EVALUATION OF THE PLANNING AND IMPLEMENTATION OF NHS LOCAL IMPROVEMENT FINANCE TRUST (LIFT) IN EAST LONDON

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ABSTRACT

Procurement of NHS primary care buildings was reserved for the DH working through PCTs until LIFT was introduced. The DH anticipated that LIFT would effectively mobilise private sector finance and expertise in improving the quality of buildings. But LIFT's suitability to achieve this is questioned on grounds that it uses market mechanisms that may fail when applied in health. This case-study explored with people directly involved in LIFT their views and experience of how it helped them in procuring desired buildings. It was driven by desire to understand whether and how contextual factors and mechanisms in LIFT supported staff efforts, hoping the findings would influence DH officials in revising the guidance to make LIFT effective.

Evidence was primarily collected through in-depth interviews with 25 informants drawn at two PCTs, the LiftCo and LIFT buildings. Data from interviews was complemented by documentary analysis and tours to make observations at four LIFT buildings. The data was coded for analysis in NVivo. The key findings were organized into four analytical categories aligned with the research questions for interpretation to generate relevant answers.

The study revealed that the important factors for progress in LIFT involved commitment of PCT boards; engaging PCT managers in strategic decisions and empowering them in influencing governance issues. Progress may be enhanced through DH officials encouraging increased collaboration between LIFT partners and promoting contractor competition in service delivery. Barriers to progress included the LiftCo over-prioritising efficiency, hiring of contractors lacking experience in health, and the DH not sufficiently supporting PCT managers in increasing their capacity to make LIFT effective. Informants believed LIFT could improve procurement provided ways of addressing the barriers were explored.

LIFT outcomes are a result of factors in its contexts influenced by policy-makers and decisions taken by operational staff. Recommendations are offered for these constituents in LIFT and for future research. DH officials should get feedback on practicalities of LIFT guidance by engaging PCT managers in making strategic decisions and empowering them in translating their experiences into actions. This could make LIFT effective and reduce the risks that were highlighted.

DECLARATION:

I certify that this thesis presentation is my own work and has not been submitted to any other University for the same fulfilment.

SIGNED:

Oliver Mudyarabikwa: _____

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Abbreviations and Acronyms used

BMA: British Medical Association

CABE: Commission of Architecture and the Built Environment

CEO: Chief Executive Officer

CCG: Clinical Commissioning Group(s)

CHP: Community Health Partnership

CMO: Context-mechanism-outcome

DH: Department of Health

GP: General Practitioner(s)

IPPR: Institute of Public Policy Research

LIFT: Local Improvement Finance Trust

LiftCo: LIFT Company

NAO: National Audit Office

NHS: National Health Service

PCT: Primary Care Trust

PfH: Partnerships for Health

PFI: Private Finance Initiative

PPP: Public-Private Partnership(s)

RE: Realist Evaluation

SPB: Strategic Partnering Board

SSDP: Strategic Services Development Plan(s)

WHO: World Health Organisation

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My parents, children, and my family – thanks for everything.

DEDICATION

This PhD is to the loving memories of:

Tsitsi Mudyarabikwa – missed but never forgotten;

Munashe Mudyarabikwa – a joyful brother; and

My father – the best a son could hope for.

SECTION 1: INTRODUCTION AND BACKGROUND

1.1 Introduction

From the 1990s, the National Health Service (NHS) experienced changes that included decentralising policy-making from Whitehall to health departments in the individual countries (England, Scotland, Northern Ireland and Wales) (Stevens 2004). Subsequently, reforms within England have favoured market mechanisms ostensibly to free the NHS' components like Strategic Health Authorities, Foundation Trusts, Primary Care Trusts (PCTs), and general operational staff from Department of Health (DH) bureaucracy in order to improve performance. The government prefers policy that de-concentrates decision-making about health provision and management from the DH to lower level NHS units. This includes encouraging agents other than NHS units in delivering healthcare and related physical infrastructure (DH 2001). Changes of this nature mean that some practices within the NHS in England could be interpreted and legitimised under the label of decentralization.

Historically, decentralization was understood from both public administration and economic perspectives. The public administration approach suggested by Rondinelli (1983) uses the concepts of devolution, delegation, and de-concentration to analyse how government departments pass authority and independence for decision-making from higher to lower levels of governance. The economics perspective considers decentralization in terms of the flow of resources for public service from the higher to lower levels within government systems (Wolman 1990).

It is argued that these perspectives to decentralization were developed at a time when health systems across the world were protected against major changes to how they were organised to function (Saltman et al 2006, Bossert 1998). They may need to be expanded to include new concepts like public-private partnerships (PPPs) emerging within most health systems (Atun 2007, Perrot 2006, Saltman 2003). Different forms of PPPs are being used to provide services or finance delivery and management of healthcare functions. Previously, the roles were reserved for the government yet the public administration and economic perspectives to decentralization do not adequately explore the role of PPPs.

1.1.1 Problem Statement

The Local Improvement Finance Trust (LIFT) is a PPP model that seeks to improve procurement of primary care buildings within PCTs (DH 2001). But some commentators argue that significant numbers of PCTs using LIFT are sceptical about its ability in helping them to efficiently procure the desired buildings (Fitzsimmons et al 2009, King's Fund 2008). Despite commitment to improve the condition of their buildings, some PCTs still have deficits in stock of new or upgraded buildings. Research has been conducted to understand the problems in LIFT but have not adequately explained whether it is the flaws in its design or challenges in executing projects that are barriers to progress.

1.1.2 Purpose of the research

The purpose of this research was to explore with staff involved in LIFT implementation their perceptions of why it produced outcomes that they experienced within their PCT areas. The views of PCT managers, the Chief

Executive Officer (CEO) at the LIFT Company (LiftCo) and GPs and administrators at LIFT buildings were prioritised because they are directly involved in executing LIFT schemes. The researcher believed that a better understanding of their experiences and perceptions about what influenced LIFT outcomes within their PCT areas may help DH officials that oversee LIFT in identifying ways of supporting local staff in making it effective. The local staff would be also helped in making more informed decisions for maximising benefits from LIFT.

1.1.3 Research questions

The following research questions are addressed within the case-study:

(i) What did DH officials perceive were the contexts and mechanisms for effectiveness in LIFT and who were expected to benefit from its outcomes?

(ii) What factors were perceived to facilitate staff directly operationalizing LIFT schemes in discharging their responsibilities?

(iii) What factors did operational staff perceive might influence or help them in progressing against LIFT's expected outcomes?

(iv) What lessons can be learnt from the case-study experiences to better explain and understand LIFT for the benefit of future schemes and other PCTs?

1.1.4 Objectives

i. To construct a case-study comprising two PCTs, a LiftCo and LIFT buildings;
ii. To gather individual and group perceptions of PCT managers, LiftCo staff, General Practitioners (GPs), and building administrators on how performance of their responsibilities is facilitated or constrained by LIFT mechanisms;
iii. To ascertain how any social, economic, or financial contexts produce effects for the different groups of LIFT participants;
iv. To synthesize the shared experiences and perceptions to suggest the critical factors which explain whether LIFT succeeds; and
v. To draw conclusions for policy-makers and practitioners adopting LIFT.

1.1.5 Overview of research design and methods

The main methodological elements of this research are described by the following: (i) context of the research; (ii) assumptions held at research commencement; (iii) rationale for using an embedded case-study methodology; (iv) rationale for choosing the case-study area; and (v) the preferred evaluation approach. Each element including procedures taken to conduct the research is discussed in detail in Section 2 (Methodology).

1.1.5.1 Context of the research

Given mixed opinion about LIFT's ability to improve procurement, the current research develops conceptual and empirical approaches to explore the real-world experience of LIFT based on a case-study of two PCTs that were part of the first wave to pioneer it within the NHS. LIFT has

since been endorsed by among others, the National Audit Office (NAO) (2005), Commission for Architecture and the Built Environment (CABE) (2008), and King's Fund (2008) for its ability to deliver improved buildings on time and within budgets.

The studies of Fitzsimmons et al (2009), Aldred (2008) and Pollock and Price (2006) criticise LIFT for having complex designs and procedures that reduce the local staff's capacity to manage related risks. Wall (2007) identifies frequent repairs at LIFT buildings as one indicator for reduced capacity of staff in monitoring to ensure that LiftCo activities in designing and constructing the buildings respect tenants' priorities. For these reasons, the commentators view LIFT as expensive compared to government led procurement.

1.1.5.2 The Researcher and research assumptions

The researcher acknowledged that his previous research experience and interest in PPPs for health could be a liability. This experience may have originated from developing countries but its potential in introducing bias in framing the research design and choosing aspects in LIFT to investigate, or where to put emphasis in interpreting the findings existed. The concern was addressed through being supervised by a team with a different orientation. In addition, triangulating data collection methods, data sources and types, and having regular reviews with the supervisors helped in minimizing researcher subjectivity to enhance credibility of the findings.

This research was done under the primary assumption that LIFT is a decentralisation strategy for both the funding and financing of primary care buildings. This assumption is based on that the DH intends to overcome

shortage of public funds and expertise needed for improving the buildings. Here, funding refers to the DH investing in activities to procure buildings without implied recovery of money spent. The government may be providing funding for the buildings but the decisions about using the funds through LIFT are decentralised from the DH right down to PCTs. Previously, the PCTs could not invest public funds in private companies like LiftCos that finance LIFT. Financing refers to DH investing in activities to procure buildings using repayable loans facilitated by the LiftCo. It means that the DH still funds the procurement but direct financing of LIFT buildings is delegated to private financiers through the LiftCo.

A secondary assumption was that if LIFT represented decentralised procurement, the PCTs will be self-directed and self-reliant in using it to improve buildings in their areas. This is guided by Mills & Vaughan (1990), and Bossert's (1998) principle that local staff are allowed sufficient authority including discretion in performing the decentralised functions. The researcher expected PCT staff to be able to vary the guidance in operationalizing LIFT schemes depending on circumstances and preferences in their areas. These assumptions were verified by examining how informants perceived LIFT mechanisms and contexts to facilitate or constrain their progress.

1.1.5.3 Rationale for an embedded case-study

Yin (2009) conceptualises embedded case-study designs as involving analyses of programmes at either more than one level or units of analysis. Although the current research focuses on the operational level at the expense of policy-making and care provision levels (Figure 1.0 page 9), it

still meets Yin's (2009) criteria for an embedded case-study on the basis of having multiple levels and units of analysis. The multiple levels and units of analyses involved are explained in subsection 1.1.5.3.1 (page 7) addressing the boundaries set to narrow the scope of this research. The PCTs, the LiftCo and LIFT buildings were considered as units to be analysed to better understand their roles in LIFT as were the different categories of staff involved. Also, how informant perceptions and experiences differed along their responsibilities in LIFT needed to be understood. For example, it may help to understand how and why estate and facilities managers' views about LIFT differ from those of the finance directors or other groups at the same PCT.

A number of studies indicated that LIFT was a complex initiative (Beck et al 2009, Fitzsimmons et al 2009, Aldred 2008). An embedded case-study design avoided attempting to analyse complex issues from the perspective of only one institution (e.g. PCT, or LiftCo, or LIFT premises); or that of one professional group. This might have risked disregarding other important sources of data on LIFT yet they could be defined within the case-study.

1.1.5.3.1 Boundaries of the research

The boundaries in this research are defined by the theory on which to base the study of LIFT; focus at the operational level for data collection; and targeting staff at the PCTs, the LiftCo and LIFT buildings as the right people to provide information. Setting these boundaries facilitated timely completion of the research by focusing it on specific aspects to analyse for developing relevant answers to the research questions. This may not have been achieved if it had considered too broad issues.

1.1.5.3.1.1 Concept on which to base LIFT

Pawson (2006) advocates for realist evaluation informed studies to prioritise analyses of theories or concepts on which a programme is based. The present research hypothesized decentralization as the concept on which LIFT is based. Decentralization is the processes of redistributing responsibilities, powers and resources for selected functions from a central location. The present research therefore sought to understand LIFT's effectiveness in dispersing key aspects in procurement of primary care buildings from the DH through case-studying two PCTs and a LiftCo located in east London.

1.1.5.3.1.2 Operational level

Within the hierarchy of LIFT activities, the focus for data collection was on the operational level illustrated in Figure 1.0 (page 9). The operational level is where LIFT's primary activities concern translating the guidance into buildings that are needed to improve patient experiences. This boundary was preferred at the expense of the policy-making level and care provision activities. These were not prioritised for focused analysis because activities at those levels are not directly concerned with executing and managing LIFT schemes.

At the operational level, the PCTs, the LiftCo and LIFT buildings were prioritised in providing data for the research. Unlike the DH, Treasury and the Strategic Partnering Board (SPB); the PCTs, LiftCo and LIFT buildings are directly affected by activities in LIFT implementation.

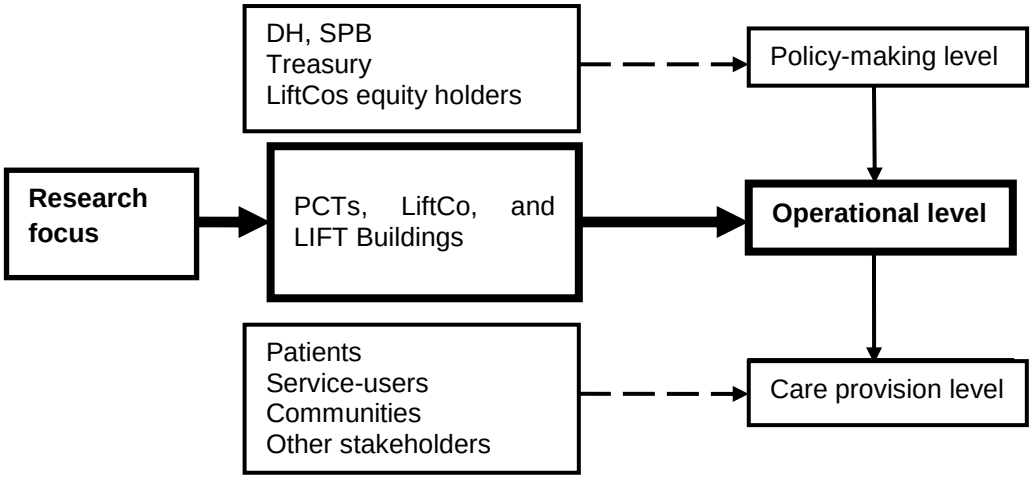


Figure 1.0: The research's focus and analysis units

The SPB is a locally based entity working as an agent of the DH and treasury in overseeing LIFT implementation. The SPB and officials at the DH and treasury were all considered to be at policy-making level and therefore distant from local experiences in LIFT. Similarly, activities at the care provision level may have less to do with LIFT than with the PCTs and GPs that retain the responsibility to provide care using LIFT buildings.

1.1.5.3.1.3 Informants on LIFT activities

PCT managers, senior staff at the LiftCo, and GPs and building administrators were prioritised as the people likely to possess relevant information and experiences for answering the research questions. Neither public sector officials nor shareholders in the LiftCo and patients would sufficiently provide the needed information. As previously indicated, they are not directly involved in local activities in LIFT.

1.1.5.3.1.4 Units of Analysis

The units of analysis comprised the elements identified within the boundaries of the research. Table 1.0 (pg 11) describes the “ordinate” units of analysis involving (i) the concept chosen for explaining LIFT (decentralization); (ii) experiences at the operational level by (iii) the different categories of sampled informants. Analysis of the “ordinate” units involved locating them in a wider context of decentralization to better understand factors that may facilitate progress by the different categories of informants at LIFT’s operational level. It is possible that the outcomes of implementing decentralization through NHS LIFT are influenced by challenges faced by participants in implementing concepts like New Public Management, “Third Way” or other variants of public-private partnerships.

A deeper understanding of LIFT was possible if the same factors identified within the ordinate units were further analysed at multiple levels of specificity. Table 1.0 (pg 11) describes the “subordinate” units of analysis which if investigated may enable understanding whether features that portrayed LIFT as decentralization at first analysis could offer consistency in explaining it the same in relation informant experiences of, for example, decision-making or procedures in financing LIFT schemes. Any inconsistencies may indicate how LIFT works in a wider policy context.

The ordinate and subordinate units of analysis contributed evidence about how in a wider policy context; factors surrounding LIFT, and mechanisms through which activities are performed affected decentralization in delivering benefits anticipated. They also indicated how the factors affected the PCTs, the LiftCo and LIFT buildings in performing their roles, and the different categories of staff in discharging their responsibilities.

Table 1.0: Ordinate and subordinate units of analysis

Ordinate units	Subordinate units	Sources of the evidence
Decentralization: theory on which LIFT is based	Elements in decentralized procurement – e.g. planning, finance, decision-making.	LIFT guidance, local documents, literature, interview transcripts
Operational level	Roles of PCTs, LiftCo, LIFT premises in addressing LIFT objectives	Literature, local documents and observations at buildings.
Operational staff (categories of staff)	Individual perceptions & experiences	Interview transcripts cross-checked against LIFT guidance
	Group perceptions & experiences – e.g. Lead GPs, administrators or Finance directors	Interview transcripts, minutes of meetings and management documents

Overall, the units of analysis recognised that perceptions about LIFT may be product of activities and experience whether at the PCTs and LiftCo levels, or by individuals or professional groups. Hence the suggestion that usage of the RE approach may facilitate better understanding of social constructs of programmes at their different levels (Pawson and Tilley 2004). The knowledge may be further enhanced by using embedded case-studies that involve multiple units of analysis (Yin 2009).

The current research did not compare experiences of staff from one PCT against another. The interest was more in what the different informants experienced in LIFT than with specifics about what happened within individual PCTs. Priority was given to understanding how, for example, the different PCT managers, LiftCo staff, and GPs and building administrators experienced and perceived LIFT either individually or as professional groups. This was achieved by examining the different types of data from documentary analyses and in-depth interviews with informants sampled at the operational level, a process of triangulating data sources (Creswell 2002).

Designing an embedded case-study and using the described research boundaries facilitated within-case data analyses. The overall analysis then reconciled the variations in experiences between informant groups and how LIFT was perceived at the local level to enhance validity of the findings without having to study a range of LiftCos. The findings could therefore show a typical PCT's experience since they were derived from experiences of people actually implementing LIFT at the local level.

1.1.5.4 The case-study area

The case-study was within the former NHS North East London. Figure 1.1 describes its geographical spread before some PCTs were merged in creating NHS London as a single health authority (NHS London 2007c). For example, City & Hackney PCT existing during the research involved merging of two health units into one PCT. At that time, east London area comprised seven PCTs including those case-studied. All the PCTs were then phased out under the Health and Social Care Act passed at the end of this research in 2012.

Figure 1.1: Geographical spread of NHS North East London

The case-studied PCTs were chosen for three reasons. First, their history of collaborative research with the University was convenient for the research. Second, they had experience as pioneers of LIFT in London. Third, they shared the same LiftCo whose portfolio of buildings allowed enquiries at sufficient number of premises.

1.1.5.5 Realist evaluation (RE)

This research was guided by RE principles. The detailed rationale for adopting this particular approach is explained in Section 2 that addresses methodological issues. RE principles facilitate explanations about how, as opposed to merely seeking answers about whether a programme works or not. Pawson and Tilley (2004) state that this is understood through asking:

> *"What works, for whom, in what circumstances, and in what respects, and how"?* (pg 2)

The questions are helpful in the present research where interest resided in capturing the real-world experiences of connections between LIFT

contexts, mechanisms, and outcomes. They offer a systematic approach in enquiring complex mechanisms and governance arrangements believed to characterise LIFT (Aldred 2008, Beck et al 2009). For example, the questions may guide in integrating different analytical strategies to explain and understand LIFT through identifying and matching major themes from documentary data with those from in-depth interviews. Using RE principles represented analytical triangulation within-case for explanations of LIFT along the ordinate and subordinate units of analysis.

Within the case-study, it helped in explaining the aspects of LIFT that worked to benefit whom, in what circumstances, and how, among the different groups of participants. Thus, the researcher was able to systematically evaluate LIFT mechanisms and contexts to understand how they supported informants in achieving the expected outcomes. The meanings of “contexts” and “mechanisms” in relation to RE principles are clarified in Section 2 (page 92). Informant experiences played an important role in identifying practices that made LIFT effective under given contexts and mechanisms.

1.1.6 Structure of the thesis

This thesis is made up of six sections including this introduction. The sections and their contents are explained as follows:

1.1.6.1 Section 1

Section 1 comprises subsections 1.1 and 1.2. Subsection 1.1 introduces the research through subsections addressing: problem statement that influenced this research (1.1.1); purpose of the research (1.1.2); research

questions (1.1.3); the objectives (1.1.4); overview of the research design and methods (1.1.5); and structure of the thesis (1.1.6).

Subsection 1.2 presents the background and context of LIFT. Subsection 1.2.0 gives the historical procurement of NHS estate before LIFT was introduced. A discussion of the conceptual framework guiding the research - decentralization is presented in subsection 1.2.1. This is followed by an explanation of the different approaches to decentralization (1.2.2) and a tracing of decentralization experienced within the NHS (1.2.3). Subsection 1.2.4 identifies New Public Management, Third Way, Localism, and PPPs as possible conceptual perspectives driving LIFT within the NHS. Their objectives are discussed in subsection 1.2.4.5.

The discussion in subsection 1.2.5 considers LIFT in context of public-private partnerships. PPP concepts are defined and their possible drivers and perceived benefits within the NHS are addressed. The discussion extends beyond the confines of the public administration and the economic perspectives to decentralisation (Rondinelli 1983, Wolman 1990). Subsection 1.2.6 traces the NHS' experiences with public-private partnerships in service delivery. It argues that PFI and LIFT are examples used to finance or deliver services by collaborating with the private sector.

1.1.6.2 Section 2

Section 2 deals with the methodology of the research. Its five subsections address specific issues of gathering and manipulating data for the research. The conceptual framework guiding conduct of the research is discussed (2.1) followed by the research design (2.2). The primary methods employed for data collection are presented in subsection 2.3 in

the order of: documentary reviews (2.3.1); in-depth interviews (2.3.2); and tours of LIFT buildings (2.3.3). This is followed by a discussion of the data analysis (2.4) and explanation of ethical issues about the research (2.5).

1.1.6.3 Section 3

Presentation of the findings is organised around the research questions and data collection methods. The findings on LIFT contexts, mechanisms and outcomes (CMO configurations) answering research question (i) based on documentary analysis are in subsection 3.1. Those answering research question (ii), based on informant interviews are in subsection 3.2. Subsection 3.3 presents the CMO configurations answering research question (iii) also based on informant interviews. Within it are subsections presenting the findings on informant perceptions of influential LIFT mechanisms; influential contexts; perceived progress against the expected outcomes; and other emerging unintended outcomes in LIFT. The findings from tours at LIFT buildings are in subsection 3.4.

1.1.6.4 Section 4

Analysis and interpretation of the findings is organised around analytic categories aligned with the research questions (4.0). The analytic categories were determined in order to synthesize the several components of the research findings. It helped in developing a holistic understanding of LIFT. A detailed discussion of each analytic category is in subsections 4.1 to 4.4. The ideas that emerge from the analysis and interpretation are then considered in revising the middle range theory explaining LIFT (4.5).

1.1.6.5 Section 5

The key findings and how they relate to literature are discussed in subsection 5.1 and their implications for policy and practice are considered subsection 5.2. This influenced the decision to provide a feel of how LIFT and the Health and Social Care Act introduced in 2012 may mesh (5.3). The section ends with a reflection on limitations of the research (5.4).

1.1.6.6 Section 6

The conclusions and recommendations are organised as follows: The conclusions on key findings and lessons learnt from the case-study are presented in subsection 6.1. Recommendations are offered for consideration by the DH officials, operational staff, and for future research on LIFT (6.3). Finally, subsection 6.4 explains the research contribution.

1.2 Background and Context of LIFT

From the public management and the economic perspectives (Rondinelli 1983, Wolman 1990), the NHS has always been a decentralised organization. Apart from services being managed through hierarchically organised administrative units of the government, significant numbers of non-governmental bodies including independent general practitioners (GPs) have been involved in NHS economic activities. In recent years, there has been a proliferation in types of NHS functions that are delivered through working in partnerships with the private sector. Perhaps it is the result of the DH being more receptive to new thinking like New Public Management and related concepts that decentralise aspects of procuring NHS functions using various strategies. For example, the financing and management of primary care buildings is done through LIFT as opposed to directly by the DH. It underlines the importance of exploring some of the factors that may influence effectiveness of decentralization strategies in delivering the desired outcomes.

There may be the case for identifying the different approaches to decentralization and analysing them to understand how their drivers may influence effectiveness in service delivery. Within the NHS, New Public Management, Third Way and Localism may be particular concepts that influenced variants of PPPs such as the PFI and LIFT. The perceived benefits and risks of using such concepts in financing or delivering public functions need to be understood whether or not applied under government regulation and supervision. The concepts are central to discussions in subsections 1.2.1 to 1.2.6 of this research.

1.2.0 Estate procurement in the NHS

The likely effects of the LIFT model of procurement may be better interpreted if read in context of how NHS estate was procured in the past.

1.2.0.1 Historical perspective

Before 1994, development of hospital accommodation in the NHS was funded by the Treasury (Pollock et al 2005). DH officials used to invite expertise from the private sector to compete in tendering for contracts funded by the Treasury. The companies would bid to design and deliver or provide maintenance at the new buildings following specifications provided by NHS managers and clinicians. At that time, the Treasury was seen as best able to mobilise money and effective at controlling expenditure by DH agencies. It changed in 1994 when the private finance initiative (PFI) was preferred to having direct recourse to public funds in developing new hospitals (Gaffney et al 1999a).

There were attempts to invest and strengthen primary care estate well before LIFT came to prominence in 2000. The DH invested in its own buildings and also provided grants for independent GPs to build new or upgrade existing private surgeries. As well as this, it encouraged third party developers working for-profit to seek loans from private banks for developing their own buildings. This could be considered DH investment in the sense of saving public money in the long run. It reduced the net present value of its liabilities by avoiding long term renting of private facilities for primary care delivery by its agencies. Yet it raises questions about whether LIFT increases or reduces investment.

Despite the attempts, centralised procurement did not meet patient demands for facilities appropriate in providing modern care (DH 2001). An analysis of the functional suitability of GP surgeries revealed that how the buildings were designed and located failed to support improvements in care provision (DH/PfH 2003). They were obstructed from delivering modern care by insufficient space for the services offered, amenities, and unsuitable environmental conditions. These factors were blamed on problems of increased costs, inadequate funding by the DH, bureaucracy, and shying away from full participation in developing healthcare buildings by some local authorities (DH/PfH 2003).

Perhaps decentralized procurement would increase the stock of appropriate buildings, at the right places, and at the time when they are needed. Proponents of LIFT believed it would solve problems of insufficient funding by the Treasury; inefficient performance by DH agencies; demands for a greater say in governance of services by patients; and economic decline in the NHS (Milburn 2004). The government advocate market mechanisms to reduce public monopoly because bureaucracy and inflexible management practices of public agencies obstruct them in cost-efficiently responding to patient demands. In this case, LIFT redistributes responsibilities and authority for risks that are important in procuring better facilities.

But there is disagreement on the most appropriate route to procure premises in the NHS. Staff at the frontline of NHS activities prefers government led procurement and management of the buildings because they believe it prioritises public interests. Government has the ability to

deliver more appropriate and higher quality buildings compared to private developers (Gaffney et al 1999b). Often, business principles that drive private developers tempt them into overemphasizing efficiency than quality in procurement and management of NHS premises. If decentralization is a response to problems in procurement; choice of the route used may be influenced perceived ability in managing risks believed to increase benefits. For example, PCTs may avoid exclusive use of the conventional route because problems in centralised procurement. But they may also avoid exclusive use of the private route if they believe that market mechanisms may introduce disadvantages in procurement activities.

1.2.0.2 The LIFT model

Perhaps the DH considered the LIFT model to be a compromise for ensuring that only the strengths of conventional and private routes were retained in procuring GP surgeries. If so, whether and the ways in which LIFT contracts increase benefits in procurement may be interpreted better by understanding how strengths vis-à-vis objectives within the conventional and private routes mesh to influence outcomes.

LIFT seeks to increase the quality and stock of modernised GP surgeries through accessing private sector capital, skills and expertise plus management practices missing in government led procurement (DH 2001). Thus, it not only changes the funding arrangements but also how GP surgeries are financed and management. The difference between funding and financing resides in their underlying motive.

Funding refers to investing in the procurement of service without intention to recoup the investment. With financing, there is always implied intention

on the part of the investor to recover the full investment plus profit. For example, with LIFT, the fact that PCTs rather than DH officials decide when to initiate LIFT projects using public resources may be construed to represent decentralized funding. The PCTs do not have intention to recoup their investment in LIFT buildings. They also choose to spread funding of the buildings over a 25 year period under LIFT contracts rather than paying cash up front. The LiftCo is delegated the responsibility to raise finance that is needed to deliver LIFT buildings. This also represents decentralized financing from the DH or Treasury to private banks through the LiftCo. But this time the banks acting through the LiftCo have implied intention to recover their full financial outlays plus profit.

From these angles LIFT may be viewed as a hybrid of decentralized funding and financing where the PCTs fund procurement through a rent payment to the LiftCo that finances delivery of the buildings without direct recourse to the public purse. The LiftCo is also delegated a central role in management of LIFT buildings, meaning financial decentralization runs alongside administrative decentralization. The funding and financing arrangements may hard press PCT and private shareholders in the LiftCo to ensure good use of resources with their governance activities ultimately influencing LIFT outcomes. Some analysts (e.g. NAO 2005 and King's Fund 2008) endorsed the model (see subsection 1.2.6.2.4 pg 85) as more efficient and cost-effective than public agencies in producing benefits in procurement.

Provisions like duration of contracts have characteristics that are likely to influence the model's effects. LIFT contracts are valid for 25 years. Over

this period, the LiftCo is expected to recover capital plus profit for the financiers through rent payments by the PCTs (DH/PfH 2003). There is therefore chance that governance arrangements may evolve to produce outcomes contradictory to the model's original objectives.

Under the LIFT model, PCTs only pay for use and not end of contract ownership of buildings which remains with the LiftCo. The change in status at the end of contract may involve either the PCTs exercising the right to buy or first refusal to buy the buildings from the LiftCo. There are instances where the land on which LIFT buildings are developed is owned by the PCTs (DH/PfH 2003) hence calling it the land retained model. In such cases, the PCTs have preferential rights to acquire the buildings at below market values should they opt to buy at the end of contract.

The alternative is the land purchase agreement model in which the LiftCo owns the land and buildings leased to the PCTs. Should the PCTs decide not to buy the buildings whether under the land retained model or land purchase model; the LiftCo is left with the risk of disposing of the buildings as they may wish. This may include continuing to lease them to the PCTs on new terms outside the original LIFT contracts.

1.2.1 Conceptualizing LIFT: decentralization and its definitions

In light of the above context of LIFT, and nature of the research questions, decentralization was chosen as the appropriate conceptual framework to guide this research. Decentralization is the process of shifting power, authority and responsibility from the national level to sub-national levels of government (Mills and Vaughan 1990). The downward flow of power, authority and responsibility may be in respect of activities to plan and

deliver selected services, or managing performance, or distributing resources to fund activities (Saltman et al 2007).

Within the UK, for example, decentralization may involve the transfer of power, authority and responsibility from the national level to the individual countries. Or, within the individual countries, it can occur when the same are transferred from the central level to organisational structures. That power, authority and responsibility to deliver selected health functions are shifted from the DH to strategic health authorities or Foundation Hospitals is one of the examples of decentralisation within the NHS in England today (Wall 2007). These sub-national government units also in turn pass power, authority and responsibility to PCTs or independent agents like GPs and voluntary service providers.

Across the world, decentralization appears to be now a common reform strategy within most health systems (Saltman et al 2007). Approaches to decentralization vary significantly from one country to another because implementation may be based on a number of concepts that are underpinned by different reasoning (Bossert 1998). Hence argument that decentralization is not a single approach but a strategy under which many approaches to shift aspects of public service delivery from central to peripheral government units may be considered (Sharma 2006).

The traditional understanding limited decentralization to the dispersal of governance in political, administrative and financial functions (Rondinelli 1983, Mills and Vaughan 1990). Contemporary commentators on health activities (e.g. Atun 2007, Saltman et al 2006) argue for decentralisation to reflect economic dispersal of control that adds tiers within the systems.

They advocate inclusion of outsourcing of public service provision and other forms of PPPs in decentralization discourse. It means that decentralization can involve, for example, the private for-profit and not for-profit providers (Bennett et al 1997).

This has given rise to differences in opinion regarding the extent to which decentralization is useful in health systems (WHO 2008). Differences also exist regarding the correct approaches to evaluation of decentralisation outcomes (Sharma 2006). Therefore, it is pertinent to consider some of the arguments offered for and against decentralization to contextualise the appropriateness of PPPs such as LIFT in reforming the procurement of NHS buildings.

1.2.1.1 Perceived benefits and risks of decentralization

When practised in health, decentralization has been associated with benefits and risks including the following:

1.2.1.1.1 The benefits

It is argued that decentralization can facilitate improvements in health systems performance leading to better health outcomes (Wolman 1990, Zwi and Mills 1995, Dubois and Fattore 2009). Some of the approaches used address the problems of government monopoly and bureaucracy that obstruct appropriate responses to changing consumer needs (World Bank 2006). In England, for example, improvements in technology and increased patient knowledge and expectations for quality put pressure on the NHS to modernise its buildings (Milburn 2004b). Yet the DH has been slow to improve the condition of buildings citing the shortage of funds (DH 2005).

In this case, decentralization may be an opportunity for the DH to reduce administrative or financial burdens that are associated with public procurement of some health functions (Atun 2007). Among other things, this can be achieved by transferring either financial, performance, or construction risks from central to lower level DH units including private partners. Within the NHS, the poor condition of buildings might be rectified by empowering PCTs to delegate responsibility in procurement to private sector partners in their areas (DH 2001, 2005). Such approaches make the health system more responsive to local priorities especially if decisions on expenditure of public funds are taken to the lower levels where the needs are better understood (WHO 2000, Saltman et al 2007). Decentralization is therefore perceived to increase efficiency in the ways to deliver public functions (Saltman 2007).

It is argued that apart from mobilising financial resources, decentralization may promote competition and innovation in health. According to the World Bank (2006), decentralising to private providers particularly carries benefits of the government accessing better skills and expertise needed for technical efficiency in service delivery. Allocative efficiency may be also achieved since recipients of the decentralised functions are expected to be specialists in those functions (Sharma 2006). Benefits accrue because the recipients are nearer and connected with the service-users compared to central government departments. This fits well with Milburn's (2004b) view that by decentralising public buildings delivery through PPPs, previous UK governments aimed at:

> *"(…) harnessing the resources and skills of the private sector to bring about improvements in services for the public – in a way that gets vital*

additional investment into frontline services in the shortest possible time, consistent with prudent management of the public finance" (page 2).

There is also the political argument that decentralization extends democratic control to local communities and health stakeholders (Mills & Vaughan 1990, Zwi & Mills 1995). It empowers them when they are prioritised for receiving enhanced authority and responsibility for health functions in their areas. This may explain recent moves to involve communities in public service delivery through the Localism Act 2011 (House of Commons 2011). Yet within the NHS, critics doubt whether PPPs are able to increase opportunity for ordinary service-users to participate in decision-making about the governance of local services (Allen 2006, Peckham et al 2005).

1.2.1.1.2 The risks

A think-tank on health reforms - Partnerships for Health Reforms cautions that one of the risks in decentralising health provision concerns mismatches between decentralised responsibility and power to control and influence relevant activities (PHR 2002). In their view, decentralization arrangements lack evidence for effectiveness against their primary intentions because of the mismatches. Sharma (2006) and Pollit et al (1998) blame this on governments' inertia. Although power and authority to make decisions over critical resources may be needed to support execution of the decentralised functions at local levels, there is government tendency to retain them at the centre. Pollit et al (1998) further argue that, whether decentralization is between government departments or through PPPs, local staff may lack sufficient discretion in processes for executing the decentralised functions. A related risk to arise

may be the suspicion that decentralization offloads government burden and accountability to local levels without offloading power to determine service delivery (Allen 2006, Savas 2000).

There is concern that decentralization may be motivated by desire to conceal government debt (Rajasulochana and Dash 2010). Public accounts may not disclose debts that result from private sector financing of public service. The government owns such debts like in the case of NHS buildings procured through LIFT. The mortgage is repaid to the LiftCo risking. The arrangement is likely to distort public investment because the buildings are reflected on LiftCo not PCT balance sheets (Beck et al 2009).

It is also possible that the government may choose to decentralize some functions as a means to gain control and influence over the independence and activities of the recipients. When not matched with adequate transfer of power and authority, failure to deliver at local levels might be used by the government to justify re-centralisation of governance of the functions previously decentralised. In light of the nature of benefits and risks of decentralization, the approaches need to be analysed to put into context how PPPs like LIFT may fit into the spectrum.

1.2.2 Approaches to decentralization

Strategies for transferring, authority and responsibility from higher to lower levels of government may involve horizontal and vertical decentralization (PHR 2002). Horizontal decentralization occurs when activities for service delivery are dispersed among organizational units that are at the same level. Within the NHS, it may mean the government spreading responsibility over specific health functions between the DH and local

authorities (DH 2012). By contrast, vertical decentralization involves dispersal of activities among units within the same organization. For the NHS, this may mean the DH spreading the roles and activities for health delivery between strategic health authorities, PCTs, foundation hospitals and mental health trusts. Activities that are decentralised may be related to human resources management, service planning, performance management, funding, or procurement of facilities.

Analysts offer different perspectives in explaining the basis for decentralising health service delivery. Mills and Vaughan (1990) adopt a political perspective to explain it as promoting democratic control and citizenship. This involves giving communities and service-users roles in the governance of health services. The approach extends on Rondinelli's (1983) administrative perspective that uses devolution, deconcentration and delegation concepts in explaining decentralization. Wolman (1990) identifies arrangements in the flow of public funds from higher to lower level government units to consider decentralization from economic and financial perspectives.

The current research moves beyond the confines of these perspectives to include the different forms of PPPs emerging within health systems in the spectrum of decentralization. Other commentators including Milburn (2004a), Saltman et al (2007), and Atun (2007) think likewise. Milburn's view is that PPPs used in procuring NHS buildings decentralise the funding and financing for local levels to improve service delivery. The current research sought to shed light on how key features of the conventional

approaches and those of LIFT mesh in explaining decentralization within the NHS.

1.2.2.1 Political decentralization

The underlying assumptions in political decentralization are that, decisions made through wider local participation are better informed, and more relevant to local priorities compared to when made by central political departments (Mills and Vaughan 1990, Pollit et al 1998). This may provide the health system with opportunities to improve the responsiveness of health activities to local needs (Cornwall and Gaventa 1999). Within the NHS, the PCTs are expected to understand and prioritise local interests and needs in the design and commissioning of services (DH 2001). To achieve this may require the presence of within-PCTs structures with a mandate to encourage effective engagement with communities in decisions about investments needed at local levels.

Aside from strengthening democratic control, it is suggested that political decentralization may produce additional economic benefits such as eliminating potential standardisation in health related goods (Saltman et al 2006). This in turn helps among other things, to achieve efficiency by reducing bureaucracy in service delivery and increasing patient choice needed to improve health outcomes. For these reasons, the present research sought to explore the extent to which decentralization through LIFT helped to achieve the pro-democracy assumptions underlying political decentralization.

1.2.2.2 Administrative decentralization

Administrative decentralization is perceived to be effective at improving health service delivery. According to Pollit et al (1998), it prioritises redistribution of authority and critical resources for health to lower levels of government. Saltman and Busse (2002) explain that the improvements are products of operational staff adopting entrepreneurial approaches to their activities. They do this by changing to either devolve, or delegate, or privatise authority and responsibility over resources needed to perform selected health functions (Saltman et al 2007).

Devolution

Devolution involves streamlining bureaucracy through redistributing authority, decision-making, finance, management, and necessary powers to semi-autonomous government units (World Bank 2006, Pollit et al 1998). Considering the wide range of the aspects redistributed, devolution might be the strongest form of administrative decentralization provided locales are allowed sufficient discretion. Discretion refers to freedom that the government accords to local staff in decisions about implementing the decentralised functions.

In the 1990s, the DH reorganised the NHS by setting up self-governing foundation trust hospitals, strategic health authorities, and PCTs to take over roles previously performed by District Health Authorities (Stevens 2004). This further devolved NHS activities in the sense that the new structures assumed accountability for delivery and local performance in health. On this basis, you could argue that LIFT represents additional structures designed to devolve planning and funding of buildings from the DH to the PCTs. In this case, devolution runs side-by-side with delegation

of delivery and part of the financing and management of buildings to LiftCos coordinated by the PCTs.

In health, governments' tendency to retain control over the essential aspects of service delivery may influence effectiveness of devolution (PHR 2002). Sharma (2006) raises concern about staff at the frontline of public service being denied adequate freedom in making strategic decisions in matters that may be important to governance of functions devolved to them. Partly for this reason, devolution may suit only systems like in the UK where the individual countries wield power and freedom from control by central government over key decisions in health delivery (Saltman et al 2007, Peckham et al 2005).

Deconcentration

Deconcentration also involves redistribution of authority, decision-making, finance, management, and powers to deliver public service to lower levels (Rondinelli 1983). Its major distinction from devolution is that the redistribution is to "lower government units" whereas devolution redistributes to "semi-autonomous government units". With deconcentration an important problem could be uncertainty about the administrative aspects that the government redistribute to lower units (Pollit et al 1998). For a variety of reasons embedded in politics, the government may not precisely state the responsibilities redistributed, meaning inadequate discretion conferred to recipients of the decentralised activities.

This may explain why some analysts consider deconcentration to be the weakest form of administrative decentralization (Saltman et al 2007).

Writing on the NHS, Allen (2006) and Klein (2007) argue that it was weak at improving effectiveness in service delivery. In their view, it merely shifted responsibility to the PCTs with the DH retaining authority for key decisions and control in financial matters. Stevens (2004) further argues that accountability within the NHS was offloaded to the PCTs and local stakeholders under the guise of promoting localism in service delivery. This influenced the current research to explore whether LIFT was free from problems in decentralising key procurement activities to PCTs.

Delegation

Within health systems, delegation involves transferring administrative responsibilities and decision-making over selected health functions to autonomous or semi-autonomous organizations outside the government's immediate control (Saltman and Bankauskaite 2006, Bennett et al 1997). Through advocacy by international organizations like the World Bank (2006) and the World Health Organisation (WHO) (2008), health systems across the world have progressive delegation either directly or through working in PPPs. It makes delegation probably the fastest growing form of administrative decentralization in health.

Within the NHS, the DH could be seen as delegating the financing, delivery, and management of healthcare buildings to private companies. This is done either directly in the case of PFI hospitals, or indirectly through PPP companies as with LIFT buildings. Delegation occurs with private for-profit and not for-profit providers including non-governmental organisations (NGOs) having increased involvement in direct care and services delivery.

1.2.2.3 Economic decentralization

Economic decentralization brings in market mechanisms to change the ways through which services are delivered, financed, or consumed (Wolman 1990, Bennett and Muraleedharan 2000). This is mainly done by government facilitating new players or state-owned organizations through reviewing legal frameworks that may have previously constrained competition in health activities. The World Bank (2006) argue that aside from removing government monopoly in resourcing and procurement, economic decentralization in health may promote competition resulting in increased efficiency, better quality of services, and improved patient experiences. Central to this argument is the belief that market mechanisms promote diversity that generates efficiency in the allocation of resources for health (DH 2010). Health systems are therefore recommended to consider involving non-governmental agents in delivering, owning, or managing selected health functions (WHO 2000). According to Normand (2011), this may facilitate access to better technical expertise in the business of service delivery.

Therefore, the current research sought to understand the extent to which LIFT portrays benefits that are central to economic decentralization. There are concerns that involved PCT staff may be unfamiliar with market mechanisms yet this is important if they are to make LIFT effective in achieving the anticipated benefits (IPPR 2004, Broadbent et al 2003). PCT staff may need to be effective at making sure that the LiftCo and its contractors do not prioritise their private goals at the expense of the public.

It appears that economic decentralization in health generates controversy by challenging public opinion about how services should be delivered. Sanderson (2003) and Stevens (2004) argue that the public expects the DH to always retain custody of health delivery rather than delegate to private providers. The controversy is particularly intense where responsibility is transferred to private for-profit providers who may have competing motives (Saltman and Buse 2002). There is concern that private for-profit providers may over prioritise efficiency by cutting back on services perceived to be costly even though consumers consider them essential. Pollock and Price (2011) explain this as the consequence of privatisation promoted through economic decentralization. This is further discussed in context of the perceived risks of using PPPs within health (subsection 1.2.5.2.2.3 page 59).

1.2.2.4 Financial decentralization

Financial decentralization changes the ways in which funds for public service delivery flow from higher to lower levels of government (Wolman 1990). It involves government departments at higher levels shifting the responsibility to raise or spend funds to their own units at lower levels. Others (e.g. Bennett et al 1997) understand it as transferring the responsibility to finance services from public to non-governmental organizations including private companies. Financial decentralization may therefore involve changes in either funding or financing of public service, or both.

In context of decentralization, it is argued that making operational staff active participants in activities to raise and spend public funds may

increase their effectiveness in service delivery (Milburn 2004b, Mills and Vaughan 1990). Yet this approach to decentralization is characterised with some important risks. Writing on LIFT, Pollock and Price (2006) observe that the LiftCos tend to borrow private finance at higher rates than would have been done by the DH making LIFT an expensive procurement method for the involved PCTs.

It is clear from examination of the different approaches to decentralization that LIFT is a hybrid of political, administrative, economic and financial decentralizations. Therefore, the present research does not anticipate benefits from being precise about what kind of decentralization LIFT represents. Its interest is in explaining how LIFT produces benefits and risks associated with political, administrative, economic and financial decentralization. This may shed light on whether the outcomes experienced in the case-study reflect managerial capabilities or effects of how LIFT is designed, or those of the different approaches to decentralization.

1.2.3 Decentralization within the NHS

Creation of the NHS was driven by desire to solve problems caused by fragmented organizational activities (Fraser 2009). It standardised governance and administratively centralised healthcare activities. Since then, decentralization through use of market mechanisms has been practiced ostensibly to improve NHS performance by involving players other than the DH.

1.2.3.1 Organizational and decentralization of governance

A review of literature on decentralization highlights that the NHS experiences significant organizational decentralization (Atun 2007; Peckham et al 2005; Stevens 2004; DH 2005; Saltman et al 2007). In the 1990s, for example, it experienced changes in the management of activities previously performed by regional health authorities and district health authorities (Saltman 2003). At that time, the number of regional authorities was reduced from 14 to eight in 1994 (Stationery Office 2002). Although their roles were increased, the moves may be construed for centralization or decentralization due to changes in numbers of the governance structures.

The merging of district health authorities with family health services authorities created 481 primary care groups in 1996 (DH 2005). This may be evidence for organizational and governance decentralisation since the primary care groups were then reduced (centralisation) to 303 upon replacement by PCTs in 2000 (Saltman et al 2007). In terms of their role, the district health authorities and PCTs differed to an extent. District health authorities did not run primary care per se. They only purchased services at local acute hospitals. In contrast, the PCTs commissioned primary and hospital care controlling 80% of NHS budget (Stevens 2004).

Organizational and governance decentralization was then accomplished by re-organising and re-naming the regional health authorities into 28 strategic health authorities in 2000 (DH 2005). The strategic health authorities were made larger by reducing their number from 28 to 10 in 2006 while that of the PCTs was reduced from 303 to 152 (Saltman and

Bankauskaite 2006). The changes in numbers confirm organisational and governance centralisation regardless of what activities the organizations did.

Organizational and governance decentralisation has been criticised on the grounds that they increased either the number of service providers or range of responsibilities without matching power for local staff to control NHS activities (Sanderson 2003, Allen 2006). Peckham et al (2005) argue that it increases administrative burden on the lower level NHS units thereby risking failure to deliver the decentralised functions. For this reason and in relation to LIFT; King's Fund (2008) sees more benefits from the DH retaining authority in delivery, ownership and management of healthcare buildings than decentralizing the roles to the LiftCos.

1.2.3.2 Economic and market-based decentralization

On economic decentralization, the NHS has always had a fair representation of the private sector. Private providers have a role in general practice, supply of pharmaceuticals, equipment maintenance, and researching new technology. Thus, initiatives like commissioning private companies under LIFT to deliver and manage healthcare buildings might be explained in the context of deregulation of economic activities for new possibilities in procurement activities. The White Paper: *"Working for Patients"* (DH 1989) probably kick-started this by proposing a split between purchasers and providers in procuring NHS services. Although district health authorities continued as providers until 2000, the DH directed them to progressively purchase patient care from new self-governing NHS Trusts whose business practices were influenced by market mechanisms

(DH 1989, Klein 2001, Stevens 2004). The White Paper arguably provided the PCTs with a platform for employing internal markets mechanisms in providing and managing health.

The concept of internal markets aimed at promoting competition within NHS organizations by discouraging centralised planning and procurement of services (Klein 2007). It introduced self-governing NHS Trusts with the expectation to streamline bureaucracy and encourage local planning and management of health activities (DH 1989). Stevens (2004) believes the objectives were achieved because the NHS Trusts received decentralised accountability for health functions from the DH. Further economic decentralization involved the DH delegating responsibility, decision-making and discretion on expenditure for health to the district health authorities and GP Fundholders (Allen 2006). The GP Fundholder concept would later reappear as Clinical Commissioning Groups (CCGs) to substitute for the PCT role in primary care commissioning (DH 2010)

Like the other types of decentralization previously discussed, economic and market-based decentralization is perceived to improve efficiency leading to better health outcomes (House of Commons 2012). The benefits are achieved by, among other ways, facilitating competition; accessing private sector skills; and passing accountability for health activities to local communities through involving them. You could argue that the DH applied market mechanisms by decentralising responsibility for financing estate improvement and management to private companies using LIFT. This is despite there being concern about possible mismatch

between what the public expects and how recipients of the decentralised activities may perform to meet the expectations (Sanderson 2003).

Writing on PFI, Gaffney et al (1999b) contend that economic and market-based decentralization risks increased cost because its centralised processes may delay activities. It is also argued that argue that market-based initiatives show little evidence for effectiveness in delivering anticipated benefits in the NHS (Allen 2006, Klein 2007). The initiatives are characterised as driven by politics more than by their proven effectiveness.

This research contends that LIFT involves decentralised decision-making by ensuring that operational staff is represented in the LiftCo board that approves local projects. The board comprises public and private sector members from diverse backgrounds and experience. It may mean that decision-making about health priorities within the PCTs is shared as opposed to being controlled by PCT staff alone. This influenced the research to explore whether LIFT conforms to the view that economic decentralization involving decision-making increases effectiveness in procurement activities (Bossert 1998, DH 2001). It is possible that changes in market factors may affect LIFT decisions. This makes it necessary to understand how LIFT activities are cushioned against possible adverse effects.

1.2.4 Conceptual drivers of LIFT

Many studies have provided explanations to understand what may drive new strategies in public service delivery (Duguid and Pawson 1998, World Bank 2006, Normand 2011, Stevens 2004, Powell 2000). Duguid and

Pawson (1998) indicate that changes in social, political and economic factors may force governments into experimenting with new strategies to keep public organizations relevant vis-à-vis their primary missions. The World Bank (2006) and WHO (2000) contend that health systems performance may be improved by deregulating the ways in which services are delivered. They put pressure on governments across the world to follow their advice.

Normand (2011) indentifies new technology and increased patient expectations for quality and better health outcomes as the major driving factors within the NHS. The DH has a similar view. As a result, when defending the new Health and Social Care Act (DH 2012) they argued that it was driven by the NHS lagging behind other European countries in terms of healthcare technology and management responsiveness to patients. Their view is that involving non-governmental agents more in commissioning health functions may enable the NHS to catch up with other European health systems.

Thus, the government may perceive New Public Management; "Third Way"; Localisms and public-private partnerships (Powell 2000, Nield 2002) as the ideas defining how public service should be delivered. The concepts advocate decentralization by replacing state monopoly with new possibilities perceived to increase efficiency in delivering quality and technologically relevant services. Figure 1.2 below explains how the perspectives may have influenced preferring LIFT as the method for procuring GP surgeries in the NHS. Thus, PPPs were probably viewed as the best strategy in satisfying objectives of the different perspectives.

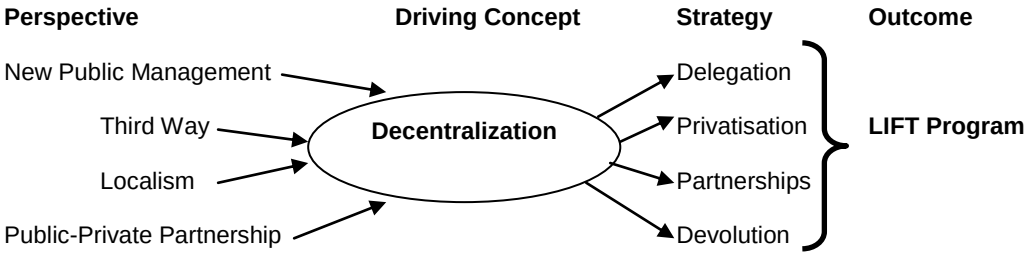


Figure 1.2: Conceptualisation of LIFT programme

1.2.4.1 New Public Management

New public management denotes initiatives that seek to modernise or make public service delivery more cost-efficient (Hood 1991). Its implementation advocates private sector management techniques and market mechanisms to achieve success in government services. Public management analysts including Pollit et al (1998) and the Organisation for Economic Co-operation and Development (2003) understand it as decentralization through organizational, structural or managerial changes to ways of delivering public functions. It involves splitting public bureaucracies into smaller agencies to facilitate competition with private companies (Pollit and Bouckaert 2000). In health, private companies may be incentivized to assume greater role in delivering services previously reserved for government departments. In relation to LIFT, there is evidence of the DH removing monopoly in procurement and management of GP surgeries in line with what New Public Management advocates.

But some public management critics challenge New Public Management when applied in health. In the NHS is argued that the ideas prioritise market mechanisms and private business principles that may undermine instead of improving performance (Sanderson 2003, Pollock and Price 2006). New Public Management principles are more or less similar to those of Localism and Third Way (Powell 2000). They re-assert community

engagement by public agencies in order to collectively increase value in service delivery. Thus, it may be argued that the new thinking all redefine relations between public agencies and citizens in delivering public service. LIFT principles qualitatively differ from those driving private businesses in the sense that they closely mimic how New Public Management, Third Way and Localism thinking are operationalized.

1.2.4.2 "Third Way"

The "Third Way" ideology deregulated public service delivery through decentralising power and responsibility to involve new players including the private sector (Powell 2000). Its practice was consistent with economic decentralization in which market forces were encouraged where they were thought to be useful while control was retained where they were not.

It appears that most drivers of new approaches to deliver public services that encourage PPPs such as LIFT to decentralise aspects of procuring healthcare buildings, resemble operationalization of the Third Way. Within the NHS, elements of the ideology described in Table 1.1a were perceived to make the health system more responsive to changes in economic and financial environments (Sanderson 2003).

Table 1.1a: Dimensions of Third Way and connections to LIFT

Delivery dimensions	Old Labour	The Third Way	New Right
Approach	Leveller	Investor	Deregulator
Outcome	Equality	Inclusion	Inequality
Mixed economy of welfare	State	Public / private civil society	Private
Mode	Command & control	Co-operation/partnership	Competition
Citizenship	Rights	Both	Responsibility
Accountability	Central state / national	Both?	Market / local
Social expenditure	High	Pragmatic	Low

Source: Adapted from Powell (2000) - Critical Social Policy 20; (1) page 42

The ideology is important to the present research because its features provide the yardsticks against which to assess LIFT's ability to generate benefits ascribed to deregulated public functions. To this end, the research sought to determine whether LIFT mechanisms promoted competition and associated benefits compared to traditional command approaches to procurement.

Although the ideology emphasized increased private sector role, sensitivity associated with radical changes to NHS responsibilities restricted full-scale privatisation of the decentralised functions (Walsh et al 2000). This suggests that the ideology may have been considered an acceptable compromise between exclusive DH and private provisions of NHS services. Where possible, it would substitute communities in the forms of PPPs, housing associations and cooperatives for both the state and the market possibly giving rise to localism in decentralizing public service delivery.

1.2.4.3 Localism

The Localism Act 2011 advocates decentralization for local authorities to have the authority and responsibility over public policy making and service delivery in their areas. Its logic is that empowered communities are able to improve service delivery by reflecting their individual preferences and circumstances through employing different ways to address them (Klein 2003). This facilitates decentralization by removing standardised delivery processes influenced by central government.

Sharma (2006) and Morgan (2001) view localism as a holistic approach to public service administration in the sense that it enables services within local areas to be joined-up with other economic activities. Within the NHS, King's Fund (2008) argues that PCTs always wanted to integrate healthcare activities with other local economic programmes to achieve better health outcomes within their areas. For example, those that adopted LIFT hoped it would facilitate integration of activities at LIFT buildings with economic programmes within their areas.

Although it became operational only in 2011, it would appear the Localism Act was merely to formalise existing practices. Some articles published before the Act explain potential disadvantages in stressing localism in service delivery (Bailey 2008, Allen 2006, Klein 2003, Saltman and Bankauskaite 2006). Referring to the NHS; the study by Allen (2006) stresses that localism partially devolved decision-making but control of critical policies was almost always retained by the DH. This may give rise to suspicion that the government recommended localism to avoid being accountable for some service outcomes (Stevens 2004). Yet some are

concerned that localism may be susceptible to central government interference (Saltman and Bankauskaite 2006). Klein (2003) explains the interference as influenced by communities' lack of propensity to take part in making decisions about their local services.

It is possible that substituting localism for a government role may risk neglect of some critical services. This happens where the recipients of the decentralised roles lack willingness to involve themselves in activities. Or they may lack skills and resources for sustaining the services. Exclusive reliance on localism may then create inequity or disparity in services due to differences in skills and resources between communities. So central government could provide insurance against the risks by retaining the role to redistribute resources between communities (Normand 2011). This may help the health system in translating the resources into healthcare activities that benefit patients.

1.2.4.4 Public-private partnerships

Another important paradigm for reforming public management involves incentivising to change the relationship between public agencies and the private sector in economic activities. Previously, public agencies monopolised the provision of public functions but world-wide they are now encouraged to work in partnership with the private sector in creating public value on citizenship lines (World Bank 2006). This has given rise to public-private partnerships (PPPs) as one of the preferred strategies in improving performance and service delivery in the public sector. Like NPM, Third Way, and Localism discussed above, PPPs are conceptualised as a decentralisation strategy (Perrot 2006, Atun 2007).

1.2.4.5 Objectives of the drivers of LIFT

Since the drivers of LIFT advocate replacing government monopoly in public service delivery, their key objectives (Table 1.1b may) may define how LIFT is expected to work. The objectives may be incentives that influence LIFT participants to generate specific outcomes. They are therefore important benchmarks in judging whether LIFT helps to solve procurement problems within the involved PCTs.

Table 1.1b: Key objectives of the drivers of LIFT

Driving idea	Pursued objectives
New public management	Professionalizing public service management by enhancing public agencies' autonomy from central government control
	Decentralizing management authority by introducing new governance structures – e.g. boards of directors in public service delivery
	Stressing private sector management practices and use of market mechanisms to foster competition in service delivery
Third Way	Re-asserting citizenship and networks in public service governance to achieve outcomes otherwise missed through employing private sector management practices or simple market mechanisms
	Selective use of private sector management practices and market mechanisms where they are useful and public control where they are not
	Increased quality and responsiveness to service users by reducing bureaucracy that stifles service delivery
Localism	Joining-up public service delivery by decentralizing management authority to networks of local consumers
	Generating democratic authorisation to co-create public value and pass accountability for service outcomes to service users.
	Increasing quality of services by making public agencies more transparent and responsive to service users in their activities
	Re-asserting the role of public agencies gaining legitimacy by engaging service users as citizens in service delivery
Public-private partnerships	Foster competition and co-provision of services between public and private sectors using market mechanisms
	Stressing role of market mechanisms and private sector management practices to enhance efficiency gains in public service
	Maximising value-for-money through exploitation of private sector expertise and skills that prioritise efficiency in service provision
	Making the public sector more responsive to service user needs for increased quality and responsiveness to service users

It is apparent that important overlaps and parallels exist in how New Public Management, Third Way, Localism, and public-private partnerships are expected to work in decentralizing delivery public service. Their objectives concern: (i) promoting participation (ii), increasing diversity, (iii) enhancing efficiency and, (iv) making government agencies more responsive to service user needs. In relation to the present research, understanding how these objectives mesh with those of the DH is it is important because this may explain how LIFT outcomes come about.

1.2.5 LIFT in context of public-private partnerships

Public-private partnerships (PPPs) divide opinion on whether they are the most appropriate to guide public management. This may be the result of differences in conceptualising PPPs and interpreting their underlying objectives.

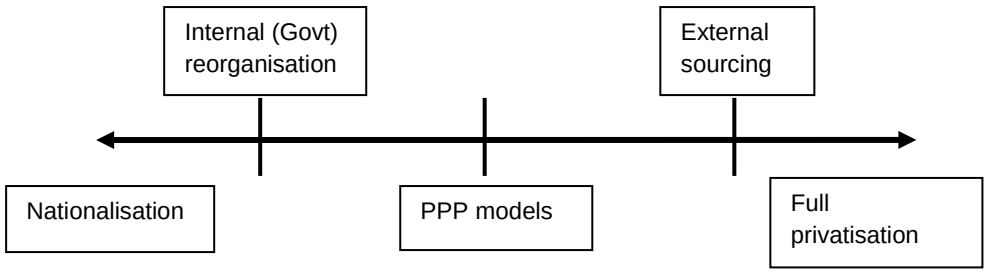
1.2.5.0 PPP concepts and definitions

PPPs are conceptualised within decentralization because of their primary intention to delegate delivery of functions traditionally reserved for public institutions (Atun 2007). The reasons for adopting PPPs vary according to what aspects of service delivery the government may wish to reform. McKee et al (2006) identify desire to share investment opportunities, responsibilities, or risks and benefits within an economy as major reasons. They argue that the private sector has comparative advantages in procurement of some public functions. Therefore, the government and private providers are willing to work in partnership where they realise that each may benefit from specific strengths in some aspects of the

partnership. The benefits may be in either financing, or designing, or managing public functions.

PPPs therefore tend to be rationalised on the grounds that they achieve greater value-for-money than would have been delivered through direct public procurement (Milburn 2004a). The benefits are produced not because either partner is more ingenious than the other. Instead, they result from symbiotic sharing of strengths plus complementarities in activities of the involved partners (World Bank 2006, McKee et al 2006). It is probably on this basis that the World Bank (2006) explains PPPs as formal collaboration in coordinating public and private expertise in economic activities. The explanation is consistent to decentralization stages described in Figure 1.2.1 (Atun 2007).

Figure 1.2.1: Conceptualising PPPs and decentralization



Source: Adapted from Atun (2007): Chapter 14: page 247. In Saltman et al (Eds.) 2007

Figure 1.2.1 describes how PPPs lie between “nationalisation” and “full privatisation” in public service delivery. They are created by government ceding some roles and retaining others. Under LIFT for example, the DH decentralises financing of buildings and accountability for performance and service outcomes while retaining the roles to regulate and monitor service delivery. Presumably, this is due to desire to ensure effective governance of public-private partnerships by facilitating redistribution of

resources to fund activities that the partnerships may not finance (Perrot 2006).

Within the NHS, the DH encourages PPPs on the argument that they help to improve efficiency through diversity and competition in service delivery (Milburn 2004b, DH 2010). This is despite that diversity and competition are sometimes criticised for fragmenting the NHS service providers (Fraser 2009). Fragmentation risks difficulties in effective monitoring of activities. It also presents challenges to PCTs in coordinating to ensure that concerned PPPs deliver anticipated benefits.

With LIFT, the roles retained at levels above the PCT boards possibly indicate what the DH perceives as significant in making it effective. For example, CHP retains an interest in intervening to regulate and monitor compliance with LIFT guidance while the SPBs monitor standards and quality of work delivered by the LiftCos. This could mean the DH uses CHP and SPBs in influencing decisions about, for example, where LIFT buildings are erected, their designs, or services that would be provided at the buildings. Such influence may unintentionally create tension especially if it were to be misinterpreted for interference with PCT activities and independence of the LiftCo.

To an extent, effectiveness of PPPs is influenced by the motive that the private partners bring within the partnership (McKee et al 2006, Bennett at 1997). On one hand, most governments lack financial resources, technology, and management expertise that are needed in providing better public services demanded by service-users. Their motive in initiating national PPPs is to benefit from accessing private sector resources and

management competences. On the other hand, private partners operating on for-profit basis are motivated by breaking into previously protected markets or safeguarding existing business.

In health, Bennett et al (1997) argue that PPPs involving private for-profit companies are likely to be less effective in service delivery than those involving not for-profit organizations. Profit motive may influence the partners to overemphasize efficiency or prioritise cheaper healthcare activities at the expense of essential services. If they lack experience, they may be also prone to the influence of practices that are unrelated to health activities because of questionable commitment to public goals that PPPs are intended to deliver compared to not for-profit organizations (Bennett et al 1997, Perrot 2006). The present research partly explored the extent to which motive and other factors influenced LIFT activities and outcomes.

1.2.5.1 The drivers of PPPs within the NHS

It was observed that a considerable number of private companies in LIFT were getting involved in NHS activities for the first time (Beck et al 2009). The companies may be anticipating benefits that are different from what the DH intended through LIFT. If they are driven by intention to have a foothold in NHS estate market, they may risk activities undermining LIFT objectives.

Large companies that take controlling equity in the LiftCo seek to make profit. In contrast, small businesses may be joining LIFT not so much for-profit than to sustain their business practices and convenience of patients. McKee et al (2006) argue that small businesses are attracted into PPPs because they want to benefit from complementarities of activities rather

than profit. Others (e.g. Holmes et al 2006) argue that there is lack of proof that PPPs lead to improvements in performance and health outcomes. Despite this, PPPs are still considered integral to government strategies in procuring NHS services (Milburn 2004b). As to what drives GPs to join LIFT, may be the possibility that it enables those owning inappropriate premises to improve them without expensive private borrowing or the PCTs and LiftCo threatening their independence.

It appears the drivers for decentralization previously discussed also explain increased use of PPPs within the NHS. Further, NHS patients are believed to have increased knowledge about healthcare technology (Normand 2011). It influences them in expecting and demanding access to better buildings that are furnished with relevant equipment (Milburn 2004b DH 2010). Significant number of the patients is ready to change their areas of residence by relocating to where their healthcare priorities are met (King's Fund 2002). Thus, changes within the NHS are necessitated by the need to reform the way health activities are delivered, and how resources are provided to make the NHS appropriately responsive in context of shrinking budgets for public services (DH 2010).

To this end, there has been a gradual reduction in DH role favouring PPPs to deliver selected NHS services. This involves extending incentives previously restricted to independent GPs for private companies to finance, or manage, or commission NHS services (DH 2010, 2005, 2001). To an extent, the different brands of localism pursued steer the NHS towards perpetuating PPPs in activities previously reserved for the DH (Klein 2003, Allen 2006, Bailey 2008, DH 2012). The benefits and risks generated may

provide the context in understanding what the PCTs implementing LIFT might experience.

1.2.5.2 Perceived benefits and risks of PPPs

Commentators on PPPs applied within health systems provide important perspectives to understanding the benefits and risks. Bennett and Muraleedharan (2000) identify the surrounding legal frameworks as a major determinant of PPPs' ability to deliver benefits. This is because the frameworks specify individual partners' obligations as well as the rewards and sanctions that may be imposed on failure to deliver. Legal frameworks therefore provide public sector staff with the necessary protection in investing effort and resources in economic activities led by private sector.

Further, they facilitate capacity in monitoring the PPP's critical activities provided the staff feel sufficiently empowered in enforcing them. With LIFT, this may mean that its ability to deliver the expected benefits is influenced by adequacy of the strategic partnering agreement and ways in which it is interpreted and enforced by PCT staff. Since the strategic partnering agreement is the legal framework governing LIFT activities, the present research explored how its contents protected or empowered PCT staff in their activities.

McKee et al (2007) identify the interactive effects between economic factors and mechanisms through which a given PPP is expected to be implemented as more important than legal frameworks and staff capacity in generating benefits and risks. They argue that changes in economic situations alter the environment surrounding PPPs and outcomes that are produced. Some expected benefits may be missed, or those that are

apparent may become risks. The present research sought to explain LIFT by exploring economic influences on its activities and outcomes in line with RE principles that guided its conduct.

1.2.5.2.1 The benefits

Various commentators describe how economic factors and the mechanisms through which PPPs are implemented may interact to produce a range of outcomes (Boyle & Harrison 2000, Renda and Schrefler 2006, Perrot 2006, World Bank 2006, Milburn 2004b, McKee et al 2007). Perrot (2006) argues that PPPs for healthcare delivery help in improving the quality of services leading to better patient experiences. Renda and Schrefler (2006) explain this as the result of private partners using their skills and expertise in prioritising quality regardless of whether the partnership is for providing care or procuring services and buildings. They do so to remain competitive and get retained in the partnership. Within the NHS, King's Fund (2008) and McKee et al (2007) identify timely delivery of high quality buildings when they are needed as important benefits.

There is also the general view that PPPs facilitate improvements in management of risks related to health service delivery (World Bank 2006, Perrot 2006). They are designed to ensure that between the public and private sector organizations, the one with capability to reduce particular risks is supported in managing them. Hence claims that PPPs are generally better than the DH at reducing costs in procuring NHS buildings (Milburn 2004b)

Within the European Union, member countries are discouraged from borrowing to finance public service because the cost of private borrowing may be too high (Perrot 2006). Such moratoriums may obviously limit national budgets for health services. Therefore there may be benefits in transferring the financing of important elements for health to PPPs (Perrot 2006, WHO 2008) as done in procuring estate in the NHS through LIFT. According to the DH (2001), improvement of GP surgeries was previously neglected due to inadequate budgets for public service. LIFT was then conceived as an effective way for facilitating continuity in investment by financing improvements leaving the DH to fund the non-immediate risks such as repaying interest on private sector finance. Since PPPs facilitate access to a variety of private sector resources and better technology, the World Bank (2006) argues that the cost of borrowing may be outweighed by benefits. Their reasoning is that PPP management has expertise and ability to reduce operational overheads through flexible procurement methods.

Within the NHS, there may be benefits in the DH using LIFT to relinquish responsibility for unpredictable risks in cost and delivery time of buildings to LiftCos. King's Fund (2008) indicates that LIFT has the ability to deliver quality buildings despite the unpredictability of these procurement risks. Other benefits may derive from transferring risks linked to appropriateness and continuous availability of buildings for use by care providers from the PCTs to LiftCos. This may also imply that the LiftCos assume a significant proportion of the residual value risk of LIFT buildings at the end of contracts. These are some of the issues that this research sought to explore to understand how LIFT transferred them from the PCTs to the

LiftCo; and whether it has the mechanisms to ensure the LiftCo respected the obligations.

It is argued that PPPs to deliver health services facilitate increased competition, patient choice, and innovation (McKee et al 2006, Normand 2011, WHO 2008, Perrot 2006, Milburn 2004a, DH 2012). The DH (2012) stresses that embracing competition and innovation within the NHS enhances opportunities for providing services that are responsive to changes in technology and patient needs. So PPPs may be reflecting DH desire for a responsive health system achieved by changes to administrative, economic or financial arrangements. This made it important for the present research to explore whether and how LIFT generated benefits of competition and innovation within the NHS.

1.2.5.2.2 The risks

The contrasting explanations about effects of PPPs in health could be evidence for uncertainty about what risks governments may wish to transfer or share, or how they expect to benefit through PPPs. Uncertainty arises because some risks may be too complex to clearly define for understanding by either the concerned partners or those expected to monitor the PPP. With LIFT, for example, LiftCos are delegated responsibility to mobilise capital for buildings but there is no guidance on the sources, borrowing levels and interest rates. The process generates inefficiency when the LiftCos borrow from expensive sources that affect PCTs liquidity through high interest repayments. This is in addition to risks of failure of market mechanisms upon which PPP activities are based (Sloan and Hsieh 2012). Market failure implicating risks in PPPs concern

externalities, asymmetric information, and unintended privatisation of healthcare functions.

1.2.5.2.2.1 Externalities

Externalities are the negative and positive effects of economic decisions made without considering other people's welfare (Sloan and Hsieh 2012). They happen because concerned people are excluded in making economic decisions about the PPP. In the real world, concern is raised about the negative rather than the positive effects of some economic decisions. With LIFT for example, an important negative effect could be the displacement of GPs that are not involved. This may happen if they feel that their business is threatened by new LIFT buildings. They may relocate elsewhere – a scenario that Hammett (1991) refers to as gentrification – and inconvenience patients. The disadvantages to patients may include having to follow their displaced GPs in order to remain connected with them at the new sites.

A positive externality in this case could be that LIFT buildings may produce spill over benefits for groups of people that were not considered initially in planning individual schemes. They may provide opportunities for other social activities not necessarily related to health but benefiting the local communities. The presence of better healthcare buildings may regenerate and increase the value of properties in the neighbourhood. This research enquired about the negative and positive externalities generated by LIFT buildings. Informants commented on how the buildings leaked benefits to consumers from outside the case-studied PCTs or beneficiary groups not initially targeted.

1.2.5.2.2.2 Asymmetric information

Some of the risks in PPPs for health may derive from problems of some participants having superior information about the relevant elements of the PPP compared to others (Perrot 2006, Sloan and Hsieh 2012). It produces inefficient markets when information that is needed for decision making within the PPP is not accessed on equal terms by all parties involved. With LIFT, for example, DH officials promoting it, private shareholders in the LiftCo, or local SPBs may know more about its critical contexts and mechanisms than each other. PCT staff and those at the LiftCo may be privy to some critical information about LIFT unknown to the other key participants like the GPs and contractors at the buildings. Asymmetric information may therefore risk adverse selection of who to partner with as well as moral hazards in activities of those involved (WHO 2000).

LiftCo staff that are more informed than PCT managers may try to take advantage of the PCTs' inferior knowledge about economic activities. They may pressurise PCTs that are not in optimal economic situations into projects that may not be worthwhile hoping that the DH will keep on bankrolling the PCTs. They may also not engage with PCTs that are in optimal economic situations since such PCTs are less inclined to use LIFT in developing their buildings. This means that economic decisions may be to an extent shaped by the information held by LiftCos or PCTs involved.

Moral hazards may be exacerbated when partners behave in ways that take advantage of one party's inferior knowledge about the critical elements of the concerned PPP (WHO 2000). With LIFT, this may mean that once contracts are signed, the concerned PCTs or LiftCos may seek to reap benefits by imposing extraordinary demands on each other where

they suspect the other party to be less informed about their obligations. Or the LiftCo may increase income by influencing its less informed clients to pay for services that have no obvious benefits for them.

1.2.5.2.2.3 Privatisation of health functions

The effect of the negative externalities and asymmetric information associated with PPPs ultimately leads to the criticism that they risk privatisation of health functions (Savas 2000, Pollock 2007, Fitzsimmons et al 2009, Pollock and Price 2011). It is argued that decisions that incentivise private involvement tend to ignore PPPs' potential negative externalities or asymmetric information or both. This drags health systems into privatisation because decisions would have prioritised the private partners' interests more than those of the public in economic activities (Savas 2000, Pollock 2007). This viewpoint is somewhat the result of promoting a broad definition for privatisation as involving any ideas that reduce government role in favour of the private sector in health activities or the ownership of assets for healthcare (Savas 2000).

This is a broad definition that other analysts believe should be accepted provided it recognises that some functions passed for delivery by the private sector may only reduce government role in one activity while increasing in another (Saltman et al 2007, Atun 2007, World Bank 2006). Using LIFT as an example, reducing DH role in procuring and managing PCT buildings in favour of the LiftCo may actually increase government regulation through new structures such as CHP and the SPBs that supervise LIFT activities. This may explain why some argue that in public policy context, privatisation is not merely involving the private sector. Instead, it should be understood as the actual transfer of assets and

responsibilities for health activities from the government to private sector (Saltman et al 2007). The transfer may be through outright sale or some other arrangements to relinquish the government assets and responsibility for the function for which the assets were previously employed (World Bank 2006). For that reason, Atun (2007) and Saltman et al (2007) conceptualise PPPs as a distinct stage with different benefits and risks in the nationalisation-privatisation continuum (Figure 1.2.1, page 49).

The narrow definition proposed by Starr (1988) and Saltman et al (2007) understands privatisation as withdrawal of public assets, functions and institutions from the government to private sector. This definition is the one used in this thesis to argue that LIFT only deregulates financing without shifting the role to procure healthcare buildings from the DH to private sector. Therefore, under the narrow definition, LIFT represents economic decentralization rather than privatisation. This is because the public assets transferred within LIFT are still employed to provide healthcare buildings used by the PCTs but managed by the LiftCo (DH/PfH 2003). When considered together with the broad definition, LIFT could be viewed as a hybrid of administrative and economic decentralizations. Its implementation transfers authority and responsibility to administer PCT buildings to the LiftCo that is simultaneously given role in economic activities to deliver related services.

According to Saltman (2003), private partners' willingness to join PPPs is more about their interest to benefit from the partnership than being committed to the public sector goals. They may have different motive and different benefits anticipated from the PPP arrangement (Perrot 2006). It is

therefore possible that their economic behaviours influence some of the risks associated with PPPs especially those related to privatised health functions. Commenting on PFI, Barretta and Ruggiero (2008) indicate that some PFI companies tended to avoid taking full share of their allocated risks. Renda and Schrefler (2006) criticise the private partners for overemphasizing efficiency by allocating resources to cheaper activities of the PPPs. Maybe they are prone to problems driving them into safeguarding their organisational and financial interests.

Those responsible for monitoring PPPs may face challenges in reducing the risks. They may either lack knowledge about what attracted the private partners in the first place, or they may be uncertain about the competences brought into the partnership. This compromises the responsible authorities' ability to work out effective mechanisms for minimising adverse activities within the PPPs. At the end, the public sector risk missing some of the benefits anticipated (Gaffney et al 1999c).

1.2.5.3 Approaches to implementing PPPs

There are different approaches to implementing PPPs for public service delivery. Some approaches may generate challenges when adopted in health (Perrot 2006, Renda and Schrefler 2006, McKee et al 2006). McKee et al (2006) remind us that local staff that have role to monitor the relevant activities may have difficulties if they lack the necessary capacity and technical know-how to handle complex PPP models. Usually, the public sector hopes to bring in new competences through PPPs but finds it must also invest in capacity building to provide local staff with the necessary competences. This might not be a major problem in developed

economies where well developed private institutions are more likely to produce benefits than risks in delivery of some public functions using complex PPP models. Some models described in Table 1.2 below may require local staff to appropriately adapt to changes in governance or routines required for them to improve performance (Renda & Schrefler 2006).

Table 1.2: - Description of the different PPP models and their risk sharing

Models	Description	Types of risk shared or transferred
Operate and maintain	Government contracts private partners to operate and maintain publicly owned facilities.	Private partners take performance risk and revenue generated. Government takes risks to invest and fund services.
Service provision contract	Government contracts private partners to provide agreed services at public facilities.	Private partner is paid for only services provided. Government procures and manages the facilities.
Lease-purchase	Private partners are contracted to deliver facilities for leasing and later sell to the government.	Private partners bear risks to invest, deliver and finance. Government takes demand risk plus purchase of facility.
Build-operate-transfer	Government contracts partners to deliver and operate a public facility for a period before transferring it to the government.	Private partners bear investment, parts of financial, performance and commercial risks. Government takes management and parts of financial and commercial risks (e.g. rent).
Design-build-finance-operate	Government gives specifications and contracts partners to design, build, finance, own and operate a public facility without obligation to pass ownership to government	Private partners take investment, construction and performance risks. Government takes operational and demand risks or parts of financial risks as tenant of the private partners.

Source: Adaptation of European Parliament IP/A/IMCO/NT/2006-3

McKee et al (2006) argue that a number of PFI hospitals within the NHS have schematic features that reflect the build-operate-transfer and design-build-finance-operate models. Aside from the risks transferred or shared, the different models can be distinguished by considering how they handle the ownership of facilities. The lease-purchase; build-operate-transfer; and design-build-finance-operate models differ in their handling of the

ownership of partnership facilities. But they have more or less similar arrangements for managing the risks. The lease-purchase model obligates the government to purchase facilities from the partnership after a given period. Under the build-operate-transfer model, the private partners should transfer facilities to government ownership after a given period. Both contrast the design-build-finance-operate model where no obligation exists to pass the ownership to government whether through purchase or transfer arrangements.

Under most PPP arrangements, central governments tend to retain risks of funding or purchasing the major activities (Perrot 2006). The private partners may be provided with capital grants to deliver the desired functions. Government then pays agreed fees for using the facilities that may also be managed by the private partners. Most PPPs within health systems are perceived to be costly in terms of money, disruptions, and staff morale (Wall 2007, Normand 2011, King's Fund 2008).

With reference to the NHS, (Wall 2007) indicates that local managers might be frustrated by being excluded from initial negotiations for PPPs. The same applies if they do not feel supported in monitoring PPP activities and engaging them may help in making the planning process more effective (Wall 2007). Local managers may, for example, influence decisions about when to use PPPs, and the choice of their role. Their local placement makes them better than central officials in deciding what risks to transfer or retain in healthcare because they are the ones that manage the relevant activities. If the planning process excludes them, risks of

increased cost and disruptions may arise where the changes are of high magnitude (King's Fund 2008).

1.2.6 PPPs within the NHS

There is a general perception that PPPs enable accessing capital and new competences needed to increase efficiency and quality in NHS activities (Milburn 2004a, DH 2010). As a result, successive governments have encouraged use of PPPs in delegating authority and decision-making about procurement, ownership and management of NHS activities (Atun 2007, DH 2012). It gave rise to PFI in the 1990s from which LIFT was an offshoot in 2000. The new Health and Social Care Act 2012 is arguably underpinned by desire to involve non-governmental providers more in NHS activities.

1.2.6.1 The Private Finance Initiative (PFI)

The PFI involved private companies taking controlling equity and long-term contracts to deliver public infrastructure. Initially, its implementation was limited to transport, communication and NHS hospitals (Boyle and Harrison 2000, Beck et al 2009). Despite being criticised as privatisation by the back-door (Gaffney et al 1999a, Sussex 2003), its retention by successive governments replaced Treasury funding of public infrastructure. It is argued that in 2000, PFI accounted for 85% of the financing of NHS capital investments (Sussex (2003).

Under PFI, the organizations bidding for procurement of public sector functions were encouraged to create "special purpose vehicle" partnership companies. Within the NHS, the companies would then lead in delivery and operationalizing PFI hospitals (DH/PfH 2003). Payments for use of the

hospitals by the beneficiary NHS Trusts were directed to the companies and spread over 30-year periods. This means that PFI decentralised procurement of NHS hospitals by delegating responsibility for relevant functions to private companies.

The PFI's ability to increase investment within the NHS has been questioned (Boyle and Harrison 2000). But it may be pertinent to appreciate that the companies had no role to assess demand for hospital accommodation as the NHS Trusts retained this. They were only invited by the Trusts to design, finance, build and operate the hospitals. Possibly, some Trusts experienced reduced liquidity due to high charges for using PFI buildings. If this restricted them in developing more facilities, then PFI could be said to have caused reduction in investment. The DH officials that promoted PFI (e.g. Milburn 2004b) argue that like other PPP models, it was effective at mobilising capital for modernising NHS hospitals.

But other commentators think otherwise. Renda and Schrefler (2006) argue that utility derived from benefits of PPPs may be missed where private partners lack preparedness for taking full responsibility for risks allocated to them. Gaffney et al (1999b) explain that PFI procurement was expensive because NHS Trusts were charged high rents for below standards hospitals. Most analysts including Boyle and Harrison (2000) and Pollock et al (2005) think this was because private providers avoided taking full responsibility for financial risks that were allocated to them. In their view, PFI failed to deliver value-for-money in procurement of NHS hospitals. Given that LIFT is an offshoot of PFI, the present research

sought to examine whether it produced value-for-money and other anticipated improvements in procurement.

1.2.6.2 Local Improvement Finance Trust (LIFT)

Within the NHS, LIFT was designed for improving the conditions at primary care buildings. The DH regularly provided independent GPs with grants used side-by-side with individual bank loans to develop their private surgeries. Yet despite providing the grants and introducing PFI, they admit that investment in upgrading GP surgeries had been neglected (DH 2001). Maybe the cost involved was perceived to be too small to generate profit that would attract investors in PFI into developing GP surgeries.

GP surgeries therefore remained inappropriate for modern care in a number of ways. Most of them were rundown because their small sizes made them susceptible to problems of congestion (DH 2001). Others were either converted residential houses or were located above shops making them not fit for their purpose (King's Fund 2008). LIFT would facilitate PCTs in accessing private sector resources needed to put in place better GP surgeries. The DH had hoped the capital would be mobilised from local private investors lacking the capacity for participating in bigger PFI projects (DH/PfH 2003, Beck et al 2009).

LIFT and PFI have similar objectives to increase value-for-money in procuring public sector facilities. But they employ different mechanisms to achieve the objectives. LIFT requires the PCTs and private financiers to create LIFT companies (LiftCos) along the lines of special vehicle partnership companies that previously led PFI activities. The companies differ in that LiftCos are PPP companies whereas special vehicle

companies under PFI were exclusively private. Their roles are similar in the sense of coordinating procurement activities including mobilising the money needed to finance delivery and maintenance of the buildings. With LIFT, local PCTs are eventually left to focus on activities to provide care using buildings that are rented from the LiftCos. The relationship is similar to what Hospital Trusts were to special vehicle companies under PFI.

It is argued that LIFT was designed in a way that helps PCTs in avoiding problems previously experienced in implementing PFI projects (Beck et al 2009). For example, PCTs implementing LIFT are represented in the LiftCo boards to make sure that their interests are prioritised in the decisions. Under PFI, the special vehicle companies' boards were made up of private investors likely to overlook NHS interests in their decisions. You could therefore argue that with LIFT, the DH decentralizes by delegating the financing of buildings to LiftCos while also using itself and the PCTs as shareholders in the LiftCo. This may allow them to exert influence and control over the LiftCos' decisions to ensure that they are not counterproductive to LIFT objectives.

LIFT differs from PFI in two important ways. First, LIFT lets the DH to use public funds and assets to acquire partnership equity in LiftCos whereas with PFI, equity was exclusively private owned. Second, LIFT contracts give the LiftCos exclusive rights to developing future buildings within PCTs whereas PFI was only an obligation about one building not future investments.

1.2.6.2.1 The drivers of LIFT

The drivers of PPPs discussed in subsection 1.2.5.1 (page 51) apply but the contexts differ from those that influenced LIFT's adoption. The major drivers of LIFT within the NHS chiefly concerned: shift in ideology for public service delivery; population growth; condition of pre-existing surgeries; and increased expectations by service-users.

1.2.6.2.1.1 Ideological shift

It was probably New Labour government that redefined the ideological framework under which reform of health service delivery was to be achieved (Powell 2000). They shifted from the old form of DH monopoly role to encourage PPPs in NHS capital funding and management by giving:

> *"...more freedom for providers to innovate and improve services in response to the needs and decisions of patients, GPs and commissioners. (...); a continuing role for PCT direct provision; more opportunities for voluntary sector, social enterprise and private sector providers where they can help deliver better services with better value-for-money"* (DH 2006a: pages 6 and 25).

The ideas that influenced LIFT's adoption feature prominently in a number of NHS strategic documents as part of a wider reform agenda (DH 2000, DH 2001, DH 2006b, DH 2007).

1.2.6.2.1.2 Population growth

The PCTs that pioneered LIFT were characterised by GP surgeries perceived to be unsuitable for meeting the healthcare demands of a growing population (DH 2001). Old buildings in inner city areas tend to attract high numbers of people because they are potentially cheaper for residential and commercial purposes (Fitzpatrick & Jacobson 2002). Regeneration of the areas fuels population growth by attracting high numbers of working people and residents who may demand for

appropriate buildings and services (Hamnett 1991). In health, LIFT was earmarked for inner city areas deprived of suitable healthcare buildings. Health authorities in such areas felt hard pressed to adopt it to make their buildings suitable for offering services demanded by the population.

1.2.6.2.1.3 Condition of pre-existing GP surgeries

Another important driver of LIFT was the poor conditions at GP surgeries. There was concern that pre-existing surgeries were either too old, or not built for purpose, or not adaptable for provision of modern care (DH 2001). At that time, the DH argued that: 80% of national primary care buildings were below the recommended size; only 40% were built for their purpose; and 50% were conversions of either residential houses or shops (DH 2001). This presented challenges in modernising the buildings without disadvantages of cost to the PCTs. Further, most of the buildings were rented from private landlords less interested in adapting them for suitability to GP activities.

LIFT was intended to address these problems by delivering new buildings designed specifically for primary care. Or it would refurbish old ones to make them adaptable to what GPs needed to offer modern care. The quality of buildings might be sustained since their management and maintenance would be done by the LiftCos that owned them. It was also anticipated that LIFT would reduce the scattering of surgeries by bringing a number of GPs to operate at same premises together with complementary service providers such as pharmacies (DH 2001, NHS London 2007b). The arrangement would offer convenience to patients and improve the coordination of services to reduce administrative overheads within PCTs. The researcher believed the arrangement to be centralisation that may

carry some risks. Hence examination of whether it did not risk disconnecting and inconveniencing patients through having to travel to their preferred GPs.

1.2.6.2.1.4 Increased expectations by service-users

The strategic document *"Our Health, Our Care, Our Say"* (DH 2006b), presented the case of NHS patients preferring to receive care nearer their homes compared to hospitals. Since LIFT prioritised upgrading of local healthcare buildings the DH probably considered it appropriate for shifting *"(...) resources and activity from acute to local settings in direct response to patient feedback"* (DH 2006b page 148). It was clear from patient feedback that they expected increased quality in terms of appropriateness of technology and convenience with which they received care (Milburn 2004b).

With LIFT, the major issues may be that patients desire access to better services at appropriate buildings that offer convenience of opening for extended hours nearer their homes. A study conducted by King's Fund (2002) also warned that patients contemplated changing their residential areas to relocate to PCTs whose health services were able to meet their expectations. Possibly, the DH officials chose to stick with LIFT upon realising that it may deliver better buildings with them showing rather than spurning economic inclusivity in distributing resources for health.

1.2.6.2.1.5 Improvements in technology

Behind all the drivers may be advances in healthcare technology forcing the DH into trying new possibilities to change routines within the NHS. Coiera (2003) reminds us that technology may shift patient expectations

and preference of ways through which to receive care. The ripple effects may involve healthcare providers changing ways through which to satisfy the changes in patient expectations and preferences. Within the NHS, increased portability in health information may mean that patients now know more about the relevant and optional treatment methods for their problems. This puts GPs under pressure to require buildings that are appropriately designed and equipped for providing the type of care expected. To a greater or lesser extent; technology impacting on the NHS' vision, patient expectations, and GPs' desire to retain competitive advantages in care provision probably forced experimentation with LIFT.

1.2.6.2.2 Expected benefits from LIFT

LIFT involves different participants but the major ones are the PCTs, the LiftCos, local investors in the LiftCo, primary care providers, and contractors at LIFT buildings. Each of these participating groups has its own set of expected benefits. Because the PCTs are the principal beneficiaries, this discussion prioritises what they are expected to realise from using LIFT. In the process, the benefits and risks of PPPs (subsection 1.2.5.2 page 53) plus endorsement and criticism of LIFT (subsection 1.2.6.2.4 page 85) are recognised.

In light of the discussed drivers of LIFT, it was expected that the PCTs using LIFT would benefit by having new and innovative ways to procure, equip and maintain their buildings (DH/PfH 2003). They get opportunity for improving the condition of GP surgeries and gain when new ideas from LiftCos substitute for poor value existing DH led procurement.

Further, LIFT would increase PCT efficiency in procurement and subsequent management of the surgeries (DH 2001, DH/PfH 2003). This is achieved by replacing old inadaptable buildings with those built for purpose. GPs using better equipment in modernised buildings would be able to practice to their full potential. Since LIFT was expected to bring a number of GPs and complementary providers to work under one roof, the PCTs would benefit through reduced overheads associated with coordinating scattered providers (Fitzsimmons et al 2009).

Possibly, the disbenefits of centralised service provision could in effect reverse benefits of decentralized financing and planning. Prior to LIFT, there was concern that private landlords would rather collect rent than spend money on adapting their buildings to suite use that is desired by GPs (DH 2001). Under LIFT, the LiftCo takes responsibility to maintain the buildings and risk losing rent if important facilities are not used due to lack of maintenance. This means that PCTs may benefit from reducing perverse incentives by private landlords.

Another expectation was that the PCTs would increase their capacities in delivering care that is consistent with patient demand. This is because LIFT was expected to increase the stock of new buildings and provide supporting management activities to leave GPs concentrating on their core activities of providing patient care. The PCTs' worry about sustainability of the gained capacity might be reduced because the risk is partly transferred to the LiftCo. More so since the LiftCo would seek to ensure availability of facilities for regular use to avoid losing rent.

The PCTs use LIFT because they want improved surgeries to support patients in receiving care in community settings (DH 2006b). They benefit when patients increase their utilization of LIFT buildings and in the long-run, it could be an efficient option compared to using hospitals in providing primary care. However, the downside could be that increased utilization of LIFT buildings may reduce activities at hospitals. Given staff numbers and the nature of equipment at hospitals, prolonged downtime due to reduced activities risk increased unit cost of healthcare for the NHS.

1.2.6.2.3 Key LIFT features needing evaluation

Evaluations are carried out for different purposes (Stufflebeam & Webster 1980, IPPR 2002, Pawson 2006). They may aim at either relating programme outcomes to objectives (IPPR 2002) or at providing an accurate accounting of outcomes to programme participants (Stufflebeam & Webster 1980). Therefore, their timing may be at the end of programme lives or at some other predetermined milestones. An ongoing programme can be evaluated to identify and assess potential costs and benefits impacting its implementation activities (Pawson 2006). From these views, it appears that evaluations seek to identify and prioritise particular features to investigate about a programme depending on desired outcome for a given study. They give the different groups of people involved chance to explain how programme activities influence the outcomes observed. In this research, Pawson's (2006) approach to evaluations is adopted to recognise LIFT as an ongoing programme.

The research sought to identify and assess potential effects of LIFT features ranging from its governance arrangements and structures to economic and financial activities. The *LIFT Prospectus* (DH 2001) and the

Strategic Partnering Agreement (DH/PfH 2003) describe among other issues: (i) LIFT constituents (Figure 1.3); (ii) LIFT contexts and mechanisms; and (iii) procedure in implementing LIFT. These are the key features in LIFT prioritised for evaluation because the information around them may provide relevant answers to the research questions.

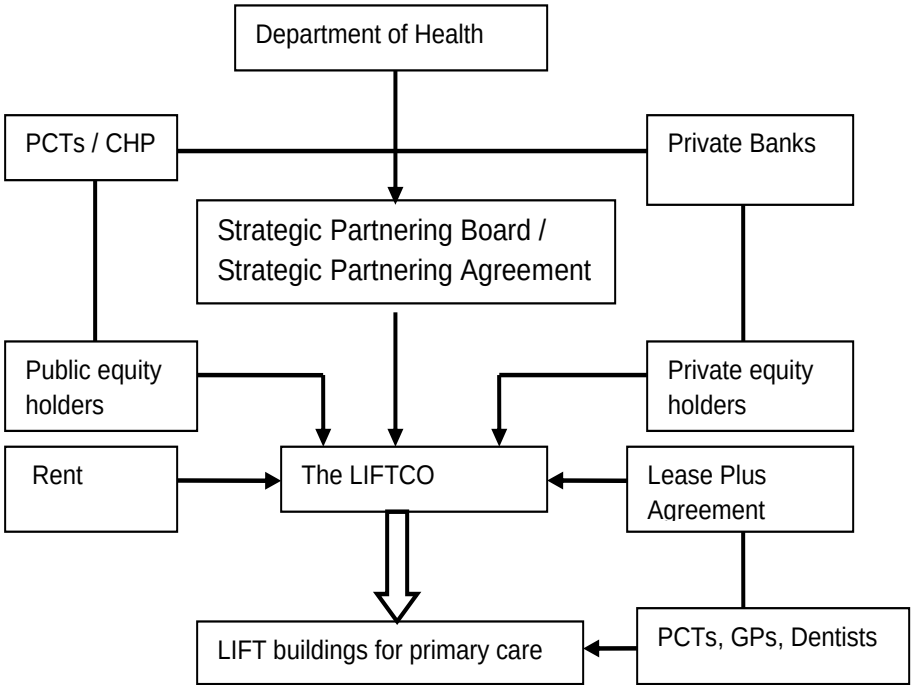


Figure 1.3: LIFT constituents - descriptions in documents

1.2.6.2.3.1 LIFT constituents

LIFT is designed to revolve around the LiftCo through its interaction with the private financers, the SPB and involved PCTs to make the strategic partnering agreement operational. The LiftCo mobilises capital and is accountable to the SPB on issues of leasing buildings to the PCTs and GPs. Therefore, how LIFT constituents interact may produce outcomes that may help in explaining and understanding how LIFT works within the case-study. The fact that private equity holders and banks have controlling equity possibly put the LiftCo under pressure to prioritise their interests

over those of the PCTs. As a context, it influences the mechanisms used by the LiftCo (e.g. having different incentives) in assuming effective leadership towards LIFT outcomes. This makes it important to assess how the distribution of equity between LIFT constituents may influence some outcomes.

1.2.6.2.3.1.1 Distribution of equity in the LiftCo

Sixty percent (60%) share of equity in the LiftCo is controlled by private investors. The DH holds 20% through CHP which is its investment arm promoting PPPs within the NHS. The remaining 20% of the equity is either held fully by the PCTs or may be shared depending on contribution of local stakeholders that the PCTs invite to participate in LIFT. This distribution of equity essentially means the LiftCo is controlled by the private investors. It is argued that the private sector may have less bureaucracy in making procurement decisions compared to the government (DH/PfH 2003, Beck et al 2009). Giving private investors control over the LiftCo may therefore speed up LIFT activities than were the PCTs to lead in procurement of the desired buildings. The present research sought to understand in what ways equity distribution influenced LIFT activities and outcomes.

1.2.6.2.3.1.2 Role of the individual LIFT constituents

Describing the constituents' role may help in assessing LIFT's performance vis-à-vis meeting its objectives. LIFT decentralises decisions about critical procurement activities from the DH to the PCTs and the LiftCo through CHP and the SPBs. Evaluating role of these elements is therefore important in understanding how LIFT works.

The DH retains influence in LIFT through its ownership of CHP that was given the role to promote PPPs within the NHS when Partnerships for Health (PfH) ceased to exist in 2007 (DH 2007). CHP controls 20% share of equity in the LiftCo and encourages stakeholders to join PCTs in acquiring part of the remaining 20% equity share in their local LiftCos. Therefore, CHP is expected to offer the PCTs and local investors with administrative or technical support needed for them to benefit from participating in LIFT.

At the local level, the SPB provides strategic and technical support that may be needed for the PCTs and LiftCo in addressing contents of the strategic partnering agreement that governs LIFT (DH/PfH 2003). The SPB comprises representatives of shareholders in the LiftCo including one recommended by the LiftCo board (DH/PfH 2003). Although the SPB is at local level, its composition appears to favour the LiftCo than PCT interests yet its mandate is to supervise the LiftCo for compliance with LIFT objectives. It is expected to periodically review local SSDPs to ensure that proposed LIFT projects originate from agreements with the PCTs (DH 2001, DH/PfH 2003). It would appear that the DH recommended SPBs as a means for facilitating exchange of ideas and reconciling PCT and LiftCo interests and expectations in LIFT. The SPB and PCT relationship does not alter the strategic role of existing PCT boards. PCT boards still influence decisions about LIFT within their areas. This may mean that the different LIFT constituents have the dilemma of whose decisions between the SPB and PCT boards to prioritise, making it necessary to assess effects of the SPB on PCTs and LiftCo activities.

The LiftCo has leadership role in translating contents of the local SSDPs into the desired buildings. Although the LiftCo's activities are supervised by the local SPB, it is managed by an independent board of directors. But that board's membership has more private than public sector representatives presumably to reflect equity distribution in the LiftCo. The strategic partnering agreement governing LIFT (DH/PfH 2003) underlines the LiftCo's influence by stipulating that PCT representatives may be changed subject to notifying the LiftCo.

The LiftCo's core role is to deliver and ensure continuous availability of buildings to the tenants. Encouraging the LiftCos in identifying investment opportunities within their areas mean giving them role in developing SSDPs from which LIFT buildings are derived (LIFT LOBI 2008). The LiftCo is also expected to help the PCTs in negotiating and recruiting tenants at LIFT buildings (DH/PfH 2003). Although giving the LiftCo such extended roles may improve LIFT activities, it may risk making the PCTs lenient with the LiftCo in imposing penalties for poor performance. Provisions exist for the PCTs to withhold rent if the LiftCo fails to make the buildings available due to lack of appropriate maintenance (DH/PfH 2003). Yet it appears that despite being landlord to the PCTs, the LiftCo is assuming more roles previously reserved for its clients. Hence the current research's interest in evaluating influence of these changes in landlord–client relationship on LIFT outcomes.

1.2.6.2.3.2 LIFT contexts and mechanisms

The relationship between role of the bodies constituting LIFT and their activities gives importance to evaluating LIFT contexts and mechanisms. LIFT constituents require specific contexts and mechanisms for them to

deliver its objectives. The different sets of contexts and mechanisms that the DH perceived to help LIFT in producing the expected benefits provided the constituents comply can be identified in the guidance. The contexts and mechanisms would work in combination to influence the benefits.

1.2.6.2.3.2.1 LIFT contexts

Contexts are the social, economic and cultural conditions under which LIFT activities are carried out. They define how LIFT employs resources such as money, materials, land, and skills and expertise needed by the PCTs in providing conditions that are conducive to improving GP surgeries (DH 2001, DH/PfH 2003). This study considers contexts under which LIFT activities are carried out as important, rather than simply assessing whether LIFT is able to achieve its objectives. Its conduct prioritises accounting for external socio-economic and cultural factors exerting on LIFT participants to affect its ability and the nature of outcomes produced.

Potentially, the participants also provide individual contexts that may facilitate or constrain LIFT. For example, priorities of the SPBs, and how the PCTs and GPs using LIFT buildings may prefer to work, are contextual considerations that to an extent influence how LIFT objectives are met. The conditions under which LIFT objectives are met may inadvertently benefit one constituent or groups more than the other. Pollock and Price (2006) argue that LIFT contexts tend to facilitate more benefits for the private sector than public sector constituents. This may be due to the private sector LIFT constituents imposing the conditions under which its activities are carried out.

1.2.6.2.3.2.2 LIFT mechanisms

Mechanisms are the opportunities and ideas which are introduced through LIFT. They involve how the resources for LIFT are used to deliver the desired buildings and related benefits. It is argued that LIFT has mechanisms like new management competences and arrangements that help the PCTs in managing risks in procuring improved buildings (DH 2001, DH/PfH 2003). Mechanisms are therefore relevant in explaining how LIFT outcomes come about. They take LIFT's internal factors that exert on its constituents into account in explaining what may influence LIFT's ability and the nature of its outcomes. Individually, the groups involved in LIFT may have internal facilitating or constraining factors.

For example, the strategic partnering agreement stipulation that LIFT buildings are translation of the SSDPs developed by the PCTs may be considered a context (DH/PfH 2003). How the LiftCo may go about to ensure that the buildings are delivered along the provided specifications embodies LIFT mechanisms. LIFT contracts such as the lease-plus agreement governing the PCTs' use of LIFT buildings have legalities that force the partners to meet their obligations (DH/PfH 2003). How the partners respect the contracts and go about to meet their obligations are some of the mechanisms that to an extent influence LIFT outcomes. The mechanisms may inadvertently benefit one constituent or group of participants more than the other. Fitzsimmons et al (2009) and Pollock and Price (2006), for example, argue that legality of LIFT contracts prevents PCTs from using other procurement methods. They also prohibit using developers other than their LiftCo thereby missing on potential benefits of competition.

1.2.6.2.3.3 Procedure in implementing LIFT

The series of activities followed by LIFT constituents under given contexts and using specific mechanisms are important because they influence progress against LIFT objectives. The procedure in implementing LIFT involves issues that are rooted on: choosing the land for LIFT buildings; agreeing on contracts; planning the projects; and operationalizing new buildings.

1.2.6.2.3.3.1 Choice of land for LIFT buildings

The issues concerning the land on which to develop LIFT buildings are addressed in the *Lease-Plus Agreement* guidance (DH/PfH 2003). Initially, LIFT buildings were to be developed on land owned by the LiftCo. The arrangement is called the Land Purchased Agreement model to recognise that the LiftCo purchased the land from either the private sector or the government (DH/PfH 2003). Maybe the private banks that finance LIFT prefer this model for giving them more income from owning the land while allowing them freehold of Title Deeds to the buildings as collateral for their finance.

In contrast, most PCTs using LIFT prefer to develop the buildings on existing government owned sites (DH/PfH 2003). This arrangement is referred to as the Land Retained Agreement model. They probably prefer the model for two reasons. First, they may perceive the sites to be still offering convenient patient access than moving to new ones. Second, the sites could be deemed to have abundant land for bigger and adaptable buildings needed to consolidate services by bringing more providers

together. LIFT then replaces the old buildings with new ones making the LiftCo a licensee of the PCTs that retain ownership of the land.

Under the land retained agreement model, the LiftCo cannot dispose of LIFT buildings unilaterally not withstanding that it carries risks associated with their delivery and ownership. The LiftCo is also required to adjust its rent charges to reflect that the land is owned by the PCT; meaning rent at such buildings should be cheaper than at those delivered under the land purchased model. Private investors in the LiftCo prefer outright purchase of the land on which to erect buildings in order to maximise income from unrestricted rent charges.

Whether under the alternative models, it may be an effect of choice of land for LIFT buildings that Treasury now expects the PCTs to reflect them in their balance sheets (Fitzsimmons et al 2009). This is notwithstanding that the same buildings may be also accounted for in the LiftCo's books. Initially, the PCTs were not obliged to account for LIFT buildings in their balance sheets on the understanding that they were owned by the LiftCo whether through the land purchased or land retained model.

1.2.6.2.3.3.2 Contractual agreements

LIFT implementation is backed by the strategic partnering agreement and the lease-plus agreement drawn prior to rolling out LIFT projects (DH/PfH 2003). The agreements are contractual agreements that spell out the rights, responsibilities, and deliverables of participants in LIFT. They are designed to dissuade the participants from activities that may be counterproductive to LIFT. Kings' Fund (2008) argues that the agreements may deter progress if the mechanisms for their enforcement are perversely

applied by one party. It is recommended for LIFT participants to embrace renegotiations on some aspects of the contracts should circumstances preventing other parties from meeting their obligations arise (DH/PfH 2003). This may enable the participants in mutually benefiting from LIFT. The present research sought to assess whether and how LIFT contracts are enforced help the involved PCTs in their procurement activities.

1.2.6.2.3.3.3 Planning LIFT schemes

There is need to understand whether the process for planning LIFT schemes gives priority to PCT interests and circumstances. This is important because of the DH's (2001) recommendation that LIFT buildings be derived from SSDPs developed by the PCT through consultation with their communities. Since translation of the contents of the SSDPs is led by the LiftCo, true aspirations of the PCTs may be at risk of not being reflected in the way LIFT buildings are designed and constructed. The LiftCo and its contractors have incentive to change some specifications of the SSDPs when designing or constructing the buildings where they feel that timely delivery is risked by inputs that are not readily available.

Whether intentionally or not LIFT standardises the planning of NHS buildings. Standardised planning through LIFT is believed to relieve GPs of the worry to develop their own surgeries leaving them with ample time for direct patient care (DH 2001). But the problem is that it risks planning buildings according to individual circumstances and priorities of the PCTs. This makes it important to understand whether and how the ways in which LIFT schemes are planned help the PCTs and GPs in increasing capacities to improve the quality of buildings as demanded by patients.

Among other things, it is important to know whether the people involved in operationalizing LIFT are clear about the guidance for translating the SSDPs' contents into building specifications and what the different participants are expected to deliver. The knowledge may be used by the concerned staff in influencing effective planning of LIFT schemes. Otherwise there could be explanations on how lack of it affects them in discharging their planning responsibilities.

It is possible that PCT staff and the LiftCo may lack prior agreement about critical primary care issues to be addressed within a PCT. In such cases, LIFT's strengths may be unclear as the preferred procurement method vis-à-vis the issues to be addressed. Thus there is the need to evaluate the quality and respect accorded by the LiftCo to contributions by the PCTs in planning LIFT buildings. Some analysts criticise LiftCos for giving the PCTs neither opportunity for effective contributions nor room for choice in planning the schemes (Beck et al 2009). But LIFT schemes are expected to be driven by consensus between LiftCo and PCTs (DH/PfH 2003),

Concern has been raised that ordinary service-users within the NHS are rarely consulted in planning local services on the pretext that they lack propensity to contribute (Klein 2007, Allen 2006). Maybe this is why, in context of LIFT, the Infrastructure Planning Commission recommends public scrutiny for proposed LIFT schemes prior to construction (DH 2006a). They probably want to ensure that LIFT schemes are in line with public interests that may have been missed in the SSDPs developed by the PCTs. If any proposed LIFT scheme fails to pass such public scrutiny, the LiftCo is required to revise the proposal to reflect the objections. It

underlines the importance of knowing about institutions whose influence is considered most in decisions for planning LIFT schemes.

1.2.6.2.3.3.4 Operationalisation of LIFT schemes

Schedule 17 Part 1 of the strategic partnering agreement governing LIFT describes the activities followed in operationalizing LIFT schemes (DH/PfH 2003 page 191). It emphasizes strategies that facilitate linking health and social care activities to improve health outcomes within PCTs. For example, there are recommendations for involving local communities in activities to deliver and utilize LIFT buildings. This enables the PCTs in extending the impact of LIFT buildings beyond the health system (DH/PfH 2003). It is therefore important to know whether operationalisation of LIFT schemes takes into account the features of national and local level arrangements for improving health and social care.

According to the DH (2001), *"development of LIFT will create a major new opportunity and significant expansion of the existing market"* (page 27), to increase the number of active participants in primary care. This suggests that the philosophy behind LIFT is to generate business opportunities for local groups of investors and service providers not directly involved in activities to provide healthcare. It is important to understand whether the LiftCo prioritises employing local contractors in construction and supplying maintenance services. The guidance's silence on the monitoring mechanisms raises the possibility of more established contractors from outside the LIFT areas being hired at the expense of the local ones despite LIFT being sold as promoting local participation in procurement.

One of the challenges faced by the LiftCo and PCTs could be that contractors and service suppliers have different motives in doing business with LIFT. It may present problems for the LiftCo in assessing the contractors in order to hire those that are connected with LIFT objectives for effectiveness in procurement. LIFT guidance has no provisions for the LiftCo in consulting or involving the PCTs or tenants at the buildings prior to hiring of building contractors and service suppliers. Neither is it clear whether the PCTs and tenants can control or influence the contractors where performance may be below the expected standards. These are some of the issues needing evaluation since they affect progress in LIFT.

1.2.6.2.4 Endorsements and Criticisms of LIFT

In context of the benefits and risks associated with PPPs applied in health, LIFT has been endorsed and criticised in a number of ways. King's Fund (2008) argues that LIFT has the ability to deliver buildings on time when they are needed. According to the National Audit Office (NAO) (2005), LIFT is a more cost-effective strategy than DH led procurement. In support of this view, the Commission for Architecture and the Built Environment (CABE) (2008) explains that LIFT's mechanisms have the ability to harness private sector skills and expertise that help in saving time and cost in procuring the desired buildings. There is also the view that private developers that are involved in LIFT have the ability to substitute between construction inputs without risking the quality of buildings (King's Fund 2008). This makes LIFT buildings a step improvement on pre-existing GP surgeries and the buildings' bigger size and regular maintenance mean that patient experience within PCTs is increased (King's Fund 2008, CABE 2008, NAO 2005, Beck et al 2009).

According to Wall (2007) and the NAO (2005), LIFT brings improvements in technology demanded by patients. The technology comes in forms of innovative ways in resourcing as well as stocking LIFT buildings with appropriate equipment and other facilities for patient comfort and safety. Beck et al (2009) argue that LIFT facilitates modernisation of GP surgeries through instigating stakeholder involvement in planning for their delivery.

But some mechanisms through which the above benefits are delivered provide bases for the criticisms levelled against LIFT. Because LIFT involves private sector leadership, it may be perceived as not conforming to the public expectation for DH responsibility in procuring NHS buildings. Pollock and Price (2006) criticise LIFT for privatising components of NHS functions because it encourages enhanced role of private for-profit companies within the NHS. Because LiftCos operate for-profit, giving them leadership in LIFT has adverse effects on the PCTs. It is argued that the LiftCos are prone to economic rationalism that influences them to make savings by cutting costs or neglecting essential services at LIFT buildings (Pollock and Price 2006, Aldred 2008). Or the LiftCos may choose to minimise maintenance efforts, or surcharge the tenants for services provided at LIFT buildings in order to save money for repaying the financing banks (Fitzsimmons et al 2009).

LIFT has also been criticised for reducing competition and standardising procurement of buildings within PCTs. Aldred (2008) explains that exclusive rights given to the LiftCos in developing future buildings make the LIFT areas geographical monopolies. It risks locking PCTs into LIFT deals that may no longer be appropriate for addressing local priorities.

Other analysts (e.g. Fitzsimmons et al 2009) argue that LiftCos may be tempted to export standardised building designs across PCTs in order to avoid architectural and designing costs. This undermines innovation that is needed to deliver buildings that reflect local priorities. Thus, restrictions on competition and standardised procurement (Aldred 2008, Fitzsimmons et al 2009) governed with prescriptive guidance may cause the PCTs to miss on the benefits that are claimed to derive from LIFT. Wall (2007) explains that the benefits may be missed through PCTs being restricted in finding creative ways to address local problems. For example, inflexible guidance prevents PCTs from renegotiating elements in LIFT contracts when they need appropriate response to changes in circumstances.

Unison, the health trade union and the British Medical Association (BMA) also expressed concerns about LIFT. Unison's (2003) concern was about the risk of LIFT influencing involved PCTs and GPs to reduce health worker numbers, or saving money by revising their conditions of service. Initially, the BMA (2008) believed that the DH was coercing GPs to take part in LIFT schemes. Consequently, they regarded LIFT as designed to usurp the independence of GPs. These views suggest that apart from economic and financial grounded criticisms, there are also behavioural issues blamed on LIFT. For example, threats to staff tenure, reduction in staff morale, and erosion of cooperative relations between the DH and independent GPs may be behavioural factors blamed on LIFT.

It may explain why some analysts within the NHS (e.g. King's Fund 2008 and McKee et al 2006) believe that patient experiences may be increased through investing to change behavioural issues in how GPs relate with the

DH than in new buildings. King's Fund (2008) suggests that effective strategies to increase patient experience should consider redirecting more resources towards strengthening collaboration plus sharing of information between the PCTs and GPs than to new buildings. LIFT may be in conformity with the proposal to increase investment in healthcare technology (McKee et al 2006) in order to increase patient experience in primary care. The current research explores ways in which collaboration between LIFT participants, their exchange of information on LIFT and technology influenced progress on LIFT objectives.

1.2.6.2.5 Rationale for LIFT within the case-study

The need to invest in primary care buildings was primarily determined by functionality of the existing stock. Within the case-study, the poor condition of GP surgeries prevented patients from accessing quality health services (Fitzpatrick and Jacobson 2002). An important problem was that the buildings were mostly adapted residential houses expensive to modify into purposeful healthcare buildings. Therefore the agenda to make primary care buildings more functional made the case-study a suitable candidate for LIFT (DH 2001, 2006). LIFT was anticipated to bring together a variety of providers in order to integrate primary care by working under one roof (DH 2006b). Within NHS London, LIFT has now been linked with the proposed polyclinic concept to the extent that some polyclinics within the case-study are in fact located in LIFT buildings (NHS London 2007a)

Modernising GP surgeries is important because they influence patients' first impressions about the quality of NHS services. Within the boroughs covered by this case-study, redevelopment of a local hospital was

observed to make the residents feel valued by the health authorities (King's Fund 2002). The investment influenced the residents that had contemplated relocating to other boroughs to postpone their desire.

This, together with perceived level of deprivation within the areas, may explain why the case-studied PCTs volunteered to pioneer LIFT schemes. The Indices of Multiple Deprivation (IMD) that measure deprivation experienced in communities rank east London boroughs low out of 326 boroughs across England. Data from the Corporate Research Unit (2011) at PCT-2 show that the boroughs (Brh-1and Brh-2) in which the case-studied PCTs are located rank 1st and 3rd respectively for widespread deprivation. Widespread deprivation is one of the factors that influenced DH authorities in initiating LIFT (DH 2001). The authorities then recommended its adoption by the affected PCTs wishing to improve their facilities. The levels of deprivation in boroughs where the case-studied PCTs are located do not significantly vary from those of neighbouring ones. For example, Brh-3 and Brh-4 rank 2nd and 13th respectively for the extent in widespread deprivation described in Table 1.3.

Table 1.3: National ranking in deprivation: four boroughs in east London (2010)

Measure of deprivation	**Ranking out of 326 boroughs**			
	Brh-1	**Brh-2**	**Brh-3**	**Brh-4**
Index of Multiple Deprivation (IMD) score	2	7	3	15
Average IMD rank	1	3	2	7
Extent in widespread deprivation	1	3	2	13
Local concentration of deprivation	49	38	51	62
Income scale	15	10	8	32
Employment scale	30	38	32	54

Source: PCT-2 Corporate Research Unit (2011)

Other factors that may have made the case-study area a suitable candidate for LIFT could be the problems of shorter life expectancy and higher maternal mortality experienced within the PCTs compared to others

in London (Fitzpatrick and Jacobson 2002). Since up to 60% of residents in the case-study belong to ethnic minority groups (NHS 2009), the PCTs may be facing challenges in developing buildings that consider differences in needs caused by diversity in ethnicity. It was hoped that LIFT would be a means to solve part of these problems by delivering buildings that not only reflect priorities of local residents but also facilitate monitoring of GPs to ensure that they contribute by offering convenience to patients through opening their surgeries for extended hours. The NHS (2009) reports that by 2008, 81% of the GPs working in PCT-1 and 97% of those in PCT-2 opened their surgeries for extended hours compared to London average of 79%. The current research investigated whether this performance was attributed to LIFT alone or other activities within the PCTs.

1.2.6.2.6 Importance of the current research

The current research was employed to develop an understanding of LIFT and what it meant from the perspectives of people involved and affected by its implementation. Its major focus was on investigating the contexts and mechanisms through which LIFT is implemented and their related outcomes rather than evaluating LIFT buildings, meaning the interest was more in LIFT process than outputs. The answers to the research questions were developed through identifying how LIFT contexts and mechanisms interacted to produce the anticipated outcomes in procurement not merely confirming the presence of buildings. Slow pace in developing LIFT buildings within the case-study suggests that the elements central to LIFT could be in some ways constraining activities.

LIFT promoters argue that it facilitates value-for-money in procurement (DH/PfH 2003). This is achieved through the LiftCos prioritising efficient and innovative ways to deliver affordable and sustainable buildings for the PCTs compared to government led procurement. But some analysts argue that differences in approaches to service delivery between the involved public and private partners may affect its ability in achieving the expected outcomes (Beck et al 2009). This researcher believed that operational staff at the frontline of LIFT activities were the best arbiters for how and why its contexts and mechanisms interacted to produce the observed outcomes. Therefore, the research used reflections on personal experiences by selected informants involved and affected by LIFT to assess whether it aligned the PCTs and LiftCo expectations. Informants provided insights into the risks, strengths, and weaknesses of contexts and mechanisms which may influence policy and practice for the PCTs working to improve their buildings using LIFT.

SECTION 2: METHODOLOGY

The Methodology section comprises six subsections explaining conceptual and practical issues addressed in fulfilling the research. Subsection 2.1 discusses alternative evaluation approaches considered initially. Subsection 2.2 discusses the research design by considering the merits of an embedded case-study (Yin 2009) in relation to this research. A detailed explanation of the embedded elements or units of analysis was provided in subsection 1.1.5.3 (page 6).

Subsection 2.3 discusses the data collection methods. The methods' individual strengths and fitness to address the research questions are discussed, and practical activities done in conducting: documentary reviews; in-depth interviews; and tours of LIFT buildings are explained. An overview of the methods and how they mapped onto the research questions is provided followed by an explanation of the fieldwork process.

Subsection 2.4 deals with analysis of the data. It discusses the approach taken, evidence extraction and coding, and how realist evaluation principles were used in interpreting the evidence. Subsection 2.5 explains the research ethics including those pertaining to its clearance, data collection, data analysis and interpretation, and ensuring objectivity of the findings. Subsection 2.6 explains the research timeline.

2.1 Conceptual Framework for the Evaluation

This subsection discusses the different possible approaches to evaluations which were considered as frameworks to guide the research. From the many approaches proposed by Donaldson (2007) and Stufflebeam & Webster (1980) for use in qualitative studies, only the

decision-oriented, consumer-oriented, and client-centred approaches may be considered appropriate. They are process models of evaluations interested in assessing programme outcomes from the perspectives of their initiators (decision-oriented), consumers, or programme clients (Donaldson 2007). In addition, the Realist Evaluation (RE) approach proposed by Pawson and Tilley (2001) was listed for consideration. RE is also interested in measuring programme outcomes but gives importance to explaining causation between processes and outcomes than looking at the outcomes in isolation. In this subsection, each approach's strengths and weaknesses are considered, and the pertinent details for preferring the chosen RE approach are explained.

2.1.1 Alternative approaches to the evaluation

An important factor for the choice of approach to an evaluation is whether a programme is ongoing or has reached its end of life (IPPR 2002, Pawson and Tilley 2004). The IPPR (2002) argue that most evaluations seek to confirm whether a programme achieved its objectives at the end of its life. But it is also argued that evaluations may seek to provide understanding about how a programme's processes facilitate or constrain progress (Pawson and Tilley 2004). The current research prioritised evaluation approaches whose epistemologies are rooted in explaining LIFT's operational issues as an ongoing programme. It preferred approaches with the ability to identify and extract practical evidence about LIFT as opposed to those that would assess it based on idealistic presuppositions of the DH officials alone. Hence contexts and mechanisms that underpin LIFT's effectiveness in meeting its objectives were to be validated by the views of staff executing the schemes as opposed to DH officials who designed it.

The observations that LIFT involved complex contexts and mechanisms (Aldred 2006, Beck et al 2009) suggest that an approach may be limited in identifying major issues for LIFT if it is exclusively used in the evaluation. In such cases, mixed approaches are recommended because they augment each other and may help in understanding a researched programme from different perspectives thereby enhancing credibility and external validity of the research findings (Creswell 2002, Chase 2005). Hence the choice of the evaluation approach in this research was influenced by their perceived epistemology and objectivity in generating knowledge about LIFT.

It has been argued that different evaluation approaches have variable utility in eliciting critical information needed for understanding a programme (Donaldson 2007, Pawson 2004, Chen and Rossi 1983). Donaldson (2007) argues that some approaches may promote existing positive or negative perceptions about a programme at the expense of its actual value. Some approaches also risk inconsistencies where in one instance they may reveal the actual value of a programme yet in the other, the same approaches may fail to reveal the features that those affected may want to see prioritised in a programme. For example, Chen and Rossi (1983) argue that randomised control experiments are evaluation approaches that can provide specific answers in healthcare yet they can have the weakness of ignoring theory based explanations for how a programme works. Taking this into account, the choice of the approach for the current research was made from a menu of four, namely (i) decision-oriented, (ii) consumer-oriented, (iii) client-centred, and (iv) realist evaluation (Table 2.1). The chosen approach would facilitate analysis of

the merits and demerits of LIFT based on objective experiences of the involved operational staff.

Table 2.1 explains the bases on which the alternatives were screened for suitability to the research. The column on “Knowledge base” indicates which perspective the individual approach was perceived to emphasise in generating evidence. The important strengths and weaknesses of each approach in relation to addressing the research questions are indicated in the last column.

Table 2.1: Screening suitability of approaches to the research

Approach	Knowledge base	Strengths (S) & Weaknesses (W)
Decision-oriented	Emphasizes views of public sector officials who initiated LIFT in getting evidence for answers to the research questions.	(S) – May justify the decision to initiate LIFT. The findings would influence improvements in policy planning (Donaldson 2007).
		(W) – Risks using the research to defend LIFT. The findings may be biased by officials / policy-makers (Stufflebeam & Webster 1980).
Consumer-oriented	Prioritises consumer satisfaction with LIFT in getting evidence for answers to the research questions.	(S) – May judge relative merits of options to LIFT using independent views. The findings may help in protecting consumers from LIFT’s ineffectiveness (IPPR 2002)
		(W) – emphasis on consumer views means the findings may not help staff that execute LIFT schemes in improving their activities (Pawson & Tilley 2004).
Client-centred	Prioritises views of PCT staff, GPs and centre administrators served by LIFT.	(S) – Provides understanding of how LIFT clients value its activities.
		(W) – The findings may be susceptible to bias of the clients and risk external credibility (Donaldson 2007)
Realist evaluation	Considers views of major stakeholders in order to develop a holistic understanding of LIFT.	(S) – Examines LIFT’s features in varying contexts and from the views of major stakeholders and staff involved in executing LIFT schemes (Pawson & Tilley 1997).
		(W) – Lack of discrete boundaries risks consensus on what to or what not to focus on in the evaluation (Marchal et al 2010).

In choosing which evaluation approach to use, importance was given to ability in facilitating explanations about process of LIFT. The issues considered in screening the competing approaches are explained below.

2.1.1.1 Decision-oriented approach

The decision-oriented evaluation approach is so called because it prioritises giving initiators of a programme under investigation opportunity to reflect on their decision to introduce it (Donaldson 2007). With LIFT, this can be a major strength in the sense that DH officials are able to clarify how they expected it to work. Insight gleaned from perceptions of DH officials may help in explaining discrepancies between what was expected and what is actually experienced in implementing LIFT. This helps in clarifying accountability for critical decisions in LIFT between the officials and operational staff within the PCTs. Such knowledge may help to influence improvements in policy and practice by DH officials presiding over LIFT guidance.

However, a major limitation of the approach could be the risk of biased information especially as DH officials behind LIFT may be tempted to defend their own decisions and blame LIFT's problems on operational staff. It explains why from the onset, the current research did not focus on public sector officials including those at the DH. The interest was in giving the operational staff directly involved in LIFT opportunity to highlight how its process affected their efforts in solving problems in procuring improved buildings. These were the essential aspects of LIFT that this research needed to disclose. Yet the decision-oriented approach risked emphasizing perhaps political issues than effects of LIFT process on local activities.

2.1.1.2 Consumer-oriented approach

The consumer-oriented evaluation approach is considered one of the strongest evaluation approaches because it seeks to emphasize views

that consumers hold about a programme (Sanderson 2003, Stufflebeam and Webster 1980). Sanderson (2003) argues that focusing on consumer perceptions helps in generating knowledge about how ordinary people that use the services value a programme being investigated. In this research, the consumer-oriented approach means giving service-users opportunity to indicate the consequences of LIFT on their experiences in patronising GP surgeries. It is argued that research findings deriving from consumer-oriented approach may help the service-users in making wiser choices about where to get care (IPPR 2002). Thus, the findings from this research may facilitate the case-studied PCTs in choosing best procurement options that may affect patient experiences especially if they know about service-user priorities.

But there are two reasons why focusing on service-users may be a wrong approach for LIFT. First, LIFT may not directly affect patient care given that the remit is to deliver and maintain buildings and not providing care. It is likely that patients within the NHS are more interested in experiencing better services and health outcomes than complex processes in procuring healthcare buildings. Second, LIFT processes may be complex for patients to understand and influence any changes. Patients may endorse LIFT based on perceived improvements at the buildings but may ignore how it could reduce funding of non-LIFT surgeries within PCTs. Further, the current research interest was in examining contexts and mechanisms through which LIFT buildings are delivered. This means that using the consumer-oriented approach may not help in generating answers to the research questions.

Nevertheless, certain strengths of the consumer-oriented approach were adopted to influence the research conduct. For example, conduct of interviews allowed informants to reflect on what they thought were service-users' experience at LIFT buildings compared to previous buildings and those outside LIFT. Tours at LIFT buildings also observed service areas that are perceived as priorities in improving patient experience.

2.1.1.3 Client-centred approach

The client-centred evaluation approach emphasizes views of institutions and people served by a programme (Donaldson 2007, Stufflebeam & Webster 1980). Donaldson (2007) argues that the approach generates research findings that can be used in improving some aspects of the programme. In relation to LIFT, the PCTs as the principal tenants at LIFT buildings are the clients to the LiftCo. The GPs, pharmacists and other primary care providers are invited by the PCTs to occupy LIFT buildings meaning they are clients to the PCTs. In some instances the GPs may be direct clients to the LiftCo provided their buildings are developed without PCT involvement. The current research captured PCT staff and GPs' experiences of LIFT as clients and sub-clients of the LiftCo. In light of the research questions, their involvement allowed them to identify what they thought helped them make LIFT more effective. The researcher believed that it was the LiftCo's clients rather than the public sector officials and service-users that often asked questions about the issues that the current research attempted to address. The client-oriented approach's strength therefore resides in facilitating PCT staff and the GPs in learning from their own experience in deciding improvement strategies although it may be questionable whether they have autonomy to do so in LIFT's governance.

There may be legal and political restrictions that deny PCT staff and GPs the independence to implement modifications to LIFT guidance. It means that evaluating LIFT from the clients' perspective alone may fail to adequately improve its implementation especially if those involved are motivated to withhold information that they may feel reflects on them badly as clients. Or they may create tension if they choose to apportion problems to the LiftCo because they want to regain control over aspects of procuring healthcare buildings in their areas. The discussion indicates an important difference between the consumer-oriented and client-centred approaches. The consumer-oriented approach concerns ordinary people that get health services at LIFT buildings and how they perceive LIFT's effects on their experience. The client-centred approach focuses on relations between the LiftCo and PCTs or GPs using LIFT buildings.

2.1.1.4 Realist evaluation (RE) approach

The RE may be viewed as a mixed approach for integrating different knowledge bases into one to develop a complete understanding of programmes under investigation (Pawson 2006, Marchal et al 2010). In the current research, for example, it can incorporate main strengths of the decision-oriented, consumer-oriented, and client-centred approaches. The current research was client-centred but it was recognized that strict adherence to client-centred principles risked missing important knowledge about LIFT that might be concealed from the clients or are hidden by LIFT's fuzzy boundaries in its implementation.

The RE approach was viewed as appropriate in this case to capture the perspectives of public sector officials and operational staff. Documentary analysis provided access to public sector official perceptions. The people

interviewed were or represented the LiftCo's clients. Their responses interpreted LIFT by explaining how its guidance designed by officials at the DH affected them in discharging their responsibilities for improving service-user experience within the PCTs. Through using RE principles, the research was able to reconcile official perceptions and client experiences with LIFT without having to interview officials at the DH officials and service-users at LIFT buildings. The details of RE principles and usage in addressing specific needs of this research are explained below.

2.1.2 RE principles and usage

The RE is a theory based evaluation approach whose primary aim is to test the theory that may have informed the initiating of a programme (Pawson and Tilley 1997). Pawson (2006) contends that RE assesses programme outcomes by identifying major and minor contexts and mechanisms that affect production of outcomes. It gives importance to using realism in generating knowledge by explaining how contexts and mechanisms interact to generate outcomes. This research argues that in context of decentralisation, New Public Management; Third Way; Localism; and public-private partnerships perspectives to public service delivery influenced the development of LIFT within the NHS (subsection 1.2.4 page 40). The RE approach appropriately offered flexibility and prioritised realism in explaining effects of multiple factors that exert on the concepts. How the concepts are expected to work are incentives that may influence LIFT contexts and mechanisms. For example, PCT staff were able to identify and explain how LIFT supported them in their activities. This possibly alerted DH officials about how staff perceived LIFT in varying contexts.

2.1.2.1 Appropriateness for the current research

Proponents of the RE approach argue that it facilitates serious scrutiny of programme contexts and mechanisms to understand how their interaction may impact the expected outcomes (Pawson 2006, Sayer 2000, and Kazi 2003). The current research generated answers to the research questions by investigating the contextual factors perceived necessary for LIFT to improve procurement of buildings. The major mechanisms through which LIFT activities produced the changes in procurement were also investigated and the outcomes that follow the contexts and mechanisms explored. Developing the answers to the research questions therefore encompassed explaining the interactive effects of contrasting economic, social and financial influences within the NHS. And this fitted well with Pawson and Tilley's (1997) argument that RE helps in examining:

> *"...which social and cultural resources are necessary to sustain changes"* (page 85) within a programme.

The RE approach made it possible to trace and analyse the cause and effect relations between LIFT objectives, contexts, mechanisms and activities (social and cultural factors). The analysis framework (Table 2.13 page 147) that was used mapped RE principles onto the research questions to identify factors that influenced LIFT's intended and unintended outcomes benefiting the different participating groups.

2.1.2.2 Definition of the terms used in RE

Adherents of the RE approach propose explaining programmes by examining and matching their relevant contexts and mechanisms to the outcomes produced (Pawson 2006, Marchal et al 2010). They argued that contextual factors combine with mechanisms to influence outcomes. So

contexts, mechanisms, and outcomes are terms central to usage of the RE approach. In relation to this research, there are possibilities that LIFT encounters variation in conditions in which it produces outcomes; and some conditions facilitate while the others inhibit expected outcomes.

2.1.2.2.1 Context (C)

The term context describes the social, economic and cultural conditions within which a programme is implemented (Pawson 2006). The conditions are external to a programme and can facilitate or constrain it in producing the expected changes, meaning ideal contexts are conducive for bringing about desired improvements. In relation to LIFT, LiftCos are invited to only develop local GP surgeries provided concerned PCTs prioritise increased stock of better ones within their areas. The PCTs influence local GPs in valuing quality in their activities, and entice them into considering using LIFT buildings. Since they invest for profit, equity holders always expect their LiftCos to employ profit maximising strategies in delivery and management of LIFT buildings. The scenarios mean that conditions where: *"PCTs prioritise increased stock of better buildings";* or *"there is collaborative working relationship between PCTs and GPs"* to support LIFT; or *"LiftCos are hard pressed to protect equity holders' interests"* are examples of LIFT contexts. The first may be an economic context within the PCTs. The second may be a social context for how PCTs and GPs relate in working. The third may be cultural context related to how for-profit companies are expected to operate. These contextual factors exist even without LIFT yet they may facilitate or inhibit its progress.

The extent to which LIFT buildings are used may be an important context for LIFT. For example, increased utilisation of LIFT buildings by service-

users may be conducive for sustaining LIFT provided they are conveniently located for service-users and GPs have willingness to operate from the buildings. LIFT may be constrained if GPs are unwilling to relocate at LIFT buildings or the buildings are located away from public transport. This leads to low patient utilization and the buildings could be viewed as *white elephants.* LIFT contexts are therefore defined by how economic conditions and interpersonal and social factors interplay to affect LIFT activities.

2.1.2.2.2 Mechanism (M)

Programme mechanisms are opportunities and ideas that are introduced through a programme (Pawson 2006). They are like in a "black box" because they cannot be seen yet they are aspects that may force a programme to produce observed outcomes. Unlike contexts that are conditions surrounding programme activities, mechanisms are features internal to programmes. Pawson and Tilley (1997) use the analogy of a clock to explain how mechanisms work. The elements that make a clock function are concealed within the clock just as mechanisms through which programme outcomes are produced are within the programmes. If the influencing features are within programme environments, then they are become contexts (Marchal et al 2010). LIFT works by accessing private sector capital for procuring public sector buildings and using private sector skills and expertise in post-delivery management of the buildings. Therefore, ability in *"accessing private sector capital"* and *"using private sector skills and expertise"* are examples of LIFT mechanisms. The first mechanism may be viewed as opportunity introduced through LIFT in

procurement of PCT buildings, and the second mechanism indicates new ideas introduced through LIFT in management of the buildings.

This research sought to distinguish ideas that run alongside LIFT from LIFT mechanisms. For example, “community engagement”; “regeneration of local areas”; and “upgrading health informatics at buildings” are ideas applied within the NHS to run alongside LIFT. The ideas are distinct from LIFT mechanisms because they are also applied in non-LIFT areas. They only become LIFT mechanisms provided their expected outcomes are affected by LIFT. For example, installation of health informatics equipment at LIFT buildings is the responsibility of PCTs and GPs. But the buildings’ designs may obstruct the PCTs and GPs in installing appropriate equipment. This research explored informant perceptions about how other health activities within their areas were influenced by LIFT to understand some of its mechanisms.

2.1.2.2.3 Outcome (O)

Outcomes refer to effects experienced due to programme mechanisms employed in specific contexts (Pawson 2006, Byng 2005). In essence they are consequences that logically flow from the interaction between contexts and mechanisms. Thus, outcomes reflect expected benefits as much as they do unexpected and unwanted effects due to real-world changes in contexts and mechanisms experienced by programmes. In relation to LIFT, this could mean that evolving contexts and mechanisms may cause its outcomes to either positively or negatively deviate from the expected result. Hence Pawson and Tilley’s (2004) caution that RE requires practitioners to appreciate that programme outcomes follow variations in contexts and mechanisms.

Examples of positive LIFT outcomes that could result from changes in contexts and mechanisms may include PCTs having an increased stock of modernised healthcare buildings. Or they may realise increased efficiency in procurement due to LiftCo skills and competences. Possible negative outcomes may include increased scepticism about LIFT among PCT staff if they feel that their priorities are not being addressed. This may create tension between PCT staff and the LiftCo. Some changes in contexts and mechanisms may result in reduced discretion over LIFT procedures by PCT staff. Others may increase procurement costs affecting PCT liquidity. The RE principles facilitated interrogating informants towards revealing LIFT's unexpected outcomes. Some positive yet unexpected, and negative outcomes may be not obvious to people unacquainted with LIFT. The researcher believed that operational staff within PCTs were the right people to provide information needed for answers to the research questions. Their personal experience with LIFT would reveal some of its concealed aspects provided they were asked the right questions.

2.1.2.2.4 Context-mechanism-outcome (CMO) configuration

The term CMO configuration describes how contexts and mechanisms interrelate and arrange themselves in ways that influence particular programme outcomes (Pawson and Tilley 2004, Sayer 2000). It suggests a symbiotic relationship between contexts and mechanisms because neither can cause a programme to produce outcomes on its own. Pawson and Tilley (2004) explain CMO configurations as the elements that when considered together define how a programmes may be understood to work from the perspective of those involved; a process they refer to as programme theory testing.

When this scheme is applied to LIFT, the CMO configurations may be identified by making sense out of the ways its contexts and mechanisms interrelate to influence outcomes. For example, when *"GPs recognise the importance of quality buildings"* (context) in increasing patient experience, there may be readiness to accept LIFT provided the GPs perceive it as having the ability to *"access private sector capital"* and *"skills and competences"* (mechanisms) required to procure *"fit for purpose buildings"* (outcome) demanded by patients.

Like with other programmes, the CMO configurations in LIFT may be better understood by analysing the cause and effect relations of its contexts and mechanisms. This may be a robust approach to consistency in evidence about the actual merits and demerits of LIFT. It also help in clarifying how the different groups of institutions and people constituting LIFT interact to cause it to produce different outcomes that differently benefit them.

2.1.2.2.5 Middle Range Theory

Adherents of RE principles argue that the middle range theory helps in specifying the theory that may have driven the introduction of a programme (Pawson and Tilley 1997, Byng 2005 Pawson 2006, Marchal et al 2010). It explains how a programme is expected to work and how it is understood based on the contexts, mechanisms, and outcome combinations (CMO configurations) observed by the different groups of people involved and affected. Pawson (2006) recommends that the views of programme designers and participants be sought in developing and validating the CMO configurations before making them central to the middle range theory. Yet other analysts (e.g. Byng 2005) argue that circumstances may obstruct researchers from seeking the views of

programme designers and in such cases, analysis of official documents may substitute for designers in developing the CMO configurations constituting the middle range theory. Because contexts and mechanisms evolve with time, it may be necessary to account for changes in outcomes that may be experienced. Thus, the middle range theory recognises that agreement about how a programme operates is transitional and marked by changes in contexts and mechanisms (Pawson 2006, Byng 2005).

The initial CMO configurations that the current research defined as central to the theory explaining LIFT were derived from documentary analyses, meaning they were based on perspectives of public sector officials that designed LIFT. Byng (2005) advises that official documents may substitute for people's past or current experiences in validating theories researchers may choose to base their studies on. The advice apply where challenges including cost and time constraints, as was the case in this research, make preliminary fieldwork not feasible. This research was based on decentralization as the theory to study LIFT. The documents analysed needed to provide an account of decentralization features that the public sector officials perceived would benefit the PCTs by adopting LIFT in procuring buildings. Those features in decentralization were then emphasized in the middle range theory about LIFT developed by the researcher at beginning of the research.

The initial explanation for LIFT was developed from analysis of mainly the *"NHS LIFT Strategic Partnering Agreement Version 5* (DH/PfH 2003) and *"LIFT Prospectus"* (DH 2001) documents. Schedule 17 Part 1 of the strategic partnering guidance (page 187) and the LIFT Prospectus (page

24) identify and describe how the different groups of participants would benefit from assuming roles in LIFT. The PCTs, GPs and investors in local LiftCos are identified as principal beneficiaries. The PCTs are expected to benefit through getting support in procuring better buildings needed in improving the quality of care and patient experiences when GPs take tenancy at LIFT buildings. The private investors would benefit from guaranteed income across a portfolio of properties within the PCTs. Eventually; LIFT is expected to reduce procurement cost within PCTs through the LiftCos spreading their capital sourcing between multiple investors or financiers and service suppliers at LIFT buildings.

In context of decentralization, it may suggest that for LIFT to work as anticipated by DH officials, the PCTs may among other things require discretion for them to be able to assess LIFT as the appropriate option for procuring the desired buildings. The discretion may extend to the PCTs influencing decisions about LIFT's critical activities. The CMO configurations described in the analysed documents suggest LIFT as decentralised decision-making in financing and management of uncertainty in the procurement and governance of primary care buildings. The decentralization is from the DH to the PCTs, the LiftCo, GPs and local stakeholders. It influenced the researcher to state LIFT's initial middle range theory as follows:

> PCTs that implement effective LIFT schemes deployed decentralised structures which support staff in influencing long-term risk management in procurement of healthcare buildings. They prefer LIFT because it is the convenient and effective option in financing and maintenance of the desired buildings. Activities to execute LIFT schemes stimulate participatory decision-making, information sharing and openness between

> PCT staff, LiftCo staff, GPs using LIFT buildings and local stakeholders and contractors providing service at the buildings. LIFT activities ensure that the LiftCo assumes higher proportion of risks associated with procurement and management of buildings compared to the PCTs. The LiftCo is familiar with, and responsive to priorities of the PCTs. Its good working relations with the PCTs promote collaboration in increasing patient experiences when they are attracted by improved conditions at LIFT buildings.

The researcher believed that the above explanation captured major ideas and opportunities through which DH officials anticipated would allow the PCTs to benefit from decentralized procurement of GP surgeries. Aside from identifying decentralization as the concept along which to assess LIFT's effectiveness, the middle range theory indicates what kind of data was needed to generate answers to the research questions. Perceptions of the research informants were analysed for them to either confirm or refute or clarify whether LIFT embodies major indicators for decentralization described in the middle range theory. So decentralization was the current research's primary unit of analysis.

This was important because official documents may characterise LIFT as decentralising the important aspects in procurement yet in practice some government departments (e.g. the DH or Treasury) may retain significant authority and responsibility over important decisions. Analytic frameworks on decentralization were used to test practices in LIFT. Bossert (1998), for example, argues that effective decentralization involves allowing operational staff enhanced freedom in decisions about important functions like financing, governance, or service arrangements. These aspects were assessed to understand the extent to which informants thought they are practiced under LIFT in light of the initial middle range theory.

2.2 The research design

This research is designed around a descriptive embedded case-study. Yin (2009) argues that descriptive embedded case-studies are a robust means to consistency in evidence due to their ability in integrating different kinds of data from different sources into a single analytical approach. In the current research, the design enables integrating different data types about LIFT to understand it better as decentralization strategy. It integrates data sourced at PCTs, the LiftCo, and LIFT buildings about LIFT contexts and mechanisms and provided by the different staff categories to understand how they are supported in their activities in LIFT. As previously discussed in subsection 1.1.5.3 (page 6) which provided the rationale for constructing an embedded case-study, decentralization theory, the PCTs, LiftCo and LIFT buildings and the different categories of staff interviewed constitute the units of analysis central to the present research.

One of the reasons for preferring this design was that relative stability of the context within a small case-study would facilitate effective investigation on experience of LIFT's contexts and mechanisms. This is despite the problem that the design could risk focusing on experiences within the case-study at the expense of the wider context of east London or London. A moderating factor could be that as pioneers of LIFT, the case-studied PCTs together with the LiftCo should now provide rich information and experience to share from some of their oldest LIFT buildings. This implies that although generalisability of the findings needs consideration, it may not be a major limitation of the present research.

2.3 The Methods

This research employed three data collection methods including documentary review, in-depth interviews and tours of LIFT buildings. The case for using mixed methods is discussed in subsection 2.3.1. Subsection 2.3.2 discusses the documentary review method by highlighting the hierarchy of LIFT documents, their sources and criteria used in selecting which documents to review. The in-depth interview method is discussed in subsection 2.3.3 where usefulness of the method for the current research is highlighted and sampling of informants at the PCTs, LiftCo and LIFT buildings is explained. The tours of LIFT buildings are considered in subsection 2.3.4 to indicate the essential service areas that were observed.

2.3.1 Case for using mixed-methods

The use of mixed methods and triangulation is important in developing a deeper understanding of a research's critical elements (Creswell 2002). Aside from increasing breadth and depth, using mixed methods may provide corroborative evidence of the information gathered within a case-study compared to relying on a single method. Yin (2009) contends that the different units of analysis characterising case-studies may mean that they need different methods to access evidence pertaining to them. The current research therefore used documentary reviews, in-depth interviews and tours of LIFT buildings in collecting the data because one method alone risked capturing insufficient evidence about experiences at the different levels investigated.

For example, documentary review facilitated understanding how officials at the DH expected operational staff in LIFT to comply with the range of guidance. A potential limitation in documentary review may be that official documents fail to articulate experiences within the PCTs or at the LiftCo. The method may fail to provide complete evidence about LIFT unless used in conjunction with interviews with the affected staff. The use of in-depth interviews had the advantage of reaching operational staff (at the PCTs, LiftCo and LIFT buildings) to share experience and their perceptions about LIFT. Yet if used alone, the method may overlook important data needed to understand LIFT. Appropriate information about conditions at LIFT buildings, (e.g. patient waiting areas and consultation rooms) is better captured by means of direct observations than by interviews. This made it necessary to organise tours for observing conditions on areas likely to be overlooked in interviews yet important indicators for LIFT's performance.

Mixing the methods facilitated combining evidence that emerged in the course of the research to develop the overall picture of LIFT. For example, the official belief portrayed in LIFT guidance was that LIFT improves management of risks in procuring buildings. Interviews with staff involved in LIFT was a way for them to validate the beliefs presupposed in LIFT guidance so that conclusions about them are drawn based on experiences and perceptions of these informants. The use of mixed-methods is therefore methodological triangulation that may help in exposing programme factors that may be hidden yet affecting outcomes (O'Byrne 2007). Some analysts including Fitzsimmons et al (2009) and Beck et al (2009) argue that LIFT guidance and networks involved are complex and hide their effect on LIFT outcomes. Therefore, a mixed-methods design

may excavate for analysis some of the hidden factors in LIFT. This could reduce potential deficits in evidence about the influential contexts and mechanisms in developing a complete understanding of LIFT.

It was also clear that neither documentary review nor in-depth interviews alone could provide sufficient evidence for the current research. Documentary review alone risks prioritising DH officials' perspectives in explaining LIFT yet the research did not give the officials opportunity to elaborate on their documented expectations from LIFT. Time and cost constraints influenced exclusion of the public sector officials in favour of operational staff at PCTs, LiftCo, and LIFT buildings. Combining the three data collection methods prevented this research from prioritising public sector officials, or the views of informants or the researcher's own interpretations of what was observed. A mixed-methods design offered the benefit of methodological synergy important in producing complete answers to the research questions.

2.3.2 Documentary review

LIFT features needing evaluation were at first identified through reviewing LIFT guidance. The major features were then used in extracting evidence from other LIFT documents and prioritised in topic guides that were used in conducting interviews. This subsection explains the processes for searching for the documents, screening to identify those for focused analysis, and how the evidence was extracted, coded and analysed for answers the research questions.

2.3.2.1 Hierarchy of documentary evidence

Scott (1990) defines a document as any written text that records and explains the intentions or what is understood about a phenomenon. In contrast, literature is explained as abstraction and critical analysis of issues that may be missing from documents (Scott 1990). This distinction was relevant to the current research in two ways namely: identifying the different types of documents to consider for analysis; and potential sources of helpful documents.

One of the ways used in identifying documents for analysis considered their origins. Most LIFT documents originated from government departments and their agents. The main publishers included the DH, Community Health Partnerships (CHP), the NHS, House of Commons, and the NAO. In this research, publications from these organizations are referred to as official documents to acknowledge that their contents reflect the views of the office bearers at these public sector organizations and departments. The officials were the ones that made the decision to introduce LIFT. They produce a range of materials such as LIFT guidance, contractual material, minutes of meetings, and departmental briefs seeking to promote the programme.

A related hierarchical approach in identifying the documents revealed that LIFT documents are produced at national and local levels. Nationally produced documents are intended to provide guidance in LIFT in the country and not in specific geographical areas. The majority of national LIFT documents are written by public sector officials at the DH, CHP, the NHS, House of Commons, and the NAO. At the local level, PCT staff as agents of the DH and the NHS produce documents that address LIFT

issues specific to their PCTs. Since the PCTs are expected to comply with LIFT guidance decided at the national level, it gives their staff the status of operational staff as opposed to officials at national level. LIFT documents produced by PCT staff tend to be restricted to business cases for LIFT schemes or, minutes of PCT boards or management team meetings reflecting on LIFT activities in their areas.

Recognizing that LIFT is a PPP arrangement, it made sense to also consider LIFT documents originating from organizations other than the government departments and their agents. The main non-governmental organizations producing nationally relevant LIFT documents include the British Medical Association (BMA), National Pharmacists Association (NPA), the Commission for Architecture and the Built Environment (CABE), and King's Fund. Publications by the BMA and NPA primarily seek to protect the interests of GPs and pharmacists that may respectively choose to take part in LIFT. Local businesses and investors with interests in LIFT is a national level lobbying group for private sector as opposed to government interests in LIFT.

Among the major non-governmental organizations publishing on LIFT, only the health think-tank, King's Fund and CABE produce documents that do not patronise particular groups of participants in LIFT. Private documents produced at local level were obtained at the LiftCo. Because of occasional overlap between LIFT documents and literature, publications by the non-governmental organizations were, notwithstanding Scott's (1990) definition, analysed in contexts of documents and literature.

2.3.2.2 Sources of LIFT documents

The sources and variety of LIFT documents are limited possibly because LIFT could be a fairly recent initiative. If the sources and diversity of documentation reflect this, representativeness of documents selected for focused analysis may not be considered a major issue. But it was not possible to review other documents that were presumed to contain important evidence. For example, agendas and minutes of the LiftCo Board meetings, LIFT contracts, and tender documents are important yet public access to these documents is restricted due to attached sensitivity. Where possible, like in the case of LIFT contracts and tender documents, templates were reviewed to get the picture of what the actual documents may contain. In searching for the documents to analyse, the leads to potential sources and types of LIFT documents with contents likely to provide answers to the research questions were provided through asking strategic questions described in Table 2.2 below.

Table 2.2: Documentary search questions

Search question asked	Examples of sources and documents identified
1. What are the likely sources of LIFT documents?	Public and private organizations: DH, CHP, NHS, PCTs, House of Commons, PPP Forum, BMA, and LiftCo.
2. What are LIFT's major features?	Those described in: Standard Strategic Partnering Agreement – Version 5 (2003), LIFT contracts, LIFT structure, & LIFT Prospectus (2001).
3. Which institutions have researched LIFT- with what findings?	The National Audit Office (NAO), Unison, King's Fund, DH, CABE, House of Commons
4. What are the origins of LIFT and how is it defined?	NHS Plan 2000, NHS-LIFT Prospectus (2001), Business Case Approval (2005) guidance, Strategic partnering agreement Version 5 (2003)
5. What are the guiding presuppositions of LIFT?	Described in Strategic partnering agreement version 5 (2003) and LIFT Prospectus (2001)
6. What are the political & economic perspectives to LIFT**?**	Publications from: Unison, King's Fund, NAO, local businesses in LIFT, and Institute of Public Policy research (IPPR).
7. What major debates surround LIFT*?*	Value-for-money, risk management, stakeholder involvement, efficiency, increased quality, competition in procurement, increasing patient experience.

Search questions numbers 1 and 3 identified that LIFT documents could be obtained from government departments and non-governmental organizations. The actual documents identified are described in subsections 2.3.2.2.1 to 2.3.2.2.4. The documents produced at the DH and CHP contain information about LIFT's major features, its origins and guiding presuppositions as asked in search questions 2, 4, & 5. The search questions number 6 and 7 identified non-governmental organizations as sources of documents containing analytical perspectives to the major debates surrounding LIFT. The official documents especially those originating from the DH and CHP do not sufficiently articulate about LIFT's contestable aspects like its surrounding political and economic perspectives and debate. It underlines the challenges faced by the researcher in accessing and extracting relevant evidence from LIFT documents. This may restrict this research from claiming to have covered all hidden explanations for LIFT despite analysing a range of documents obtained from different organizations.

2.3.2.2.1 Department of Health (DH)

The list of LIFT documents obtained at the DH is described in Table 2.3 below. Most of the documents including those published between 2001 and 2003 can be downloaded in printable format by accessing the Archives page of the DH website. The DH facilitates easy access and no restrictions on its publications.

Table 2.3: National / Official documents retrieved at DH

Document (Year)
• About NHS LIFT (NHSLIFT/DH 4000519) • Business case approval guidance for PCTs with existing Local Improvement Finance Trusts (2009) • DH: NHS and Pharmacy (2005) • DH: Listing of All LIFT Projects - Progress to date (2008) • DH: White Paper 2010: Equity and Excellence: Liberating the NHS (2010) • Guidance for PCTs on taking shareholding in a local LIFT Company • Guidance: Strategic Partnering Agreement (2006) • Guidance for Enabling Funds for LIFT (2008) • Health Reforms in England: update and commissioning framework (2006 • LIFT Prospectus (2001) Modernising Primary Care in the NHS (2001) • NHS Plan 2000 • NHS Lease Plus Agreement Guidance for GPs (2003) • NHS: Working separately together: A guidebook for successful partnering between organisations within the NHS: Resource Guide 12 of The Commissioning Friend for PCTs (2003) • NHS LIFT Business Case Approval Guidelines - Establishing a LIFT company (2005) • NHS LIFT: Frequently asked Questions (2007) • Our Health, Our Care, Our Say: A new direction for community services: Health and Social care working in partnership (2006) • SDO Project: The Role and effectiveness of PPPs (NHS LIFT) in the development of enhanced primary care premises and services (2009)

The DH site http://www.dh.gov.uk/ contains a range of publications. These include survey and statistical reports, and descriptions of circulars and legislation. Most of the relevant documents like White Papers, LIFT Guidance and NHS Plans were retrieved from its Publications, Communications and Archives pages. The Publications page contains documents produced within the last 12 months. The Communications page contains documents, circulars and letters up to three years old. Some documents can be retrieved from both Publications and Communication pages. It is also possible to use the links provided on these to retrieve other related documents from the NHS website.

Publications used as reference in retrieved documents were directly searched from the Internet if they were not listed on the DH website.

2.3.2.2.2 Community Health Partnerships (CHP)

Unlike the DH that archives diverse materials on health services, CHP dedicates its website http://www.communityhealthpartnerships.co.uk/ to exclusive archiving of LIFT documents. The documents listed on CHP website concern general information on LIFT, various guidance including standard contracts and checklists used by local staff in ensuring compliance with guidance to achieve value-for-money in procurement. The relevant documents retrieved from CHP website are listed in Table 2.4.

Table 2.4: National / Official documents retrieved at CHP

Document (Year)
• Accounting Guidance for LIFT (2006). At: http://www.doh.gov.uk/nhslift/pdf/accounts) • General information on NHS LIFT (2003) • Guidance: Strategic Services Development Planning (2003) • Guidance for New LIFT Projects (2005) • Guidance: LIFT Communication Tool Kit (2005 • Guidance: LIFT Programme and Project management (2005) • Guidelines for operationalizing LIFT Express Projects (2005). At: http://www.doh.gov.uk/nhslift/pdf) • Guidance: NHS LIFT Lease Plus Agreement Guidelines for GPs (2006) • Guidance for use of Enabling Funds (2008) • New Guidance on approval of investment in NHS LIFT (2005). At: http://www.doh.gov.uk/nhslift/pdf) • NHS-LIFT: Operational Phase Guidelines (Transfer of PCT Estate) (2003) • NHS LIFT Starter Pack (2002) • Interactive Guide to Partnerships and Financing (2005) • Innovation and Value-for-money in LIFT (2003) • Standard Contractual Documents (2003)

CHP's website offered convenience to the current research in two ways. First, exclusively archiving LIFT documents meant that most retrieved documents were either relevant for analysis or for contributing evidence in

some other ways. Second, the website is linked to that of the DH, which was convenient for downloading and cross-checking to ensure that important documents transferred between the websites were reached.

For example, LIFT documents produced by PCTs after 2009 and LIFT Express documents are listed on CHP website. But it is only possible to download them through the DH website using links provided on CHP pages. Although CHP succeeded Partnerships UK in leading LIFT activities, its website does not list the earlier documents like LIFT Prospectus. Instead, most are archived and accessed at the DH using the "Library Search" link. But for LIFT contracts and tender documents, only their templates were available. The detailed documents are considered rather sensitive for disclosure to the public.

2.3.2.2.3 Primary Care Trusts (PCTs)

The number of LIFT documents produced within PCTs depends on intensity in developing LIFT buildings. When the current research began in 2008, LIFT buildings involved in this case-study were already open for patients for at least two years. Thus, agendas and minutes of PCT boards and management meetings contained few items on LIFT. That the minutes of PCT boards meetings are kept online for only one year further limited the number of relevant documents to review. But through searching the Archives pages of the involved PCTs, a number of documents addressing some aspects of LIFT and dated from 2006 were retrieved. As described in Table 2.5 below, most of the documents retrieved at the PCTs were minutes of PCT boards meetings although some Annual Reports, a Strategic Services Development Plan (SSDP), and a Business Case for a proposed project were also analysed.

Table 2.5: Local / Official documents retrieved at PCTs

Source	Documents
PCT-1	• Annual Reports 2006 – 10 • Board meeting: agenda and minutes 05/12/2006 • Board meeting: agenda and minutes 16/01/2007 • Board meeting: agenda and minutes 15/052007 • Board meeting: agenda and minutes 18/09/2007 • Board meeting: agenda and minutes 15/01/2008 • Strategic Services Development Plan 2008 – 17: Better Services, Better Health
PCT-2	• Annual reports 2003 – 2005 • Board meeting: agenda and minutes 19/01/2006* • Board meeting: agenda and minutes 20/04/2007* • Board meeting: agenda and minutes 21/05/2008 • Board meeting: agenda and minutes 13/11/2008 • Board meeting: agenda and minutes 09/12/2008 • Board meetings: agenda and minutes 2009 - 10 • (...) Centre Business Case Proposal (2010)

At PCT-1, the agendas and minutes of board meetings addressing LIFT were on its website (www.PCT-1.nhs.uk/documents/corporate/board-papers/) listing board meetings. The meetings were held between the end of 2006 and the beginning of 2008. The annual reports were listed on (www.PCT-1.nhs.uk/documents/corporate/publications/AnnualReport/) together with other corporate documents.

The agendas and minutes of board meetings at PCT-2 were retrieved on www.PCT-2.nhs.uk/about-us/who-we-are/PCT-2-board-meetings/. Only two meetings held on 19/01/2006 and 20/04/2007 contained issues on LIFT. Three out of seven annual reports (2003, 2004 and 2005) listed on: www.PCT-2.nhs.uk/publications/corporate-publications/) reported on LIFT.

2.3.2.2.4 Other sources of documents

Besides the DH, CHP and the PCTs, additional documents were obtained from other public sector and non-governmental sources including professional representative associations. The public sector organizations whose documents were analysed in this case included the House of Commons, National Audit Office (NAO) and Treasury. The non-governmental sources that contributed documents included the King's Fund, CABE, PPP Forum and local businesses with investment in LIFT.

Professional representative association whose publications were analysed included the BMA and Unison. The BMA's publications on LIFT are directed at its membership (GPs) participating in LIFT. Unison is a health worker trade union. Its publications are therefore directed at professional groups that likely to be affected by LIFT. The publications from the BMA and Unison provided the researcher with insight into possible discrepancies between the DH officials and health professionals' perspectives to LIFT. As previously hinted, there were occasional overlaps between LIFT documents and literature, and publications retrieved from PPP Forum's website *www.pppforum.com/documents/* were also analysed as literature. Table 2.6 lists the documents retrieved from other sources. Other miscellaneous yet informative documents were also provided by colleagues.

Table 2.6: Documents retrieved at other sources

Source: Document
• BMA General Operational Staff Committee and Partnerships for Health (PfH): Lease Plus guide for GP surgeries (2003) • BMA: Guidance for GPs: NHS LIFT - Local Improvement Finance Trust (England only) (2001) • Commission of Architecture and the Built Environment: Assessing design quality in LIFT primary care buildings (2005) • European Parliament: DG Internal Policies of the Union: Public-Private Partnerships: Models and Trends in the European Union (2006). • House of Commons: Research Paper 01/117: The Private Finance Initiative (PFI) (2001) • King's Fund. Claiming the health divide. London (2002) • King's Fund: Under One Roof: Will polyclinics deliver integrated care? (2008). • King's Fund / LSE: Investing in health buildings: public-private partnerships (2000) • Local businesses with interests in LIFT (LIFT LOBI): Submission to the DH consultation on Business Case Approval Guidance for PCTs with existing LIFTs (2008) • National Audit Office: Innovation in the NHS (2005) • National Pharmaceutical Association: understanding primary care strategy: a resource for PCT pharmacy advisers (2003) • PFI Newsletter (July 2005) • PPP Forum Conference Speech: Allan Milburn (2004): The future of PPPs • Treasury Office: PFI Meeting the Challenge (2000) • Unison Report: LIFT: What you need to know and what you need to ask: A briefing for non experts (2005). • Unison: Primary Care Reforms Glossary (2007)

2.3.2.3 Screening of the documents

Whenever possible, the documents were saved in the Endnote library that was created for their management. The documents were screened to identify the ones relevant for focused analysis. Those identified were then uploaded for storage and management in NVivo software that was used in their analysis.

The screening process revealed that Annual Reports and minutes of PCT boards meetings from 2007 to 2010 contained little information on LIFT. This may be explained by reduced momentum in developing new LIFT projects within the case-study. With such documents, only the pages

addressing LIFT were identified, copied and uploaded onto NVivo for analysis. The strategy saves time compared to reading through whole documents.

It was considered not feasible to predetermine the number of documents to analyse since the list of available LIFT documents is unknown. Some analysts like Scott (1990) argue that when analysing documents, relevance of contents and credibility of the producers vis-à-vis the research questions may matter more than quantity analysed. There is the confidence that the current research analysed different types of documents that addressed different aspects of LIFT from the perspectives of various organizations with interests in it.

The elements that were believed to provide answers to the research questions involved LIFT contexts, mechanisms and expected outcomes; and these were addressed in the selected documents. Despite providing context about LIFT, generic PPP documents were not considered for analysis because they did not focus on LIFT. Similarly, those concerned with care provision within PCTs were excluded as such activities were not within LIFT's remit.

The screening attempted at avoiding exclusive analysis of documents produced by the DH because they are intended to promote LIFT. It explains why, for example, those produced by organizations like CHP, the BMA, NAO and Unison were selected for analysis. Such documents were likely to shed light on LIFT ideas not articulated in most official documents. Some organizations tended to paste executive summaries of LIFT documents separately from the main documents on their websites. A

decision was taken to prefer the full documents over executive summaries in the analysis. Table 2.7 lists the documents that were prioritised for focused analysis.

Table 2.7: LIFT documents prioritised for analysis

Documents analysed
• BMA: Guidance for GPs: NHS LIFT - England only (2001) • DH / CHP: Business case approval guidance for PCTs with existing LIFTs (2009) • DH / CHP: Guidance for use of Enabling Funds (2008) • DH / CHP: NHS LIFT: Lease Plus Agreement Guidelines for GPs (2006) • DH: Guidance Strategic Services Development Planning (SSDP) (2003) • DH: Guidance SSDP (2005) • DH: Guidance: LIFT Programme and Project Management (2005) • DH: Guidance for PCTs on taking shareholding in a local LIFT company (2002) • DH: Implications of commissioning a patient-led NHS LIFT (2005) • DH: New Guidance on approval of investment in NHS LIFT (2008) • DH: NHS LIFT Business Case Approval Process – Establishing a LIFT Company Version 7 (2005) • DH: NHS LIFT Prospectus: Modernising Primary Care in the NHS (2001) • DH: NHS LIFT Starter Pack (2002) • DH: NHS-LIFT: Operational Phase Guidelines • DH: NHS LIFT and Pharmacy (2005) • DH / Treasury: Guidance: Accounting for LIFT (2006) • King's Fund: Claiming the health divide. London (2002) • King's Fund: Under One Roof: Will polyclinics deliver integrated care? (2008) • LIFTLOBI: Business Case Approval Guidance for PCTs with existing LIFTs (2008) • National Audit Office: Innovation in the NHS (2005) • National Pharmacists Association: understanding primary care strategy: a resource for PCT pharmacy advisers (2003) • PCT-1: Annual Reports 2002 - 10 • PCT-1 Board meeting: Agenda and Minutes 05/12/2006 • PCT-1 Board meeting: Agenda and Minutes 16/01/2007 • PCT-1 Board meeting: Agenda and Minutes 15/052007 • PCT-1 Board meeting: Agenda and Minutes 18/09/2007 • PCT-1 Board meeting: Agenda and Minutes 15/01/2008 • PCT-1 SSDP 2008 – 17: Better Services, Better Health • PCT-2: Annual Reports 2003 - 2006 • PCT-2: B-4 Maintenance Logbook and Records • PCT-2: B-4 Room utilisation booking schedule • PCT-2: (...) Business Case Proposal (2010) • PCT-2: Board meeting: agenda and minutes 19/01/2006 • PCT-2: Board meeting: agenda and minutes 20/04/2007 • PfH/DH: NHS LIFT Strategic Partnering Agreement Version 5 (2003) • Unison: LIFT, What you need to know and what you need to ask (2003)

The documents that were finally selected for focused analysis originated from different organizations distributed between the public and private sectors. They addressed different aspects of LIFT perceived to help specific groups of participants in discharging their responsibilities. Sourcing the documents widely helped in bridging gaps in evidence likely to arise from over dependence on official documents that may have failed in articulating about contestable aspects of LIFT. No time limits were imposed on publication of documents due to desire for understanding how LIFT has evolved since its launch.

An important reason for selecting documents from as early as 2001 was that they contained the original LIFT guidance. While the core ethos of LIFT may not have changed significantly, it remains important to explain why and how it has benefited from any revisions to resolve possible partialities within some documents. For example, the BMA's concern that GPs involved with LIFT needed to have their independence protected from the DH and PCTs' influence contrasts with the DH's view that the GPs are partners whose interests should mesh those of the local PCTs.

2.3.3 In-depth interviews

This research selected the in-depth interview as the second method for data collection. This subsection discusses the method's usefulness to the current research and explains how the informants were sampled and the challenges faced in organising the interviews.

2.3.3.1 Usefulness of in-depth interviews

The interview method was considered to be an effective technique in eliciting the views of operational staff at the PCTs and those at the LiftCo

and LIFT buildings. Because they are directly involved in LIFT, the researcher felt that the staff would be experts in providing information about LIFT. Creswell (2002), Mack et al (2005) and O'Byrne (2007) contend that in-depth interviews facilitate capturing perspectives of the people directly involved in a programme. Researchers using the method have opportunity to probe and seek clarifications on aspect of a phenomenon under investigation to develop an in-depth understanding of how those involved may relate to it. In this research, it was felt that asking the right people the right question would enable them in explaining how aspects of LIFT contexts and mechanisms prioritised in the interview topic guides affected them in discharging their responsibilities. The relevant answers to the research questions might then be generated using informants' personal experiences in explaining LIFT.

Mack et al (2005) state that interviews may facilitate discussion of sensitive aspects about programmes that some people may be reluctant to discuss in groups. Some analysts including Beck et al (2009) argue that controversial aspects in LIFT obstruct some staff within PCTs from discussing it openly. They are concerned about possible backlash if perceived as critical of LIFT. In light of this, the interview method was considered appropriate for the present research. It may provide the opportunity for informants to articulate the contestable aspects of LIFT from personal experience especially as the interviews were conducted with one person at a time. The benefits of collecting data through in-depth interviews in this research are explained in Table 2.8 below.

Table 2.8: Appropriateness of in-depth interviews

Purpose served	**How it was achieved in the research**
Learning about perceptions held about LIFT.	Knowledge about LIFT was derived from informants' individual perceptions and experience and not the official story.
Allowing informants to share personal perceptions and experiences with LIFT.	Informants freely expressed themselves. They indicated how they preferred to procure desired buildings and questioned the wisdom behind some LIFT guidance.
Gaining insight into how informants evaluated LIFT.	Informants drawn at PCTs, LiftCo and LIFT buildings indicated contextual factors and mechanisms perceived to facilitate or constrain LIFT and staff in discharging their responsibilities.
Addressing some of the controversial aspects of LIFT	Informants freely expressed criticisms and indicated contestable aspects of LIFT.

The interview method facilitated informants in freely expressing criticisms and their different opinions about whether LIFT's various contextual factors and mechanisms helped them in discharging their responsibilities. This was made possible by conducting the interviews with one person at a time. It is unlikely that any other method would have uncovered such sentiments from those directly responsible for implementing LIFT.

2.3.3.2 Sampling of informants

The informants prioritised for interviews were those considered to be directly involved and affected by LIFT. This restricted the sampling to PCT staff and those at the LiftCo and LIFT buildings. It was felt that the categories of staff at the operational level potentially held evidence relevant to the research questions. Such evidence involved their actual experiences in operationalizing LIFT schemes. This approach to sampling fitted well with purposive sampling that Creswell et al (2004) advocate for saving time within case-studies. The informants were pre-selected using criteria that they would be able to: represent the public and private sector

views on LIFT in their positions as PCT managers, LiftCo executive, GPs, and centre administrators. They would also have experience and active involvement in LIFT activities.

Although the PCT programme managers and centre administrators shared personal perceptions and experiences of LIFT, their views may be construed to prioritise the public sector interests in LIFT. The same applies to the GPs especially those that coordinated delivery of the individual buildings because they assume the agency of the PCTs in doing so. Investors in the LiftCo were not considered for interviews because their role is in financing and not directly involved in planning and operationalizing LIFT schemes. This role is delegated to the LiftCo. The views of the LiftCo CEO were sought at personal level and on behalf of the private sector participants including the financiers and different contractors that are hired to construct and supply post delivery services at LIFT buildings.

The desire to reach as many informants as possible meant that no fixed sample size was determined prior to the interviews. To this end, the researcher was flexible to substitute deputies or other experienced staff for unavailable primary informants where necessary. For example, a clinical officer substituted for a GP at B-4 in PCT-2 whereas an accountant substituted for the finance director at the same PCT. This provided the researcher with a picture of the extent to which information on LIFT was shared between the different staff. Eventually, 25 informants drawn from the LiftCo, the PCTs, and LIFT buildings were interviewed.

Table 2.9: Descriptions of informants and interview schedule

Informant description	LiftCo	PCT-1	PCT-2	When interviewed
Chief Executive Officer	1			November 2009 December 2009
GP / Primary Care Coordinator		1	1	PCT-1: Oct – Nov 2009 PCT-2: July - Aug 2010
Strategy & Regeneration / Public Health		1	1	PCT-1: Oct – Nov 2009 PCT-2: July - Aug 2010
Clinical Governance		1	1	PCT-1: Oct – Nov 2009 PCT-2: July - Aug 2010
Commissioning		1	1	PCT-1: Oct – Nov 2009 PCT-2: July - Aug 2010
Communications Director		1	1	PCT-1: Oct – Nov 2009 PCT-2: July - Aug 2010
Estate & Facilities		1	1	PCT-1: Oct – Nov 2009 PCT-2: July - Aug 2010
Finance		1	2	PCT-1: Oct – Nov 2009 PCT-2: July - Aug 2010
Centre Administrators		2	 1 1	PCT-1: August 2010 PCT-2: September 2010 PCT-3: October 2010
GPs at LIFT buildings		3	2	May – June 2011
Total Informants (25)	**1**	**12**	**12**	October 2009 – June 2011

The first batch of interviews in October 2009 involved staff at PCT-1 and the LiftCo. The second batch took place between July and August 2010 involving staff at PCT-2. Interviews with centre administrators were done in October 2010. The GPs at LIFT buildings were interviewed between May and June 2011. The spacing of interview batches underlines the challenges faced in securing interviews with the informants especially the GPs.

2.3.3.2.1 Sampling at the LiftCo

At the LiftCo, the CEO was the only one eligible because the company is manned by himself and the personal assistant. It would have been helpful if there were more staff to provide more perspectives to LIFT at the LiftCo. To this end, a suggestion to interview the LiftCo board chairman involved with this particular LiftCo from the beginning was made. Although it may have helped in understanding how the LiftCo may have evolved over time, the suggestion was not pursued. The reason was that the research focused at the operational rather than the policy-making level where the chairman was considered to be. The CEO was interviewed twice after the first interview was interrupted by his other commitments and each interview took up to 80 minutes.

2.3.3.2.2 Sampling at the PCTs

At the PCTs, all programme managers were considered eligible for interviews to understand how LIFT affected them in their activities. Where the managers were not available due other commitments, their deputies were used as substitutes provided they met the criteria for inclusion, especially those of experience and active involvement in LIFT. Fifteen informants drawn from different categories of managers were interviewed between the two PCTs.

2.3.3.2.3 Sampling at LIFT buildings

At LIFT buildings, only the GPs and centre administrators were considered eligible. Except one, each LIFT building had a Lead GP previously delegated responsibility by the PCTs in planning and ultimate delivery of the individual building. The centre administrators are PCT employees responsible for handling LIFT issues arising at the buildings. Their role

provides linkages between the PCTs, the LiftCo and care providers based at their buildings. For these reasons the GPs and centre administrators were considered to be important for the research. The GPs may have their own practice administrators that are restricted to facilitating clinical activities of the concerned GPs. Such staff and the rest at the buildings were not involved with the research because their duties may be outside LIFT. Although other primary care providers like retail pharmacies use LIFT buildings, the GPs were made central to the research because LIFT was primarily initiated to improve GP surgeries than pharmacies.

One of the main stated intentions of LIFT was to improve patient experiences in getting care. The DH (2011) argue that condition of the pre-existing GP surgeries obstructed patients from accessing modern and integrated healthcare services. It may have been helpful to give patients the opportunity to indicate whether LIFT supported them in increasing their experience in accessing healthcare services than before. But patients were not involved for the reasons that focus of the research was on operational level (Figure 1.0 page 9) not care provision where patients get the experience.

Initially, it was intended to involve patient liaison officers that monitor patient experiences at NHS healthcare buildings. Their views were considered to be a reasonable substitute for patient interviews. Unfortunately, no positions for patient liaison officers existed at LIFT buildings, at least within the case-study. This may not significantly affect the research for the important reason that its primary interest was in understanding effectiveness of contexts and mechanisms used to deliver

LIFT buildings as opposed to care provision activities within the PCTs. This underlined the appropriateness of GPs and centre administrators that directly monitored these aspects of LIFT in providing information needed for answers to the research questions compared to either patients or patient liaison officers.

2.3.3.3 Interview Topic Guides

The researcher used the major aspects of LIFT that were identified during documentary analyses as the framework to design the interview topic guides. The aspects identified defined the contexts and mechanisms through which LIFT schemes were to be delivered from the perspectives of officials at the DH. Therefore, the researcher decided to generate the answers to the research questions by examining the CMO configurations in LIFT based on the views of the local staff directly involved in activities to operationalise LIFT. The interview topic guides (Appendix 1.0 page 321) were therefore aligned to the research questions and gave informants the opportunity to reflect on CMO configurations encountered in operationalizing LIFT. This involved them sharing their individual perceptions and experiences on whether and how the contexts, mechanisms and outcomes recommended in LIFT guidance supported their own effort in achieving the expected outcomes.

Although different staff categories were interviewed, the researcher did not design different sets of topic guides to suit the different categories. Instead, the topic guides were used for all staff categories and informants whether at the PCTs, LiftCo or LIFT buildings were asked similar questions. This enabled the researcher to gather evidence on similar issues in LIFT from different staff categories. For example, the estate and facilities

directors, GPs, centre administrators and LiftCo CEO all commented and emphasized different issues on costs incurred at LIFT buildings. This could not have been achieved if the questions were reserved for one staff category, say the estate and facilities directors or finance directors only. The use of standardised topic guides also helped in testing the level of involvement and extent to which information of LIFT was known between the different staff categories.

2.3.3.3.1 Part 1 of the topic guides

The research sought to determine informants' perceptions of the primary care problems existing within their PCT areas. For PCT staff, how they understand the need for improvement may have influence on decisions to adopt LIFT. With the GPs, this may affect the choice to involve themselves in LIFT. The informants were expected to show that they understood, among other things, the main objectives that LIFT sought to address, its appropriateness and strengths and weaknesses vis-à-vis the tasks to be accomplished and the options considered before LIFT was adopted.

The questions here attempted at determining the benchmarks against which to assess progress achieved within the PCTs through asking about what informants believed were the issues that LIFT was intended to address. There was an assumption that strong sentiments for or against LIFT may exist among the informants to make it necessary to test how LIFT was understood. The interviews gave informants opportunity to interpret the contexts and mechanisms recommended in LIFT to indicate best ways that they thought the issues in procuring the desired buildings could be addressed.

2.3.3.3.2 Part 2 of the topic guides

Initial analysis of the documents revealed that LIFT guidance was intended to give the PCTs leads to technical support that may be needed in implementing LIFT. Due to changes in contexts surrounding LIFT, the PCTs may be faced with challenges that affect their ability to implement LIFT effectively. In their justification for using LIFT procurement, the DH (2001) argues that:

> *"The process of negotiating and procuring new buildings is currently complex and time-consuming whichever route is used. Many GPs find this a necessary but unproductive use of their time and energy"* (page 23).

The perspective of the DH officials is that LIFT provides operational staff with technical support needed in dealing with challenges faced in procuring buildings. Part 2 of the topic guides was therefore designed to have three subsections where among other things, the first subsection asked about the forms of internal (within PCT) and external support that the informants thought they received to progress with LIFT, the organizations with influential roles, and those that authorised what aspects of LIFT and how they did so. Asking about these issues helped in developing an understanding of the existing support mechanisms and how they influenced progress in activities leading to construction and successful delivery of individual LIFT buildings within the case-study.

Within Part 2, the second subsection asked about LIFT projects completed and outstanding, time taken to deliver individual buildings, how the buildings were financed, and the organizations that promoted the financing packages. The researcher expected that within a decentralised procurement strategy, and in light of the DH's perception of LIFT quoted above, major participants like programme managers, GPs and centre

administrators interviewed would be conversant with the financing packages used and time taken to deliver their buildings. The questions helped in reconciling LIFT objectives, support provided, and accomplishment of targets within the case-study.

The current research sought to evaluate how activities between PCT staff and the LiftCo presented challenges that influenced progress against LIFT outcomes. This is because of some analysts' (e.g. Beck et al 2009) recognition that lacking skills in managing PPPs presented challenges for PCT staff in making LIFT effective. Therefore, within Part 2 of the topic guides, the third subsection asked about how the LiftCo hired the different contractors involved in LIFT, the guidance followed in hiring the contractors, and discretion that the informants thought they were allowed in varying LIFT guidance according to local needs. The informants reflected on how and in what ways activities by the DH and its agents like CHP and locally based SPBs, and those working through the LiftCo supported local effort towards LIFT objectives. The questions helped in developing an understanding of where to attribute any problems in LIFT between its guidance and management activities at the operational level.

2.3.3.3.3 Part 3 of the topic guides

In the process of documentary analysis, it became apparent that success with LIFT depended on the PCTs and LiftCo adhering to their obligations. It raised the need to understand how staff at the PCTs and LiftCo went about with their commitments to LIFT and ensured that they delivered their obligations. Pursuant to this, Part 3 of the topic guides was designed to have four subsections seeking to understand the decision-making processes and the LiftCo's role in solving procurement problems within

PCTs. The first subsection asked informants to specify centrality of the LiftCo's remit to the PCTs' needs. Informants were further asked to relate between their LiftCo's skills sets and perceived quality of LIFT buildings. Since the LiftCo's activities revolve around specifications in the strategic partnering agreement, lease-plus agreement, and on facilitating the utilization of LIFT buildings, the contexts and mechanisms involved may either facilitate, or hinder progress against LIFT objectives. Or they may influence unexpected or unwanted outcomes within the PCTs. Thus, aside from helping to understand whether what the LiftCo was expected to deliver was clearly defined so that performance could be assessed on the basis of stated rather than implied targets, responses to the questions provided pointers to how informants interpreted quality and improvement in procurement through LIFT.

Because it is argued in the guidance (DH 2001, DH/PfH 2003) that using LIFT facilitates the PCTs in increasing efficiency through transferring risks in procurement to the LiftCo, the second subsection asked informants to identify procurement services and commercial activities that were transferred from the public sector to the LiftCo. Informant responses helped in confirming whether and how LIFT effectively transferred risks given the DH officials' claims.

The third subsection investigated whether LIFT's achievements were assessed formally within the PCTs. Informants were asked to comment on whether and how any economic effectiveness analyses of LIFT buildings were done, and how they thought the LiftCo influenced synergy and stakeholder engagement in delivering LIFT buildings. Their responses

helped in understanding whether LIFT increased capacity in procurement within the PCTs. The fourth subsection sought indications about whether the pattern of changes in healthcare within the PCTs was attributed to LIFT. This helped in understanding LIFT's wider impact including whether LIFT buildings had a multiplier effect on investment within the PCTs areas.

2.3.3.4 Conduct of the interviews

At the PCTs, interviews were arranged by personal assistants to the contact directors. Those with the centre administrators were arranged from the LiftCo. The researcher arranged those with the GPs. All interviews were conducted face-to-face to give informants opportunity to share their individual perceptions and experience with the information sought. All the questions on the topic guides were addressed to all informants and the interviews were completed at one sitting. The informants had the freedom and appeared comfortable in expressing opinion including their lack of knowledge about the issues discussed although some especially those at the PCTs seemed at first to be cautious in expressing their opinion. This disproved the initial fear that the informants may be uncomfortable with the discussions due to likely sensitivity attached to some aspects of LIFT.

Some PCT managers and lead GPs believed that they had ethical responsibility to criticise aspects of LIFT that may be inappropriate for their activities. This presented challenges for the researcher in ensuring that informants especially those motivated to portray LIFT favourably or negatively did not influence what topics to discuss at the expense of the topic guides during the interviews. All questions prioritised in the topic guides were addressed and the entire interviews were tape recorded. Part

of the data analysis and interpretation involved distinguishing the facts from opinions.

The duration of interviews varied according to how informants were involved with LIFT activities. The average time per interview was 70 minutes but took longer with the GP/primary care coordinators, estate and facilities directors, the lead GPs and the LiftCo CEO. The interviews with directors for communication and corporate affairs averaged 45 minutes and may suggest that the departments are less involved in LIFT.

Tape recording the interviews facilitated the cross-checking of responses to ensure that potential distortions were avoided during transcription. Transcription done within 48 hours of every interview served as early stage analysis to make sense out of the data. It also helped in relating the interview responses to the research questions. For security, all the taped records were stored as password protected uploads onto a desk top computer.

2.3.4 Tours of LIFT buildings

The research used observations as the third method for data collection. Given the DH's (2001) argument that the development of LIFT was influenced by poor condition of primary care buildings, the observation method was considered to be an effective technique in cross-checking the improvements achieved. Among other concerns, pre-existing buildings were blamed for risking patient congestion due their small sizes, inconveniencing patients by not being co-located with a pharmacies and important social services, and not sustaining quality services due to poor maintenance (DH 2001). Officials at the DH (DH/PfH 2003) stated that

almost half the facilities in inner city areas were not fit for purpose because they adapted residential buildings that potentially restricted physical access by the disabled patients. The researcher considered tours as a helpful approach to assessing whether and how LIFT buildings were a step improvement in solving these problems.

2.3.4.1 How the buildings were chosen

At the time of the research, the case-studied PCTs had seven operational LIFT buildings. It was decided to involve only the buildings where significant maintenance work would neither inhibit the tours nor obstruct their outlook. The buildings needed to provide a range of services as opposed to walk-in centres that may be too small to adequately inform the research. At least one building was chosen from each PCT. For convenience of the research, it was decided that the buildings to be toured would also offer the GPs and administrators needed for interviews.

With guidance from the LiftCo that knew about situations at LIFT buildings, including the GPs and centre administrators with sufficient experience of LIFT, only three buildings between PCT-1 and PCT-2 were considered to meet the inclusion criteria. Since two of these were in PCT-1, it raised the concern that the selection favoured the experiences of PCT-1 than PCT-2. The concern was addressed by involving a LIFT building from a neighbouring PCT even though that PCT was not a participant in the case-study. That building is owned by the LiftCo case-studied meaning its involvement may not distort the findings. The distribution of the buildings eventually case-studied is shown below.

Table 2.10: LIFT buildings selected for the research

Responsible PCT	Number involved	Building code
PCT-1	2	B-1 & B-2
PCT-2	1	B-4
PCT-3	1	B-3
Total	**4**	

The codes given to the buildings follow the order in which the tours were made, meaning B-1 in PCT-1 was toured first followed by B-2. The third tour involved B-3 in neighbouring PCT-3 and B-4 located in PCT-2 was toured last.

2.3.4.2 Features observed at the buildings

The pre-existing GP surgeries were criticised for being small and cramped, poorly maintained, and too scattered for delivering improved and integrated primary care (DH 2001, DH/PfH 2003). This research involved tours in order to observe whether features at LIFT buildings showed evidence for increasing patient experiences by removing obstacles to accessing better services at improved buildings. Hence prioritising features within the service areas described in Table 2.11.

Table 2.11: Features observed at LIFT buildings

Service area	Features observed and performance indicators
External area	Entrance directions; parking spaces; condition of walkways; external outlook; lighting; access for wheelchairs; potential hazards; and proximity to by public transport.
Reception area	Manning arrangements at the receptions; facilitation of patient flow; confidentiality for patients; staff security; availability of phoning facilities for patients; and internal lighting.
Waiting area	Waiting area's size in relation to congestion; space to manoeuvre wheelchairs and children's pushchairs; access to toilets; signposts for the GPs; clarity of information displays and patient calling.
Treatment rooms	Room sizes in relation to types of care; equipment including for heating and cooling fixtures; patient privacy; and whether rooms are shared or GP have their own room.

Service area	Features observed and performance indicators
Staff facilities	Staff resting facilities, socialisation (e.g. prayer) and refreshment rooms; working area space in relation to congestion control.
Buildings' comfort	The buildings' heating, cooling, ventilation, lighting, and furniture; general finishes that indicate quality; levels of internal & external noise impacting on patient comfort.

LIFT buildings were intended to be delivered in context of regeneration of infrastructure in deprived areas (DH/PfH 2003). Investigating their external condition like the outlook, safety of the walkways and potential hazards helps in understanding whether LIFT improved on previous problems. The external condition at the buildings may be also the basis on which patients develop impressions about how they are valued by the health authorities. There was interest in observing whether LIFT complied with the DH's desire to bring primary care "nearer home" in line with patient preferences expressed in *Our Health, Our Care, Our Say* (DH 2006b).

The decision to observe condition of the reception and waiting areas was influenced by the finding from documentary analysis that the old surgeries experienced patient congestion. Officials at the DH (DH 2001) argued that due to their small sizes against a background of increased demand for services, most GP surgeries were cramped and restricted physical access by disabled patients that used wheelchairs and pushchairs. Through observing the reception and waiting areas, you could determine whether their conditions promoted patient circulation to reduce congestion and potential dilapidation of fixtures. Patient experience is also enhanced by the general comfort that the buildings may offer. Hence, among other things, checking condition of the heating, cooling and internal and external

noise impacting on patients using LIFT buildings. The observations helped in understanding whether LIFT buildings were designed to reflect the aspirations of the PCTs. Where some GPs required significant modifications to their buildings, you could argue that the LiftCo had failed in its interpretation to design and deliver buildings along specifications in the SSDPs.

2.3.4.3 Conduct of the tours

All tours were done in the company of centre administrators considered appropriate to explain circumstances of the features observed in the different service areas. Their escort facilitated easier access to the service areas and helped in minimising disruptions especially at the treatment rooms. The conditions in the consultation rooms were observed at the time of interviewing the GPs with the concerned GPs rather than the centre administrators explaining circumstances of the features observed. The nature of the service areas prioritised for the tours meant that no distortions were risked by the centre administrators giving access to only the features that favourably portrayed LIFT.

Aside from the service areas described in Table 2.11, observations were made to check if the buildings had specific arrangements for the security and health and safety of staff and patients. For example, condition of alarms for emergencies and burglary, and where applicable, arrangements for the storage of staff and patient personal belongings and for hazardous substances used at the buildings were observed. The duration of tours averaged 60 minutes per building.

2.3.5 Alignment of the methods to research questions

As portrayed in subsection 2.3, this research used a mixed-methods research design comprising documentary reviews, in-depth interviews, and tours at LIFT buildings. The methods were aligned to the research questions (subsection 1.1.3 page 3) to generate the relevant answers. Table 2.12 shows how the methods were each aligned to the research questions.

Table 2.12: Alignment of the methods to the research questions

Research method used	Research questions addressed
Documentary reviews	(i)
In-depth interviews	(ii), (iii) and (iv)
Tours of LIFT buildings	(ii), (iii) and (iv)

The first research question sought to understand the beneficiaries of LIFT and outcomes through which they were expected to benefit from the perspectives of DH officials who wrote LIFT guidance. The answers were obtained through documentary analysis. The second research question investigated factors that operational staff perceived to facilitate and/or constrain them towards LIFT objectives within their PCT areas. The fourth question investigated factors within the case-study that informants perceived could help them in discharging their responsibilities. The third research question was about what could be learnt from the case-study experiences to inform future schemes and other PCTs implementing LIFT. The answers to research questions number (ii), (iii) and (iv) were obtained through in-depth interviews and observations on tours at LIFT buildings cross-checked against those obtained through documentary analysis.

2.3.6 Fieldwork process

This subsection explains the researcher's practical activities done to obtain access to the case-study. The access was needed to collect data through the interviews and tours at LIFT buildings. The process of getting documentary evidence has already been explained in subsection 2.3.2.2 (page 116).

2.3.6.1 Access at the PCTs

In the company of the academic supervisors, the researcher arranged meetings to introduce the research to the contact directors at PCT-1 and PCT-2. The objective was to inform them about the purpose of the research, its proposed methods, inviting participation of the PCT managers and agreeing on the interview schedule. The existing research and other relations between the PCTs and university facilitated obtaining written agreements supporting this research. All programme managers at the PCTs were eligible for interviews. A schedule for data collection was used by the personal assistants to the contact directors in confirming the timing for interviews with programme managers who agreed to be interviewed at each PCT. Introducing the research prior to fieldwork helped in clarifying questions and concerns that the informants may have had over discussing perceived sensitive aspects of LIFT. As a result, those that agreed to be interviewed appeared comfortable about it and were able to share information and documents that they believed to contain relevant evidence on LIFT within their PCT areas.

2.3.6.2 Access at the LiftCo

Recognising that past research (e.g. Pollock et al 2006) criticised some aspects of LIFT, there was concern that the LiftCo may be unwilling to

support the current research. There was the need to persuade the LiftCo Chief Executive Officer (CEO) to support the research as a neutral academic exercise rather than a fault finding on the LiftCo. This was achieved by clarifying the purpose of the research, its proposed methods and inviting the LiftCo's participation at a meeting with the CEO. The LiftCo expressed commitment to facilitate the research and provided written agreement to this effect.

2.3.6.3 Access at LIFT buildings

The LIFT buildings included in the research were identified by the LiftCo based on convenience that the buildings offered for progress with the research and staff experience with LIFT. The researcher did not formally introduce the research at the buildings as done at the PCTs and the LiftCo. This was done by the LiftCo despite the centre administrators and GPs to be interviewed being PCT employees and independent operators respectively. The interviews with centre administrators were coordinated by the LiftCo CEO's personal assistant and the researcher coordinated those with the GPs.

2.4 Data Analysis

The issues pertaining to data analysis are discussed in three subsections. Subsection 2.4.1 explains approach to the analysis. Subsection 2.4.2 explains how documentary evidence, interview transcripts and observation notes were extracted and coded in NVivo. How the RE principles were applied in data interpretation is explained in subsection 2.4.3.

2.4.1 Approach to the analysis

The challenge in data analysis was in deciding which data to prioritise out of the large amounts collected. The collected data was in some cases broad and indicated good, neutral and occasionally negative experience of LIFT. The idea was to neither accept nor reject the collected evidence at face value. Doing so risked prioritising the perspectives of certain individuals or group of informants over those of the others in explaining LIFT. A balanced explanation needed the evidence to be localised to understand the actual experiences within the case-study by distinguishing the facts from informant opinions by means of an analysis framework designed to analyse documentary notes and interview transcripts.

2.4.1.1 Analysis framework

The analysis framework in Table 2.13 helped in identifying and describing risks, challenges, and factors that the informants perceived to cause LIFT outcomes experienced in their areas. It facilitated in tracing the cause and effect relations between LIFT objectives, contexts, and mechanisms. RE principles were then mapped onto the emerging relations to provide answers to the research questions.

Table 2.13: Analysis framework for cause-effect relations in LIFT

LIFT features	Verifiable Indicators	Means of verification	Assumptions
Objectives	Descriptions of how LIFT helps PCTs to improve buildings	Information provided in official documents	Major LIFT documents are in public domain
Contexts	Specific conditions in LIFT that made PCTs effective	Review documents and interview responses to identify factors that promote or hinder LIFT	There are past LIFT reviews to learn from. Stable environment exists within PCTs.
Mechanisms	The ways or activities through which the resources for LIFT are used to make PCTs effective in procuring buildings.	Review documents and interview feedback to identify inputs and activities used towards LIFT objectives	There are past reviews to learn from. Stable environment exists within PCTs. There is continuity in flow of funds to support PCT efforts.

LIFT features	Verifiable Indicators	Means of verification	Assumptions
Inputs	Resources (money, skills and expertise) and ideas needed to implement LIFT.	Reviewing documents and feedback from interviewees	There is continuity in flow of funds and PCT support for LIFT.
Outcomes	Reported effects of context, mechanism, inputs and activities on LIFT's goal.	Using RE principles to interpret interviewee feedback on LIFT features.	External environment is stable enough to attribute local outcomes to LIFT

The analysis framework helped in making sense of the data to develop knowledge about LIFT's most influential contexts and mechanisms plus some of its hidden effects from informants' perspectives. LIFT works by providing contexts and mechanisms conducive for helping PCTs in improving procurement of their buildings. The evidence about how the contexts and mechanisms contributed to improvements in procurement within the case-study was verified through analyses of documents and informant feedback. RE principles were then applied in interpreting the outcomes to get relevant answers to the research questions. Interpretations of the outcomes were done under variable assumptions that the researcher made for each LIFT feature being analysed.

The advantages of the analysis framework were twofold. First, it facilitated exploring to understand causality between specific LIFT contexts, mechanisms, and operational problems experienced within the case-study. Second, evidence about how, why, and under what conditions LIFT produced specific outcomes was derived from actual experiences of the different categories of informants involved. This is described in Tables 3.5 (page 176) to 3.13 (page 205).

2.4.2 Evidence extraction and coding

The documents prioritised for analysis (Table 2.7 page 125), interview transcripts, and notes on observations at LIFT buildings were managed and analysed using NVivo 9.0. Occasionally, some documents (e.g. Annual Reports) were too huge for uploading onto NVivo in which cases only sections with the relevant information were copied and uploaded as MS Word files. The uploaded materials had large amounts of textual data likely to present challenges in analysis if handled manually. NVivo offered the advantage of having the capacity to store, and efficiency to analyse many documents including interview transcripts. It also facilitated a systematic approach to coding complex and broad issues from several documents obtained from a variety of sources for analysis without having to create numerous files. Within NVivo, it was possible to retrieve the data for analyses and manipulation needed in linking between ideas that emerged during data interpretation.

Data extraction focused on identifying issues that provided answers to the research questions. Among other things, evidence needed to indicate how LIFT responded to the influence of factors surrounding its implementation, and to identify what information could help in suggesting improvements needed in targeting and managing future LIFT schemes. Such evidence identified inputs and activities (described in the analysis framework) embodied in contexts and mechanisms as descriptors of how LIFT responded to influence factors surrounding its implementation. The range of such issues in LIFT documents and those raised during the interviews meant that diverse sets of codes for the evidence, examples of which are shown in Table 2.14, were initially created.

Table 2.14: Examples of codes used for the evidence

• Risk management • Relations and culture • Quality of buildings • Competition and provider diversity • Value-for-money • Private sector skills and expertise	• Technical support • Cost containment • Influence • Governance arrangements • Discretion • Information dissemination

Some elements of LIFT contexts and mechanisms (e.g. the different types of risks or how certain risks were to be managed) are explicitly defined in the documents and interview transcripts making it straightforward in creating relevant codes. In a number of cases, interpretative codes had to be created especially where the issues were just described in context of processes or particular LIFT activities. The codes on *"relations and culture", "conflict of interest"* and *"private sector skills and expertise"* are examples of those created through interpretation of descriptions. Thus, the coding used in this research may not be the exhaustive list considering that some of LIFT's critical issues could be obscure in official documents and possibilities exist for people to differently code LIFT issues in one document due to lack of consensus in interpretations of some issues.

Notwithstanding this, the coding attempted at closely matching the ideas discussed in the different documents and those mentioned during interviews to the created codes. Figure 2.1 illustrates the different types of evidence searched for matching to the code *"value-for-money"*. It illustrates that value-for-money may be measured using different indicators such as whether LIFT use comparable government buildings in assessing feasibility of projects, or economic and strategic benefits that LIFT may bring within PCT areas vis-à-vis overall costs met by the concerned PCTs.

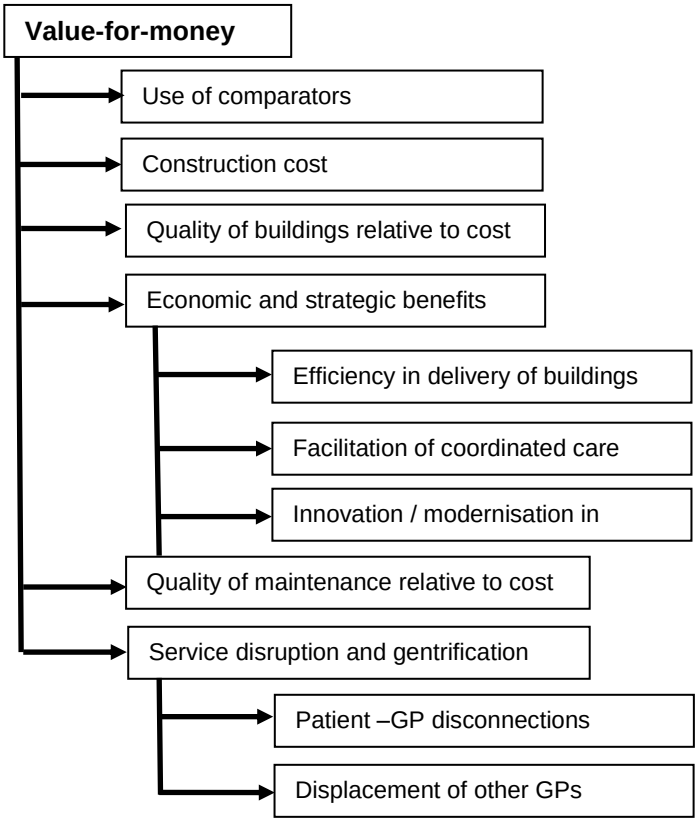


Figure 2.1: Examples of NVivo nodes – Value for money

The codes initially involved using unrestricted branch-codes that were later reduced through repetitive grouping and cross-sharing between appropriate codes in rounds of analyses. In the process, some codes were renamed while new ones were created until those comprehensively explaining related ideas were finally determined and categorised into LIFT contexts, mechanisms, and outcomes during interpretation of the findings. The evidence from observations at LIFT buildings was cross-checked against informant responses in the interviews for coding at the relevant codes that supported or refuted whether LIFT had the ability to improve procurement. For example, evidence from observing the sizes and designs of treatment rooms and reception and waiting areas was coded on the codes explaining quality of LIFT buildings. This is because descriptions in the documents are that LIFT was to support the PCTs in procuring

buildings with features that promote physical access by all types of patient (DH 2001, DH/PfH 2003).

2.4.3 Using RE principles in data interpretation

The use of RE principles concerns interpreting data to develop a real-world based understanding of evidence about how processes within a programme (contexts and mechanisms) may interact to produce the observed outcomes (Byng 2005, Kazi 2003, and Pawson 2006). It is considered important for researchers to clarify why and how programme outcomes whether expected or unexpected benefit the different groups of participants in different ways. In this research, data interpretation involved distinguishing facts from individual opinions to identify the groups of LIFT participants that the informants had consensus on as benefiting or losing from specific contexts surrounding LIFT and mechanisms used in procuring LIFT buildings. This was then reconciled with what officials at the DH had anticipated LIFT to achieve.

Aside from providing answers to the research questions, the findings could identify the ideas to make central to the theory explaining how LIFT is understood to operate based on perspectives of informants within the case-study. Pawson (2006) argues that this is the ultimate intention of data interpretation in research informed by RE principles.

Initial documentary analysis revealed that LIFT was intended to decentralise aspects in procurement by supporting PCTs towards improving the condition of buildings through competitive procurement that transferred related risks to the LiftCo and increased efficiency using private sector skills and expertise. These are some of the ideas tested

using RE principles to understand their alignment or contrast to what actually obtained within the case-study - a way of prioritising real-world experiences shared by the people interviewed because they are directly involved and affected by LIFT.

The use of RE principles in data interpretation was considered to be useful in highlighting how circumstances specific to the PCTs influenced other important outcomes to feed into the theory explaining LIFT. It was recognised that changes within the economy and the NHS were likely to affect LIFT outcomes. For example, loss of experienced staff at government departments with strategic roles in LIFT may prevent the PCTs from getting sufficient technical support needed in LIFT. This may mean the PCTs risk missing on some important expected outcomes like improvement in risk management or better value-for-money. The potential effects of all possible changes in social and economic factors surrounding LIFT needed to be accounted for in interpreting evidence about the outcomes experienced within the case-study. Using RE principles facilitated this including exploring whether LIFT's capacity to produce benefits depended on complexity of its surrounding contexts and mechanisms. It is possible that LIFT outcomes are not always along what officials at the DH expected because in reality, some of its contexts and mechanisms cause participating groups to benefit in different or unintended ways.

This is not to suggest that RE principles made it easier to interpret and explain some of the evidence. Some documentary sources of evidence on LIFT tend to contain hidden interests of their producers not easy to

interpret in research. For example, even RE inspired analyses may have difficulties in interpreting the salient meanings behind designs of some of the buildings. Their meanings may be only known to the LiftCo. Notwithstanding this, RE principles are considered as important in understanding whether or not explanation derived from data interpretation match what was initially understood about a programme (Pawson 2006). The researcher attempted at thinking about the broader theoretical and practical implications of this research by adjusting the initial middle range theory, hoping that the revised one may help informants and others externally in making informed decisions to improve LIFT.

2.5 Research ethics

The important ethical issues in qualitative research relate to minimising potential harm to participants and ensuring intellectual coherence of research findings (Marshall & Rossman 2006, Mack et al 2005, Kvale 1996). Mack et al (2005), state that harm to research participants is not only about physical injury but also threat to integrity and other forms of backlash people may suffer upon participating in research. In seeking to explain intellectual coherence of qualitative research findings, Kvale (1996) and Marshall and Rossman (2006) consider it ethically important for researchers to aim at minimizing potential biases that may exist in the design or during implementation or analysis of the collected data. The steps that the researcher took to have this research cleared and to ensure ethically sound data collection, data analysis and interpretation and objectivity of the findings are explained below.

2.5.1 Research clearance

Initially, the researcher contacted the Research Unit at PCT-2 for advice on ethical issues in the current research. In their view, the research did not require ethical clearance from the DH because it did not involve patients. The University Research Ethics Committee (REC) was then approached to provide the clearance. The REC assesses ethical issues of all research proposals to ascertain intellectual coherence of proposed research. The necessary ethics application forms including a personal risk and health and safety form were completed and backed with letters from the PCTs and the LiftCo indicating their support of the research. The REC considered these submissions sufficient for this research without the researcher having to orally defend the proposal before the committee.

2.5.2 Data collection

The steps taken to ensure ethically sound data collection were previously discussed under conducts of documentary analysis, in-depth interviews, and tours of LIFT buildings. Within documentary analysis, it was mentioned that steps were taken to review templates of some restricted documents like LIFT contracts and tenders that were perceived as too sensitive to share with the public. This helped the researcher to have a feel of the actual documents.

With regards to the interviews, all interviewees were informed about the purpose of the research prior to their volunteering. It is argue that informed consent enables interviewees to self-judge their ability to contribute to research (Mack et al 2005). In this research, it helped in reducing risks of the interviewees withholding important information about LIFT. This is because they realised that the research did not threaten their interests in

light of the sensitivity attached to some aspects of LIFT. The tours of LIFT buildings were timed to avoid inconveniencing the GPs and other service providers by disturbing their routines.

2.5.3 Data analysis and interpretation

Previously, subsections 2.4.1 to 2.4.3 explained the steps taken in minimizing potential biases in the conduct of data analysis and interpretation. One of the ethical considerations involved giving codes to the concerned PCTs and LIFT buildings in data analysis, interpretation, and reporting of the findings. This was in line with anonymity promised to participants at beginning of the research. The case-studied PCTs were coded as PCT-1 and PCT-2. The codes B-1, B-2, B-3 and B-4 were used to anonymise the involved LIFT buildings throughout the research.

All the individual informants were promised confidentiality of their contributions. Accordingly, their names and circumstances that may make them identifiable were removed. Throughout this research, informants are identified by their positions – e.g. GP/Primary care coordinator, Lead GP or Clinical Officer. The raw and processed data that they contributed was stored as password protected files. Within embedded case-studies, there may be challenges in anonymising the places and individuals. Because of the many units of analysis involved, some of the units may remotely suggest the identities intended for hiding (Yin 2009). In this case-study, it was fairly easy to anonymise the PCTs, LIFT buildings and informants. But the fact that the PCTs may have slight variations in the titles held by people with similar responsibilities may make anonymising informant positions not entirely foolproof. But this was not considered to be a

problem since coding the PCTs, the buildings, and avoiding informant names meant that citing the positions may effectively disguise identities.

2.5.4 Objectivity of the findings

The criterion of objectivity of the findings is a major consideration in study design, data collection, and data analysis and interpretation (Marshall and Rossman 2006, Creswell 2002, Guba and Lincoln 1998). It questions about accuracy and credibility of the findings from the perspectives of the researcher, or participants or readers. While recognizing the challenges in ensuring objectivity of findings from qualitative research, Guba & Lincoln (1998) consider it ethically unsound if the findings result from subjective bias of the researcher rather than being a product of the research. In this research, informants were selected on strength of their official positions rather than private interests in LIFT. Throughout the research, data interpretation sought to ensure that the views central to the findings were traceable back to informants not the researcher.

2.6 Research Timeline

The research timeline shows that it was registered in August 2008. It was introduced at the LiftCo in March 2009 and at PCT-1 in April 2009.

Table 2.15: Timeline of research activities (2008 -2013)

Research activity / Year	2008	2009	2010	2011	2012	2013
Registration of PhD	Aug					
Introductions: LiftCo PCT-1 PCT-2		 March April	 June			
Documentary review	Aug →	→	→	→	→	Ongoing
Fieldwork: LiftCo PCT-1 PCT-2 Centre administrators GPs		 Oct Oct - Nov	 Jul – Aug Jul – Oct	 Apr – Jun		
Data entry and analysis		Oct →	→	→	→	→
Writing of the Thesis			Jan →	→	→	July
Submission of Thesis						August

The actual fieldwork started in October 2009 and ended in June 2011. Its duration was prolonged by challenges in getting the GPs to commit themselves for interviews. The fieldwork coincided with DH phasing out PCT role in commissioning primary care through the Health and Social Care Act 2012. Given centrality of the PCTs in this research, there was some urgency to complete fieldwork while they still existed. To this end, part of the data entry and analysis was done in conjunction with the fieldwork. The thesis was eventually submitted in August 2013.

SECTION 3: THE FINDINGS

This research explored with staff involved in executing LIFT schemes their perceptions of why LIFT produced outcomes that they experienced within their PCT areas. The researcher believed that an in-depth understanding of LIFT based on operational staff's experiences would allow DH officials to proceed from an informed perspective in considering ways of reviewing the guidance to make them more supportive on LIFT activities. This belief resided in that the research informants may highlight LIFT's contextual factors and mechanisms perceived to facilitate or constrain, and those perceived to be helpful in making it more effective.

This section presents that findings obtained from analyses of LIFT documents; interview scripts from 25 informants drawn at two PCTs, the LiftCo and four LIFT buildings; and observations during tours of four LIFT buildings. From the documents analysed and through interviewing the informants, the researcher obtained accounts of the contexts, mechanisms and outcomes (CMO configurations) expected and experienced in LIFT. The answers to the research questions were then derived through coding of categories of evidence in NVivo during to understand the CMO configurations central to LIFT as experienced within the case-study.

The findings are presented and explained in the form of CMO configurations. Explanations of how the CMO configurations were constructed and the ways in which the overall findings could be interpreted to answer the research questions are provided.

Presentation of the findings is organized around a discussion of key answers to the research questions one by one. The major finding is spelt out first for each research question followed by explanations of the evidence about how each question might be answered. The findings are presented in subsections 3.1 to 3.5. Subsection 3.1 presents the CMO configurations answering research question (i). Subsection 3.2 analyses the CMO configurations answering research question (ii). It identifies what informants thought were the facilitating and constraining factors in LIFT. Subsection 3.3 analyses the CMO configurations answering research question (iii). It identifies what informants perceived were the factors that may help them to progress against LIFT outcomes. Subsection 3.4 presents the findings from the tours of LIFT buildings. Subsection 3.5 synthesizes the findings to construct a revised middle range theory explaining how LIFT was understood to operate at least in the case-study.

As previously indicated, informants were promised anonymity and confidentiality of information. Thus, informant names and those of the PCTs, LIFT buildings and anything that may closely identify the data sources have been avoided in presenting the findings. Informants are identified by their professional titles (e.g. estate manager, centre administrator, or lead GP) together with their PCTs or buildings respectively coded as PCT-1 and PCT-2, and B-1, B-2, B-3 and B-4.

3.1 CMO configurations answering research question (i)

The evidence to answer research question (i) was obtained through documentary analysis. The contents of the documents prioritised for analysis indicate what DH officials that designed LIFT and wrote its guidance perceived were its key CMO configurations.

3.1.0 Construction of CMO configurations - research question (i)

The CMO configurations for evidence about the first research question were constructed through documentary analysis. The analysis identified repeatedly emphasized contexts and mechanisms that the DH officials perceived as fundamental to maximising benefits from LIFT if operational staff were to comply. This implies that the contexts and mechanisms may be viewed as the benchmarks for what DH officials perceived to facilitate achievement of LIFT objectives. The analysis framework developed in the research (Table 2.13 page 147) was then applied to understand causation between major contexts, mechanisms and outcomes in evaluating LIFT's ability to facilitate progress.

Most of the CMO configurations were derived from the following documents:

- NHS Local Improvement Finance Trust Prospectus (DH 2001);
- NHS-LIFT Strategic Partnering Agreement: Version 5 (DH/PfH 2003);
- NHS-LIFT and pharmacy (DH 2005, Gateway Ref: 5535); and
- NHS-LIFT Business Case Approval Process – Establishing a LIFT company Version 7 (DH 2005, Gateway Ref: 5268);
- LIFT Guidance for GPs: NHS England only (BMA 2001)

The DH officials perceived that the guidance provided would deliver benefits for LIFT participants chiefly: the PCTs; primary care providers; investors in the LiftCo; and contractors in LIFT (DH 2001, DH/PfH 2003, DH 2005). These participants have different roles in coordinating, financing, managing and providing services at LIFT buildings. Depending on their roles, the participating groups may require specific contexts and employ unique mechanisms to achieve LIFT outcomes. The guidance issued by the BMA (2001), for example, provide GPs with advice on how they could minimise risks when using LIFT mechanisms recommended in documents written by DH officials.

Schedule 17 Part 1 of the strategic partnering agreement Version 5 (DH/PfH 2003) provides the basis for an initial description of CMO configurations in LIFT by describing how LIFT participants are expected to perform their roles. The LIFT Prospectus (DH 2001, page 22-29) is also explicit about the benefits that the participants may realise through LIFT. These documents describe LIFT's expected outcomes more than the corresponding contexts and mechanisms. The analysis framework described in subsection 2.4.1.1 (page 147) was used in examining the expected outcomes aligned with the different participating groups. The aim was to determine the relevant contexts and mechanisms which the groups employed to achieve LIFT objectives. The findings are therefore presented in the reverse order to the norm in RE. In the illustrative tables, the expected outcomes are described before their relevant mechanisms and contexts. This distorts neither meaning nor logic in causation between contexts, mechanisms and outcomes. The RE principles permit such flexibility in making sense of a programme's features (Pawson 2006).

3.1.1 Key Finding 1: *Aside from the PCTs, LIFT was designed to benefit a range of other participants within the NHS.*

The overriding finding of this research is that LIFT is primarily intended to benefit PCTs through improved procurement of healthcare buildings. But its implementation encourages other players, chiefly primary care providers, investors in the LiftCo, building contractors and service-suppliers to involve themselves in procurement of local primary care buildings. The DH officials believed that these groups would make LIFT work provided they complied with the guidance (DH 2001, DH/PfH 2003). This finding suggests that LIFT decentralises roles in procurement of healthcare buildings by providing CMO configurations conducive to PCTs and other players to benefit as follows:

3.1.1.1 CMO configurations affecting PCTs

Table 3.1 draws on documents that were analysed to summarise findings on expected outcomes, mechanisms used, and surrounding contexts that DH officials anticipated would affect PCT activities in LIFT. Most of the expected outcomes were explicitly stated in the documents analysed. Mechanisms are the ways through which LIFT works to achieve the expected outcomes, and contexts are the environment or conditions under which the mechanisms work for LIFT to produce the expected outcomes. The terms “mechanisms” and “contexts” were seldom used explicitly in the documents making it necessary to tease them out from elaborated descriptions of the expected outcomes.

Table 3.1: CMO configurations affecting PCT activities

Expected outcomes	Mechanisms	Contexts
PCTs will have up to date Strategic Services Development Plans (SSDPs) at all times (DH 2001, DH/PfH 2003).	The LiftCo participates in auditing the condition of buildings to match patient demands.	There is external technical support in developing SSDPs within PCTs.
		PCTs prioritise engaging the LiftCo in planning improvements at healthcare buildings.
Stock of higher quality buildings is increased (BMA 2001, DH 2005).	Participants in LIFT value quality and reflect priorities in condition of LIFT buildings	The LiftCo prioritises equipping GPs with improved buildings, relevant technology or working environment.
Improved coordination of primary care within PCTs (DH 2001, DH 2005, DH/PfH 2003).	Buildings are co-located with social care services and complementary services.	PCTs and the LiftCo appreciate benefits of the "whole-systems planning" approach in their areas.
Better value-for-money in procurement (DH 2001, NHS Gateway Ref 5268, Unison 2003, DH/PfH 2003).	LiftCo prioritises competition in financing and hiring of contractors.	There is actual competitive bidding to deliver services at buildings.
		Contractors prioritise quality and reduce variations in standards.
	Bigger buildings facilitate efficiency through providers working under one roof.	LiftCo is flexible to renegotiate aspects the contract for alignment to changing PCT circumstances.
Procurement costs are reduced through using standardised delivery (DH/PfH 2003).	Batching schemes promotes economies-of-scale and efficiency in procurement.	LiftCo seeks agreement with PCTs on what to standardise at the buildings.
		Standardisation is within rather than across PCTs.
Flexibility procurement increases efficiency within PCTs (DH/PfH 2003).	Buildings are delivered in response to changes in PCT priorities.	PCTs recognise their problems and have ability to prioritise strategies for addressing them.
		Participants share optimism in LIFT and are prepared to meet their obligations.
Increased access to capital within PCTs (DH 2001, DH/PfH 2003).	LiftCo has expertise in mobilising resources needed for sustaining investments.	PCTs can assess LiftCo's strengths and weaknesses to influence borrowing levels.

The CMO configurations in Table 3.1 suggest that LIFT is intended to facilitate improvements in primary care through better quality buildings coordinated with social care within the PCTs. This is achieved through the LiftCo providing contexts and mechanisms conducive to PCTs' investments in improving the quality of procuring healthcare buildings. LIFT involves deregulating procurement activities and management of the buildings to work in partnership with local stakeholders led by the LiftCo

and advised by the PCTs. Within the PCTs, LIFT prioritises investments that are derived from agreed Strategic Services Development Plans (SSDPs). The DH (2005) reiterates that the SSDPs are developed through a "whole system" approach that enables local stakeholders in influencing how their healthcare buildings are procured. Contextual factors to achieve this include the PCTs giving priority to consulting local communities for input in LIFT schemes, and the LiftCo hiring financiers, and contractors based on their competitive advantages like being able to deliver quality buildings and services on time when they are needed and at cost that is affordable for the PCTs.

To deliver buildings efficiently, the PCTs show commitment to the spirit that underpins LIFT by engaging the LiftCo. This enables the LiftCo to minimise the risks in procurement by harnessing private sector skills and expertise in delivering and managing projects. Thus, collaboration between PCTs and LiftCo is supposed to help LIFT to achieve increased value-for-money in procurement of PCT buildings. The CMO configurations further suggest that the LiftCo's flexibility in renegotiating and realigning the contract's critical aspects in response to changing circumstances within PCTs is a requirement for success. For example, even though standardisation in delivery and management of buildings is to reduce cost and increase efficiency, the context may require modifications to standards within PCTs so that new LIFT buildings reflect local priorities.

3.1.1.2 CMO configurations affecting primary care providers

The main primary care providers expected to benefit through LIFT comprise GPs, dentists, pharmacists, and opticians opting to operate at LIFT buildings. Table 3.2 summarises findings on expected outcomes,

mechanisms used, and surrounding contexts that define activities of primary care providers from the perspectives DH officials and professional representative bodies like the BMA. The outcomes through which the primary care providers are expected to benefit are explicit in key documents. A number of the corresponding mechanisms and contexts were worked out from expected outcomes described in the analysed documents.

Table 3.2: CMO configurations affecting primary care providers

Expected outcomes	Mechanisms	Contexts
Increased quality of care and patient experience (DH 2001, BMA 2001, DH/PfH 2003).	Buildings meet patient expectations for improved conditions and technology.	Buildings are designed to reflect patient preferences and expectations
	LIFT facilitates GPs in integrating patient care.	GPs' business practices change to prioritise integrated care at buildings.
Work environment for providers is improved (DH 2001, BMA 2001, DH 2005 Gateway Ref 5535)	Buildings designed to fit their purpose match provider roles.	Providers recognise practical economic benefits in relocating to LIFT buildings if supported by PCTs.
	Buildings provide staff and patient comfort and security.	Providers recognise work environment as important to improving the quality of care.
Integration of care is enhanced (DH 2001, DH 2005 Gateway Ref 5535)	Providers offer care side-by-side with complementary services at LIFT buildings.	Providers prioritise collaboration in meeting patient expectations for experiencing seamless services.
Reduced burden in looking for buildings or loans to build their own facilities (DH 2001, BMA 2001).	Ownership and cumbersome procurement of buildings is transferred to the LiftCo.	Providers recognise practical economic gains in using LIFT procurement than doing it themselves.
		There sufficient information to help providers in choosing between LIFT and having own buildings.
Long-term use of buildings is secured (DH 2001, DH/PfH 2003, King's Fund 2008)	LIFT releases providers from inflexible contracts at private buildings.	Evidence for the LiftCo's comparative advantage over private landlords is clear.
		Relocating to LIFT buildings is neither cumbersome nor a threat to business viability for providers.

To achieve the expected outcomes, the care providers need to recognise existing weaknesses in primary care in their PCT areas. The recognition may influence them in developing a firm commitment to LIFT as a useful

approach to addressing these weaknesses. LIFT mechanisms and contexts are expected to be conducive to care providers benefiting through quality working environments, safer buildings, and flexible entry and exit in LIFT deals backed with financial support from the PCTs.

The pre-existing primary care buildings were criticised as being unfit for purpose as well as having poor maintenance that did not help primary care providers in meeting increased patient expectations for modernised care (DH 2001). The DH (2001) raised concern that the primary care system experienced problems in coordinating and integration of patient services because of GP surgeries scattered all over the PCTs. Independent GPs' effectiveness in improving services was affected by them experiencing negative equity associated with renting buildings from private landlords (DH 2001). The mechanisms and contexts described in Table 3.2 are what the DH officials and professional representative bodies like the BMA perceived to be ideal in addressing problems in the primary care system under LIFT.

3.1.1.3 CMO configurations affecting private investors in LIFT

As the authors of most documents analysed in this research, the DH officials anticipated that private equity holders in the LiftCo that spearheads LIFT activities would also benefit through LIFT outcomes, mechanisms and contexts summarised in Table 3.3. The equity holders in the LiftCo are expected to mainly comprise private companies and possibly individuals and local stakeholders. The CMO configurations affecting the private investors can therefore be construed to also affect activities of the LiftCo representing the equity holders.

Table 3.3: CMO configurations affecting private investors

Expected outcomes	Mechanisms	Contexts
Enhanced involvement in developing local buildings (DH 2001, DH/PfH 2003).	LiftCo facilitates within PCT involvement of communities in health	Stakeholders are willing to take financial interests in local buildings.
		Diversity is encouraged to replace preference of particular stakeholder.
Specialisation in delivery and management of buildings (DH 2005 Gateway Ref 5268, DH 2001, DH/PfH 2003).	LiftCo prioritises specialist roles in hiring contractors.	LiftCo has appropriate skills and optimistic about LIFT objectives.
		Contractor hiring is based on competitive advantages plus commitment to LIFT objectives.
Improvements in risk management (BMA 2001, DH 2001 Gateway Ref 5268, DH/PfH 2003)	Roles are allocated based on ability to deliver.	Contractor skills and expertise are not taken for granted before hiring.
		There is respect for competition and negotiations in shared interests.
	Changes in demand for buildings are anticipated better.	PCT staff feels empowered to use experience in protecting public interests in LIFT.
Increased efficiency due to risk spreading (DH 2001, BMA 2001, DH/PfH 2003).	LIFT spreads risks in procurement between participants.	Risk is allocated based on ability to manage and experience translated into practice.
		Risks in LIFT are understood and there is recognition that effective management may be affected by individual values.
Flexibility in sourcing capital (DH 2001, DH/PfH 2003, NHS Gateway Ref 5268).	Investors have freedom to acquire or dispose equity in the LiftCo.	Established financiers impose no barriers for smaller investors.
		Helpful information is provided for those wishing to acquire equity in their LiftCo.

The above CMO configurations indicate that LIFT emphasises citizenship in planning local buildings. It encourages “people” and “system” oriented practices to influence communities in taking an active financial interest in delivery of local buildings. LIFT’s expected outcomes and mechanisms affecting the investors in the LiftCo are believed to be achieved through using appropriate skills and expertise held by individuals and grouped investors within communities. The important mechanisms include emphasizing specialist roles in LIFT activities through allocating the roles and risks based on participant’s ability to deliver and manage. Most documents from the DH portray LIFT as having mechanisms for facilitating

private investors to freely acquire or dispose equity in their local LiftCo (DH 2001, DH/PfH 2003, DH 2005).

These mechanisms require facilitative contexts that include encouraging diverse stakeholders to take financial interests in local healthcare buildings, and the LiftCo hiring contractors with proven competencies and commitment to subordinating their professional or group values to LIFT's objectives. Thus, enhancing capability to deliver the expected outcomes also depends on investors understanding of the risk components in LIFT and appreciating that inflexible adherence to individual values may affect effective sharing and management of the risks (NAO 2005). Mutual trust between the local investors and between other constituents of LIFT is considered an important contextual factor explicitly stated in the strategic partnering agreement document governing LIFT (DH/PfH 2003). Having mutual trust between LIFT investors, PCT staff and service suppliers facilitates sharing of ideas which promoted LIFT objectives. The DH (DH/PfH 2003) argues that this also discourages equity holders in the LiftCo from imposing barriers to investment by smaller investors.

3.1.1.4 CMO configurations affecting contractors

Here, *contractors* in LIFT refer to the different groups hired by the LiftCo for roles in delivering and maintenance of LIFT buildings. The LiftCo hires architects to design buildings along specifications in the SSDPs before hiring building contractors to erect the buildings. Thereafter, non-clinical services at the buildings are supplied by different specialists ranging from cleaners, security providers, and equipment repairers to building maintenance specialists. The outcomes, contexts and mechanisms that the DH officials perceived to affect activities of this variety of contractors

for non-clinical functions in LIFT are described in Table 3.4. Those affecting clinical service provision have been described in subsection 3.1.1.2 (page 165) under the CMO configurations affecting care providers.

Table 3.4: CMO configurations affecting LIFT contractors

Expected outcomes	Mechanisms	Contexts
Businesses opportunity within the health estate market (DH 2001, DH/PfH 2003)	LIFT deregulates activities to procure public buildings within PCTs.	Contractors are able to identify opportunities within PCTs. They possess recognisable competitive advantages in their speciality areas.
Potentially long-term contracts with the LiftCo (Unison 2003, DH 2001, DH/PfH 2003)	LiftCo's exclusive rights with PCTs guarantee continuity in engaging contractors.	Gains from long-term contracts are translated into improved quality at buildings.
		PCTs are empowered in monitoring to influence contractor performance.
Enhanced involvement in local activities (DH 2001, DH/PfH 2003)	LIFT facilitates contractors' involvement in delivering services at their own local buildings.	Contractors recognise they have a social contract to service buildings as part of the community.
		Contractors value the importance of quality in reducing transaction costs.
		There is maximum exploitation of professional diversity or experience of contractors.
Improved quality of buildings (DH 2001, DH/PfH 2003, Unison 2003)	Competitive advantages in speciality areas increase quality of services.	Quality benchmarks are clearly defined for effective evaluation of performance
		PCTs are empowered in penalising underperforming contractors.

Table 3.4 shows how LIFT provides opportunities for a variety of contractors to enter the previously restricted NHS estates market. This mechanism may enhance efficiency through competition in delivering services. That the LiftCo has exclusive rights to deliver buildings specified in the SSDPs is a mechanism that potentially ensures continuity in investment by the LiftCo and guarantees long-term engagements with the contractors. LIFT presupposes that income guarantees encourage service-suppliers in prioritising quality in order to retain contracts. They also incentivise suppliers to reduce transaction costs in LIFT, thereby aligning

financial practices to PCTs goals. It influences delivery and maintenance of buildings for availability at the time when they are need.

Another important mechanism is that more private cleaning companies and other service suppliers are involved in maintenance of healthcare buildings in their areas upon being hired by the LiftCo. Previously, these functions were provided by staff and tradesmen directly hired by the PCTs. This suggests the LiftCo considers the private contractors as elements of the community to allocate roles in procuring healthcare buildings needed by their PCTs.

LIFT seeks to improve the conditions of buildings using the mechanisms of spelling out quality benchmarks against which contractors' performance is monitored. The necessary contexts for the mechanisms to produce the expected outcomes include contractors with recognisable competences being able to identify opportunities to acquire contracts to provide their services under LIFT. The outcomes are also achieved provided the contractors understand and adhere to quality benchmarks, and translate experience from long-term contracts into prompt responses to requirements at LIFT buildings. The LiftCo hires the contractors and allows them to adopt innovative ways towards meeting the tenants' needs at LIFT buildings. Therefore, from the contractors, the LiftCo exploits professional diversity and experience that LIFT seeks to tap from the private sector (DH/PfH 2003). Progress is eventually achieved provided the PCTs as the ultimate clients of the LiftCo, feel empowered in monitoring to control underperformance by the LiftCo and its hired contractors.

These CMO configurations support the view that LIFT participants need to have capacity for assessing how LIFT adds value to their activities. Among many other outcomes, they may want to understand, for example, whether LIFT impacts patient choice, displaces smaller care providers, affects governance of primary care buildings, or increases the stock of buildings. The official documents also emphasize commitment and trusting relations as important contexts that facilitate LIFT mechanisms and outcomes (DH 2001, DH/PfH 2003). It is argued that the contexts ensure accountability and enhance value-for-money through openness in risk management, prioritising quality, and regular evaluations to improve LIFT's performance.

3.2 CMO configurations answering research question (ii)

The evidence to answer research question (ii) was obtained through in-depth interviews with informants drawn at the PCTs, the LiftCo and at LIFT buildings. The informants comprised different categories of staff directly involved in executing LIFT schemes in their PCT areas. They shared their experiences and perceptions of the contextual factors and mechanisms (CMO configurations) that they perceived facilitated or constrained them in discharging their responsibilities. The evidence was then derived from analysis of significant themes generated in coding of interview transcripts in NVivo software through application of the analysis framework previously laid out in subsection 2.4.1.1 (page 147).

3.2.0 Construction of CMO configurations – research question (ii)

The use of in-depth interviews is considered an effective way in collecting data within case-studies (Creswell 2002). But Yin (2009) argues that it presents challenges in understanding personal feelings and experiences

expressed by different informants drawn from different places. The important challenges experienced in this research are highlighted here in order to illuminate how the CMO configurations central to findings from in-depth interviews were developed.

The purpose of analysing interview transcripts was to compare and contrast different individual perspectives in order to identify areas of agreement and disagreement in their interpretations of LIFT. The perspectives were then reconciled to build a possible theory explaining LIFT, at least within the case-study. It is possible that some PCT staff interviewed were uncomfortable with the LiftCo's role because it reduced their control over some aspects of procuring and managing buildings. The risk of polarised opinions between informants at the PCTs and those at the LiftCo may potentially distort objectivity of some information from interviews making it difficult to distinguish official from unofficial stories in explaining LIFT. Thus, completeness of the perspectives used in developing the final CMO configurations explaining LIFT may be uncertain.

There was concern that some of the informants potentially used power bestowed by their positions to control the nature and depth of information shared with the researcher. This concern arises from the fact that responses like: *"I don't know", "I am not involved in that"* or *"Estate department knows better"* occasionally punctuated the interviews making it hard to tell when informants lacked the knowledge and when they were just reluctant to delve into potentially sensitive information. Since analysis of the interview transcripts attempted to distinguish between "facts" and "opinions", the CMO configurations constructed and presented here may

be viewed as a reasonably accurate reflection of the views and how 15 PCT programme managers, LiftCo CEO, five GPs and four centre administrators that were interviewed understood LIFT to be working within the case-study.

The informants were interviewed using topic guides that addressed issues on contexts, mechanisms and outcomes (CMO configurations) derived from documentary analysis. Some CMO configurations developed during documentary analysis were either discarded or modified in light of evidence from interviews. New ones were added depending on significance of their rating by informants. Therefore, CMO configurations developed from in-depth interviews critiqued what in LIFT guidance the DH officials perceived would make LIFT effective. In context of RE, Pawson (2006) argues that causation between programme factors may be better understood if those directly affected are given opportunity to share their experiences. With this in mind, informants in the current research were given opportunity to shed light on various contextual factors and mechanisms they perceived to either facilitate or constrain their efforts in LIFT.

The evidence for answers to research question (ii) is presented in subsection 3.2.1. Subsection 3.2.1.1.1 presents perceptions on LIFT's facilitating mechanisms. Subsection 3.2.1.1.2 presents the perceived facilitating contexts. The constraining mechanisms are presented in subsection 3.2.1.1.3. Subsection 3.2.1.1.4 presents perceptions on constraining contexts.

3.2.1 Perceived facilitating or constraining factors

In the interviews, informants shared their experiences and perceptions of how LIFT contexts and mechanisms supported them in achieving the intended outcomes. This included commenting on LIFT and the LiftCo's strengths and weaknesses vis-à-vis tasks to be accomplished within the PCTs. The responses were analysed to identify the factors perceived to facilitate or inhibit progress and those considered necessary yet missing in order to achieve the benefits.

3.2.1.1 Key Finding 2: *Most informants perceived LIFT as having mixed facilitating and constraining factors some of which inherent to how LIFT is designed and others due to problems in implementation.*

The primary finding in relation to research question (ii) is that LIFT has positive and negative effects resulting from either variation in contextual factors surrounding its implementation or mechanisms through which the activities are carried out. Some of the contexts and mechanisms facilitated operational staff in their activities while others constrained them. LIFT is perceived to also produce some positive outcomes and unwanted outcomes that the DH officials may not have expected. Informants perceived the pertinent details about the evidence as follows:

3.2.1.1.1 Facilitating mechanisms

The mechanisms perceived to facilitate LIFT outcomes are summarised in Table 3.5 below. The findings were deduced from analysis of significant themes generated in coding of interview transcripts in NVivo software during data analysis. The column on "Outcomes" indicates the facilitating themes that emerged on coding of categories of information in NVivo. The column on "Mechanisms details" shows the researcher's analyses of

interview material showing how informants understood the mechanisms as facilitating them in achieving LIFT outcomes.

Table 3.5 shows that LIFT was perceived to have mechanisms that facilitated flexibility in sourcing the finance needed to complete started projects and adapting buildings to meet tenant requirements. Keeping the same staff in charge of LIFT activities at the LiftCo was associated with increased value-for-money in LIFT. The ability of both the LiftCo and PCTs to seek internal and external technical support for effective delivery of buildings was mentioned as an important LIFT mechanism. Other facilitative mechanisms were thought to involve the continuous flow of projects within PCTs, and the LiftCo being able to anticipate changes in primary care demand and GP strategies for responding to the changes while retaining tenancy at LIFT buildings.

Table 3.5: Mechanisms perceived to facilitate LIFT outcomes

Outcomes	Mechanism details
Increased flexibility in procurement	Easy flow of capital in and out of the LiftCo ensured availability of resources to construct and maintain buildings (LiftCo Rep., Finance Director, PCT-2).
	LiftCo adapted buildings to meet tenant requirements (LiftCo Rep, Lead GPs B-1, B-2, B-4 Clinical Officer).
Increased scope within PCTs	The LiftCo facilitated speedy delivery of buildings and continuity in services (Administrators B-1 & B-2).
	Internal and external technical support improved the delivery of buildings (Corporate & Communication Director PCT-2).
	New ideas substituted poor value existing procurement ways (Estate & Facilities directors PCT-1 & PCT-2).
Better management of uncertainty in demand for facilities	LIFT encouraged GPs to modernise their surgeries or move into new buildings (Lead GPs B-1 & B-2, Estate & Facilities Directors, PCT-2)
	LiftCo anticipated changes in demand (patients & GPs) and improves size and designs of buildings (Lead GP B-4, GP B-2, LiftCo Rep)

Outcomes	Mechanism details
Increased GP & PCT collaboration in estate planning	Minimum standards were met through active involvement of Lead GPs in planning and delivery of buildings (LiftCo Rep, Lead GP, B-2).
	GPs were consulted and they provided specifications prior to construction of buildings (Lead GPs B-1 & B-2, Risk, Health & Safety Director PCT-2).
	Higher utilisation showed PCTs, GPs and patient satisfaction with improved quality at LIFT buildings (Clinical Officer B-4, Lead GPs, Administrator, B-1).
Improved quality with no service disruptions	LIFT replaced old buildings without displacing providers (LiftCo Rep, Lead GPs, Estate & Facilities Director PCT-1).
	GP relocations to centralised buildings did not affect or disadvantage their patient lists (Lead GPs).

GP willingness to take part in LIFT through coordinating delivery, and taking occupation of new buildings were mechanisms perceived to facilitate progress. The PCT programme managers interpreted higher service-user patronage at LIFT buildings as confirmation of LIFT's ability to increase patient experience. This encouraged them to continue using LIFT in procuring new buildings. A related perceived mechanism was that LIFT provided the PCTs with opportunities to replace old buildings and relocate GPs to central sites without risking disconnection of patients from their GPs. Yet another facilitative mechanism was that LIFT buildings neither involved GPs changing geographical areas nor patients experiencing distance disadvantages to their preferred GPs.

3.2.1.1.2 Constraining mechanisms

The mechanisms perceived to constrain progress against LIFT outcomes are described in Table 3.6. The column on "Outcomes" indicates the constraining themes that emerged on coding of categories of informant experiences in NVivo. The column on "Mechanisms details" shows the

researcher's analyses of interview material showing how informants understood the mechanisms as operating to constrain them in achieving LIFT outcomes.

Table 3.6: Mechanisms perceived to constrain progress

Outcomes	Mechanism details
LIFT guidance were inflexible for staff to implement effective schemes	LIFT was promoted as the only way to procure primary care buildings (Strategy Director PCT-1, Lead GPs B-1 & B-4)
	PCTs roles were interfered with through being forced to comply with LIFT stages (Estate & Facilities Director PCT-1, Lead GP, B-1).
	Compliance with LIFT stages exacerbated bureaucracy that delayed projects (Estate & Facilities Director PCT-1, Lead GPs B-1 & B-2).
	Legal barriers precluded PCTs from revising contracts that may have become obsolete for local interests (Corporate & Communication Director PCT-2, Finance Director PCT-2).
Evidence for LIFT enhancing value-for-money in procurement was questionable	No economic evaluations like cost-benefit analysis or cost-effectiveness analysis were expected prior to constructing LIFT buildings (GP/Primary care coordinator PCT-1, Lead GP B-2).
	There was exemption on using comparable public facilities to assess feasibility of LIFT buildings (Finance directors PCT-1 & PCT-2).
	LIFT has no agreed benchmarks against which to measure evidence for value-for-money (Lead GP B-1, GP/Primary care coordinator PCT-1).
LiftCo has exclusive rights in delivering SSDP's contents	Lack of competition excluded small developers in LIFT and made the LiftCo complacent (Lead GP B-1 & Administrator B-3).
	Contractors with multiple projects risk quality by rushing to new sites (Administrator B-3 & GP/Primary care coordinator PCT-1).
It is challenging for PCTs to make LIFT affordable and sustainable	PCTs paid unaffordable rates because they lack influence on LiftCo's borrowing (Lead GPs B-1 & B-2, Commissioning Director PCT-2).
	Anticipated benefits from competition were missed due to exclusivity clauses LIFT (Finance Director PCT-2, Lead GP PCT-1).
	LiftCo delivered only what PCTs can afford risking loss of innovation & decreased durability of buildings (LiftCo Rep, GP/Primary care coordinator PCT-1).
PCT capacities has not increased after LIFT	Inappropriate surgeries still exist because bureaucracy limited the LiftCo in managing demand (Lead GP B-1, Clinical Officer B-4).
	PCTs are not adequately supported in monitoring LIFT activities (Strategy Director PCT-1 & Lead GP B-2).

Outcomes	Mechanism details
Consultation and citizenship in LIFT is not effective	Consultation time was inadequate for better input by staff (GP/Primary care coordinator PCT-1, Finance Director PCT-2).
	PCT and stakeholder inputs were not entirely respected in designing of buildings (Commissioning Director PCT-1 & PCT-2).

Some of the mechanisms constrained informant's individual efforts in various ways, either increasing costs or decreasing quality in LIFT. Most informants wanted to avoid inflexible procedures but were unable to do so because they had to comply with LIFT guidance. This was perceived to lock the PCTs into long-term expensive and unsustainable LIFT deals. LIFT guidance was criticised for failing to give PCT staff freedom to consider options that matched local resource availability in delivering the desired buildings. Informants expressed that the LiftCo was often not willing to make the necessary structural changes to LIFT buildings. High costs were quoted to deter tenants from pursuing the desired alterations.

Most informants commented about the problems of the PCTs being unable to influence the LiftCo's levels of borrowing from private banks. They argued that traditional procurement may not have been perfect but could have been considerably cheaper. High interest rates paid on the LiftCo's borrowing were passed over to the PCTs through rent and fees. This was perceived as affecting the long-term affordability and sustainability of LIFT. Affordability was cited as the probable driver for the LiftCo not prioritising innovations for quality, design and increased durability of buildings. Yet the LiftCo argued that it was committed to innovating within the limits of what the PCTs can afford. A clinical governance director in PCT-1 summed

up most informants' confession of unawareness about how individual LIFT buildings were financed:

> *"It is difficult to understand how LIFT projects are financed. We know that the LiftCo is an investment arm of private banks and shareholders whose origins and motives are varied yet united in making profit. Ordinary people cannot grasp the financing structures."* (Clinical Governance director, PCT-1, Interviewed)

This raises issues about quality and level of stakeholder involvement in LIFT. Most informants felt progress was inhibited by inadequate engagement with local staff, community groups and service-users; meaning that LIFT failed to prioritise local needs and interests in delivering buildings despite this being highlighted in the guidance (DH/PfH 2003 page 192). But they believed PCT staff and GPs were better consulted than were service-users.

The problem is that the quality of contributions is reduced when a short lead time is given because of the LiftCo's desire to reduce planning time to speed up delivery of the buildings. So the trade-off between consultation and speedy delivery means that LIFT buildings may miss out on some quality elements such as reflecting cultural diversity of local service-users. A director in PCT-2 observed that:

> *"The LiftCo deliberately gives short deadlines to give meaningful feedback on the plans. Neither service-users nor health and safety experts are consulted for basic fittings. There is a rush to meet construction deadlines so tenants are sometimes consulted after the work is already done and there is no scope to reverse anything"* (Risk, Health & Safety Director, Interview).

3.2.1.1.3 Facilitating contexts

According to Pawson (2006), contextual factors facilitate programme mechanisms to produce intended outcomes. Thus, Table 3.7 summarises the contexts that informants in the current research perceived as

facilitating LIFT mechanisms in producing the expected outcomes. The column on “Outcomes” indicates the root themes that emerged on coding of categories of informant experiences of contextual ideas about the facilitators. The column on “Context details” shows the researcher’s analyses of interview material showing how informants understood the conditions or environment (context) required for LIFT mechanisms to produce expected outcomes.

Table 3.7: Contexts perceived to facilitate LIFT mechanisms

Outcomes	Context details
Increased GP & PCT collaboration in estate planning	LiftCo & PCT saw benefits from a continuous flow of projects within their area (LiftCo Rep).
	Collaborative working relationship was valued by the PCTs and LiftCo (LiftCo Rep, Estate & Facilities Director PCT-2).
	PCT boards supported managers in activating desired mechanisms (Estate & Facilities Director PCT-1, Strategy Director PCT-1).
Better management of uncertainty in demand for facilities	Stability at the LiftCo and committed CEO allowed planning of projects ahead of demand and their timely delivery (Estate & Facilities Director PCT-1 & PCT-2).
	LiftCo took time to update local SSDPs and reflects to correct operational problems (LiftCo Rep, Strategy Director PCT-1).
Increased scope within PCTs	LiftCo and SPB participated and were familiar with local SSDPs (LiftCo Rep, Clinical Officer B-4, Estate & Facilities Director PCT-2).
	LiftCo innovated and consulted stakeholders for contributions before constructing buildings (LiftCo Rep, Lead GP B-2 & B-4).
	PCTs required discretion to use other procurement methods proved to be better than LIFT
	PCT staff required discretion to influence choice of contractors employed by the LiftCo
Improvements in quality without service disruptions	GPs recognised quality buildings as fundamental to improved care and were optimistic about PCT intentions to modernise buildings (Lead GP B-2, GP/Primary care coordinator PCT-1).
	GPs were willing to relocate to LIFT buildings (Lead GPs, B-1 & B-2)
	GPs saw benefits in leading the development of LIFT buildings (Estate & Facilities Director PCT-2, Lead GP B-1, B-2 & B-4).

Outcomes	Context details
Increased flexibility in procurement	LiftCo was skilled at mobilising capital to complete started projects (Clinical Officer B-4, Estates & Facilities Director PCT-2, LiftCo Rep).
	LiftCo reimbursed tenants for "self-help" expenses incurred at buildings to maintain standards (LiftCo Rep, Lead GPs B-1, B-2, & B-4, Administrators B-1, B-2, B-3).
	LiftCo was prepared to adapt buildings according to tenant requirements (Lead GP B-2, Administrator B-2, LiftCo Rep).
Increased value-for-money in procurement	LIFT buildings showed evidence for improvement on quality compared to procurement by government (Lead GPs B-1, B-2, & B-3).
	Contractors had competitive advantages in project delivery and reduced cost by substituting inputs without compromising quality (LiftCo Rep, Clinical Officer B-4, Administrators, B-1 & B-2).
	LIFT buildings showed evidence for innovation and high utilisation by patients (Lead GPs B-1 & B-4).

The overriding facilitative context was perceived to be the PCTs and LiftCo's acknowledgment of the poor condition of primary care buildings and the need for improvement. This led PCT boards and managers to commit to having a continuous flow of LIFT projects in order to urgently deliver improved buildings. It also helped them to win the trust of the residents by demonstrating that the PCTs valued their wellbeing:

> *"...the residents here strongly believe that we are short-changing them, and we cannot blame them for contemplating to leave the borough when the conditions of our GP surgeries are so poor. They feel undervalued by the responsible authorities."* (Clinical Governance Director, PCT-1, Interviewed)

Most informants expressed that progress was achieved because there was relative stability at the LiftCo. They argued that having the same CEO in charge throughout LIFT projects enhanced value-for-money in procurement. It encouraged trust and collaborative relations between the PCTs, the LiftCo and centre administrators and care providers at LIFT

buildings. This allows the LiftCo to deliver services in a timely manner through projects that are planned ahead of demand. Collaborative relationship was particularly emphasised by the LiftCo representative who perceived it creating goodwill that reduces conflict in resolving problems in LIFT:

> *"There is a good public relation between the LiftCo and PCTs. Shared interest for progress means that neither party is driven into situations that create conflict. LIFT contracts are specific on our expected deliverables and methods to resolve issues without resorting to invoking discretionary rights."* (LiftCo CEO, Interviewed)

Another important facilitative context that was present is that the LiftCo is familiar with the local SSDPs that are the blueprints for LIFT buildings. Buildings were therefore delivered with reduced bureaucracy when they were needed. The GPs within the PCTs were perceived to value quality in service delivery. As a result, they were willing to take up leadership roles in developing LIFT schemes and to relocate to new premises, meaning that the quality of care was improved with minimum disruptions.

Some PCT managers felt that the LiftCo increased flexibility in procurement by bringing in skills in sourcing the capital needed to complete projects. Some thought that the LiftCo was also willing to adapt LIFT buildings according to the requirements of the tenants. It was pointed out that when the LiftCo reimbursed its tenants for expenses they may have incurred through individual initiatives to fix problems at LIFT buildings, the tenants felt encouraged in maintaining quality at the buildings. Other important facilitative contexts reported included competitive contractors that made LIFT a step improvement in procuring quality buildings by reducing costs through innovation.

Places where LIFT buildings were erected were mentioned as a facilitative context. Proximity to public transport or being reached by walking or riding increased utilisation and also promoted physical activities for service-users. LIFT buildings in regeneration zones tend to show higher utilisation by patients.

3.2.1.1.4 Constraining contexts

The findings about the contexts perceived to constrain LIFT mechanisms and outcomes are described in Table 3.8. The column on "Outcomes" shows the root themes on which corresponding contextual ideas about the constraints were coded in NVivo during data analysis. The column on "Context details" shows the researcher's analyses of interview material showing how informants understood the conditions or environment (context) that constrained LIFT mechanisms in producing expected outcomes.

Table 3.8: Contexts perceived to constrain LIFT mechanisms

Outcomes	Context details
PCT capacities not improved	PCTs were incapacitated by lack of discretion over critical LIFT processes (GP/Primary Care Coordinator PCT-1).
	LiftCo had more discretion and support of the SPB in LIFT than PCTs (Lead GP B-1, Administrator B-3).
	The LiftCo was small and cannot meet demand for improved GP surgeries through managing multiple projects (Lead GP B-1, Health, Risk and Safety Manager PCT-2).
Reduced flexibility in LIFT activities	PCTs had little latitude to adapt guidance for suitability to local situations (Strategy Director PCT-1, Commissioning Director PCT-1, & PCT-2).
	Creativity to join-up activities at LIFT buildings and PCT wide activities was limited by restrictions on using LIFT's "enabling funds" (GP/Primary Care Coordinators PCT-1, PCT-2).
Affordability and	Cost of renting LIFT buildings was high because PCTs had no influence on level of borrowing by the LiftCo (Lead GP B-1, B-4,

Outcomes	Context details
sustainability of LIFT schemes	Clinical Officer B-4).
	Cost of land reduced opportunities to innovate, expand or add amenities (e.g. parking for staff) at buildings (LiftCo Rep, Lead GP B-4, Clinical Officer B-4).
Questionable value-for-money evidence	Contractors lacked appropriate skills and experience in maintaining healthcare buildings (Administrators B-1, B-2 & B-3, Strategy Director PCT-1).
	Frequent rotation of contractors and delaying repairs failed to reconcile quality and rent at buildings (Administrators B-2 & B-3, Lead GP B-1).
	LiftCo had no dedicated maintenance staff to provide consistence in performance benchmarks (Estate & Facilities Director PCT-1).
Asymmetric information on LIFT activities	Tenants cannot assess their financial gains prior to joining LIFT because they do not know the pertinent details about the buildings more than the LiftCo does (GP B-2, Clinical Officer B-4).
	Exchange of LIFT ideas to benefit PCTs was hindered by centralised decision-making at SPB and DH (Strategy Director PCT-1, Corporate Director PCT-2, Lead GP B-1).
Contestable governance	PCTs always sought clearance for decisions from the DH or Treasury (Finance Director, PCT-2, Health, Risk and Safety Manager PCT-2).
	SPB prioritised LiftCo to PCT interests (Estates Director PCT-1, GP/Primary Care Coordinator PCT-1).

The behaviours of public sector officials and service contractors hired by the LiftCo were most often cited as constraining contexts. PCT managers argued that public sector departments, especially the DH and Treasury did not adequately decentralise decision-making responsibilities for important LIFT processes and functions to the PCTs. As a result, LIFT was perceived not to have increased the PCTs' capacity to improve procurement of the desired buildings. Informants thought that progress was restricted by lack of discretion and contestable governance issues at PCT levels.

Progress was also limited when DH officials interfered in local activities. Interference was perceived to restrict the activation of mechanisms

thought to produce desirable outcomes. One lead GP argued that the DH's requirement for numerous additions to the process of procurement inflated the final costs for preparing tenders for their building:

> *"...the LiftCo spent a lot of money to produce unnecessary volumes of tender documents. Too many consultants were engaged at the behest of the DH. ….they forced the LiftCo to gobble a lot of money on tenders alone."* (Lead GP, B-1, Interviewed)

It was further pointed out that when information about critical developments in LIFT was inadequate, local staff would be ill-equipped to handle challenges imposed by inflexible guidance. GPs particularly found it difficult to see how they could financially gain from relocating to LIFT buildings because critical information about LIFT remained with the LiftCo or the Strategic Partnering Board (SPB), or the DH and Treasury. Such centralisation of information reflects the concern that LIFT was characterised by lack of open debate and staff hesitation in questioning some of its aspects. Commenting on LIFT's strengths and weaknesses, a director at PCT-1 thought lack of openness in activities blocked staff in monitoring improvement processes:

> *"Nobody wants to openly discuss or explain LIFT. It leaves people to familiarise themselves with it through reading rather than open debate. It is deliberate to withhold information because if we become more conversant, we may cause problems by asking many questions risking abandoning LIFT."* (GP/Primary Care Coordinator, PCT-1, Interviewed)

Most informants felt achieving value-for-money in LIFT was constrained by using private contractors who often lacked experience and appropriate skills within healthcare. This affected their response to important maintenance jobs at the buildings. It reduced the quality at LIFT buildings causing tension between the LiftCo and tenants.

The underlying problems in LIFT may be public and private sector differences in approaches to deliver healthcare service. For example, while the DH (2001) sees LIFT as offering opportunity for independent GPs to operate at more permanent premises than before; the GPs themselves do not consider longer stay at LIFT buildings as a priority. They prefer short contracts to have the freedom in changing places if they feel demand for services at LIFT buildings is reduced. As a result, some GPs are unwilling to occupy LIFT buildings and how they make demands could be an important contextual factor for progress as explained by the lead GP at B-2:

> *"GPs have almost a veto with regards to occupying LIFT buildings. The PCT can do nothing without our express consent. We forced the PCTs into offering GPs 5-year contracts at LIFT buildings when they wanted more. The PCT cannot dictate because they need our support for LIFT to succeed."* (Interviewed)

Most informants believed that in the long-run, LIFT would be neither affordable nor sustainable. They argued that the cost of inner-city land was likely to force the LiftCo into borrowing expensively from private banks with the costs eventually being passed over to the PCTs through rent and other surcharges. Anticipated benefits from competition in financing LIFT buildings were missed because LIFT areas were geographical monopolies of the LiftCo.

3.3 CMO configurations answering research question (iii)

The evidence to answering research question (iii) was obtained through in-depth interviews with informants directly involved and affected by executing LIFT schemes within their PCT areas. Among the facilitating contextual factors and mechanisms, they identified those they believed

facilitated them most in their activities. Some contextual factors and mechanisms were perceived as missing or operating to constrain them in achieving LIFT outcomes. Based on this, they rated how they perceived to have made progress in the PCT areas.

The findings are presented subsections 3.3.1 to 3.3.5. Subsection 3.3.1 presents what informants perceived to be the most influential mechanisms in LIFT. Indications about perceived influential contexts are presented in subsection 3.3.2. Subsection 3.3.3 presents the contexts, mechanisms and outcomes (CMO configurations) that informants did not identify as important. Subsection 3.3.4 presents how informants rated themselves on progress against LIFT outcomes in the case-study. Subsection 3.3.5 presents what informants thought were emerging unexpected or unwanted CMO configurations due to LIFT.

3.3.1 Perceived mechanisms that most influence LIFT outcomes

The analyses identified mechanisms that informants thought helped them most to achieve LIFT outcomes whether at the PCTs, LiftCo and LIFT buildings. The mechanisms identified at each level of data collection are described in Table 3.9 below.

3.3.1.1 Key Finding 3: *While informants lacked consensus about most mechanisms, they perceived collaboration in activities between operational staff as the mechanism that helped them most to achieve LIFT outcomes.*

The primary finding here concern informants' acknowledgement of LIFT as having mechanisms perceived to influence expected outcomes. But effectiveness of some of the mechanisms was contested. Informants

indicated the mechanisms that they perceived to be present or contestable yet important in influencing progress in LIFT as follows:

Table 3.9: Mechanisms that most influence LIFT outcomes

Analysis level	Influential mechanisms on outcomes	Status
PCT level	PCT Boards and managers were committed to LIFT procurement method (Strategy Director PCT-1, Estates and Facilities Director PCT-2).	Present
	Local GPs collaborated by leading in coordinating delivery of individual buildings (Lead GP, B-2).	Present
	PCTs were represented in LIFT boards to improve feedback and influenced LIFT procedures (LiftCo Rep, GP/Primary care coordinator PCT-1).	Contested
	A single rather than multiple LiftCos developed familiarity with SSDPs and strengthened collaboration (LiftCo rep, Estates and Facilities Director PCT-1).	Present
	PCTs had ready to implement SSDPs (Estates and Facilities Director PCT-1, Lead GP, B-1, LiftCo Rep).	Contested
LiftCo level	LiftCo was resourceful to complete and maintain buildings (Lead GP B-4, LiftCo Rep).	Present
	LiftCo collaborated in developing SSDPs and was familiar with PCT priorities (LiftCo Rep, Primary care and commissioning Director PCT-2).	Present
	Contractors were skilled and hired in collaboration with tenants (LiftCo Rep, Lead GP, B-4, & Administrator B-3).	Contested
	Flexibility in adapting buildings to tenant requirements was observed for continuity in services (clinical Officer B-4, LiftCo Rep, Administrator, B-3).	Contested
LIFT buildings	Administrators shared experience with colleagues at different buildings within their PCT (Administrators B-1 & B-2).	Present
	Trade-people at buildings provided better maintenance than government (LiftCo Rep, Administrator B-3, Lead GP, B-1).	Contested
	Receptionists collaborated in processing patient appointments for other GPs (Administrators B-1 & B-2)	Present

Whether at the PCTs, LiftCo or LIFT buildings; collaboration in activities between PCT boards and management team members, LiftCo and PCT staff, and care providers and centre administrators was mentioned as the most influential mechanism. It increased quality and flexibility in LIFT

activities as well as scope within PCTs through sharing new ideas. Encouraging participants to engage and support each other was seen as important for maximising benefits from LIFT.

Having a single rather than a series of LiftCos within PCTs was believed to enhance progress against outcomes. It helped in strengthening relations between PCT and LiftCo staff and the contractors because confusing diversity caused by a series of LiftCos is avoided. By participating in developing local SSDPs, the LiftCo developed familiarity with PCT priorities which enabled it to manage uncertainty in demand for buildings and to be flexible in adapting buildings according to needs of the tenants.

PCT staff did not believe that having a ready-to-implement SSDP affected LIFT outcomes. They argued that they were expected to work on the basis of SSDPs whether or not implementing LIFT. But the LiftCo representative believed that having ready-to-implement SSDPs speeded up delivery of buildings. Whether or not the SSDPs were truly products of stakeholder engagement was not seen as an influential mechanism from the LiftCo's perspective even though it was considered desirable at the PCTs.

PCT staff contested the effectiveness of private sector skills and expertise. It was argued that most contractors lacked appropriate experience in health. As a result, they did not significantly help in solving problems associated with healthcare at LIFT buildings. Moreover, their technical skills were not perceived to be better than their public sector counterparts:

> *"The LiftCo may be doing its best to hire competent tradesmen. But our position is that if the services were provided by government artisans, repairs would be done expertly and promptly to give us the comfort of knowing that those doing the jobs are skilled and familiar to our peculiar needs."* (Lead GP, B-1, Interviewed)

Staff at LIFT buildings contended that in the past, they received better maintenance outcomes from PCT trades-people compared to the present performance of LiftCo contractors.

The LiftCo cited collaborative management of the supply chain to account for high quality of buildings yet staff at the PCTs and LIFT buildings thought otherwise. Prompt response to repairs or adaptations at the buildings was again perceived an absent yet important mechanism. The administrator at B-3 thought the LiftCo was lax at monitoring the contractors it used to keep buildings in useable condition:

> *"Initially, the LiftCo was quite effective. (...) we are not sure whether they are complacent, but it is clear that our expectations on maintenance are not being met. Small jobs like lights or lock replacement are not promptly attended to at the buildings."* (Centre Administrator, B-3, Interviewed)

Seconding PCT managers to the LiftCo board was intended to provide feedback and influence prioritisation of PCT interests in LIFT (DH/PfH 2003). This mechanism is present but was contested by PCT staff. They argued that since their representatives were outnumbered by the private investors in the board, PCT interests were not prioritised. They wanted more managers to be seconded to the LiftCo board to increase technical scrutiny of LIFT decisions currently perceived to be favouring the LiftCo.

3.3.2 Perceived contexts that most influence mechanisms and outcomes

It is argued that programme mechanisms require specific contexts for them to produce the expected outcomes (Pawson 2006). In light of this, the analyses identified contexts that informants thought most helped LIFT mechanisms to produce the expected outcomes.

3.3.2.1 Key Finding 4: *Although they lacked consensus, informants indicated that they wanted enhanced discretion in LIFT activities to progress. Stability at the LiftCo and GP willingness to take part in LIFT were cited as influential contexts.*

The overriding finding is that informants expressed mixed perceptions about contextual factors perceived to influence LIFT outcomes. The contextual factors corresponding to main LIFT constituents and believed to be either present, or absent or contested yet important in influencing LIFT outcomes are presented in Table 3.10. The main LIFT constituents analysed are identified in the 1st column and the corresponding contextual factors are described in the 2nd column. The 3rd column indicates whether informants believed the context were present, absent, or contested.

Table 3.10: Contexts that most influence mechanisms and outcomes

Features analysed	Influential contexts on mechanisms and outcomes	Status
SPB	SPB robustly enforced compliance with LIFT (LiftCo Rep, Strategy Director PCT-1 & Estates & Facilities Director PCT-2).	Present
	Discretion was encouraged in executing LIFT schemes (GP/Primary care coordinator & Finance Director PCT-1).	Absent
	SPB enforced PCTs and LiftCo in meeting their obligations (LiftCo rep, PCT-1, PCT-2, Lead GP, B-1).	Contested
	Technical support was provided where PCT capacity was low (LiftCo Rep, Primary care and Commissioning Director PCT-2).	Contested
LiftCo	LiftCo had positive and trusting relations with PCTs and tenants (LiftCo Rep, Estates and Facilities Director PCT-2, GP/Primary care coordinator PCT-1).	Contested
	LiftCo promoted diversity in financiers, designers, and contractors (LiftCo Rep, Finance directors PCT-1 & PCT-2).	Contested
	Innovation in procurement and management of buildings was prioritised (Lead GP, B-4, LiftCo Rep, Strategy Director PCT-1).	Contested
	The LiftCo's size was ideal for averting bureaucracy (Estates and Facilities Director PCT-2).	Present
	There is optimism about LiftCo's commitment to LIFT goal	Contested

Features analysed	Influential contexts on mechanisms and outcomes	Status
	(Administrator B-1, Clinical Officer B-4, & Administrator B-3).	
	LiftCo mobilised capital requirements better than government (Estate and Facilities Director, PCT-1).	Present
	Contractors were competitively hired based on their skills and competences (Lead GP, B-4, Strategy Director PCT-1).	Absent
	Stability at LiftCo strengthened collaboration with the PCTs (LiftCo Rep, Strategy Director PCT-1).	Present
	Learning from experiences and mistakes enabled improved practices (Lead GPs, B-1 & B-2).	Absent
LIFT buildings	Cost of buildings made LIFT affordable and sustainable for PCTs (Clinical Officer B-4, Finance Director PCT-2).	Absent
	Maintenance was standardised by channelling problems through centre administrators (Administrator B-2, LiftCo rep).	Present
	Combined tenant meetings promoted collaborative problem solving at buildings (Administrator B-1, lead GP, B-1).	Present
Care providers	Care providers valued improved facilities and are willing to use LIFT buildings (GP tenant B-2, Lead GP B-1).	Present
	GPs recognised benefits from coordinating delivery of LIFT buildings (Lead GP, B-2, Strategy Director, PCT-1).	Present
	Care providers had confidence with the LiftCo in addressing gaps in quality at buildings (Lead GP, B-1, Administrator B-3).	Absent
	Participation at national or local LIFT conferences influenced GPs in prioritising innovation (Lead GP, B-2, LiftCo Rep).	Present
PCT boards	Importance of improved buildings in meeting patient demands was recognised (Lead GPs B-1 & B-4, GP/Primary care coordinator PCT-1).	Present
	PCTs evaluated options to procure buildings (Finance Director PCT-1, Estates and Facilities Director PCT-1)	Absent
	A sense of owning LIFT increased PCT commitment (GP/Primary care coordinator PCT-1).	Absent
	PCT boards supported adoption of LIFT in their areas (Strategy Director PCT-1, Primary care & commissioning Director PCT-2).	Present
	Staff felt their contributions were valued (GP/Primary care coordinator PCT-1, Lead GP, B-1).	Absent
	Diverse skills and experience of PCT staff were used to maximise benefits from LIFT (LiftCo Rep, Strategy Director PCT-1)	Contested

There was mixed perception about influential contexts affecting the SPB. PCT staff contested favourability of a number of the contexts present. For example, they felt that the context provided by the SPB was not conducive for mutual respect of agreed upon roles between the PCTs and LiftCo. This is reflected by the SPB failing to provide adequate technical support needed to increase PCT capacity to monitor LiftCo activities. It was argued that giving the LiftCo more discretion over critical activities in LIFT compared to the PCTs prevented some mechanisms from facilitating progress. Further, robust enforcement of compliance with LIFT means the PCTs were not given enough time to evaluate the impact of changes in the ways the DH prefers to procure NHS buildings. It suggests that enforcing rigid guidance is no remedy in procurement.

> *"We had no choice but to accede to LIFT since the DH would not fund any other route. If options were considered at DH, they were never communicated to us. We are unaware of criteria used to judge LIFT's suitability for our needs." (*Finance Director, PCT-1, Interviewed*)*

The frustration felt by PCT programme managers that their contributions in LIFT were never valued was more than matched by an anxiety from most managers that their diverse skills and experience were not tapped in translating LIFT guidance into practice. Yet these could have been useful in increasing LIFT's effectiveness and improving relations with the SPB and LiftCo. Informants reiterated that progress in LIFT depended on collaboration in activities. This was achieved provided those involved in executing LIFT schemes show genuine commitment to LIFT objectives.

Positive and trusting relations were mentioned as ideal contexts, yet were contested by some informants. For example, the LiftCo's commitment to maintenance of buildings was questioned on grounds of using cheap

labour presumably to cut cost. Some informants believed the LiftCo was not innovative in delivering the buildings considering their frequent modification to meet tenant requirements. However, centre administrators remained optimistic that the LiftCo had the commitment to maintenance despite complaints about delays to some works. Estate and Facilities managers that are more involved in LIFT than others perceived the LiftCo's size as an important context for progress as pointed out by the manager at PCT-2:

> *"We tend to see advantages of having a small LiftCo. It is more efficient than bureaucratic structures of the government. Besides, the board is dynamic in terms of expertise and skills to protect us from problems of monitoring a bigger LiftCo."* (Estate & Facilities Director, PCT-2, Interviewed)

PCT managers raised concerns about situations when they felt frustrated by lack of open debate on facilitative mechanisms. They preferred contexts that give security in openly debating or giving feedback on how LIFT procedures impact local activities. These important conditions were absent because of perceived politicisation of LIFT. Hence the feeling that staff contributions in improving LIFT were neither valued nor respected yet the LiftCo influenced a fair share of the outcomes.

Most PCT staff thought private sector skills and expertise including experience in maintenance of healthcare buildings were important contexts for success but absent in practice. There was concern that contrary to official assumptions, service suppliers lacked appropriate skills and expertise. This reduced progress in effectively substituting for poor value DH procurement and PCT performance. It may affect the residual

value of buildings leading to PCT staff concern that LIFT may not be a convincingly value-for-money procurement method:

> *"...people hired by the LiftCo on short-term contracts have no health sector background. They have difficulties in connecting local health priorities to buildings designs without input from the PCTs yet they are more expensive than the government."* (Strategy Director, PCT-1, Interviewed)

GPs expressed contrasting views that LiftCo contractors have an accumulation of skills and experience in project management. According to a lead GP at B-4, this helps the PCTs in benefiting from cost-effective procurement:

> *"The LiftCo and its contractors have experience in delivering projects. It makes them to be more cost-effective in developing multiple projects at the same time without time overruns compared to the government." (Interviewed)*

Other GPs thought simultaneous development of LIFT buildings and using DH grants to modernise private surgeries was a missing yet important context which could enhance PCT capacity through increasing the stock of appropriate buildings compared to using LIFT alone. Previously, the DH assisted GPs with grants to upgrade their buildings (DH 2001). Now the GPs are encouraged to use LIFT even though the LiftCo may lack capacity to meet demand within the PCTs:

> *"Shortage of improved buildings has not been addressed because only four LIFT buildings have been completed within this PCT. There are sites that certainly require face-lifting and indications are that we need more upgraded premises." (Lead GP, B-1, Interviewed)*

This clearly shows that GPs think LIFT may have neither increased investment nor addressed the problems of many wrong surgeries within their areas. It suggests that few gains may have been achieved from

substituting LIFT for DH grants in managing uncertainty of demand for buildings.

3.3.3 CMO configurations perceived not important

From the menu of CMO configurations emerging in data coding, the analyses identified those perceived not important by informants. Such CMO configurations may be prominent in the documents analysed and interview transcripts yet informants did not believe they added value in the case-study.

3.3.3.1 Key Finding 5: *PCT managers believed that some contexts, mechanisms and outcomes emphasized in LIFT duplicated existing practices within the PCTs.*

PCTs managers expressed that guidance that merely encouraged what they already practiced within their PCT areas added no value to their activities. They expected LIFT to introduce new ideas and opportunities rather than duplicating what they were already doing. Table 3.11 describes the CMOs that informants identified as not important to their activities in LIFT.

The 1st column in the table indicates the outcomes emerging from data coding and the 2nd column explains what would influence the outcomes. The 3rd column shows the researcher's analyses of ideas in the documents analysed and interview transcripts to identify whether the description details were perceived to be contexts or mechanisms.

Table 3.11: CMO configurations that informants believed not important

Expected Outcome	Description details	Category
PCTs will get support in developing SSDPs	SPB facilitated exchange of ideas on LIFT.	Context
	LIFT promoted sharing of essential procurement information within PCTs.	Mechanism
	LiftCo knows and understands the priorities within PCTs.	Context
	LiftCo used its skills to translate knowledge into written local SSDPs.	Mechanism
Increased community involvement in estate planning	LIFT buildings were agreements of PCTs and LiftCo with their communities.	Context
	Communities participate in LIFT to influence sites and designs of their buildings.	Mechanism
Increased efficiency in procurement	LiftCo prioritises value-for-money strategies including competition in procurement.	Mechanism
	Patient convenience is prioritised in locating buildings.	Context
	LiftCo flexibility enables adaptation of buildings along tenant needs.	Mechanism
Procurement risks are transferred from PCTs to the LiftCo	LiftCo manages uncertainty in demand for buildings.	Mechanism
	Maintenance standards are met and measured to replace ineffective contractors.	Mechanism
LiftCo assumes risks in management of contractors	Hiring contractors based on ability to manage risks increases efficiency.	Mechanism
	Contractors have long-term contracts for consistence in standards within PCTs.	Context

Informants argued that they adopted LIFT in their areas because, like the officials, they recognised the importance of improved conditions of buildings to enhancing patient experience. But they were not convinced of the importance of the CMO configurations described in Table 3.11 to their effort in improving the condition of buildings. From the officials' perspective, effective LIFT mechanisms and contexts involved, among other things, the SPB providing technical support to the PCTs, the LiftCo assuming procurement and management risks, and communities contributing in developing local SSDPs and influencing where to site the buildings.

Yet most informants thought such CMO configurations neither brought additional benefits within PCTs nor improved individual performances in carrying out their responsibilities. They pointed out that prior to LIFT the

PCTs delivered buildings on basis of SSDPs that were always products of community engagement and public scrutiny in compliance with Planning Commission requirements (DH/PfH 2003). It was also argued that the PCTs were as interested as ever in modernising buildings but felt under funded by the DH. PCT staff suggested that like the LiftCo the PCTs had always hired and managed relevant contractors at primary care buildings where they lacked appropriate skills. For these reasons the informants considered the CMO configurations described in Table 3.11 to be unimportant because they had always been integral to PCT activities through existing PCT Boards and managers. Some still existed within PCTs with or without LIFT.

For example, Estate and Facilities departments still coordinated development of SSDPs, and delivery and maintenance of buildings. While the LiftCo is acknowledged for sourcing finance that the DH fails to provide for buildings, in other roles, together with the SPB they are perceived to duplicate some functions that still existed within PCTs. The duplications risked increasing cost compared to investing in mechanisms that increased capacity to influence stronger collaboration between care providers under PCT leadership.

3.3.4 Perceived progress against LIFT outcomes

In line with research question (iii), the influence of the perceived facilitating and constraining factors was cross-checked by analysing informants' rating of the achievement of expected outcomes in their PCT areas.

3.3.4.1 Key Finding 6: *Informants indicated that to some extent they achieved improvements in the quality of buildings, value-for-money and risk management in procurement, and diversity in ownership of buildings and integration of care within the PCTs.*

Informants indicated the outcomes which they agreed on or contested about in rating the achievements. The lack of agreement on some perceived achievements may be a result of informants facing challenges in assessing their progress due to changes in socio-economic factors surrounding LIFT. PCTs managers felt that more progress could have been achieved if they were given more discretion in LIFT activities. Among other things, they wanted freedom to use other procurement methods where these were superior to LIFT, freedom to influence choice of contractors hired by the LiftCo, freedom in using funds set aside to assist GPs in relocating to LIFT premises and to link activities at LIFT buildings with other PCT programmes. In Table 3.12, the column on "Status" indicates whether informants had agreement or contestation on perceived progress corresponding to the expected outcomes.

Table 3.12: Perceived progress against expected outcomes

Expected Outcome	Perceptions of progress	Status
Improved quality of buildings	Buildings were designed to fit their purpose better than pre-existing surgeries (Lead GPs B-1 & B-4)	Agreed
	Buildings were conveniently located nearer patient homes (Administrator, B-1)	Agreed
	Buildings were maintained better than before (Clinical Officer B-4, Estates & Facilities Director PCT-2)	Contested
	Buildings accommodated more patients without problems of overcrowding (Lead GPs B-2 & B-4)	Agreed
Increased value-for-money in procurement	Efficiency was prioritised to reduce construction and maintenance costs (LiftCo Rep, Communication Director PCT-2)	Agreed

Expected Outcome	Perceptions of progress	Status
	LIFT procedures consumed staff time by including activities of little relevance to solving PCT problems (GP/Primary Care Coordinators PCT-1)	Contested
	Being fixated on efficiency compromised quality by the LiftCo (Administrator B-3, Estates Director PCT-1, Lead GP, B-1)	Contested
Improved risk management	Partners respected their share of agreed upon risks (LiftCo Rep)	Contested
	LiftCo provided capital for desired buildings in the absence of government funding (LiftCo Rep, Estate Director PCT-1)	Agreed
	Risk of demand for buildings was transferred from PCTs to the LiftCo (LIFT Rep, Finance Director PCT-2)	Contested
	Risk of residual value of buildings was retained by the LiftCo (LIFT Rep, Estate and Facilities Director PCT-1 & PCT-2)	Contested
Increased stock and diversity in ownership of buildings	LiftCo has addressed contents in the agreed SSDPs (LIFT Rep, Lead GP B-1, Strategy Director PCT-1)	Agreed
	LIFT encouraged competition in delivery and maintenance of buildings (Administrator B-1, LIFT Rep)	Contested
	LIFT does not determine investment needed to increase PCT capacity. It only finances PCT investment (Finance Director PCT-2).	Agreed
Integration of care within PCTs	More GPs are willing to operate at LIFT buildings (Finance Directors PCT-1 & PCT-2)	Contested
	LIFT buildings offer a range of curative and health promotion services (Lead GPs B-1, B-2 & B-4)	Agreed
	Centre administrators relieved GPs of administrative duties (Administrators B-1 & B-2, Lead GP B-2)	Agreed
	LIFT has not enhanced integration of activities within PCTs (Strategy Director PCT-1)	Agreed

Informants agreed about progress made in improving conditions at primary care buildings. Most felt that LIFT buildings were appropriately designed for their purpose and also conveniently located for patients in line with

their preferences expressed in *Our Health, Our Care, Our Say* (DH 2006b). Having bigger buildings promoted increased utilisation by patients without the problems of overcrowding. But the quality of maintenance at LIFT buildings was contested. High frequency modifications and lack of prompt response to repair jobs were cited as indicators of contestable quality.

Although informants agreed about LIFT prioritising efficiency to increase value-for-money in delivery and management of buildings, they thought some mechanisms used constrained progress. It was argued that being fixated on efficiency drove the LiftCo to reduce the quality of construction and maintenance inputs. This in turn risked reducing the residual value of LIFT buildings. PCT staff further felt that they lost valuable time and resources on LIFT procedures of little relevance to solving problems in discharging their responsibilities. If these costs are factored and considered side-by-side with sustainability vis-à-vis lengths of LIFT contracts, progress could be less:

> *"(...)...it is unsustainable that this building cost more than £2m per year. Twelve percent fixed rent plus 6% for hard furniture make the interest rates higher than for ordinary mortgage. In 25 years we could develop 10 similar buildings from the interest alone." (Lead GP, B-1, Interviewed)*

Some informants advised against rating progress merely on whether LIFT increased efficiency as this failed to account for adverse effects of some mechanisms.

PCT staff believed that progress in risk management was achieved only when the LiftCo was able to mobilise capital needed to deliver buildings in the absence of DH funding. They were concerned that the LiftCo often failed to respect its share of agreed upon risks indirectly forcing PCTs into self-help activities for continuity of services at LIFT buildings. Furthermore,

the PCTs and not the LiftCo retained risk of demand for buildings. Others contested that at the end of LIFT contracts, PCTs risked inheriting buildings with reduced useful lives given the frequency of repairs that they currently experience.

Most informants contested the outcome of LIFT increasing the stock of upgraded buildings within PCTs. They argued that investment decisions were made by the PCTs with the LiftCo invited only to finance them. There was agreement that the LiftCo addressed most contents of the agreed SSDPs. But the number of new or upgraded buildings was perceived inadequate to satisfy demand within the PCTs. This suggests that the LiftCo has not been effective in increasing PCT capacities by helping to update the SSDPs as expected. The fact that the PCTs were geographical monopolies of a single LiftCo meant that anticipated competition in procurement of the buildings did not exist and PCTs missed on the benefits expected from competition.

Regarding integration of services, most informants agreed that LIFT buildings offered a range of care and health promotion services. Operating under-one-roof was perceived to reduce administrative overheads as pointed out by the finance director at PCT-1:

> *"...Rather than paying for different activities scattered all over the Trust, overheads are reduced because the PCT focuses at central premises occupied by multiple providers."* (Interviewed)

The presence of centre administrators meant that GPs were relieved of administrative duties to focus on patient care. PCT managers agreed about a negative outcome that activities of GPs based at same LIFT buildings were neither linked to each other nor joined up with PCT initiated

programmes. Some GPs contested the expected outcome that LIFT would encourage more care providers to operate under one roof at LIFT buildings. They argued that rent charges and oblique financial gains presented challenges in convincing GPs owning their own buildings to prefer LIFT buildings.

Overall, informants thought some limitations on progress were explained by their initial inexperience of LIFT. Progress against the more challenging outcomes increased due to new schemes using experience or lessons learnt from older schemes.

3.3.5 Other emerging CMO configurations due to LIFT

Further evidence for research question (iii) was obtained by analysis of other contexts, mechanisms and outcomes perceived to emerge within the PCTs as a result of using LIFT procurement. Realist evaluation (RE) principles have the advantage of giving informants opportunity to highlight some CMO configurations whose effects within a programme may not be otherwise known or expected (Pawson 2006).

3.3.5.1 Key Finding 7: *Informants pointed out that using LIFT procurement produced other positive and negative contexts, mechanisms and outcomes that the DH officials did not foresee in designing LIFT.*

The findings about CMO configurations perceived to emerge within the case-study are summarised in Table 3.13. The first column describes what informants perceived to be the outcomes emerging within their PCT areas. The column on “Mechanisms” shows the positive (P) or negative (N) ways through which the outcomes were perceived to be produced. The positive and negative prevailing conditions for the outcomes are shown in the “Contexts” column.

Table 3.13: Other emerging CMO configurations due to LIFT

Emerging Outcome	Mechanisms	Contexts
GPs gain influence in strategic services planning	**P** - Independent GPs coordinate delivery of buildings (Estate & Facilities Director, PCT-1).	**P** - GPs are trusted to use their experience to improve buildings (LiftCo Rep).
	P - GPs gain knowledge about governance of buildings (GP B-2).	**P** - Lead GPs' role is valued within PCTs (Finance Director PCT-2, LiftCo Rep).
Increased expertise exchange between public and private sectors	**N** – Government interference in LIFT fuel staff resignations (Lead GP B-1).	**N** – Staff believe they are not valued and seek opportunities elsewhere (Lead GP B-1).
	P - Managers bring experience of LIFT from non-health sectors into PCTs (Estate & Facilities Director PCT-1, LiftCo Rep).	**P** - Partners use different experienced professionals (LiftCo Rep, Estate & Facilities Director PCT-2).
Some PCT staff are affected by conflict of interest in their roles	**N** – PCT managers are appointed to LiftCo board. (GP/Primary Care Coordinator PCT-1).	**N** – PCT representatives are outnumbered by private investors in the board (GP/Primary Care Coordinator PCT-2).
Parallel programs are increased within PCTs	**N** - GPs at LIFT buildings retain individual independence (Lead GPs B-2 & B-4).	**N** - GPs don't value joint working and sharing of practices (Risk, Health & Safety Director PCT-2).
	N - Restrictions on "enabling funds" prevent linking activities at LIFT buildings with other PCT programmes (Finance Director PCT-1)	**N** - Providing seamless services within PCTs is not prioritised for funding by the DH (GP/Primary Care Coordinator PCT-1).
Service continuity at sites is achieved	**P** - Disruptions caused by frequent search for buildings are reduced (Administrator B-1).	**P** - LiftCo has less perverse incentives than private landlords (LiftCo Rep).

On the positive side, it was indicated that LIFT increased independent GPs' involvement in influencing strategic planning and delivery of buildings within their PCTs. The GPs were given leadership in coordinating delivery of individual LIFT buildings as agents of the PCTs and in consultation with prospective tenants meaning they were increasingly collaborating with PCTs in improving conditions at publicly used buildings. According to the lead GPs, their effort in modernising healthcare buildings through LIFT

gave them local, national and international recognition. For example, two LIFT buildings within the case-study attracted national and international visitors in recognition of showcasing innovation. Such outcomes reinforced GP commitment to working with the PCTs more than before.

Another positive outcome was that GPs and centre administrators believed LIFT ensured continuity of activities at permanent sites. This reduced disruptions caused by frequent relocations when care providers searched for appropriate buildings needed to meet increased demand caused by population growth within their PCTs. LIFT gave them opportunity to plan for the long-term without having to worry about adequacy of space or suitability of their buildings. This happened because the LiftCo was perceived to have less perverse incentives than private landlords in managing buildings.

The outcome concerning increased movement of expertise between the public and private sector was mentioned as having both positive and negative effects. On the negative side, concern was raised that frustrations encountered at government departments with strategic role in LIFT may be influencing increased loss of skilled and experienced public sector workers through resignation of posts to seek opportunities elsewhere:

> *"Frustrated government workers may be resigning their posts where they feel not valued. Some end up investing in LIFT connected companies and run it from the private sector side because it is not clear who buys private equity in the LiftCo." (Lead GP, B-1, Interviewed)*

The opinion may not be backed with strong evidence. However, it suggests that LIFT could be generating mistrust within PCTs especially in context of lack of clarity about people that are eligible for private equity in

the LiftCo. Public sector workers' feelings of not being valued may be due to factors other than LIFT. Loss of experience at departments with strategic roles in LIFT may impact progress within PCTs and private companies may also profit from employing senior health workers leaving DH employment.

On the positive side, movement of expertise was seen as opportunity for the PCTs and LiftCo to recruit staff and contractors with LIFT experience from outside the health system. Their experience helped to influence PCTs in making progress against LIFT objectives. For example, one manager at PCT-1 had coordinated LIFT projects that delivered Sure Start Children's Centres. Another at PCT-2 had accumulated experience in managing Housing Association projects that mimic LIFT. The two were convinced that their experiences put them in good stead to influence progress within their PCTs.

PCT staff raised concern that seconding some managers to the LiftCo board had a negative effect of creating conflict of interest in their roles. The managers were torn between satisfying the interests of private equity holders in the LiftCo and protecting PCT interests. This risked damaging trust that is essential in fostering teamwork between PCT staff:

> *"...people seconded to LiftCo boards don't seem to give us technical help to objectively scrutinise LIFT activities. Our managers are not actively involved in the delivery of buildings since the LiftCo got operational" (GP / Primary Care Coordinator, PCT-1, Interviewed).*

Conflict of interest came about because of the negative context that PCT representatives in the LiftCo board were outnumbered by private equity holders. Their contributions and measures to protect PCT interests may be outvoted, meaning their inability to influence board decisions exacerbated negative outcomes. Hence concern that PCTs were forced to rubber stamp

board decisions that failed to consider their local priorities. PCT staff still valued being represented in the LiftCo board provided their number was increased in order to effectively influence critical decisions.

Some PCT managers were concerned that bringing care providers to operate under one roof failed to translate into seamless caring for patients as had been hoped. GPs at LIFT buildings still worked independently and showed little interest in integrating their services. Parallel activities therefore existed at LIFT buildings and within the PCTs. Managers were unable to use the funds set aside for relocating GPs in linking up LIFT based activities to those outside. On their own, providers using LIFT buildings lacked incentive in integrating their services.

Whereas the LiftCo tended to disclose more positive than negative emerging CMO configurations, informants at the PCTs and those at LIFT buildings emphasized the negative more than the positive. Overall, analyses of the findings suggested that the LiftCo was risk averse and lacked promptness in attending to maintenance jobs. Neither was it ready to reimburse the PCTs for maintenance expenses incurred if the LiftCo delayed attending to requests at the buildings. This is likely linked to the necessity to prioritise shareholder value.

Another unexpected finding was the view that LIFT was implemented in the context of different cultural values between PCT staff and the LiftCo and its contractors. Some PCT staff divided opinion about the emerging CMO configurations by believing that their colleagues were unrealistically negative about LIFT under prevailing economic conditions. This may suggest differences in their views driven by evolving contexts and

mechanisms upon how PCT functions could be delivered. Yet convergence in values was expected in order for LIFT to deliver the desired outcomes.

3.4 Findings from the tours of LIFT buildings

Tours of buildings were organised because service areas were not specifically discussed in the interviews yet their quality can be considered a useful indicator of improvements in condition of buildings. The researcher's assessment of, *inter alia*, the buildings' fitness for purpose, accessibility by patients, patient comfort and safety, and show of innovation was compared with informants' ratings of progress against quality outcomes.

3.4.1 Key Finding 8: *The conditions at LIFT buildings were sufficient to promote continuity in care providers' activities. They appeared to support informant perceptions that the quality of LIFT buildings was significantly better than pre-existing ones.*

Although informants raised the concern that conditions at the buildings were affected by the LiftCo not promptly responding to maintenance requests, they did not perceive this as causing non availability of essential facilities for use by the care providers. Findings on status of the essential service areas that were observed are presented in Table 3.14 below. The 1st column shows the service areas that were analysed. The 2nd column on "Main findings" shows the researcher's interpretation of the corresponding conditions. The 3rd column indicates the individual buildings affected by the respective findings.

Table 3.14: Observations on essential service areas

Service area	Main findings	Buildings affected
External	Access for patients using wheelchairs and pushchairs was provided.	B-1, B-2, B-3, B-4
	External painting was required at one building.	B-3
Receptions	Receptions were manned and prioritised patient privacy and staff security.	B-1, B-2, B-3, B-4
Waiting area	There were sufficient seats and space for wheelchairs and pushchairs.	B-1, B-2, B-3, B-4
	GP stations were signposted and facilitated patient circulation.	B-1, B-2, B-3, B-4
	Toilets and refreshment areas were accessed by people with disability.	B-1, B-2, B-3, B-4
Treatment rooms	GPs had separate consultation rooms accessed by patients including those with disabilities.	B-1, B-2, B-4
	Rooms had sufficient lighting, heating and cooling.	B-1, B-2, B-3, B-4
Security	Where needed, lockers for patients' personal possessions were provided.	B-4
	Rooms had appropriate locks and lockers for hazardous substances used at the buildings.	B-2, B-3, B-4
Staff facilities	Staff are provided with sufficient working space and refreshment facilities jointly used with patients.	B-1, B-2, B-3, B-4
	Premises lacked sufficient parking space and social amenities (e.g. prayer rooms) for staff.	None
Buildings' comfort	Buildings showed innovation and cleanliness.	B-1, B-2, B-3, B-4
	Buildings display energy performance certificates.	B-2, B-4

Analysis at the level of the service areas rather than at the level of the whole building helped in unpicking the impact of LIFT on the condition of buildings as opposed to the effect of circumstances unconnected to LIFT. For example, where faults are not reported on time, poor conditions may reflect tenants' performance as opposed to the LiftCo that repairs them upon being informed on time.

The primary beneficiaries of LIFT (PCT staff and GPs) endorsed LIFT for delivering improvements in standards and quality of primary care

buildings. Although no comparable government buildings were toured to confirm their views, they believed LIFT buildings were better than pre-existing ones as indicated by the lead GP at B-1:

> *"…the buildings that we used before LIFT were of poor quality in all respects. LIFT certainly provides buildings that are of better quality."* (Interviewed)

Although external paintwork and repairs to a non-functional entrance were required at one building (B-3), conditions at all the buildings were sufficient to promote continuity in provider activities.

While the LIFT buildings toured in the course of the research were large, it was not possible to conclusively judge whether they were able to accommodate heavy flows of patients without congestion problems. This is because tours were organised outside the busiest times in order to enable GPs and administrators to take part in research interviews. The GPs indicated that the buildings had capacity to handle increased volumes of patients.

Security was generally good except at B-1 where one consultation room had the problem of a broken down lock. The affected GP raised concern about security of his tools of trade. He took initiative to personally replace the lock but not with the expected professionalism. Building B-4 prioritised security of patient personal possessions by providing lockers needed by maternity patients.

The buildings provided parking facilities for staff but not for patients. The GPs and centre administrators felt that parking spaces for staff were inadequate for their numbers. This was reported to cause inconveniences such as staff being late for work or leaving early to avoid parking fines

when using public spaces. Lack of parking space for patients was not seen as a major inconvenience because LIFT buildings are well serviced with public transport. Some are located within residential areas for easy access by walking or riding which also promote physical activity. Centre administrators raised concern about the LiftCo's delay in attending to repairs at the buildings. At B-3, repainting had not been done despite request made four months before the tours. The same building's main entrance was not working at the time of the tour. The lack of urgency in attending to repairs and the LiftCo's perceived tendency to hire cheap labour in maintenance was reported to reduce quality at the buildings as pointed out by the administrator at B-3:

> *"The LiftCo is not prompt to our distress calls for repairs and compromises itself by hiring cheap labour to further affect quality. We are talking of simple maintenance that the LiftCo is failing to provide yet they are supposed to be specialists in estate management."* (Interviewed)

Such concerns potentially caused tension between tenants and the LiftCo. Prolonged delays pushed the tenants into doing the jobs to keep the buildings useable despite being concerned that the LiftCo takes long to reimburse them. At B-3, no energy performance certificates were displayed as required. The administrator explained that:

> *"The performance reports are not displayed because they have not been provided despite us paying the LiftCo every month. We have never seen the actual bills for us to monitor how this building performs for water, gas and electricity consumptions."* (B-3 Administrator, Interviewed)

All the buildings lacked dedicated socialisation facilities such as prayer rooms. It forced staff to use either unoccupied rooms or neighbouring buildings for prayers. But service delivery at the buildings had not been disrupted by lack of maintenance. That building B-3 required repainting soon after opening may indicate poor initial work by the contractors.

SECTION 4: ANALYSIS AND INTERPRETATION OF FINDINGS

This research explored with people directly operationalizing LIFT schemes their perceptions of why LIFT produced outcomes that they experienced. Evaluating activities around the planning and execution of LIFT schemes was hoped to give staff at the operational level opportunity to shed light on how LIFT contexts and mechanisms facilitated or impeded their efforts. It was anticipated that the findings would then influence DH officials in improving LIFT guidance, and help the case-studied PCTs to improve their practice. Other PCTs wishing to adopt LIFT could draw lessons from the case-study in order to execute successful schemes.

4.0 Research questions alignment with Analytic Categories

The research sought to address these questions:

(i) What did DH officials perceive were the contexts and mechanisms for effectiveness in LIFT and who were expected to benefit from its outcomes?

(ii) What factors were perceived to facilitate staff directly operationalizing LIFT schemes in discharging their responsibilities?

(iii) What factors did operational staff perceive might influence or help them in progressing against LIFT's expected outcomes?

(iv) What lessons can be learnt from the case-study experiences to better explain and understand LIFT for the benefit of future schemes and other PCTs?

The research questions were to a large extent answered by the findings so far presented. This was achieved through reconciling documentary evidence, interview transcripts and observations at LIFT buildings. The central finding was that informants within the case-study were not convinced about LIFT's effectiveness in helping them to solve problems in procuring healthcare buildings under conventional method. They contested LIFT's ability on grounds of mechanisms and contexts perceived to facilitate while others were barriers to progress. Informants believed that inability in helping them was compounded by perceived lack of enhanced discretion in LIFT activities. This prevented them from adapting some LIFT guidance to circumstances within their PCTs. The pertinent findings aligned with research questions and data collection methods were presented in Section 3.

In this section (Section 4), the findings are integrated to develop a holistic explanation of LIFT. The section analyses and interprets the emerging themes to get possible answers to the research questions. To this end, the findings are organised along analytic categories aligned with the research questions as follows:

(a) Reconciling DH officials and operational staff perceptions to LIFT's helpful mechanisms, contexts and outcomes (CMO configurations) and intended beneficiaries (Research question (i) and (ii))

(b) Perceptions about factors that facilitate or constrain progress against LIFT outcomes (Research questions (ii) and (iii))

(c) Perceptions about factors most influential or helpful on staff activities in LIFT (Research questions (ii) and (iii))

(d) Lessons learnt from the case-study in explaining and understanding LIFT (Research question (iv)).

This synthesis analyses and interprets perspectives of the different categories of informants from whom information was obtained. The objective is to understand any similarities and differences in what they meant in the key findings. For example, estate and facilities managers' perception of LIFT may be compared against those of the lead GPs or building administrators.

How the findings on the research questions relate to each other is also analysed. This enables the researcher to reconstruct a complete picture of LIFT as understood at least in the case-study. The synthesis concludes by revising the middle range theory that the researcher developed at the beginning of the research to incorporate the emerging ideas and lessons learnt from the case-study. This is consistent with analytic category (d) and answers to the fourth research question.

4.1 Analytic category (a): *Reconciling DH officials and informant perceptions of helpful CMO configurations in LIFT*

The findings being interpreted under this analytic category were derived from information answering research question (i) and part of research question (ii). Research question (i) sought to understand what the DH officials thought were the contexts and mechanisms that would make LIFT effective if the intended beneficiaries comply. Part of research question (ii)

attempted at determining informants' views regarding whether LIFT guidance considered their role in facilitating the expected outcomes.

It was found out that aside from the PCTs, LIFT was designed to benefit a range of other participants in NHS activities. From the DH officials' perspective, the guidance was expected to encourage other players to involve themselves in procurement of healthcare buildings within their PCT areas. The main players expected to benefit from LIFT are: primary care providers; investors in the LiftCo; building contractors; and service-suppliers at LIFT buildings. Previously, these players had roles in NHS activities but not in the procurement of buildings for the PCTs. Thus, LIFT could be interpreted as the DH decentralization of aspects in procurement of buildings from PCTs to primary care providers and private contractors led by the LiftCo and coordinated by the PCTs.

This development may explain why most informants thought that LIFT was a drastic change in procurement arrangements. They believed it was conceived by DH officials with neither consultation nor their input despite them being the ones affected by the guidance. A GP/Primary care coordinator at PCT-1 argued that:

> *"LIFT is an edict from the government. It was pushed on us and no one within the PCT understands how such a drastic change in approach to procure public buildings through private providers should work."* (Interviewed)

Perceiving LIFT as an imposition by the DH may be a major impediment on progress. Fitzsimmons et al (2009) argue that PCT managers may not be connecting with LIFT because they feel excluded at its conception. Similarly, Beck et al (2009) associate perceived imposition with reduced motivation among PCT managers in acquiring skills needed in dealing with

challenges encountered in implementing LIFT. The DH officials had hoped that LIFT guidance would help PCT staff by providing contexts and mechanisms for using new skills and expertise of the LiftCo. They anticipated that the PCTs would benefit from efficiency generated by competition in procurement. This would translate into them getting affordable buildings that increase their capacity in service delivery.

But what the DH officials anticipated from LIFT does not appear to reconcile with perceptions held about influence of the guidance and who may be benefiting from them. PCT managers believed that through their skills and experience, they could have improved procurement of buildings without the DH having to recommend LIFT. In their view, they had similar skills to those of the private contractors. Further, they believed that their better experience in managing healthcare functions might give them an edge over the LiftCo. Thus, the managers and involved GPs are not convinced that LIFT promotes efficiency in order to deliver affordable buildings. Neither does LIFT increase their capacity in procurement because the way it was designed impinges progress through restricting competition in procurement activities. It appears that PCT managers believe anticipated benefits in LIFT could be achieved provided DH officials prioritised them retaining leadership roles, and allowing them power and authority to influence the LiftCo's activities. At present, the LiftCo is perceived as having power to exert control over LIFT activities. This is because controlling equity in the LiftCo is reserved for private investors.

4.2 Analytic category (b): *Informant perceptions about factors that facilitate or constrain progress against LIFT outcomes*

The findings were derived from information to answer research questions (ii) and (iii). Research question (ii) sought to understand informant perceptions of factors that facilitated or constrained them in LIFT activities whereas research question (iii) required them to distinguish those perceived as most influential on staff activities. Informants used their actual experience to indicate which and how LIFT contexts and mechanisms influenced them in making progress within their PCT areas. These findings may help the researcher in developing a holistic understanding of helpful factors in LIFT since they are based on the views of people actually involved in its implementation.

Most informants in this case-study believed that they experienced positive and negative effects on their activities. They indicated that LIFT had facilitating and constraining contexts, and facilitating and constraining mechanisms. This may be explained by possible variation in either contextual factors surrounding LIFT activities or mechanisms through which the activities are carried out. Pawson (2006) and Marchal et al (2010) explain that changes in any programme contexts and mechanisms may either facilitate or constrain operational staff in their activities.

Informants indicated that facilitating factors included their PCT boards' commitment to using LIFT procurement, and GP willingness to take part in LIFT whether as coordinators in delivery of individual buildings or through using the buildings. On the surface, it appears these factors would facilitate staff activities. But this may not influence progress unless PCT

staff actually show personal commitment, skills, and competence in handling constraining factors in LIFT. For example, their approach to dealing with perceived inflexible LIFT guidance under conditions of restricted discretion over key processes may determine success more than commitment of PCT boards and GPs' willingness to take part. The estate and facilities manager at PCT-1 reflected this view when he argued that:

> *"LIFT guidance gives the impression that involvement of GPs facilitates our activities yet not. Success is a result of our own initiatives than guidance by DH that prioritise LiftCo discretion and not our inputs in LIFT."* (Estate and Facilities manager, PCT-1, Interviewed)

This idea further suggests that PCT managers perceive not being consulted in some LIFT activities and their lack of discretion as barriers to progress. But this may be a temporary constraint because they also reported using their experience to circumvent problems in LIFT. This may explain why some of them thought the constraints to progress in LIFT were not insurmountable. They indicated that LIFT outcomes envisaged by the DH officials were generally achieved within their PCT areas mainly because of their determination to succeed. This suggests that PCT managers may have now accepted LIFT and understand how using their experience helps in reducing the impact of constraining factors on their activities.

The majority of informants in this case-study indicated that LIFT delivered buildings that were of better quality than the pre-existing ones procured through conventional route. But they expressed reservations about some of the contexts and mechanisms through which this success was achieved. They felt that the process to deliver LIFT buildings did not

sufficiently involve them in the practical aspects of procurement. Consequently, there was the perception that LIFT neither empowered them in decision-making nor increased their capacity in improving future procurement within their PCT areas.

The essence of an effective decentralization strategy is its ability in giving local staff a sense of ownership of decisions and increasing their capacity in activities to deliver the decentralize functions (Peckham et al 2005). In this case-study, lack of these elements was perceived to restrict progress. It could be that PCT staff and GPs at LIFT buildings may be reflecting on their experiences to realise that some contexts and mechanisms envisaged by DH officials through LIFT guidance may be ineffective at facilitating their activities. This reality may have afforded the opportunity for them in being more critical of using LIFT. They now know what could have been done better, with what mechanisms, and under what contexts to improve their buildings.

In summary, two issues concerning *involvement* and *engagement* of local staff in LIFT's strategic decisions emerged as key factors facilitating or restricting progress against expected outcomes. Involving and engaging management staff was perceived to motivate them in acquiring skills for handling challenges in procurement of buildings. At the same time, it may reinforce commitment to using LIFT. When neither consulted nor engaged, PCT managers particularly felt not being valued. Hence the belief that the DH officials viewed them as recipients rather than as participants in shaping strategic decisions within their own PCT areas. This may cause tension between PCT managers and Strategic Partnering Boards (SPBs)

recommended by DH officials to influence LIFT activities on behalf of the PCTs. Allowing PCT managers to influence strategic decisions may help in nurturing a sense of their owning LIFT and motivating them in acquiring skills for making it more effective.

4.3 Analytic category (c): *Informant perceptions about the most influential or helpful factors on staff activities in LIFT*

Perceptions derived from information to answer research questions (ii) and (iii) concerned what informants thought were factors that most helped or impinged their progress. The researcher's belief was that critical views about factors believed to be most helpful could be a more reliable bank of practical "dos and don'ts" in informing future LIFT schemes than centrally issued guidance alone. PCT managers and GPs at LIFT buildings argued that even where most success was achieved, some aspects could have been done better under different contexts. In light of this, they indicated what they believed were factors that helped or deterred them in improving matters about: governance of LIFT; quality of buildings and their maintenance; and obtaining value-for-money in their activities.

4.3.1 Execution and governance of LIFT

Informants provided insight into what helped or constrained them most in activities for improving execution and governance of LIFT. They perceived the helpful and constraining factors to be in: the quality of LIFT procedures; handling of tenders; role of the SPB; and the extent to which PCT managers were engaged for effective contribution to decisions on governance.

While agreeing that LIFT facilitated improvement in the quality of buildings, PCT managers' concern over some of the mechanisms used in executing LIFT schemes suggests lack of consensus about the quality of LIFT procedures. This may mean that managers value the quality of buildings but not at the expense of quality in the mechanisms through which success is achieved. The managers reported being prevented from considering other procurement methods. Thus, being able to assess LIFT's feasibility against options was perceived as a missing yet fundamental part of procuring the desired buildings. The following comment by a director for quality and governance at PCT-2 sums up what most managers placed on assessing options to LIFT in improving buildings in their areas:

> *"We are unaware of any alternative or criteria used to judge some options as unsuitable for our needs. We believe that refurbishing existing facilities would have been more affordable than adopting LIFT to meet our primary care objectives."* (Quality and Governance Director, PCT-1, Interviewed)

This perception may be understood in light of what Gaffney et al (1999b) believed was required in the context of PFI hospitals within the NHS. They recommended testing feasibility of projects by comparing different procurement ways prior to construction. PCT managers saw it as anomalous for LIFT to have the exemption when it was an offshoot of PFI.

If PCT managers know the necessary benchmarks against which to measure improvement in procurement; it is possible that appraising the options may help them in making informed choice between different ways to procure desired buildings before choosing LIFT. This was missing in the case-study hence perception that it restricted progress in improving procurement using LIFT.

While the DH officials believed that LIFT procedures would help in cutting bureaucracy and speeding up procurement (DH/PfH 2003); informants in the case-study thought that the governance arrangements could generate perverse incentives. Their perception that the DH officials retained decision-making over important LIFT procedures could be interpreted as bureaucracy or interference potentially constraining effectiveness in governance. One of the GPs highlighted impact of this constraint by reflecting on how tenders at their building were handled:

> *"We realised that the LiftCo spent £500,000 on tender documents only because DH officials forced them to engage too many consultants."* (Lead GP, B-1, Interviewed)

Directives by the DH officials and changing project specifications midstream may increase cost in LIFT. This makes it difficult to understand whether LIFT is an efficient procurement method on its own. The LiftCo wanted the PCTs to fund incremental costs for transactions forced by DH officials and those for project specifications changed midstream even if that may have been caused by changes in PCT priorities.

> *"Because the PCTs bear no risks at Pre-Stage 1, the DH and the PCTs find it easy to recommend completely new procedures and projects that may require separate feasibility analyses. It is only fair that the PCTs share the risk to discourage directives or abandoning projects on which the LiftCo has already invested"* (LiftCo Rep, Interviewed).

Potentially, how payment for these costs is handled may cause tension between PCT managers, DH officials and the LiftCo. PCT managers want the costs to be directly paid by the DH or the LiftCo. The managers also believe that it may be misplaced to expect the LiftCo alone to provide best value governance in context of DH control. Consequently, they expect the DH to directly pay for directives in LIFT activities.

The following comment describes some of the informants' confession about their fading enthusiasm upon realising that governance arrangements in LIFT did not sufficiently support them to use their professional judgement and discretion:

> *"You can invest effort in LIFT if you feel valued. Otherwise you become detached from its development."* (Estates and Facilities Director, PCT-1, Interviewed)

Despite PCT representation on the LiftCo board, managers and GPs may be feeling excluded from important decisions. They are unconvinced that their views conveyed through the representatives influenced decisions made by the LiftCo board. Maybe the managers and GPs see themselves as more familiar with healthcare needs and priorities about desired buildings within their PCT areas compared to other constituents of the LiftCo board. This may explain why most of them thought it would be helpful in addressing these issues in governance if PCT representation on the LiftCo board was increased.

Further, the DH officials might have envisaged presence of SPBs within PCTs that implement LIFT as facilitating staff in making progress. With the role to supervise the LiftCo, the SPB was expected to ensure that its activities do not prioritise LiftCo shareholder interests over those of the PCTs and LIFT's primary objectives (DH/PfH 2003). This may involve it facilitating exchanging ideas in LIFT to prevent problems that may arise from the LiftCo being more aware about important issues on governance arrangements than its clients. Yet the following comment may suggest that the SPB was not tolerant to open exchange of ideas leading to the concern that it prioritised LiftCo's decisions over contributions by PCT staff:

> *"(...) the SPB muzzles debate about LIFT and we do not raise critical views for fear of being labelled as trouble makers."* (GP/Primary Care Director, PCT-1, Interviewed)

Although the SPB is largely made up of PCT representatives, it is possible that it feels under pressure from the DH to make LIFT succeed by enforcing PCT compliance. This interpretation may be understood in light of one of the lead GPs' description of how the government values completed LIFT projects:

> *"(...) the government wants to see LIFT succeed. We went to No. 10 Downing Street when this building opened. They were quite excited and congratulated us for adopting LIFT."* (Lead GP, B-1, Interviewed)

In addition, this may explain some informants' opinion that support received by the PCTs from either the DH officials or the SPB sought to enforce compliance with LIFT rather than increasing staff capacity in making effective procurement decisions. The NAO and the Planning Commission were identified as sources of less partisan advice and support:

> *"...we see the NAO and Planning Commission as giving us more appropriate advice. They want us to redirect our activities towards influencing the LiftCo and its contractors to collaborate in maximising benefits from LIFT."* (Estate & Facilities Director, PCT-1, Interviewed)

The findings revealed GPs to be less concerned than PCT managers about being excluded from strategic decision-making. This may be because GPs are not held accountable for LIFT outcomes. Meanwhile, lead GPs were satisfied that coordinating delivery of individual LIFT buildings gave them sufficient involvement in procurement of permanent buildings from which to operate. In line with one of the expected outcomes (Table 3.2 page 166), LIFT spared them of the need to procure and manage private buildings.

An important problem cited by the GPs was that LiftCo bureaucracy and monopoly led to delays in responding to maintenance jobs at the buildings. Perhaps the LiftCo in this case-study has grown too powerful for the GPs to monitor and control as observed by one of the lead GPs:

> *"(...) a group of companies may own a series of LiftCos that share strategies and information across a number of PCTs. If the LiftCo gets bigger than the PCTs that it is supposed to serve, it may have more discretion over LIFT processes than PCT staff and GPs."* (Lead GP, B-1, Interviewed)

It cannot be assumed that the people implementing LIFT will necessarily have discretion over all its activities. In context of decentralization, discretion is an important factor that cannot be taken for granted because of its effect on executing the decentralised functions (Bossert 1998, Saltman et al 2006). The researcher defined discretion in terms of the freedom that the operational staff held in determining or crafting the way important LIFT activities were delivered within their PCT areas. Understanding why the different categories of informants felt constrained in LIFT could be a function of the freedom they perceive to hold in determining important ways to carry out their activities.

A number of PCT managers reiterated that they were constrained by the DH officials' unwillingness to fund procurement methods other than LIFT. This suggests that the DH is determined to reduce its role in developing primary care buildings in favour of using LIFT. Staff within the PCTs may not contemplate other options in the absence of funding from the DH. In addition, legal implications of the exclusivity clauses in LIFT contracts prevent PCT staff and GPs from considering other procurement methods. Then the need to increase stock of modernised buildings forces the case-

studied PCTs to stick with LIFT. This lack of discretion as an obstacle to progress was framed by one informant as follows:

> *"We could have considered the traditional procurement route but are prevented from making choices. We desperately needed improved buildings but have to deliver them through LIFT and using the appointed LiftCo."* (GP/Primary care coordinator, PCT-1, Interviewed)

Bossert (1998) and Sharma (2006) remind us that decentralisation within health systems is often ineffective because government departments tend to restrict discretion at lower levels. With LIFT, it may be in the interest of fairness if DH officials were to consider allowing PCT managers and lead GPs increased discretion compatible with its governance arrangements because they are the ones directly involved and affected by its implementation. Most informants thought it was one of the helpful ways likely to increase progress in LIFT.

4.3.2 Quality of buildings and their maintenance

In addition to helpful factors and barriers to improved governance, informants highlighted the factors that they perceived to influence progress in the quality of LIFT buildings and their maintenance. Knowing why they succeeded and what restricted their success may give the researcher a realistic picture of LIFT's contribution to improvements in the condition of primary care buildings within the case-study.

Most informants perceived LIFT buildings to be a step improvement in quality measured in terms of: sizes of the buildings; fitness for their purpose; and availability for continuity in service provision compared to the pre-existing ones. They cited the LiftCo's ability in: innovation; prioritising efficient delivery of buildings; and providing buildings that are affordable relative to appropriateness for need by the PCTs as factors that supported

or presented barriers to progress. Other factors influencing quality of buildings and their maintenance involved: the LiftCo's ability in delivering buildings that are easily accessed by patients; responding to maintenance jobs; and flexibility in maintenance. This could be interpreted to mean that, at least in the case-study, informants prefer using multiple indicators for quality in assessing LIFT activities.

The perception of some of the informants was that LIFT significantly differed from conventional practice by sourcing private sector capital and expertise to deliver PCT buildings. This may explain why they considered it as innovation that increased the quality of building compared to government led schemes. They probably viewed innovation as new ways that increased benefits in procurement including utilisation of primary care buildings. PCT managers and GPs using the buildings could be noticing the added value of LIFT given that desired buildings would have been still delivered without LIFT. This interpretation is illustrated by a GP who cited their buildings getting local and international recognition as evidence of innovation:

> *"This building is top class to the extent of attracting local and foreign visitors to view it. (...) the Prime Minister has been here to recognise us for winning awards for creativity."* (Lead GP, B-3, Interviewed)

Other informants thought that LIFT did not innovate per se. They argued that it standardised buildings within the economy through LiftCos importing technology that was tested outside health into the NHS. Such informants may understand innovation as introducing technology that is unique within their PCTs rather than adapting old ones like experience from delivering Children's Sure Start Centres being used within the NHS.

One possibility could be that LiftCos within the NHS are perceived as motivated to reduce or recover costs for designing individual buildings by using the same technology across a number of PCTs. While this may increase the quality of buildings, the risk could be that innovation gets questionable when buildings fail to reflect unique circumstances or priorities within PCTs.

The findings that LIFT had the ability to deliver high quality buildings within budget, and on time, corroborate the views of King's Fund (2008), the CABE (2008), and NAO (2005). Informants explained this as a consequence of the exploitation of the skills and experience of the private contractors which helped reduce procurement costs.

But GPs and administrators at LIFT buildings felt that LiftCo performance in relation to day-to-day management of buildings was not satisfactory and deterred progress. The buildings administrators particularly raised concern about the LiftCo's commitment to quality and thought that the contractors hired at LIFT buildings lacked appropriate maintenance skills. But it is also possible that the reported need for frequent repairs at fairly new LIFT buildings may be evidence that fast delivery of buildings sometimes compromised quality.

Another explanation as to why PCT managers did not find LIFT quite helpful may be due to what they perceived to be mismatches existing between rents and quality of maintenance of the buildings. Issues were raised about the affordability and sustainability of LIFT because staff within the PCTs felt limited by a number of factors in setting up affordability caps prior to developing LIFT buildings. The urgent need to upgrade GP

surgeries gave the LiftCo chance to dictate the rules. And even if LIFT was deemed unaffordable, there is no other option the DH is willing to fund. Legal agreements also force the PCTs to use and pay agreed rent for LIFT buildings. One director framed the dilemma in reconciling affordability and quality of maintenance as follows:

> *"...the LiftCo extends no favours in terms of cheaper rent compelling us to pay more than market rate for similar buildings. Its income is guaranteed because once it delivers the buildings, we have to use them despite poor maintenance."* (Finance Director, PCT-1, Interviewed)

This suggests that the LiftCo may be getting income safe in the knowledge that its buildings will be occupied despite poor maintenance. It may explain why some managers and GPs felt that 25-year contracts were too long and affected long-term liquidity of the PCTs. The contracts risked future investment in buildings given the reported mismatches existing between quality and cost of LIFT buildings. But the LiftCo representative believed that LIFT helped in matching what the PCTs wanted in buildings with what they could afford:

> *"Our opinion is that 25-year contracts attract financiers needed to help in improving the quality of buildings. It allows them to recover costs without straining the PCTs because shorter contracts increase rent charges which affect PCT liquidity."* (LiftCo representative, Interviewed)

The perception of how LIFT helps to increase investment is reflected in Beck et al (2009) and the NAO (2005) studies that argue that LiftCos have the ability to attract capital needed to complete and maintain buildings. In contrast, PCT managers and GPs feel that the LiftCo may borrow expensively straining the PCTs through repaying unaffordable interest rates. Maybe at their micro-levels, the managers and GPs are less interested in capital flows within LiftCos than how they are supported to adapt and use the buildings to improve patient experiences. This may

explain why they expected the DH to improve the quality of buildings by funding the extras that the PCTs may demand from the LiftCo.

Another dimension of quality was perceived to involve how the LiftCo was flexible in matters of adapting LIFT buildings as required by tenants. It was indicated that only the LiftCo provided the necessary authority to carry out or contract the changes. While this may be logical as the LiftCo owned the buildings, some GPs and building administrators wanted to be delegated the authority to make desired modifications because they did not feel that the LiftCo appreciated or responded to urgency of some jobs. The administrator at one of the buildings supported the LiftCo retaining authority and responsibility arguing that it restricted haphazard alterations that may reduce quality and life of the buildings:

> *"(...) people may see it as being inflexible when the LiftCo discourages unauthorised alterations because they do not realise that the LiftCo's contractors understand the maintenance of buildings. Restrictions ensure discipline to control tampering that may affect residual value of the buildings."* (Administrator, B-2, Interviewed)

Observations by the researcher during tours of the buildings corroborated previous findings by King's Fund (2008) that LIFT buildings absorbed large patient volumes. Their sizes and appropriate technology speed up patient flow. This is what the DH officials primarily intended to achieve through adopting LIFT (DH 2003). Improvements of this nature may help in preventing dilapidation that is caused by congestion as happened at the old surgeries. This is important in light of increasing population, at least within the case-studied PCTs.

4.3.3 Value-for-money

Value-for-money assesses whether or not, within available resources, maximum benefit is obtained from service providers' activities (Sloan & Hsieh 2012). In the current research, it could not be taken for granted that LIFT provided value-for-money for the PCTs simply because it involved private sector providers that are assumed to be experts in their allocated roles. Aside from measuring the direct cost of buildings and their maintenance, value-for-money in LIFT requires taking account of the mix of governance and quality issues already discussed above. By commenting about: the quality of LIFT buildings and their maintenance and costs; how resources for LIFT were used; timeliness of LiftCo activities; and the LiftCo's fitness for purpose in procuring PCT buildings, informants considered these elements together to indicate whether or not LIFT constituted good value.

Except for the LiftCo representative, informants thought that the mechanisms for financing LIFT schemes were too complex to reveal the true value of the buildings. Most informants could not articulate the financing mechanisms and tended to refer to finance directors within their PCTs as more likely to clarify whether the PCTs obtained value-for-money from how LIFT schemes were financed. Despite their being uncertain about the actual cost of individual buildings, the finance directors concurred with their colleagues that LIFT was an expensive procurement method compared to the government route.

Complexity of LIFT financing and its value-for-money contribution may be understood in the context of variations in valuation of the buildings by the finance directors and the LiftCo representatives. At PCT-1, the finance

director believed the cost of one of the buildings (B-1) was £11m. The LiftCo representative reported £9m for the same building. At B-4, the lead GP reported £30m as the cost of the building but the figure was three times as much as £10.2m reported by the LiftCo. Sloan and Hsieh (2012) remind us that assessing value-for-money has challenges including difficulties in measuring some elements while others may be misunderstood. This may be the case when PCT staff wishes to conduct value-for-money audits in LIFT. At the same time, it may explain the reason as to why estimates of the costs of buildings among PCT managers and GPs differed significantly from those of the LiftCo representative in the case-study.

It raises questions about whether procedures in assessing value-for-money in LIFT activities are circumvented, and if elements included in costing of the buildings are complete and accurate. Some PCT managers suspected that the cost of maintenance contractors at LIFT buildings was underestimated. This echoes the concern by Pollock et al (2005) that private developers have an incentive to understate costs to make procurement through PPPs attractive to government. Hence the House of Commons (2001) recommendation for addressing such concerns by having direct delivery and maintenance costs included in value-for-money procurement audits. Perhaps this desire for inclusiveness may explain why the House now expects PCT accounts to show the value of LIFT buildings (Beck et al 2009).

With this research, a potential limitation may be the lack of quantitative evidence for value-for-money. The research neither gathered quantitative

cost information nor assessed options to LIFT. This may preclude the researcher from making a firm judgement about whether the case-studied PCTs obtained better or less value-for-money from LIFT than other options. Some of the views on value-for-money may be subjective due to reliance on informant reports of their individual experiences even though some of them lacked detailed knowledge of financial aspects of LIFT and were uncomfortable in discussing this.

By characterizing LIFT as an economic, efficient and effective procurement method, Milburn (2004b) and the NAO (2005) were suggesting that it prioritised careful use of public resources to save time, effort and cost in delivering better public sector buildings. When expressing their views of helpful factors on progress in governance and achieving quality in LIFT; informants in the current research were inclined to reflect on the manner in which LIFT buildings were delivered and managed. This is because they considered it as an important element in assessing whether or not they got maximum benefits from LIFT given the resources available to them and the working relations it promoted. One respondent at PCT-1 explained how strained relations between the LiftCo and contractors may affect the PCTs in obtaining value-for-money:

> *"The LiftCo did us no favours by firing the contractor that had a history of good relations with this PCT. We were getting value-for-money from the contractor's quality workmanship but the manner in which they lost their contract prevents them from returning to fix problems at some buildings."* (Deputy CEO, PCT-1, Interviewed)

A related perception of PCTs managers and building administrators was that close monitoring of the performance of contractors involved in LIFT was necessary to ensure that LIFT becomes economically more efficient

and effective than government procurement. It was indicated that the contractors hired by the LiftCo were less experienced and less skilled than government tradesmen in providing maintenance services at healthcare buildings. Yet they were more expensive for routine services provided as stated by a manager at PCT-2:

> *"The LiftCo uses short term consultancy to hire contractors lacking health sector background. Without our input, they have difficulties in connecting healthcare needs with building designs yet they charge high fees eventually paid by the PCTs"* (Estate & Facilities manager, PCT-2, Interviewed)

This perception may mean that LIFT is yet to convince PCT managers that it helps in reducing procurement costs and improving management of buildings. It also raises the question of why the DH officials recommended LIFT when according to operational staff, it is not accompanied with additional skills and expertise needed to increase value-for-money in their activities. Instead, LIFT may be said to bring about additional costs when the LiftCo passes over contractors' fees to the PCTs. It may have been avoided were the PCTs responsible for all activities in procuring the buildings.

This may be further understood in light of Milburn's (2004b) argument that PPPs may be the quickest and convenient way to accessing private sector resources and management competences in procuring NHS buildings. In this case, it may suggest that LIFT was designed for the PCTs to benefit from substituting LiftCos for poor value government led procurement. Besides mobilising private sector capital to reduce direct DH funding, LIFT would exploit private sector skills and competences to achieve efficiency and effectiveness in procuring better quality buildings. But there may be

questions as to whether LIFT has the capacity to take on increased procurement and management risks, and determining or timing for when to deliver new buildings as currently done by PCT staff.

The fact that PCT managers advocated renegotiating the maintenance contracts in favour of government tradesmen may mean that they perceive them as better at managing risks in procurement to obtain maximum value-for-money benefits from LIFT than the LiftCo and its contractors. This may be economically sensible in that if the tradesmen have skills and competences similar to those of the private contractors, as the cheaper option, they may convey efficiency and savings to the PCTs. More value-for-money could be achieved because government tradesmen may use their familiarity with requirements at healthcare buildings to adopt more cost-effective ways in service provision than private contractors.

In considering whether value-for-money has been satisfactorily achieved or not, benchmarks against which to pass judgements may be required. Perrot (2006) and McKee et al (2007) consider them as helpful indicators for whether expectations on performance or quality are realistic. This is because some elements in performance and quality may be intangible. In this research it may mean that differences might exist in informant views about the mix of quality, costs, convenience, or fitness for LIFT in procuring desired buildings. Such difference could be evidence for contested benchmarks about these elements in judging value-for-money obtained from LIFT.

This was illustrated by differences among PCT managers about expectations on LiftCo activities. Some managers believed that their

expectations for the LiftCo to offer value-for-money by reducing expenses and time in delivery while offering better quality were unrealistic under the standards within the estates industry. The logic of this argument may reside in that the buildings that LIFT was replacing were designed, built, and maintained by the DH. Yet despite being less than 25 years old, the buildings were already deemed rundown and inappropriate for desired services. Expecting LIFT buildings to be cheaper and yet again of higher quality to outlive what could have been delivered by the DH may be therefore considered unrealistic.

The GPs using LIFT buildings perceived 25 year contracts governing PCT-LiftCo relations to be unfeasible for their business. Their preference for five year contracts with the PCTs may be evidence for them having problems reconciling length of LIFT contracts and expected value-for-money under unpredictable patient demands at LIFT buildings. Or it may be show of whom between GPs and PCT managers actually influence progress in light of one of the GPs' statement that:

> *"...the PCT wanted our contract to run for 25 years but we thought it did not make business sense; (...) we forced them to offer 5 year contracts. Some GPs refused to join because the PCT did not guarantee continuity of business in the event of reduced patient demand before maturity of LIFT contracts"* (Lead GP, B-2, Interviewed)

Another possible explanation as to why GPs perceived better value-for-money under shorter contracts may be due to difficulties in predicting neither what patients would want nor how they may expect to respond to these demands or changing service configurations 25 years into the future. The DH desire to bring healthcare "nearer home" in line with patient preferences expressed in *Our Health, Our Care, Our Say* (DH 2006b) may

also cause uncertainty about appropriateness of LIFT buildings if services are reconfigured before the expiry of LIFT contracts. GPs and building administrators raised the concern that rents for LIFT buildings were payable whether they were fully occupied or not. It means that GPs may be perceiving 25 year contracts as locking them into deals with declining value-for-money due to changes in circumstances. In comparison, private companies renting private buildings prefer short contracts that give them freedom to maximise value-for-money by moving with changes in circumstances.

The fact that risks in supply of LIFT buildings were perceived to be fairly predictable and easier to manage than those on the demand side was considered as influential on progress. PCT managers did not consider it as a significant benefit that LIFT buildings were delivered on time and within budget. This is because they believed that the risks involved and borne by the LiftCo were predictable and easy to manage since LIFT buildings were derived from agreed and ready to implement SSDPs. The SSDPs were developed by the PCTs through interpreting complex and unpredictable demand factors. It left the LiftCo to only take risks to deliver buildings along agreed specifications and quality standards. The belief that the PCTs retained unpredictable risks in demand for buildings may explain why most managers thought that LIFT neither provided enhanced value-for-money nor improved risk management in procurement.

Apart from being considered as predictable; construction delays and cost overruns were risks perceived to also benefit the LiftCo more than the PCTs if managed effectively. In fact some managers and building

administrators believed that contractors sometimes paid attention to avoiding some risks at the expense of quality which reduced value-for-money the PCTs may obtain from LIFT activities. They pointed out that delaying maintenance was strategy forcing tenants into expenses not fully reimbursed. Inadequate consultation of PCT staff in planning stages was also cited as strategy for the LiftCo to avert cost overruns by beating delivery deadlines.

The nature of the boundaries between the LiftCo's responsibility in managing financial risks, and PCTs' ultimate responsibility to meet their costs if realised to some extent influenced value-for-money obtained in LIFT. PCT managers maintained that the LiftCo only managed whereas PCTs retained most risks in LIFT. In their perceptions, rents and maintenance fees at the buildings were negotiated with a view to ensuring the LiftCo could recover its capital and make profit. This may mean that PCT managers see LIFT as not conveying value-for-money if costs are passed over to the PCTs directly. At times these were passed over indirectly through either unreimbursed expenses or reduced quality of services. It may mean that LIFT imposes extra risks for PCT managers who believe they lack adequate power to penalise the LiftCo for not meeting standards agreed on.

Feedback on whether LIFT replaced buildings because they were at wrong sites provided insights into value-for-money obtaining from decisions about where LIFT buildings are built. The indications were that all except one of the LIFT buildings toured were on the same site as a pre-existing government building, meaning PCT managers consider the pre-existing

sites as still appropriate for their needs. The managers use LIFT to only improve their buildings. An alternative explanation could be that the PCTs perceive loss if they were to sell the land that they owned for using the proceeds in acquiring a new one and renting LIFT buildings. Simultaneous land retention and using improved buildings may be consensus within PCTs that value-for-money is achieved through high value LIFT buildings substituting for existing poor value ones. This could present LIFT as not the disposal of PCT buildings but a change in ownership; where the change is merely a strategy to finance delivery and subsequent management of better quality buildings.

In summary, why different categories of informants in this research experienced mixed progress in LIFT could be a result of complex sets of factors. To a greater or less extent, a number of factors in LIFT appear to facilitate while others constrain progress. It does not appear progress was a function of issues on governance, or quality improvement, or activities with best value-for-money alone. The extent of their influence is likely to be a function of, for example, the ease with which some LIFT outcomes may be either measured or understood; plus whether the outcomes are intangible or subjective interpretations by those affected. Despite the complex factors, most informants in this research thought that LIFT had the potential to help them in meeting patient expectations for better quality buildings in terms of sizes, fitness for purpose and modern technology compared with pre-existing surgeries.

4.4 Analytic category (d): Lessons learnt from the case-study experiences to better explain and understand LIFT for the benefit of future schemes and other PCTs

Since the present research focused at LIFT's operational level and excluded policy-making and care provision levels, the following lessons (4.4.1 to 4.4.4) deriving from the findings reflect on experiences and views of staff at the frontline of LIFT activities:

4.4.1 LIFT is not just about delivery of improved buildings but decentralising four important aspects in procurement:

(i) It reaffirms decentralised planning for primary and social care buildings from the DH to the PCTs. In turn, PCTs decentralise through involving and giving roles to the LiftCo and independent GPs. The LiftCo takes part in developing the SSDPs from which LIFT buildings are derived. Unlike in the past, GPs have a role to coordinate delivery of buildings on behalf of the PCTs.

(ii) LIFT devolves financing of the buildings used by PCTs from the DH and Treasury to private financiers through the LiftCo. The LiftCo mobilises finance needed for all procurement stages up to making the buildings available for use by the PCTs.

(iii) LIFT decentralises maintenance of the buildings from PCTs to the LiftCo. Decentralisation is then extended by the LiftCo hiring different contractors at the buildings rather than relying on its own staff.

(iv) LIFT could be a DH strategy to centralise control and influence over general practice at LIFT buildings through the PCTs. PCTs

are the principal tenants and they decide which GPs to contract for providing specific services at LIFT buildings.

4.4.2 In this context of decentralisation, LIFT on its own may not increase the stock of buildings. It is the PCTs that ascertain demand for buildings and invite the LiftCo to deliver new or refurbish existing ones based on agreed SSDPs. Thus, LIFT is a way of financing PCT investment decisions and maintenance thereafter.

4.4.3 Interpersonal factors are perceived as more influential on progress than presence of new features in governance. This lesson resides in that *commitment*, *engagement,* and *collaboration* between PCT and LiftCo staff, and GPs and contractors at LIFT buildings were repeatedly alluded to during interviews. The DH officials anticipated that the SPB would facilitate progress yet it was perceived to cause confusion by duplicating role of the existing PCT Boards.

4.4.4 A related lesson was that PCT managers are predisposed to positively assess their role in LIFT. They emphasize their strengths and not weaknesses in explaining progress. In their view, progress was achieved because being professional, committed, and working as teams spurred them in taking risks that enhanced benefits. The managers blame governance arrangements in LIFT for restricting progress by not helping them in translating their experience and professionalism to improve imperfections of DH led procurement. Although they may have possible weaknesses like, for example, doing some activities wrongly or making wrong decisions and choices, the managers rarely talk about them in relation to restricted progress in LIFT.

4.5 The revised middle range theory

This subsection uses the first person to clarify how the middle range theory was revised. Prior to fieldwork, I analysed documents to understand how LIFT was expected to work. The documents were mostly written by DH officials as guidance for LIFT. Thus the initial theory that I developed had a limitation of favouring DH officials' perspectives in explaining LIFT. At that time, my understanding was that the officials perceived LIFT as a strategy for decentralising some aspects in procurement and management of primary care buildings. This led me to state the initial middle range theory (page 108) to the effect that:

> PCTs that implement effective LIFT schemes deployed decentralised structures which support staff in influencing long-term risk management in procurement of healthcare buildings. They prefer LIFT because it is the convenient and effective option in financing and maintenance of the desired buildings. Activities to execute LIFT schemes stimulate participatory decision-making, information sharing and openness between PCT staff, LiftCo staff, GPs using LIFT buildings and local stakeholders and contractors providing service at the buildings. LIFT activities ensure that the LiftCo assumes higher proportion of risks associated with procurement and management of buildings compared to the PCTs. The LiftCo is familiar with, and responsive to priorities of the PCTs. Its good working relations with the PCTs promote collaboration in increasing patient experiences when they are attracted by improved conditions at LIFT buildings.

In context of RE methodology, Pawson (2006) recommends refining the middle range theory in light of key findings and lessons learnt from research. In this research, part of the contribution of in-depth interviews was in helping to explore how staff implementing LIFT confirmed, refuted or refined my initial understanding of LIFT using their individual experiences. The interviewees were directly involved and affected by LIFT

and could therefore enlighten the theory about how LIFT actually worked rather than me relying on documentary evidence alone. Based on the findings and lessons learnt, I adjusted the middle range theory to state that:

> PCTs that implement LIFT schemes fail in achieving some of the anticipated benefits. They are restricted by the fact that the DH officials conceived LIFT with neither involvement nor engagement of frontline staff that are expected to implement it. Consequently, PCT staff lack motivation in developing skills and expertise needed in managing risks to effectively achieve LIFT objectives. PCTs still use LIFT despite it possessing challenges in improving efficiency, or making the procurement of buildings more affordable and sustainable than conventional method. Using LIFT does not promote competition that is needed to generate anticipated benefits. Its governance helps little in increasing PCT capacities in improving procurement. PCT managers perceive the DH officials as not prioritising their engagement for practical issues in implementing LIFT. Consequently, they feel that LIFT's mixed achievement is influenced by a mismatch between their responsibilities, and power and authority to control the LiftCo. Combinations of these factors create negative atmosphere yet LIFT could be more effective if PCT staff had enhanced discretion to promote commitment, trust and collaborative relations with the LiftCo.

The overall findings may be considered as confirming the research's primary assumption (1.1.5.2, page 5) that LIFT decentralises both funding and financing of primary care buildings. It was revealed that the responsibility to develop SSDPs and business cases for LIFT schemes was passed over from the DH and strategic health authorities to the PCTs. The PCTs decided on whether or not to partner with the LiftCo in procuring desired buildings. Financing of buildings was decentralised to holders of private equity in the LiftCo.

The second assumption was that the PCTs had discretion to increase effectiveness by varying LIFT guidance including choice of options in procurement. The findings so far incorporated in the revised middle range theory revealed that this assumption was partially correct. PCT staff lack adequate discretion over LIFT's critical procedures. It means that progress achieved so far owes much to staff commitment in collaborating with the LiftCo than ability to manipulate LIFT guidance. Interpersonal factors were cited as effective in facilitating progress compared to governance structures such as the SPB and LiftCo board that merely increased bureaucracy. These issues have been so far incorporated in the revised theory but may not be the ultimate explanation of LIFT. It may require continual testing in different case-studies to get an apt explanation as recommended in RE practice (Pawson and Tilley 1997).

SECTION 5: DISCUSSION

In the previous section, the overall research findings were integrated and interpreted to construct common themes explaining LIFT. The discussion in subsection 5.1 considers the key findings in relation to literature some of which is already embedded in the Background section (Evans and Gruba 2002). Subsection 5.2 considers the findings' implications for policy and practice before LIFT is contextualised to the 2012 Health and Social Care Act (subsection 5.3). The discussion concludes with a reflection on limitations of this research (subsection 5.4).

5.1 Key findings and how they relate to literature

The present research chose decentralization as the concept on which LIFT was based. So, the discussion here considers the key findings emerging from the analyses in the light of literature on decentralization and public-private partnerships (PPPs) in which domain LIFT falls. Attention is given to explaining whether and how the findings make LIFT consistent or different from decentralization theory and literature. A great deal of the literature is already embedded in subsection 1.2 of this thesis.

5.1.1 LIFT involves and benefits a range of participants

The first major finding from the analyses indicated that, aside from the PCTs, LIFT involved and benefited a range of other participants namely: primary care providers; investors in the LiftCo; contractors; and service suppliers at LIFT buildings. This finding aligns considerably to the discourse on evolving approaches to public service delivery within the UK. Commentators use either New Public Management (Hood 1991, Pollit and Bouckaert 2000) or Third Way (Powell (2000) in describing trends that

increase role for more non-governmental agents in public service delivery. In the UK, the trend is perceived as relentless within the NHS (Klein 2003, Allen 2006 and McKee et al 2006).

That LIFT facilitates increased role for more players in procurement and management of healthcare buildings is consistent with New Public Management theory and practice in context of decentralization. International agencies such as the WHO (2000) believe that health systems that deregulate more health functions may improve performance. This further aligns LIFT with the various decentralization strategies in the sense that financing of buildings is passed over to investors in the LiftCo and private companies are involved in construction and post-delivery management of the buildings.

There is also the perception that PPPs along which LIFT was designed are a way of engaging and involving communities in influencing investment decisions in their areas (Milburn 2004a). The finding that LIFT involves and benefits a range of participants may therefore suggest that it is entrenched in operationalizing "community involvement" ideology. If so, you could argue that DH officials behind LIFT conception used a broad definition of "community involvement" as involving any entities including private corporations. This may invite controversy as analysts (e.g. Morgan 2001) prefer a narrow definition that considers community involvement as involving ordinary service-users affected by official decisions. Thus, it may not be surprising that involvement of private companies in LIFT is central to controversy surrounding its use within the NHS (Pollock & Price 2006, Aldred 2007).

5.1.2 LIFT embodies mixed facilitating and constraining factors

The finding that LIFT had mixed facilitating and constraining factors correlates with literature regarding challenges to maximising benefits from decentralization strategies. It was reiterated that mixed experiences with LIFT was primarily due to some problems inherent to how it was designed and others due to problems in implementation. This finding may be possible in light of challenges that have been highlighted as affecting effective implementation of PPPs within health systems. Perrot (2006) reminds us that if PPPs are too complex, they prevent people that are expected to implement them from translating their professionalism into desired improvements. Operational staff may have mixed experience depending on their individual skills and expertise.

Various commentators (Pollock & Price 2006, Beck et al 2009, Aldred 2008, and Fitzsimmons et al 2009) concur that progress in LIFT is deterred by its complex design and governance arrangements. In most cases these elements obstructed operational staff from maximising value-for-money, improving quality and management of risks in procurement activities. In the present research, informants believed that they achieved progress but still felt that more progress could have been achieved if LIFT was less complex.

This finding is also reflected in literature reporting that PCT staff generally lack skills and expertise and may need support in managing PPPs in the health system (King's Fund 2008, NAO 2005, Beck et al 2009). The complex nature of LIFT means that PCT staff encountered more

constraints in discharging their responsibilities. Fitzsimmons et al (2009) argue that financial diligence is necessary in maximising benefits from LIFT but PCT staff are constrained by inadequate skills in financial matters related to risks in procurement.

Highlighting why some decentralization strategies may constrain progress, Pollit (1998) and Bennett et al (1997) point at lack of clarity about activities being decentralised. Confusion arises if operational staff are unable to identify who is responsible for what important activities. Unclear accountability risks neglect of important activities when staff avoids doing them thinking other parties are responsible. In this research, informants indicated that confusion about responsibility for decisions in monitoring the LiftCo's activities between PCT managers and the SPB restricted their progress in LIFT.

A further explanation for the finding about mixed facilitating and constraining factors may be due to misunderstood or problems in measuring LIFT outcomes. In light of complexity of LIFT previously cited, it may be that some participants' expectations are unrealistic and probably beyond the LiftCo's ability. In particular, PCT managers may be struggling to achieve their expectations and when they fail, the feel not adequately supported in their activities. Having higher expectations is not necessarily an anomaly as it is consistent with literature. For example, Stevens (2004) argues that those in charge of new initiatives in service delivery at local levels expect significant improvements in their performance. They are sceptical about the initiatives if the benefits obtained are marginal or more or less similar to what they would have achieved using conventional ways.

This may explain why some informants in this case-study believed that improvements in procurement and management of primary care buildings would have been better through their leadership rather than the LiftCo's.

5.1.3 LIFT's most helpful mechanism is participant collaboration

Informants in this case-study lacked consensus about some LIFT mechanisms' influence or helpfulness on progress. But they agreed about collaboration in activities between participants in LIFT as probably the most influential mechanism to achieve success. This finding is consistent with literature suggesting that whether in health or other sectors, success with PPPs hinge on participants collaboration. Perrot (2006) explains the effect by noting that:

> *"...success of agreements requires the active participation of the partners as well as complementarities between resources, technology and know-how. (...) these are agreements in which partners define the terms of reference for the co-operation, i.e. how they pool their resources on day-to-day basis to reach the targets they have set." (*page 863*)*

In relation to the present research, informants reiterated that GP willingness to take part through coordinating delivery of individual schemes, and relocating their practices to the new buildings show collaboration in meeting LIFT objectives. Other studies (e.g. King's Fund 2008) have suggested that primary care within the NHS may be enhanced through the DH investing in promoting collaboration between PCTs and GPs. If PCT managers perceive GPs as already collaborating, then LIFT may be the springboard for improvement in primary care. Strengthening this may now require the DH ensuring that GP resources, technology and know-how (Perrot 2006) are joined to those of the PCTs for enhanced synergy in activities. Currently, there is concern that progress is restricted by PCT activities and those at LIFT buildings being parallel.

By definition, mechanisms are factors within a programme that either facilitate or constrain progress (Pawson 2006). In this research, LIFT's ability to mobilise capital needed to complete projects and maintenance of buildings was cited as an important mechanism. Yet when asked to identify mechanisms that helped them most in achieving LIFT outcomes, informants emphasized behavioural factors. You would have expected them to cite economic factors internal to LIFT that influenced progress because some of the behavioural factors involved may overlap as contexts in explaining the most helpful LIFT mechanisms.

Despite them providing contexts conducive for progress, theories about *involvement, commitment* and *engagement* of PCT managers in making strategic decisions were alluded to in discussing helpful mechanisms. This may indicate that informants are more interested in *process* of delivering LIFT buildings than *what* resources, technology and know-how LIFT brought within their PCT areas. Their possible belief could be that with or without LIFT, procurement inputs would still be provided under their leadership, hence interest in improvements that LIFT makes on conventional procurement procedures.

5.1.4 Progress in LIFT may be increased with enhanced discretion

At the same time, PCT managers and building administrators impressed that it may be misplaced to expect them to achieve progress solely on collaboration between LIFT participants. They wanted enhanced discretion in LIFT activities to increase progress. In context of decentralization, this finding is consistent with literature explaining why some reform strategies may fail to achieve progress. Authors including Bossert (1998), Savas (2000), and Peckham et al (2005), argue that decentralization within

health systems primarily seeks to improve performance by allowing local staff freedom in decision-making about how to effectively deliver services. In this case, progress is therefore not so much about collaboration or benefiting from extra resources, skills and expertise, as opposed to empowering local staff in making decisions about meeting their priority needs. This is achieved by allowing them freedom in issues of governance (Bossert 1998), financing (Savas 2002) and management of the decentralized functions (Peckham et al 2005, Mill & Vaughan 1990).

Some studies dealing with challenges in increasing LIFT's effectiveness (Beck et al 2009, King's Fund 2008, Aldred 2007) have cited inflexible guidance as restricting progress. PCT managers that coordinate LIFT activities lack adequate discretion in adapting the guidance to local circumstances. In relation to the present research, the perception that progress in LIFT may be achieved with increased discretion might be warranted for one important reason. PCT managers may be feeling that inflexible LIFT guidance restrict their progress. In fact, previous research commissioned by the DH (e.g. Peckham et al 2005, Beck et al 2009) have highlighted inflexible guidance as one of the challenges in implementing LIFT. Yet in the current research, PCT managers still feel they lack adequate discretion over its main activities.

Conflict of interest is one of the challenges that may restrict progress with PPPs (Bennett & Muraleedharan 2000). It causes tension if those directly involved in implementing partnerships perceive disproportional discretion allowed between their activities. With LIFT, PCT managers felt that progress was restricted by their LiftCo wielding more influence on activities

compared to them. They see potential conflict of interest arising when the LiftCo charged with delivering buildings is also involved in developing the SSDPs that specify what they are expected to deliver. The LiftCo may do so knowing that PCT managers lack discretion in dealing with its activities. This issue may be consistent with the World Bank's (2006) concern that:

> *"Risks of a conflict of interest arise with PPPs that both provide input into the approval process (...) and play a role in identifying and preparing projects. Conflicts can also arise if a PPP promotes or assists in developing projects and then is asked to carry out ex-post evaluations"* (page 3)

The concern that LiftCos may wield power and control over PCT managers and GPs' procurement activities may therefore indicate that informants worried about potential conflict of interest as a constraining factor.

This may explain as to why some informants thought progress achieved so far was because the small size of their LiftCo prevented it from dictating terms in procurement activities. Having a small LiftCo that is stable in terms of keeping the same CEO in position for long may help in making the LiftCo familiarized with PCT priorities. It also facilitates progress by reducing confusion caused by high churn of CEOs. The finding may mean that PCT managers felt constrained by high turnover of CEOs at the LiftCo in the early years; reducing the momentum on progress especially when new CEOs were getting to familiarize themselves with their responsibilities.

5.1.5 Duplication of existing practices deters progress

PCT managers had the perception that some contexts, mechanisms and outcomes emphasized in LIFT duplicated existing practices within the PCTs. In context of decentralization, literature that reflect on this argue that strategies that merely pass over existing responsibilities to new

beneficiaries of decentralized functions may not only affect staff morale but also restrict progress (Flinders 2004, Dubois & Fattore 2009). Duplication of practices may not be a cost-effective way of using resources in LIFT. This may also explain why PCT managers and GPs echoed findings in previous research (Pollock & Price 2005, Aldred 2008, Fitzsimmons et al 2009) that criticise LIFT for using a lot of money to develop and maintain fewer buildings than conventional method.

Another possible explanation for raising the issue about duplicating existing practices could be related to concern about its effect on accountability in LIFT activities. PCT managers might be concerned that sharing the same activities between PCT staff and those from the private sector may cause neglect in carrying out some activities if there is passing back of accountability between those involved. This may not reflect well on the PCTs because the DH expects them to be ultimately accountable for LIFT outcomes. It is also possible that this finding arises from PCT managers' desire for regaining influence over procurement activities perceivably lost to the LiftCo. They may be hoping that by citing duplication of existing practices, DH officials may be persuaded to revise LIFT guidance in favour of PCT staff compared to those of the LiftCo.

5.1.6 LIFT objectives have been achieved to an extent

Notwithstanding challenges in implementation, at least in this case-study, LIFT objectives have been achieved to lesser or greater extent. This is consistent with literature that has endorsed LIFT for improving the quality of buildings in terms of bigger sizes, fitness for their purpose, and having appropriate technology to increase patient experience (King's Fund 2008,

NAO 2005, Beck et al 2009). Other commentators (e.g. Pollock and Price 2005, Aldred 2007, Fitzsimmons et al 2009) have, like informants in this case-study, criticised LIFT as a convoluted arrangement that makes procurement expensive and unsustainable for the PCTs. Despite this, most informants acknowledge that the quality of LIFT buildings was significantly better than pre-existing ones. This finding correlates the researcher's observations during the tours that the conditions at LIFT buildings were sufficient to promote continuity in GP activities (Key Finding 8).

With regards to some of the criticism levelled against LIFT, it is possible that some informants may have encountered problems in measuring its outcomes especially those related to value-for-money. A considerable number of LIFT outcomes may be intangible and therefore misunderstood, meaning some informants may be hard on their achievement by reporting limited progress sometimes. Or they may even overstate their achievement due to the subjective nature of some expected LIFT outcomes. Further, considering the PCTs case-studied as part of the pioneers of LIFT in London, it may be that negative views on LIFT were influenced by experiences at the beginning. Over the years, LIFT may have improved in economy, efficiency and effectiveness yet scars from pioneering it remain vivid in informant perspectives.

5.1.7 Success and failure in LIFT

With over 50 operational schemes across London alone, DH officials may view LIFT as a success especially after endorsement by the National Audit Office (DH 2007, NAO 2005). Yet problems cited by its critics suggest that different criteria and factors are used in judging success in LIFT.

5.1.7.1 Criteria to measure success

The criteria seen to contain useful indicators for success concerned LIFT's ability to: (i) support the PCTs towards meeting their objectives; (ii) deliver gains that commensurate with amounts of capital invested by the PCTs; (iii) increase PCT capacity in procurement activities; and (iv) generate future opportunities for the LiftCo and PCTs (IPPR 2004). For example, completing started projects was seen as indicating success under the first criterion; and delivering buildings within budget indicated success under the second criterion. Caution may be recommended against isolated use of individual criteria to measure success. It is possible that confounding factors other than LIFT influence the outcomes. For example, some indicators for success like increased staff morale due to using more comfortable buildings; or GPs using relevant treatment technology in appropriately designed buildings, are crossover of success between different criteria driven by different LIFT mechanisms. Similarly, when PCTs experienced financial challenges in meeting their obligations, it was seen as failure (Milburn 2004) along different criteria to measure success.

Within the case-study, how the conceptual bases of LIFT (subsection 1.2.4 page 40) are expected to work tend to influence the criteria used in measuring success. For example, how public-private partnerships work to solve problems in procurement had bearings on perceived effectiveness of LIFT in addressing declining investment in GP surgeries. If LIFT was seen as driven by "localism", its responsiveness to patient demands for a greater say in improving local surgeries may be affected by how it is implement. It means that how conceptual bases of LIFT are expected to work were incentives influencing LIFT outcomes. These were some of the criteria that

research informants used in explaining whether LIFT was able to replace PCTs in delivering GP surgeries efficiently. Some were also used in judging whether LIFT was able to improve democracy in activities for improving the quality of services demanded by patients at GP surgeries.

5.1.7.2 Success factors

In this case-study, informants believed that the criteria to measure success in LIFT were influenced by behavioural, institutional and economic factors. Success was achieved provided DH officials, the Strategic Partnering Board, and LiftCo executives joined and supported PCT management staff in working as a chain of commissioners. PCT managers believed that joining up institutional efforts would reduce confusion and counter suspicion that constrained progress in LIFT. Yet DH officials and the Strategic Partnering Board were perceived as not sufficiently engaging PCT managers in making critical decisions in LIFT.

The DH officials and local strategic partnering boards are expected to seek consensus on governance issues by coordinating strategic decisions in LIFT. This may help in translating PCT priorities into desired buildings. For example, the case-studied LiftCo participated in identifying investment opportunities for inclusion in the PCTs' strategic services development plans. It then created synergy within PCTs by making LIFT buildings available free of charge for community initiated social activities whenever not needed for health provision. The local strategic partnering board ensured success by robustly enforcing compliance with LIFT. But PCT managers felt that way compliance was enforced alienated them because consensus on important issues was not prioritised.

Another factor for success concerned continuity in demand for utilization of GP surgeries. East London areas experienced high population growth meaning increased demand for appropriate buildings. PCT managers explained that patients within their PCT areas were now more knowledgeable about the quality of services they expect from providers. It empowers them to influence their GPs and other providers in prioritising appropriate buildings and technology. Thus, the PCTs are persuaded to have continuous demand for using LIFT to deliver the desired facilities and the providers being ever prepared in taking LIFT accommodation for their business. Presence of these factors may explain success achieved so far within the case-study. But the Liftco's capacity to deliver is outstripped by demand for alternative accommodation to replace old buildings.

Economic and financial factors especially those about who pays for what activities are also important factors for success in LIFT. The lead GPs and LiftCo chief executive officer were concerned that the cost of land in east London was high. It inhibited expansion or delivery of new buildings with amenities that may take up too much land. Because of population concentrations in some areas in the case-study, LIFT was prevented from erecting appropriate GP surgeries without financial disadvantages to the PCTs and the LiftCo. This is because the necessary land or modifying existing buildings is expensive.

5.1.7.3 LIFT's success and failure in the case-study

It was previously argued (subsection 1.2.4 page 40) that LIFT conceptually represented DH operationalisation of New Public Management, Third Way, Localism and PPP perspectives in public service delivery. Thus, the criteria to measure its ability to produce benefits might be similar to those

explaining how these conceptual perspectives (Table 1.1b pg 43) are expected to work. The perspectives and LIFT's underlying objectives concern: (i) increasing participation; (ii) diversity; (iii) efficiency; and (iv) resolving conflict on appropriate ways to deliver public services. It might be more helpful to use the underlying objectives as the important benchmarks against which to judge LIFT's success and failure than isolated consideration of its delivery of the desired buildings.

5.1.7.3.1 Participation

Through LIFT, the DH hierarchically reorganised authority for the PCTs to get responsibility in addressing problems in improving GP surgeries. LIFT guidance (DH 2001, DH/PfH 2003) facilitated participation by PCT managers in strategic decision-making with some degree of liberty from DH officials. Although PCT managers always had responsibility to prepare business cases for desired GP surgeries, through LIFT the got authority to invest public funds into private companies tasked with delivery and management of the buildings. Previously, the role was performed by the DH officials or their agencies. The reorganisation of participation possibly increased effectiveness in procurement and quality in management of GP surgeries.

Some PCT managers contest this by questioning the quality of participation in LIFT. They are concerned that the DH officials excluded them in designing LIFT and feel they are not allowed sufficient discretionary powers in its governance. For example, they cannot use funds set aside for assisting GPs to move into LIFT buildings for other LIFT related activities without approval from the DH. So while

acknowledging that LIFT marginally increased their participation in decision-making about procurement; the managers are unconvinced with the quality of their participation. They explain it as the result of the DH officials and the local strategic partnering board prioritising their LiftCo's contribution over that of the PCT managers. This gives rise to the perception their participation in LIFT's critical decisions is cosmetic because it is run from the DH and forced on the PCTs. You could therefore argue that LIFT's ability to increase participation in procurement activities is variable. Its procedures in the case-study involved insufficient consultation or lack of equality in partnership between the PCTs, LiftCo and public sector officials overseeing its implementation.

5.1.7.3.2 Diversity

Advocates of decentralization argue that compared to decisions only made by officials at national level, involving better informed diverse groups may produce more relevant decisions (Silverman 1992). LIFT may be thus a response to demands for increased competition in procurement of GP surgeries in line with New Public Management, Third Way, and PPP perspectives in public service delivery. Its implementation involves diverse interests in society joining up to plan, finance, deliver, and manage desired buildings. To an extent, LIFT has increased diversity in these aspects of procurement including in ownership and maintenance at GP surgeries. Previously, the roles were reserved for the DH or its PCT agencies.

Success on diversity in the case-study is variable due to how LIFT was designed. On the one hand, the LiftCo has exclusive rights to developing future buildings within the PCT areas. It may be a failure in the sense that the LIFT areas become geographical monopolies of the LiftCo thereby

negating the benefits of increased competition in improving the GP surgeries. On the other hand, too many participants may increase problems in implementing LIFT. For example, in the case-study, concerns about poor workmanship or delaying responses to maintenance jobs at LIFT buildings were explained as the result of diversity. It brought in providers lacking experience in health. According to administrators at LIFT buildings, diversity introduced challenges in monitoring performance of multiple maintenance providers. They preferred it only if increased their capacity in procuring and managing the buildings.

5.1.7.3.3 Efficiency

The government perceived LIFT as a means to increasing efficiency in procuring primary care buildings with improved conditions (DH 2001, DH/PfH 2003). Efficiency was understood as delivering buildings of the desired quality on time and within budget without direct recourse to DH funds. Towards this end, private investors were given controlling equity in the LiftCo as incentive for them to apply private sector management practices and expertise in reducing inefficiency in bureaucracy of DH led procurement. Efficiency would be achieved if the LiftCo and PCT managers collaborate in procurement because their proximity to GPs and service-users allowed them more timely delivery of the desired buildings than the DH officials. But efficiency in this case is likely to depend on how PCT managers felt motivated by having discretion over their own creativity or initiatives in LIFT within their areas.

The findings so far presented on this case-study indicate variable perceptions about LIFT's ability in increasing efficiency in procurement. On the one hand, they corroborate those of past research that portrayed LIFT

as efficient at improving the quality of primary care buildings. King's Fund (2008) and Beck et al (2009) reiterate that it increases efficiency in procurement compared to using the DH route by delivering buildings on time and within budget.

On the other hand, PCT managers argue that the measures for efficiency in LIFT should not consider ability to deliver buildings on time and within budget only. They argue that their LiftCo pegged budgets for the buildings higher than market norms to accommodate its failure in reducing procurement costs. Coupled with the criticism that the LiftCo and its contractors cut-corners in construction or substituted poor quality inputs for the standard ones specified by the designers; the claims for efficiency in LIFT are perceived to be inflated. This is because the buildings are delivered using processes perceived to prioritise efficiency at the expense of quality. Thus, some PCT managers are not convinced about durability of LIFT buildings because of their speedy construction and poor quality inputs used to save delivery cost. Hence argument that it was more efficient to procure similar size and designed buildings through the DH route than using LIFT.

5.1.7.3.4 Conflict resolution

Within the NHS, opinion is divided on which between the DH, market, and LIFT routes is the most appropriate one in procuring premises. Some public management analysts (e.g. King's Fund 2008) advocate moratorium on investment in new premises to redirect resources to strengthening collaboration between DH agencies and independent GPs using the existing in buildings. There is also conflict between advocates for markets and citizenship (e.g. Milburn 2004b, CABE 2008, NAO 2005) and those

favouring government retaining custody of public interests in procuring public functions (e.g. Powell 1998 and Pollock and Price 2006).

Although LIFT is a drastic change in solving problems in procurement, it was probably seen as a better compromise in reducing conflict in procuring NHS premises. It neither fully privatises nor nationalises procurement activities. Its drastic introduction neither prepared PCT managers in dealing with problems nor resolving conflict in economic matters of its implementation. The conflict is also sustained by the fact that LIFT transfers influence of PCT managers on critical procurement decisions to the LiftCo to the extent that the PCTs continue using it only because the DH is reluctant to fund any procurement options.

The DH (DH/PfH 2003) hoped that LIFT would make PCTs effective at improving GP surgeries by removing obstacles in economic and financial activities in the NHS. Yet PCT managers directly involved are not convinced that LIFT helps them in improving procurement. They cite their experience to point that it neither increases PCT capacities nor management capability in solving problems in public procurement. It corroborates work by Beck et al (2009) alerting us to the fact that some PCT managers still lack skills and expertise in monitoring performance of their LiftCos despite years of implementing LIFT in their areas.

5.1.8 Using LIFT produces some unexpected outcomes

The issues cited as unexpected outcomes that the DH officials did not foresee in recommending LIFT procurement concerned: increased role of independent GPs in developing PCT buildings (positive outcome);

exchange of expertise between the public and private sectors (positive and negative outcome); and conflict of interest (negative outcome).

It is possible that increased role of GPs in developing PCT buildings is not so much an unexpected outcome but rather consistent with the DH's determination in reducing its role in selected procurement activities. The unexpected may be the degree to which the GPs influence LIFT activities. For both the DH officials and the PCT managers, increased influence by the GPs is a positive outcome although for different reasons. The DH officials want to shed their role whereas PCT managers desire collaboration with the GPs in procurement activities. Hence GPs delegated role in coordinating delivery of individual buildings (King's Fund 2008).

Increased exchange of expertise between the public and private sectors may affect LIFT activities positively or negatively. Let us consider the loss of staff with LIFT experience at Treasury for example. Given Treasury's strategic role in LIFT, PCT activities may be inconvenienced by lack of appropriate financial advice especially if Treasury finds it difficult to replace the lost expertise. A positive development though is that PCTs benefit from recruiting staff from private companies and other non-health public sector departments. In this case-study; the director for estate and facilities at PCT-1 had experience with LIFT from leading the delivery of Sure Start Children's Centres whereas the LiftCo CEO had experience from working for a housing association. Their experience increased PCT capacity in relating well with the LiftCo and their skills mix was applied to improve LIFT outcomes.

Previous research by Aldred (2006) and Beck et al (2009) argued that seconding PCT managers to the LiftCo board could create conflict of interest in LIFT. The managers may be hard pressed to balance between PCT interests and those of the private equity holders in the LiftCo. This may negatively impact progress. Even if PCT nominees to the board achieved a good balance in their concerns with PCT and LiftCo interests, the suspicion that they did not do so may damage relations among PCT team members.

The findings from this case-study indicate that progress in LIFT is more likely to the result of complex sets of factors. It does not appear to be solely a function of how LIFT is designed, mistakes in implementation activities, guidance not helping staff within the PCTs, or the involved staff lacking sufficient motivation. Casting progress on these individual sets of factors may be misplaced because the findings here revealed that economic, social and political factors significantly interacted to influence progress. For a variety of reasons, changes in these factors may trigger, for example, resignations of key staff at government departments with strategic roles in LIFT – and these may impinge progress. In this case-study, the cost of land was found to inhibit delivery of buildings with amenities that required too much land. Areas that were affected with high population concentrations risked missing appropriate buildings because the cost of acquiring land for expansion is prohibitive for the PCTs. In summary, the factors impacting progress are not always the result of LIFT.

5.2 Implications for policy and practice

Public-private partnerships (PPPs) are believed to facilitate government access to private sector finance, skills and expertise needed in improving public service delivery (WHO 2000, World Bank 1993). But their use within health systems tends to divide opinion and is sometimes criticised for making procurement of services cumbersome. Some critics (Gaffney et al 1999b, Flinders 2004, and Aldred 2008) argue that PPPs are promoted by people whose agendas are motivated by profit making. In light of this criticism, people involved in LIFT partnerships have divided opinions on its value and adequacy of its implementation.

The findings being discussed here may present limitations in making conclusive lessons because they are based on one case-study involving a single LiftCo. Despite this, they still show possible links between contexts, mechanisms, and outcomes from which to draw out some implications for effective policy and practice for LIFT in other PCT areas. The findings revealed that most informants believed *collaboration, involvement* and *empowerment* were the important foundations for LIFT to be successful.

Because they felt excluded by DH officials at conception of LIFT, PCT managers appear to lack sufficient motivation in influencing LIFT to succeed. In their view, LIFT could have been more effective if they were involved or engaged to indicate their priorities in improving procurement. This could imply that success may depend upon how a policy is interpreted by those affected by its implementation. PCT managers are critical to LIFT's success because: they assess demand for buildings in their areas; develop the SSDPs that are the blueprints for LIFT buildings;

and coordinate delivery and use of the buildings by the GPs. The problem is that they do not feel connected with LIFT and question its credibility on the belief that it was imposed by the DH. Allen (2006) reminds us that involving or engaging local staff at the design stages of public programmes may increase their commitment as they are bound to value their own contributions.

Another success factor may concern empowerment of PCT staff in monitoring and controlling LIFT activities. Given centrality of PCT managers to success as explained above, it would be reasonable to expect them to be sufficiently empowered in LIFT's critical activities. The managers wanted to have a role in assessing relevance of skills and expertise that the LiftCo could bring in solving problems within their PCTs areas. Currently, they do not feel sufficiently empowered in influencing the LiftCo on issues about who to employ under what circumstances - giving rise to criticism that the LiftCo employs inexperienced contractors for jobs that could be handled by experienced PCT staff.

Perrot (2006) contends that PPPs are effective at improving service delivery provided their activities focus on addressing specific problems identified by those affected. PCT managers and GPs in this case-study thought that progress achieved so far was due to their clear understanding and ability to identify problems and their possible solutions. This influenced them to mobilise themselves into action to develop SSDPs that specify their priorities making the LiftCo's activities easier. Thus, despite some problems in implementation, staff within the PCTs may be making LIFT effective at addressing their local objectives.

This research found that DH officials and PCT managers recognised the need to have adequate stock of buildings with improved conditions to meet the needs of different patient groups. This finding appears to be consistent with literature that says prior agreement in purpose and practice are important foundations for successful public policies (IPPR 2002, Stevens 2004). Although discordance may exist on whether LIFT was the suitable strategy to address the problems in conditions of buildings, in terms of policy, it is at least with the backing of a shared purpose between DH officials and PCT managers. It would appear they agree that buildings matter and initiatives like LIFT may increase patient experience in NHS activities. Agreements of this nature remain important even where some analysts (e.g. King's Fund 2008) argue for supporting management practices that promote collaboration among providers within their PCTs than investing in LIFT.

Pawson (2006) contends that people involved in policy implementation benefit from hindsight and experience to understand some unexpected and unintended effects. Similarly, informants in the present research may have benefited from experience to change their views about LIFT's contribution in improving conditions at buildings within their areas. PCT managers acknowledged LIFT's rationale yet they were concerned about the effects of some of its mechanisms on their ability to discharge their responsibilities. With hindsight, they may be realising that LIFT has problems like denying them adequate discretion in decision-making. Their other worries may be also consistent with anxiety resulting from using the new policy (Lipsky 1980). Such anxiety might fade as they familiarise themselves with LIFT, hence attributing progress to their effort.

Although not specifically addressing LIFT, the IPPR (2002) advocates policies that promote collaborative relations in delivering public service. The current research also revealed that collaboration between independent GPs and PCT staff existed in a number of ways in LIFT. The GPs took risks of leadership roles in coordinating delivery and post-delivery occupation of LIFT buildings. Further, they "hot-desked" and opened their surgeries for extended hours in line with PCT objectives to offer convenience to patients. On their part, PCT staff retained responsibility for uncertainty in demand for buildings. Such collaboration enhanced LIFT's credibility by ensuring that the buildings were not viewed as "white elephants". A policy and practice lesson from the findings is that commitment to collaboration may be fundamental to success with LIFT and other PPPs.

The findings from this research partly confirm those of the study by Beck et al (2009) that argue that the net gains in LIFT are possibly less than the risks. This implies that DH officials might have oversold LIFT by emphasizing its benefits and understating the risks to make it acceptable to the PCTs. For example, PCT managers in this research felt that delays and below standard maintenance jobs at LIFT buildings may cancel out savings made by the LiftCo in delivering buildings within budgets. Duplication of PCT roles also made LIFT's overall cost higher than conventional procurement. Thus, questions arise about whether it is the general practice for DH officials to be optimistic and less critical about some elements in implementing new policy initiatives. This probably leaves PCT staff as the best arbiters of initiatives like LIFT within the NHS.

Discordance between the LiftCo and PCT staff in interpreting LIFT implies that success may depend upon how PCT interests are protected. LIFT is a business that is expected to protect investor interests. However, its objectives may be achieved less controversially provided the LiftCo does not adopt business practices that undermine PCT interests when using LIFT as a method of procuring public buildings. Fitzsimmons et al (2009) raise concern that progress in LIFT is restricted because PCT managers lack experience in managing PPPs compared to LiftCo staff. Aldred (2008) argue that some of LIFT's problems emanate from lack of experience and discretion over its strategic activities. These factors may reduce PCT managers' confidence in effectively transferring some risks to the LiftCo especially given LIFT's complexity. It underlines the need for DH officials to support PCT managers in ensuring that procurement risks are managed in their favour. If left alone, the LiftCo may have no incentive to take full share of the agreed risks. Its priority may be to make profit for investors. Despite the concern about interference by DH officials, how the LiftCo interprets LIFT makes occasional intervention necessary to provide technical support within PCTs.

Technical support enabling staff to translate LIFT guidance into expected outcomes could be more influential on success than quantity and frequency of guidance issued. LIFT guidance is perceived as inflexible for adaptation to suit specific circumstances within PCTs. If the DH seeks to decentralise some elements in procurement, flexible guidance accompanied with increased discretion in essential decisions might make PCT staff more optimistic especially when they feel their contributions in making LIFT effective are valued. Saltman et al (2008) argue that people

implementing policies are willing to take accountability for local outcomes provided they have discretion over key decisions.

With LIFT, this may require DH officials making proper use of intelligence from PCT staff by soliciting regular feedback about practical issues that could help make its procedures adaptable to local priorities. This is consistent with Bossert's (1998) argument that decentralisation is effective when local staff are allowed sufficient freedom in influencing operational decisions. Most informants in this research thought this was missing in LIFT. They believed it risked tension with the LiftCo believed to influence key decisions compared to PCT managers. Maybe DH officials were concerned that giving PCT managers increased discretion could exacerbate bureaucracy that LIFT was intended to avoid.

An issue seldom discussed in literature around LIFT concerns whether it was necessary to invest in completely new primary care buildings. Commentary tends to advocate strengthening interpersonal relations between PCT staff and GPs in parallel with LIFT (King's Fund 2008, IPPR 2004). In this case-study, PCT managers and GPs wanted the number of modernised buildings increased. But they were concerned that LIFT used a lot of money to deliver a small number of completely new buildings. Most argued that it would have made better economic sense had the funding been spread to upgrade a large number of existing small GP surgeries as opposed to LIFT buildings. Although they acknowledged the poor conditions at pre-existing buildings, they felt that the problems could have been solved in other ways. In terms of policy and practice, this may

underline the importance in understanding problems within PCTs before imposing strategies for solving them.

The findings highlighted how staff that operationalise LIFT schemes measured the promised benefits of LIFT against actual experience. The staff judged LIFT according to how they perceived its ability to increase PCT and individual capacities in improving procurement activities. It was apparent that most informants wanted LIFT to show that it could increase efficiency in discharging responsibilities by genuinely engaging with them in prioritising PCT interests. PCT managers explained their frustration about shortfall between what they were promised and what they experienced with LIFT. It is possible that they may be unclear about their role in LIFT and what to expect from it. Perhaps clarification about this from DH officials may help PCT managers in adjusting their expectations. The DH officials may need to specify activities where PCT managers should expect to be consulted and stakeholders not to be missed in consultations. In all this the managers should feel sufficiently empowered to demand their roles. These elements were missing despite being perceived as important for staff to invest more effort and commitment in LIFT.

5.3 LIFT in context of the Health and Social Care Act 2012

The Health and Social Care Act that reorganised commissioning of primary care became operational while this study was still ongoing. Previously, PCTs were central to delivery of GP surgeries through their coordination of LIFT. Their phasing out under the Act transferred governance powers and funding of commissioning activities to local non-public sector providers with the potential to present opportunities and risks

for LIFT. Changes within the Act are fairly complex and a discussion of the Act's intricate governance structures has been avoided since they are not the focus of the present research. This discussion only gives a feel of ways in which the research findings may apply in health service mechanisms and structures under the Act.

5.3.1 Opportunities for LIFT under the Act

The fact sheet that the DH (2012) produced in clarifying the Act shows parallels with logic of the previous government in introducing. This may indicate opportunities for LIFT in a number of ways. LIFT was previously explained as driven by increased demand and cost in procuring new buildings (DH 2001, Milburn 2004a). The same argument can be traced in the justifications for the reforms (DH 2012, Dixon and Ham 2010) on the basis that they are due to meeting the needs of an ageing population. So, similar to LIFT, the new Act envisages that its changes will enable the NHS to increase efficiency and provide more relevant and acceptable care by using commissioning approaches that increase value-for-money (DH 2001, DH 2012).

It may be an opportunity for LIFT that the new Act is also premised on the DH desire to address problems of variations in patient experiences in accessing NHS services (DH 2010, DH/PfH 2003). The Act criticises the poor condition of NHS buildings, technology used to provide care, and management responsiveness to patient needs for causing patients to experience inferior services compared to those in other European countries (DH 2012). Its objective to address these problems appears to be consistent with LIFT's current remit. LIFT was also driven by the need to address problems of residents within inner-cities experiencing less quality

of their lives and healthcare received. Then, old healthcare buildings and poor technology were blamed for preventing GPs from making their services more responsive to patient needs (DH 2001, Fitzpatrick & Jacobson 2002).

Despite their different timing, LIFT and the new Act also seem to have been influenced by the state of public funds. The DH has always funded improvements in health but prefers to do this by increasing PPPs within the NHS to increase value-for-money (Flinders 2004). Emphasising increased value-for-money from reduced public investment may be the DH strategy for reducing challenges in maintaining previous levels of funding for NHS activities due to economic recession experienced since 2009 (Pollock and Price 2011). This may give chance for LIFT being retained as the appropriate strategy to deliver buildings especially given the previous endorsement for prioritising efficiency to save public sector expenses (King's Fund 2008, NAO 2005).

There is also chance that LIFT and reforms under the new Act may be dependent on each other to the advantage of both considering the DH's desire to address problems due to inappropriate healthcare buildings. Chance exists for the Clinical Commissioning Groups (CCGs) required under the Act riding on LIFT's experience to deliver better healthcare buildings in line with the objective for improving the quality of services. The Act empowers CCGs in arranging *"for the provision of services or facilities as considered appropriate for the purposes of the health services that relate to securing improvement"* (House of Commons 2012, page 8).

5.3.2 Concerns about LIFT under the Act

Initial controversy generated by the Act makes it necessary to highlight the ways in which it may affect procurement and management of primary care buildings when CCGs' substitute for PCTs that previously coordinated the activities through LIFT. Prior to the Act, PCTs and independent GPs were integral parts of LIFT activities. The PCTs had both a strategic role and equity in the LiftCo (DH/PfH 2003). As commissioners, PCT managers in consultation with the GPs set the terms of what buildings to deliver, benefiting which providers, and offering what services using LIFT. Under the new Act, power, responsibility and funding previously held by PCT managers is devolved to CCGs that mainly comprise independent GPs (House of Commons 2012). It is argued that substituting the CCGs for PCTs in commissioning activities may make the NHS more responsive and technically efficient in delivering patient services (DH 2012).

But with the phasing out of PCTs, questions arise regarding the fate of the public equity in the LiftCo that was held by the PCTs. It is neither clear who may inherit the equity nor how it may be disposed under the new Act. What is clear is that disposing it may be seen as disinvestment in health. This may add up to concerns since raised that the Act privatises NHS functions especially if the equity was to be transferred to CCGs that are dominated by private GPs.

Another concern seldom discussed in context of the Act is around risk on investing in healthcare buildings. Debate tends to focus on the Act's potential effects on care provision and management activities without attention on procurement of healthcare buildings for the public. Given their role in driving the SSDPs from which future LIFT buildings were derived,

the risks in phasing out PCT structures may have been ignored if this leads to stagnation in growth of stock and upgrading of buildings. Any commissioning group will need adequate buildings – what LIFT has been providing - to achieve the Act's objectives.

There is yet another concern deriving from this research's finding that having adequate and appropriate buildings matters in improving patient experience. It was found that despite getting help from experienced PCT staff, LIFT failed to satisfy demand for upgraded buildings. This raises questions about whether inexperienced GPs or the new CCGs will influence LIFT better in delivering adequate stock than the PCT staff. Already, a survey by King's Fund and Doctors.net.uk (2010) revealed that 25% of GPs were not convinced of the new Act helping them to either increase efficiency or patient experience. The people that previously endorsed LIFT for delivering quality buildings are therefore sceptical about the Act's helpfulness in maintaining momentum.

Under the new Act, the NHS Commissioning Board has the role to support commissioning groups in increasing their capacities and capabilities as effective purchasers for services (DH 2012). Further support is provided by local Health and Wellbeing Boards (HWBs) seeking to ensure that the clinical commissioning groups prioritise their communities' needs (House of Commons 2012). But it is unclear whether the support extends to activities in procuring healthcare buildings. The Act does not specify who will plan, finance and coordinate delivery of healthcare buildings as previously done by PCT staff through LIFT. It is likely that support by the different boards may focus on medical activities than delivering buildings.

In this research, PCT managers indicated that some critical decisions in LIFT were neglected because of confused responsibilities between PCT boards and SPBs that oversee its implementation. Yet the Act does not provide a platform for addressing the problem and risk confusion between the CCGs, care providers, NHS Commissioning Board, local authorities, and HWBs regarding the responsibility for procuring buildings. Some critics of the reforms (e.g. Dixon & Ham 2010, Cotton 2010, Pollock and Price 2011) are doubtful whether the governance structures introduced to either support or oversee the clinical commissioning groups will have the relevant experience and skills in developing healthcare buildings.

Essentially, procurement of buildings may require commercial skills and expertise. Yet even PCT managers in LIFT were found lacking this despite getting support from Treasury, CHP and local SPBs (Fitzsimmons et al et al 2009). A big concern might be the governance structures under the new Act failing in providing adequate support in procurement. This may not prevent the commissioning groups from having divided attention in procuring and managing buildings as the PCTs did through LIFT. Some of the efficiency savings intended by the Act may be missed if commissioning groups feel tempted to hire teams of administrators, accountants, or other professionals to do the jobs previously done by PCT staff.

Drastic policy changes within the NHS have been criticised for risking disruptions unless existing programmes are cushioned in some ways (King's Fund 2008, Normand 2011). For example, the Act could have clarified whether and how LIFT would be protected against any possible challenges that may prevent it from delivering long-term benefits.

Considering that the first LIFT building opened is now still only 10 years old, you could argue that we have gained experience of how to deliver it well and make its future effective. Yet the Act does not seem to recognise this. Continual reorganization of NHS activities may also reduce GP commitment to LIFT if changes involve service reconfigurations that may threaten viability of business at LIFT buildings. The LiftCos may also reduce their commitment to investing in NHS buildings unless they are certain about continuity of LIFT as the preferred procurement method. The safeguard for LIFT may be its contracts that make it difficult for the DH to terminate them prematurely.

During this research's fieldwork, some GPs at LIFT buildings indicated that they belonged to some CCGs required by the new Act well before it became operational. This could be a market failure in improving service delivery through fair competition as desired by the Act (Cotton 2010, King's Fund 2010, Pollock & Price 2011). This is because such GPs possibly took advantage of their current use of LIFT buildings to block those outside from belonging to provider consortia owning better buildings. GPs in LIFT know about the locations, range of services, and leverage carried by different LIFT buildings and this may be a barrier to competition in forming provider consortia required under the Act. Given Aldred (2006) and Pollock & Price's (2006) criticism that LIFT restricted diversity in the ownership and management of buildings, you would have expected the changes to provide a platform for competition especially if LIFT retains role to deliver and maintain buildings for the GP consortia.

The new Act empowers Monitor in regulating NHS activities to ensure service purchasers respect competition and fairness in relating to each other (DH 2012). However, questions may arise about whether Monitor will have effective mechanisms for preventing existing private companies and those already involved in LIFT from dominating the ownership and management of healthcare buildings across large areas. Without strict regulation, it is possible that some LiftCos - currently restricted to delivery and maintenance of buildings - may be tempted to venture into clinical activities. This may risk entrenching business practices that prioritise efficiency and shareholder interests instead of the DH goals that the Act seeks to achieve. At present, LIFT's failure in delivering some expected benefits is seen as the result of the LiftCo being protected from competition and lacking mechanisms for providing equal opportunity to other developers and service-suppliers.

Other potential determinants of LIFT's future as a procurement method include: shifts in patient preferences; service reconfigurations; and advances in technology. These factors influence whether LIFT, or its buildings, or using GP consortia remain as appropriate options in improving NHS activities. The Act could be opportunity for LIFT being retained as the method for procuring buildings for the CCGs. But advances in technology like e-healthcare or tele-healthcare now popular within the NHS could influence patients to change their preferences affecting the use of LIFT buildings.

Again, there is a common argument that LIFT (King's Fund 2008) and the Health and Social Care Act (Cotton 2010, Dixon & Ham 2010, Pollock &

Price 2011) lack inbuilt mechanisms for ensuring fairness in use of public resources. But at least LIFT gave PCTs opportunity to have part ownership of buildings through equity in the LiftCo while retaining land on which the buildings were erected. In contrast, the Act appears to entrust independent GPs with the management of the bulk of NHS budget (DH 2012). This paints the picture of government "privatising" NHS activities further to replacing PCT managers with DH officials in influencing commissioning of services. Yet LIFT sought to decentralise in order to improve performance by addressing imperfections in DH led procurement.

5.4 Limitations of the Research

This subsection acknowledges ways in which some issues in process of the research may have shaped decisions about what aspects of LIFT to focus on or the data types to collect at the expense of others. Banister et al (1994) consider such reflexivity important in qualitative studies. Whereas the views at the operational level were prioritised over those at the policy-making and care provision levels, the findings revealed that LIFT is swamped with complex yet all important issues to investigate in order to better understand it. The researcher believed that people charged with LIFT implementation may provide more realistic evidence about how it works than those promoting it. Potential limitations in the research design and usage of qualitative methods were acknowledged and ways to minimise their impact considered.

5.4.1 Limitations in design of the research

Since this research was based on only one case-study involving a single LiftCo operating across the concerned PCTs, its critique may be possible

limitations in generalizing the findings to other PCTs and LiftCos. Single case-studies are criticised for restricted focus which risks producing findings that may have limited generalisability (Yin 2009). In this case, there may be limited possibility of using the findings in explaining how LIFT could work in other areas.

Although generalisability was not the current research's primary goal, ways of accounting for this limitation were considered. The researcher designed an embedded case-study to understand LIFT based on an increased number of units of analysis (Yin 2009). It involved two PCTs, four LIFT buildings, the LiftCo, and 25 informants comprised of different categories of staff providing data on LIFT. As one of the pioneers of LIFT, this case-study was preferred because the informants were thought to have invaluable experience to inform about LIFT and its evolution compared to other areas served by young LiftCos.

Another critique of this research may be its focus on evaluating procurement of buildings using LIFT without evaluating optional methods for comparison. This implies limitations in making conclusive judgement about which between LIFT and options is the better procurement route. For example, comparing LIFT to the DH route may be inconclusive because no comparable government delivered buildings were observed in the research.

Another issue was that the research focus was at the operational level where it sought to reconcile DH officials' – policy-makers - expectations and operational staff experiences of LIFT. It means the research did not give the involved officials opportunity to say their side of the story yet they

were the ones that conceived LIFT and provided its guidance. They probably needed the chance to elaborate on their expectations in contextualising informants' interpretations and experiences of LIFT. Other groups whose views were missed yet important in understanding LIFT included investors in the LiftCo, contractors at LIFT buildings, and patients that patronise LIFT buildings. This research was interested in implementation process rather than all aspects of LIFT. So these groups were considered as not directly affected by how LIFT projects were planned and executed compared to staff at the PCTs, the LiftCo and LIFT buildings. But their views may need to be respected in the interest of citizenship in LIFT.

Usage of qualitative research methods restricted the study to understanding how LIFT contexts and mechanisms affected the concerned informants in their activities. Social and behavioural perspectives were therefore emphasized in describing LIFT's effects at the expense of quantifiable outcomes like costs and risks. This may invite disagreement with other studies where consensus on either precise definitions of LIFT outcomes or how to measure them may be lacking. Thus, it may be hard to compare the current findings with previous work that may have focused on broader or the quantifiable aspects of LIFT. The findings from previous work might have been also influenced by different contexts and circumstances from those currently surrounding LIFT.

5.4.2 Limitations due to data collection methods

The current research might be also limited by subjectivity emanating from interviewing and dependence on the experiences of people directly involved in LIFT. It is possible that they brought bias into the research due

to their interests affecting them in being more critical about LIFT where they felt it reduced their influence. Morgan (2001) reminds us that people that are directly involved in implementing public programmes may not be the best at informing about how the concerned programmes are valued by ordinary service-users. Some people may experience difficulties in balancing between their official positions and personal experiences. In this research, this potentially tempted some informants into carefully selecting what information on LIFT to share or withhold from the researcher. It is therefore possible that the research missed the benefits of non-selective disclosure of information; and the findings may vary from those of previous studies informed by other groups of LIFT participants.

Reducing potential bias in the data that was collected involved explaining the purpose of the research and promising anonymity of informants and confidentiality of the data before the interviews. Carefulness on choice of the data to analyse and distinguishing facts from opinion were also prioritised in data analysis. Objectivity of the findings in answering the research questions was also increased through blind coding of interview transcripts and associating the coded data with informant positions rather than their names during data analysis in NVivo.

There may be issues within the representativeness of the documents reviewed in this research. There was always going to be challenges in decisions about the number and types of LIFT documents to review to better understand it. Some documents especially from the private sector constituents of LIFT were possibly missed on the list of those prioritised for review. The researcher recognised this limitation and countered it by

analysing as many types and sources of documents as possible, prioritising publications from sources seeking to inform a critical public audience. This helped to avoid disproportional exposure to subjective information from officials interested in promoting LIFT. To this end, documents from Unison and King's Fund were analysed because their contents may consider the public view and interpretation of LIFT and its impact on patient experiences.

In general, conduct of this research was robust to counter possible grounds for doubting authenticity and objectivity of the findings. All informants volunteered to contribute data and the recorded views are accounts of what they understood about LIFT. Deeper knowledge about LIFT was developed by using interview topic guides that were designed for relevance to all categories of staff with different roles in LIFT. They complemented each other in exposing issues considered to be influential on progress to enable the researcher in attributing the reported outcomes to either LIFT design or implementation practices. Depending on their role, informants had different explanations for LIFT. In their explanations, the PCT managers used political and social perspectives; the GPs emphasized economics; and the LiftCo representative considered LIFT as a business model.

SECTION 6: CONCLUSIONS AND RECOMMENDATIONS

This research explored with people involved in executing LIFT schemes their views about why LIFT produced outcomes that they experienced within their PCT areas. The findings were presented in Section 3; analysed and interpreted in Section 4; and discussed in Section 5. In this section, the key findings are consolidated into themes aligned to the research questions (Table 6.1) along which conclusions are to be drawn (6.1). The consolidated key findings reconcile DH officials and informant views by addressing: conceptual explanation for LIFT (6.1.1); perceptions and experiences with LIFT outcomes (6.1.2); perceived facilitating or constraining factors (6.1.3); and lessons learnt from the case-study (6.1.4) in providing answers to the research questions.

Table 6.1: Alignment of key findings and research questions

Consolidated thematic findings	Research question answered
Conceptual explanation for LIFT	(i), (ii) and (iii)
Perceptions / experiences with LIFT outcomes	(i) and (ii)
Facilitating and constraining factors	(iii)
Lessons from the case-study	(iv)

Based on the conclusions in subsections 6.1; subsection 6.2 offers recommendations for the DH officials; staff implementing LIFT schemes; and future research. Contribution of the present research is explained in subsection 6.3.

6.1 Conclusions on the key findings

It is possible that gaps in information might be observed in the conclusions drawn and recommendations put forth. The gaps may be explained by limitations already discussed in subsection 5.4 (page 279).

6.1.1 Conceptual explanation for LIFT

This research provided evidence that LIFT was perceived as decentralisation strategy in procurement and management of healthcare buildings within PCTs. Decentralisation was may be driven by new perspectives to public service delivery, the most probable of which are New Public Management, Third Way, Localism, and Public-private partnerships. The evidence was articulated and at times implicitly described in the analysed literature, official documents and informant interviews.

The overall conclusion drawn from this finding was that LIFT is a PPP model designed to decentralise aspects in procurement. It primarily decentralises financing of the buildings from central government to private financiers through the LiftCo. Traditionally, government worked through the DH and Treasury to directly fund delivery of public sector buildings. Under LIFT, the LiftCo is delegated the role to mobilise finance without direct recourse to the government. Decentralisation is extended through the LiftCo assuming leadership in coordinating activities for construction, delivery, and subsequent maintenance of the buildings.

Although the PCTs lead in developing SSDPs from which LIFT buildings are derived, the LiftCo is expected to be an active participant. This is yet another indication of decentralised planning under LIFT. Previously, the DH and its agents were responsible without the involvement of private sector representatives. Further decentralisation takes the form of independent GPs being delegated the role to coordinate delivery of individual LIFT buildings. This function was previously reserved for estates and facilities directors at the PCTs.

Other dimensions of decentralisation under LIFT concern ownership and post-delivery maintenance and management of the buildings. That the LiftCo is a PPP company means that LIFT buildings are jointly owned by the private financiers and the concerned PCTs. The LiftCo's maintenance and management functions may be an example of LIFT risking privatisation of some NHS activities (Pollock and Price 2006) because previously, PCTs would directly use own staff or hire contractors at their buildings. In context of decentralisation, this may indicate that PCT managers believe the recommended LIFT guidance constrain more than facilitate their activities in making LIFT an effective strategy.

6.1.2 Perceptions and experiences with LIFT outcomes

The first set of significant findings on this revealed that LIFT was recognised as relevant to addressing poor condition of primary care buildings. This is despite its unstable surrounding socio-economic and political environments making it a complex initiative. Informants felt that their experience made it possible to execute successful schemes in spite of the complexities in LIFT. This influenced the conclusion that staff within PCTs had the commitment and willingness to translate their experience into making LIFT effective.

Their views and experience were examined to clarify how LIFT's intentions and practices influenced staff activities in producing the reported outcomes. In context of decentralization, the findings revealed lack of clarity on whether LIFT was driven by administrative, economic, financial, or technical requirements. Neither official documents nor informants could articulate LIFT's underlying intentions. This influenced the conclusion that most informants speculate about LIFT - particularly that political reasons

superseded any others in decentralising aspects of procurement using LIFT.

The second set of significant findings concerned implementation procedures and governance in LIFT. Elements of enhanced discretion and engagement of local staff are often cited as part of the benefits of decentralization (Sharma 2006, Bossert 1998). But PCT managers felt that they lacked adequate discretion and serious engagement in influencing governance and key procedures in executing LIFT schemes. They considered these elements, especially in decision-making, as helpful yet missing factors for progress. Hence conclusion that, LIFT does not convincingly help the managers in realising the major benefits of decentralization.

They also expressed concern that DH officials tended to decentralise responsibility for LIFT but not the necessary power and authority for key decisions and control. This led to the conclusion that progress was achieved because of commitment within the PCTs rather than due to the strengths of LIFT. Despite feeling excluded at its conception, PCT boards and management staff have accepted LIFT and invest in using it to procure desired buildings. There was consensus that governance at LIFT buildings satisfied the main expectation to increase patient experience.

The quality of procedures followed to deliver LIFT buildings was perceived to affect success. Political interference in implementing LIFT was mentioned as a factor that restricted the PCTs from getting maximum benefits. PCT managers felt that the DH officials interfered in local activities. They also did not feel that they were sufficiently engaged to give

input in designing LIFT buildings despite their experience in such activities. GPs were delegated the role to coordinate delivery of individual buildings but the managers felt PCT aspirations especially in reducing costs were not prioritised. Two conclusions drawn from this finding were that: (i) it is uncertain whether designs of LIFT buildings reflect true priorities and aspirations of the PCTs; (ii) PCT managers are unconvinced that the buildings' long-term values are commensurate to their mortgages. LIFT buildings were believed to risk rapid dilapidation due to frequent modifications to correct initial inappropriate designs. Some managers doubted ability of lead GPs that coordinated delivery of individual LIFT buildings in representing PCT aspirations. These conclusions underline the challenge facing DH officials in convincing PCT managers that LIFT and delegating the GPs some roles may help in improving procurement.

The third set of significant findings concerned the quality of buildings. The majority of informants believed that LIFT improved quality with the GPs expressing that buildings were bigger and designed to handle heavy flow of patients compared to their old surgeries. The conclusion drawn from the findings was that tenants at LIFT buildings prefer multiple indicators in measuring quality at the buildings. Besides physical outlook and cleanliness, they are interested with relevance of the designs to local needs, regular availability for use, and comfort offered to patients.

Part of the analyses examined how the LiftCo innovated in terms of introducing new ideas in delivery and management of buildings within PCTs. The LiftCo's ability to innovate in improving the buildings was acknowledged. According to the GPs, increased patronage by patients

was partly the result of better quality buildings. They thought the LiftCo was driven to innovate in order to keep pace with changes in demand patterns and care provision methods preferred by GPs. It was therefore concluded that quality of LIFT buildings reflected the LiftCo's commitment to ensuring their continuous availability to tenants. In future, its ability in innovation might be tested by how well it will adapt LIFT buildings to handle increased patient demand at premises where available land may restrict easy expansion.

The fourth significant set of findings considered mechanisms used to achieve value-for-money in LIFT. The DH officials were optimistic that LIFT would enhance technical and economic efficiency through PCTs getting opportunity to access private sector resources including skills and expertise in procurement (DH/PfH 2003). But the findings revealed that LIFT was not perceived as working to improve value-for-money in procurement. PCT managers and building administrators believed that it was an expensive option compared to conventional route whether from financial, economic or technical perspectives. They were concerned about opportunity cost arguing that it cost more per LIFT building than upgrading a number of old surgeries.

These findings influenced the conclusion that LIFT sufficiently increased neither scope nor capacity of the PCTs to improve more buildings. This was because it used more money to deliver fewer and centralised buildings. PCT managers wanted the money spread to upgrade an increased number of smaller GP surgeries. Related conclusions were that LIFT failed to increase the stock of buildings and PCT managers are

sceptical about private contractors used in LIFT having better skills than them in maintenance activities. These elements were considered as important for the PCTs to obtain value-for-money from LIFT. Yet there was concern that PCTs paid a lot of money for few LIFT buildings of which the quality of maintenance was questionable.

PCT managers and GPs perceived the manner in which LIFT's economic and technical matters are managed to be an influential factor for value-for-money especially if there is burden on the PCTs. The managers wanted activities of PCT staff and GPs based at same LIFT buildings to be linked up in order to provide seamless care. They felt that activities were currently not coordinated for patient convenience. This led to a conclusion that LIFT buildings do not necessarily stimulate efficiency savings achieved through coordinated and collaborative care provision. The reason could be partly because PCT activities are not financially supported by the DH towards this goal. Funding gives PCT managers impetus in preventing parallel activities at one building because care providers may lack motive to coordinate their activities despite working under one roof.

Further, the findings gave the impression that value-for-money was influenced by where leadership in developing NHS buildings should lie. PCT managers and GPs preferred DH leadership working through PCTs over that of the LiftCo. Their view was that this would ensure that PCT interests were prioritised and cost of the buildings reduced. To this end, they wanted LIFT contracts to be renegotiated to give PCT staff necessary authority including discretion to prefer other methods of procurement. Hence conclusion that the lack of economic evaluations of LIFT projects

undertaken to determine value-for-money prior to construction of buildings is an undesirable result of PCTs having no options to using LIFT. Some projects may be done without the backing of evidence that they will work in the best interest of the PCTs.

Despite the concerns, informants in this case-study agreed that challenges in LIFT were not insurmountable. Their optimism stems from having the commitment plus experience from working in partnerships with other health and social care providers. A number of voluntary providers, private Trusts, and housing associations within the PCTs had projects regularly monitored by PCT staff making it reasonable to conclude that they all value collaborative working as stakeholders in solving health problems in their areas. With time they may use this experience to make LIFT more effective.

6.1.3 Facilitating or constraining factors

The fifth set of significant findings concerned informant perceptions of what facilitated or constrained them in making progress. This included indications of factors that were thought as most helpful in making progress. A combination of factors including how other programmes worked was thought to influence activities and progress against LIFT outcomes. Having PCT boards and an experienced team of managers that valued commitment to improving the quality of buildings were revealed to be fundamental to success by influencing adoption and perpetuation of LIFT within PCTs. To put this into perspective, the case-studied LiftCo postponed activities in a neighbouring PCT because the responsible board and managers were not keen on LIFT despite needing improved buildings. The conclusion drawn from this finding was that, PCT boards and

managers in the case-study recognise the poor state of their buildings. It gives them high level commitment to using LIFT in addressing these problems and initiated projects are always completed despite challenges in execution.

Another finding was that size of the involved LiftCo matters. A small LiftCo that experiences less frequent turnover of staff was believed to enhance progress. PCT managers argued that keeping the same CEO in charge at the LiftCo significantly increased value-for-money and improved solutions to operational problems. Stability allowed the LiftCo to familiarise itself with PCT priorities and increased efficiency in translation of contents of the SSDPs into desired buildings. Hence the conclusion that initial problems in executing earlier schemes are explained by high churn of CEOs at the LiftCo. The successful completion of LIFT projects and continued optimism about challenges not being insurmountable could be explained by the long tenure of the LiftCo CEO. Informal contact between the CEO and PCT managers reportedly kept the LiftCo abreast of priorities within the PCTs.

The sixth set of findings concerned what was thought to constrain staff activities in LIFT. In this case inflexible guidance, lack of good information and insufficient discretion over critical LIFT processes were cited as major barriers. These findings raised two conclusions. First, PCT staff wanted LIFT guidance to be made flexible believing that if accompanied with sufficient discretion, they may adapt them to suit their local priorities. The current standardised guidance disregarded differences in circumstances that may exist between different PCTs using LIFT.

Second, progress was thought to be restricted when LIFT participants received different sets of guidance from the DH and their professional representative bodies. In addition to guidance issued by the DH, for example, GPs and pharmacists respectively received guidance from the BMA and NPA while private contractors received more from local business organizations with interests in LIFT. It was therefore concluded that guidance obtained from multiple sources created inconsistency in the type of information used by the major participants in LIFT. A framework of accountability for managing risks in LIFT is essential for progress. But this may be missed because of confusion arising from participants getting different sets of guidance.

PCT managers wanted all participants to use guidance originating from the DH to address potential inconsistencies in awareness about new developments and changes in LIFT. They also thought that the DH did not help in keeping them abreast with developments in LIFT because it lagged behind the BMA and interested local businesses in issuing up to date information. Hence concern that the LiftCo was more informed about LIFT than the PCTs.

Most PCT managers raised concern about the quality of LIFT governance. In their view, both CHP and the locally based SPB were not reliable sources of information useful for making LIFT effective. There was concern that critical views about LIFT raised by PCT managers were suppressed by the SPB while CHP was criticised for recommending governance arrangements that were not tailor-made for the PCTs' individual needs. These findings raised a common conclusion highlighting significant

scepticism among PCT managers about LIFT governance's ability to facilitate progress. The managers are not convinced that they are technically helped in discharging their responsibilities so there is counter-passing of some roles between PCT staff and the SPB or CHP. Therefore it might be concluded that some operational roles such ensuring that only competent contractors are retained at LIFT buildings were neglected because of the confusion.

Both the SPB and CHP were believed to prioritise LiftCo's interests and contributions more than those of the PCTs. PCT managers felt unvalued and frustrated when their contributions to delivering effective LIFT schemes were not respected. The first of two conclusions drawn from this finding was that PCT managers wanted to have a stronger voice in LIFT because they are ultimately accountable for its outcomes. Second, it can be concluded that most managers are not convinced that LIFT governance is effective or genuinely valued their contributions. This suggests lack of trusting relations between key governance structures in LIFT despite it being perceived as a significant factor for progress. LIFT sought to streamline procurement yet its governance is blamed for adding to existing bureaucracy.

Despite the challenges, informants indicated that they achieved progress to some extent. Progress does not appear to be a result of how LIFT is designed, its governance structures being able to support local staff activities, or guidance being flexible for adaptation to local circumstances. To some extent, these factors constrain but PCT managers and GPs have the determination to retain effective working relations with the LiftCo. They

used communication strategies like informal contacts that helped in short-circuiting bureaucracy within LIFT. It was thus concluded that PCT representatives on the relevant boards and the LiftCo CEO may be sharing appropriate information as feedback to keep PCT managers abreast with critical issues in LIFT. As a result, most managers are fairly articulate about LIFT despite perceived inadequacy of information from DH officials. Progress achieved so far may be a result of the managers' determination in making LIFT work than its ability to facilitate their activities. No obvious evidence suggested that poor relations between PCT managers and the LiftCo threatened LIFT's viability. There is a belief that the LiftCo was doing well to retain relations conducive to collaborating in a complex initiative.

6.1.4 Lessons from the case-study

Overall, seven lessons deriving from this case-study are drawn as follows:

First, LIFT is understood as a way of the DH decentralizing the financing of primary care buildings to private financiers led by the LiftCo and coordinated by the PCTs (subsection 4.4, page 240). This decentralization extends to the LiftCo being delegated the role to manage and maintain the buildings once delivered.

Second, it became clear that the criteria perceived to contain useful indicators for measuring success in LIFT were its ability in: (i) supporting staff activities towards meeting objectives within PCTs; (ii) delivering gains that commensurate with amounts of capital invested by the PCTs; and (iii) generating future opportunities for improving primary care organisation within the PCTs. Completing started projects was, for example, believed to be a useful indicator for success under criterion (i) as was delivering

buildings within budget under criterion (ii). Ability of buildings in facilitating integration of health and social care to promote healthy communities was believed to be a useful indicator for success under criterion (iii). Inevitably, confounding factors other than LIFT were involved in each criterion meaning caution may be recommended against isolated use of one criterion in measuring success. Some indicators may crossover between all criteria despite being driven by different mechanisms. For example, increased staff morale; enjoying appropriately designed buildings; and GPs using relevant treatment technology may be indicators for success under all criteria yet could be driven by different mechanisms. Similarly, if PCTs experience financial challenges in meeting their obligations, it may indicate LIFT's failure along all criteria when measuring success.

The third lesson concerned the factors for success in LIFT. It was emphasized that success depended upon commitment by PCT managers and co-operation by the LiftCo in making LIFT an effective procurement method. The managers' commitment is enhanced provided they feel engaged and their contributions respected by DH officials in making strategic decisions about LIFT. Prioritising LiftCo's contribution over that of the PCT managers restricted success.

Emphasizing behavioural factors in explaining progress suggests that LIFT may not be inherently flawed as decentralization strategy in procurement. A fair share of its operational problems may be due to either oversights by the responsible authorities in supporting PCT activities or mistakes made by key participants in executing LIFT schemes. The problems and mistakes may affect progress more than how LIFT is designed.

The fifth lesson highlighted LIFT contexts and mechanisms that presented risk of significant unexpected and unwanted outcomes. It was learnt that cost-effective delivery of projects is constrained by DH bureaucracy and occasional interference. These factors are inconsistent with desire to streamline procurement. At one of the buildings, the LiftCo felt pressurised by DH officials into producing huge tender documents resulting in avoidable expenses. A fair share of LIFT's cost-ineffectiveness may be therefore emanating from neither the PCTs nor LIFT itself. Instead, DH directives and inflexible guidance may increase costs causing tension when the LiftCo seeks to recover them from the PCTs rather than the DH.

The sixth lesson was that PCT managers acknowledged the importance and strategic roles of Treasury and DH officials in LIFT. They recognised that loss of experienced staff at Treasury or the DH affected progress in their PCT areas when technical advice required within the PCTs was delayed, or important decisions risked being postponed. The managers took some comfort from the fact that their PCTs occasionally recruited staff with LIFT experience from outside the NHS. They also compensated for lost skills by using independent GPs to coordinate delivery of individual LIFT buildings. Despite this, in terms of experience at the national level, Treasury and the DH may be losing more than they gained because better pay and pension in the private sector attracted more experienced government workers than the converse.

But attributing the above lesson solely to LIFT might be misplaced because attractive conditions of service within the private sector are not due to LIFT but its surrounding economic context. For various reasons other than LIFT,

senior civil servants may join private companies giving them increased influence in overall NHS activities. Therefore, socio-economic contexts surrounding LIFT may affect progress by risking some unexpected outcomes.

Conflict of interest arising from seconding PCT managers to the LiftCo board emerged to be one of the unexpected negative outcomes in LIFT. It risked the managers having the dilemma to balance between PCT priorities and LiftCo interests. Further, it compromised their positions and potentially damaged team spirit at the PCTs. But actual impropriety did not seem to be a major issue in LIFT at least in this case-study.

Related to this, a seventh lesson may be that PCT managers in LIFT are getting sufficient feedback to enable them in carrying out their activities with minimum constraints. They were mainly concerned about the level of influence that their representatives exerted on the LiftCo board. Although this may be resisted by the majority shareholders in the board, the managers wanted their representation to be increased hoping it would enable them in influencing decisions more effectively. Currently, the representatives are outnumbered and therefore outvoted in decisions that prioritise PCT interests.

Seconding PCT managers to the LiftCo board generated mixed views about the benefits. Some managers thought it potentially caused conflict of interest. But others believed it gives them chance to influence decisions in LIFT provided their representation is increased. It was argued that the DH and the SPB had incentive to promote LIFT as a success. This in a way influenced them in supporting board decisions that conflicted with PCT

priorities. Hence the seventh lesson that conflict of interest in LIFT sat with these officials more than PCT secondments to the board.

Initially, the researcher believed that GPs at LIFT buildings risked conflict between their own financial interests and those of the patient if they held shares in the LiftCo. It was learnt that conflict of interest from the GPs' angle is not an obvious issue. This derives from the finding that, at least within the case-study, GPs were neither direct nor indirect shareholders in the LiftCo. The only problem could be that as for-profit providers, LIFT facilitates the GPs in using publicly funded buildings. The GPs may avoid risks such as financing expenses that they individually requested at LIFT buildings forcing the PCTs to fund them to sustain services. Hence the importance of helping building administrators with a framework for reconciling GP and PCT responsibilities for costs at the buildings.

It was finally learnt that the GPs are in LIFT because of perceived benefits on their individual businesses as opposed to influence by the BMA. For a variety of reasons, the BMA were initially viewed as opposed to LIFT raising suspicion that their advice might have sought to shape GP attitudes. But GPs in this case-study reiterated that their joining LIFT was driven by desire for appropriate buildings to meet growing patient lists and demand for improved care. Their attitude may therefore reflect individual rather than BMA interests.

6.2 Recommendations

The current research confirmed that it is the DH officials and operational staff that are central to making LIFT effective in procurement. DH officials initiated LIFT and are responsible for issuing the guidance that is overseen by SPBs that are based within PCTs. PCT staff and those at the LiftCo and LIFT buildings are responsible for executing LIFT schemes. This makes it logical to offer recommendations for the DH officials (6.3.1); operational staff (6.3.2) and for future research on LIFT (6.3.3). Since the conclusions so far presented are based on experiences of one case-study, caution may be required in generalising the recommendations. It is possible that some PCTs elsewhere with the same experience may have already adopted similar recommendations.

6.2.1 Recommendations for the DH officials

The DH officials and the SPBs overseeing LIFT implementation within PCTs, in consultations with Treasury are recommended to consider:

6.2.1.1 Improving the quality of LIFT guidance. The guidance need not only to be clear and consistent in origin but also flexible to adaptation for suitability to PCT specific circumstances. Currently, they are perceived as confusing because apart from what the DH issues, different bodies with interests in LIFT also issue their own versions targeting the same people. Strategies for quality improvement involve getting regular feedback and effecting changes based on practicalities of the guidance advised by those directly executing LIFT schemes. This eliminates constraints in guidance that fail to recognise PCT variations in contexts that determine the best way to make LIFT more effective.

6.2.1.2 Putting measures in place to ensure active participation of operational staff in LIFT's strategic decisions. PCT staff and GPs in this case-study recognised involvement and engagement in strategic decisions as key yet missing factors. Being actors rather than passive recipients of decisions may give them an incentive to be more accountable for LIFT outcomes within their PCTs than at present.

6.2.1.3 Revising LIFT governance to have a fairer distribution in influence between the LiftCo and PCTs. Currently, the LiftCo is perceived to wield more influence than the PCTs. Among other things, this may be addressed through facilitating equal shareholding in the LiftCo. Or decisions for enhanced progress may be ring-fenced for PCT staff and non-partisan stakeholders. This would prevent the existing structures from prioritising LiftCo interests over those of the PCTs. PCT managers wanted to be empowered on governance issues because their PCTs are the principal beneficiaries in LIFT.

6.2.1.4 Providing financial resources additional to LIFT budgets. This enables PCT staff in integrating care activities by promoting collaboration among GPs and between GPs and PCT staff working at same buildings. Currently, GP providers neither sufficiently coordinated their activities nor linked up with those provided by PCT staff at same buildings. This raised the concern that activities at LIFT buildings were run in parallel due to inadequate funds needed to link them. PCT managers wanted restrictions on funds set aside to enable progress with LIFT to be relaxed for this purpose.

6.2.2 Recommendations for operational staff

Operational staff in LIFT comprise PCT staff, LiftCo staff, and GPs and building administrators. As they are directly involved and affected by activities in executing LIFT schemes, they are recommended to consider:

6.2.2.1 Using experiences of other PCTs to save time and money. While their circumstances may be different, identifying successful schemes in other PCTs and adapting the strategies for success may enable the LiftCo to cut planning and delivery cost and time currently believed to limit progress in improving more buildings.

6.2.2.2 Maintaining the momentum gained so far by taking advantage of general satisfaction with collaboration between PCTs and the LiftCo. Indeed investment may be required to improve on the concerns raised. But this is achievable in light of existing strengths, especially the optimism among PCT managers and LiftCo staff that problems in LIFT were not insurmountable. Among other strategies, this may involve operational staff spelling out and agreeing on performance benchmarks in quality and risk assumptions. It reduces friction caused when the LiftCo and its contractors consider expectations of PCT managers, GPs and building administrators as pitched above industry norms and standards.

6.2.2.3 Developing additional technical skills in interpreting whether architectural designs of buildings reflect PCT aspirations and being able to align the designs with cost attached to the buildings by the LiftCo. These were thought to be some of the main challenges in making LIFT effective. If PCT managers were to acquire extra skills and build on their experience with LIFT to date, it may make them stronger in lobbying for DH revision of

constraining guidance. It may also allow them in demanding empowerment in governance matters that make LIFT more effective. At present, LiftCo staff may be stronger than PCT managers because of the support obtained from private sector professionals.

6.2.2.4 Capitalising on the DH's desire for competition within the NHS. The LiftCo should be encouraged to open its contractors to compete with multiple providers including public sector trades-people. The current assumption that private contractors have better skills and competences required in maintenance of buildings was contested among GPs and building administrators. Some contractors' lack of familiarity with the NHS potentially disconnected them from priorities at healthcare buildings risking the PCTs to miss some anticipated benefits from competition.

6.2.3 Recommendations for future research

In light of the increased role of PPPs in delivering services within the NHS, further research is needed to understand how their effectiveness can be improved.

6.2.3.1 It was clear from analyses of the findings that *DH officials'* inertia in providing technical, decisional and informational resources; robust enforcement of PCT compliance with inflexible guidance by the SPB; and the manner in which the LiftCo performed its role, risked constraining progress more than how LIFT is designed. Future research should consider investigating the mechanisms for effective collaboration between these elements in LIFT and the involved PCTs. Previous research including the present one has not sufficiently highlighted what is needed most to make LIFT effective. Investigating mechanisms for effective

collaboration may heed interests of PCT managers that cited promoting better relations as likely to increase progress with LIFT.

6.2.3.2 The current study has the limitation of focusing on one case-study and a single LiftCo. Research that conducts multiple comparative case-studies is recommended to test relevant factors that facilitate or deter progress with LIFT. This may enhance generalisability of the findings and advice to future schemes.

6.2.3.3 This study considered LIFT in context of changes embodied in the new Health and Social Care Act. But still more light needs to be shed on how the changes mesh to influence LIFT's future. Given most PCT managers and GPs' belief that LIFT used a lot of money to deliver few buildings of contestable quality and services; challenges may exist in the DH achieving efficiency savings anticipated in the Act if LIFT is retained in procuring NHS buildings.

6.3 Contribution of the Research

The current study gained insight into how LIFT operates through analyses of literature and documents, in-depth interviews with operational staff, and tours arranged to observe essential service areas at LIFT buildings. The researcher consolidated the insight into new knowledge around theoretical contribution (6.4.1 and 6.4.2); contribution to policy and practice (6.4.3) and practical contributions (6.4.4).

6.3.1 Confirmation of literature on LIFT

The research confirms what other researchers have written about LIFT. Aldred (2007) explained LIFT as rooted in neo-liberal approaches that make it a consistent example of New Public Management, "Third Way",

and PPP approaches to NHS service delivery. The research produced evidence that LIFT encourages going beyond DH paternalism in procuring NHS buildings by embracing private capital and management processes. Embracing market mechanisms in procurement and management of public service through engaging for-profit providers is the hallmark of New Public Management, "Third Way" and PPP approaches nested in implementing decentralization (Powell 2000). Consistent with Pollock and Price (2006) and Fitzpatrick's (2009) characterisations of LIFT, informants in this case-study thought this risked privatisation. They raised the concern that pro-market mechanisms embodied in LIFT adversely affected their ability in procuring and managing GP surgeries more effectively.

6.3.2 Alternative conceptual explanation for LIFT

Despite illuminating important factors for success, previous studies on LIFT may be criticised for lacking an integrated framework that can be used to explain it. In this research emerging evidence was used to build on existing knowledge for arguing that LIFT might be explained better using decentralization concept. There is evidence that it represents decentralization of the responsibility to fund the procurement of buildings from the DH and strategic health authorities to the PCTs. This happens together with delegating private companies to finance the buildings. There is also an element of recentralisation of the ownership of buildings to the PCTs. This occurs because LIFT influences reduction in DH grants for private GPs to develop their owned surgeries encouraging them to move into LIFT buildings. Recentralised ownership may be running in parallel to recentralised control of the content of GP practices by the PCTs through influencing which providers to use LIFT buildings.

6.3.3 LIFT's effectiveness as decentralization strategy

Within the framework of decentralisation, the research explored how LIFT was effective at decentralising aspects of procuring the desired buildings. It produced evidence that LIFT is surrounded by contexts of DH inertia in: providing sufficient technical, decisional or informational resources; and adequate discretion needed to support effective procurement by the involved PCTs. The evidence was derived from the collective experiences of staff directly involved in executing LIFT schemes. Their interpretations and meanings that they attached to LIFT fitted well with the criticism that failure by central government departments to relinquish the support mechanisms, rather than flaws in decentralisation were barrier to progress (Bossert 1998, Sharma 2006, Saltman et al 2007). The findings may help to distinguish the reasons why at the national and PCT levels, LIFT may experience limited progress against its intended outcomes.

6.3.4 Practical contributions

Finally, this study argues that using LIFT procurement within the NHS may be more effective provided DH officials regularly considered the actual experiences of people that are involved and affected by its activities. The ideas central to this argument were diffused through presentations at international and local conferences (Geneva Health Forum and University of East London Research Day). A book chapter on PPPs as decentralization strategy was written drawing on aspects of this PhD. Its publication by Springer Publishers is planned for November 2013.

Afterword

While PPPs are considered as able to improve service delivery, this research revealed that the LIFT model is swamped with a multitude of complex yet important issues in mechanisms and relations which influence how well it performs. Its complexity presents challenges in deciding the aspects to investigate and the data types to collect at the expense of others for someone lacking experience with the NHS. This makes it important to consider the views of staff directly involved in LIFT in order to better understand how it may work. Studying LIFT may require significant human skills to access the data sources and analytical skills to understand the values held by the different categories of participants while mustering the appropriate jargon. Thanks to my supervisors and interviewees – the research was completed within the expected timeframe. The findings influenced me in acknowledging that PPPs for health may not be as beneficial as what the proponents make us to believe.

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Appendices

1.0 Topic Guides for the in-depth interviews

Evaluation of the planning and implementation of LIFT schemes in East London

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ORGANISATION _____ **Voice Tracer Number:** _____

Name: _____ **Surname:** _____

Position: _____ **Job Title:** _____

Address: _____

Tel: _____ **e-mail:**_____

1. What are the issues LIFT is seeking to address in your PCT area?

_____

2. Can you comment on appropriateness of PCTs using public funds for LIFT to procure their buildings? _____

3. In what ways was LIFT the most appropriate route to address the primary care deficits in the PCTs?

_____

4. What other options were considered and how were they unsuitable?

_____

5. Would another route be better placed now than LIFT for the objectives in the area?

_____

6. Can you specify the key objectives of LIFT in PCT areas served by the LiftCo?

_____

7. In what ways could have some of LIFT's objectives become redundant since delivery of the buildings in the PCTs?

_____

8. What are LIFT's strengths and weaknesses vis-à-vis the intentions and nature of tasks to be accomplished? Would you say its governance arrangements are the most appropriate ones for the tasks?

_____

PART 2 – PLANNING PROCESSES FOR LIFT SCHEMES:

Processes before and leading to construction of buildings

9. What forms of external support have the LiftCo and PCT received from any organisation or agency through the different stages of developing LIFT buildings?

_____

10. Which departments / agencies played what role in the stages of preparing the Tenders and their adjudication of the right candidate: (a): who to partner with? (b): who to design and construct the buildings?

_____

11. Have designs of LIFT buildings been subject to authorisation from any government agencies? What specific aspects did the interest of the agencies focus on?

_____

12. Who participated and what were the considerations of the feasibility studies preceding setting up LIFT buildings – (a) health priorities of within PCTs, (b) impact of buildings' designs on the economic and financial balances of the PCT?

_____

What further analysis was used to support LIFT as the preferred route? - e.g. service accessibility, effectiveness in delivery, external impact (other organisations and services beyond PCTs)_____

LIFT outputs delivery and financing process

13. What infrastructure has been built or is in the pipeline using LIFT?

_____

- Total cost of the scheme: _____
- Range of services _____
- Size of buildings _____

13.1 Could you specify the nature and source of funds and proportional contribution of the funding partners?

_____

14 Who has been the key agents promoting the financing packages in LIFT and basis for this?

_____

15. Comment on how long it took to complete the buildings (facilitating and inhibiting factors and implications of the experience)

_____

16. Have penalties ever been applied for delays in the completion of the buildings?

_____

17. What are the outstanding outputs and why still outstanding (resource constraints, timing, LiftCo underperformance, unsatisfied need)?

_____

Processes for selecting the private sector partners

18. Could you comment on the process of selecting private partners to LIFT?

_____

19. Is there guidance for the selection process? Who determined it and on what basis?

_____

20. What discretion is there to vary LIFT guidance to suit PCT needs and circumstances?

_____

PART 3 – THE IMPLEMENTATION PROCESSES

Remit of the LiftCo

21. How was the length of the contract between the PCT and the LiftCo determined?

_____

22. What is the estimated life of the buildings constructed through LIFT?

_____

23. What is the remit of the LiftCo and how is this central to the given rationale for LIFT in the areas?

_____

24. Could you please comment on appropriateness of the skills sets of the LiftCo vis-à-vis local health objectives specified in the SSDP?

_____

Contractual obligations – PCTs and the LiftCo

25. Based on the specifications of the contract, what services does the PCT receive or will receive from its LiftCo? Are there penalty provisions and how do they work?

_____

26. What types (and criteria used) of commercial activities have been transferred to the LiftCo and its contractors?

_____

27. Will the LiftCo receive a sum (outlay contribution) based on the proportion of the value of the buildings? How was this determined?

_____

28. How, and in what ways do lease contracts distinguish between different forms of remuneration from the PCT to the LiftCo – e.g. payment for the use of the infrastructures from reimbursement for extraordinary cost of delivery of different services?

_____

29. What is the estimated cost (and who bears it) of writing and developing the LIFT Tenders and associated Contracts (this includes: external consultancy, advertisement of tenders, adjudication)

_____

30. In the PCT–LiftCo contract, what criteria have been considered in allocating risk sharing?

_____

31. Has there been any economic effectiveness analysis of the private sector partner and / or LIFT arrangement conducted since commissioning of the buildings?

_____

Outcomes of LIFT buildings

32 Has the public sector evaluated LIFT outcomes in order to assess their achievement of the original objectives and how has this been done?

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33. Comment on how the LiftCo has influenced on the following strategic added value outcomes of the buildings:

- *Strategic leadership and catalyst*
- *Strategic influence*
- *Leverage* and *Synergy*
- *Engagement*

Wider impact, attribution and additionality

34. What has been the impact of LIFT outputs and outcomes on local conditions (patterns of change in the local areas)? How and who explored the impact?

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35 Which of the following factors could you say have significant play in the delivery of primary care and services in your area and how do they do so?

- Wider macroeconomic influences
- Competitors in health
- Activities of mainstream partners
- Other agencies and DH health intervention programmes

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36. In your view has LIFT alone been responsible for the identified impacts in the areas? To what extent are LIFT outputs and outcomes adding value over what would have occurred without it?

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37. Could you comment on the following regarding outputs and outcomes of LIFT schemes?

- the extent to which LIFT reduced activities elsewhere (displacement)
- proportion of outputs and outcomes benefiting consumers from outside the target area or beneficiary groups (leakage) and,
- extra primary care services generated by other buildings / providers because of the presence of LIFT facility in the locality (health multiplier effect).

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38. What steps are undertaken to ensure that LIFT buildings (outputs) are fully occupied and translated into real benefits originally desired by the initiative (measuring effectiveness of LIFT)?

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39 Are there any potential services now seen as missing from the offer-lists and are there some now realised as insufficiently prioritised yet prominently profiled in the SSDP?

40. Any other pertinent information you might want to share for LIFT performance?