

LIFT GUIDANCE

Part A: Contract documentation to be used for NHS LIFT schemes that are large and/or complex

New policy requirements

1. DH has recently received several requests for advice from local health economies as to whether or not LIFT can be extended to areas such as acute services for mental health and maternity units and larger and/or more complex community facilities.
2. When considering such requests, the Department assumes that the relevant NHS body has established that the procurement of complex facilities using existing LIFT contracts is legally possible. The Department is not in a position to express a view on this issue as regards individual schemes, but local participants in LIFT are advised to seek professional advice before proceeding.
3. LIFT was not originally intended as a vehicle for the delivery of larger and more complex developments such as these. They are very different facilities to the standard GP surgery and primary and community care facilities that LIFT has been so successful in delivering, and they require an approach to risk transfer and service provision that is comparable to other, existing NHS accommodation. Nevertheless, provided it has been established that these facilities can properly be procured through LIFT and using the form of contract referred to below, there is no objection in principle to NHS organisations using LIFT to develop such facilities. Of course, the relevant NHS organisations must be legal parties to the LIFT, i.e. signatories to the Strategic Partnering Agreement.
4. Therefore in future all schemes over £25m in capital value and developed via existing and fourth wave LIFTCos must use the standard form PFI contract, including all risk transfer principles. It should be noted that this only applies where a single scheme (i.e. a single facility) has a capital value of more than £25 million. If a tranche of schemes has a capital value of over £25 million, but no single scheme within that tranche has a capital value of over £25 million, then the standard LIFT Lease Plus Agreement will be used. The definition of capital value is obviously important and will be the subject of a separate annexe to the guidance to be issued very shortly.
5. Requiring LIFTCos to use the standard form PFI contract will ensure appropriate risk transfer and payment and performance mechanisms for larger projects, including (for example) asset ownership in the post-concession period.

6. This will ensure that all schemes of this nature comply with DH and Treasury policy, which is to use standard contractual terms and principles for similar types of procurement, and that they are put on a par with capital developments for similar facilities elsewhere in the NHS.
7. In common with similar procurements carried out in PFI, any amendments to the standard form PFI contract (which should only cater for project-specific variations) will have to be agreed with the Private Finance Unit in DH. In order to avoid unnecessary delays to the approvals process, it is advised that any proposed variation is discussed with the PFU as soon as it arises.
8. The only exception to this requirement to use the standard form PFI contract for schemes over £25m in capital value, is where the LIFTCo acquires and owns the freehold to the land. In these cases, the PFU will need to agree the best contracting form on a case by case basis.
9. Care will be needed when dealing with issues of land ownership. Where the PFI standard contract is used, it is a requirement that the facilities must be handed back to the NHS in good condition at the end of the contract, without additional payment. This means that it will not normally be advisable for land to be transferred into the ownership of the LIFTCo, as happens in many LIFT schemes. The reason for the different approach is that the private sector has been unwilling to accept risks associated with the residual value of land in cases where the land is used for acute hospital facilities. These have little alternative use if the NHS no longer requires them. In contrast, the private sector is able to accept residual value risks for premises such as GP surgeries, which are relatively easy to adapt to an alternative use.
10. For complex schemes with a capital value of less than £25m (see Annexe A for a definition of “complex”), PCTs need to ensure that the contract documentation delivers adequate risk transfer to the LIFTCo and provides appropriate remedies for dealing with any non-performance issues. As a minimum, such facilities should operate to the same standards as the rest of the NHS. Consequently, we would expect the DH Estates Standard Service Level Specification (SLS) to be used for all the services comprising the scheme. (Further details on this will be covered in a separate annexe to the guidance to be issued very shortly.) The LIFT LPA payment mechanism should be tailored to interface with the SLSs in these circumstances. In addition, for complex schemes under £25m, PCTs can use the PFI Standard Form of Contract if they judge it to be more appropriate.
11. In relation to procurement issues, PCTs will need to satisfy themselves that their schemes can be delivered using the LIFT structure in accordance with the Procurement Regulations and their Standing Orders.

Part B: Acute schemes taken forward by participants in the Strategic Partnering Agreement

12. Paragraphs 9.3.3 and 9.3.7 respectively of the Strategic Partnering Agreement state that acute healthcare schemes or schemes procured or occupied by an NHS Trust can be taken forward by a LIFTCo. In these cases, the Trust should show that :

- it has obtained legal advice that supports its view that it has the legal powers to use LIFT;
- the OJEU notice and the MOI has been drafted widely enough to cover the use of LIFT for the proposed scheme;
- other legal documentation supports the proposed scheme;
- selection of the form of procurement is made on the basis of a comparative value-for-money analysis taking full account of risk transfer and transaction costs.

Annexe A

Definition of a “complex” scheme

A complex scheme can be defined as one which contains accommodation that will be used for any of the following services:

- acute or mental health beds;
- patient care that is predominantly medical (requiring consultant support);
- any inpatient surgery;
- diagnostics and outpatients that are not safe and cost effective to provide outside an acute hospital setting;
- long stay beds; or
- full A&E services (as opposed to minor injuries units).