Leicester (Leicester City West PCT, Eastern Leicester PCT)
- Liverpool/Sefton (Southport and Formby PCT, South Sefton PCT, North Liverpool PCT, South Liverpool PCT, Central Liverpool PCT)
- Medway (Medway PCT)
- North Staffordshire (North Stoke PCT, South Stoke PCT Staffordshire Moorlands PCT, Newcastle-under-Lyme PCT)
- Redbridge and Waltham Forest (Walthamstow, Leyton and Leytonstone PCT, Redbridge PCT, Chingford, Wanstead and Woodford PCT)

## 7.4 First wave

- Barnsley (Barnsley PCT)
- Camden & Islington (Camden PCT, Islington PCT)
- East London and City (Newham PCT, Tower Hamlets PCT, City & Hackney PCT)
- Manchester, Salford & Trafford (Salford PCT, North Manchester PCT, South Manchester PCT, Central Manchester PCT, Trafford North PCT, Trafford South PCT)
- Newcastle & North Tyneside (North Tyneside PCT, Newcastle PCT)
- Sandwell (Rowley Regis & Tipton PCT, Wednesbury & West Bromwich PCT, Oldbury & Smethwick PCT)

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# 8. Glossary

**Capital funding:** money that a public sector body can use to build buildings.

**FundCo:** a shell company within the LIFTCo structure, effectively the landlord of one building or group of buildings.

**LA:** Local Authority

**LIFT:** Local Improvement Finance Trust

**LIFTCo:** LIFT Company, the limited company formed to develop primary care centres in a local area.

**MHT:** NHS Mental Health Trust; provides and commissions mental health services.

**NAO:** National Audit Office

**PCT:** Primary Care Trusts. NHS bodies which currently manage 75% of the NHS budget. They provide and commission primary care services.

**PFI:** Private Finance Initiative.

**PPP:** Public-private partnership. Includes PFI, LIFT, and other types of privatisation that aren't just a straightforward sale of assets to the private sector.

**Primary care:** The initial contact for many people with a health problem is with a primary care professional, usually their GP. Other primary care professionals include nurses, health visitors, dentists, opticians, pharmacists and specialist therapists.

**Procurement processes:** The means through which public sector organisations select private companies to fulfil contracts.

**PUK:** Partnerships UK. 51% owned by private sector companies and 49% owned by the Treasury. Helps the public sector develop PPPs.

**Revenue funding:** money that a public sector body must use to pay for services, not to build buildings. Almost all PCT funding is revenue funding – which creates enormous pressure to use LIFT or PFI to get new buildings.

**SHA:** Strategic Health Authority. Monitor PCTs and develop plans for health services in the area. There are 28 in England.

**SPB:** Strategic Partnering Board – established by the PCTs and other relevant public sector partners, although private sector representatives also sit on it. It is supposed to monitor LIFTCo and plan its future direction. Also grants approval to LIFT schemes, which is a two-stage process.

**SSDP:** Strategic Service Development Plan. PCTs are supposed to develop SSDPs. The SPB reviews and approves the SSDP, which outlines the medium-term strategy for primary and community based health services.

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# 9. Resources

## UNISON Publications

| Title | Stock no. |
|---|---|
| The private finance initiative a policy built on sand (October 2005) | 2449 |
| PFI – Against the public interest (July 2004) Why a 'licence to print money' can also be a recipe for disaster | 2353 |
| Public Risk for Private Gain? (July 2004) The public audit implications of risk transfer and private finance | 2350 |
| Not so Great: Voices from the front-line at the Great Western PFI Hospital (Oct 2003) | 2255 |
| LIFT: Local improvement Finance Trust (August 2003) What you need to know and what you need to ask | 2235 |
| The PFI Experience: Voices from the frontline (March 2003) | 2187 |
| Profiting from PFI (February 2003) | 2158 |
| PFI: Failing our future: A UNISON Audit of the Private Finance Initiative (September 2002) | 2108 |
| What's good about the NHS: and why it matters who provides the service (April 2002) | 2053 |

*All reports can be accessed online at www.unison.org.uk. Paper copies can be ordered from www.unison.org.uk/catalogue or by faxing 02120 7551 1461 quoting the relevant stock number.*

## Websites

UNISON PFI and PPP pages,
http://www.unison.org.uk/pfi/

House of Commons Select Committee for Public Accounts, Oral evidence from meeting on Local Improvement Finance Trust (uncorrected transcript).
http://www.publications.parliament.uk/pa/cm200506/cmselect/cmpubacc/uc562-i/uc56202.htm

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John Lister, Health Policy Reform: Driving the Wrong Way? – A Critical Guide to the Global 'Health Reform' Industry. *Middlesex University Press, 2005.*

Allyson Pollock, NHS Plc: The privatisation of our health care. *Verso, 2004.*

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