REVIEW OF HURDLES AND BARRIERS

London Thames Gateway Social Infrastructure Framework

NHS

NHS London Healthy Urban Development Unit

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1. Introduction

1.1.1. The Executive Summary of the London Thames Gateway Social Infrastructure Framework "Case for Social Infrastructure Planning" identifies a number of challenges and barriers which are hindering the ability to capitalise on the opportunities for providing social infrastructure.

1.1.2. This Report identifies those "Hurdles and Barriers" and makes recommendations as to how to begin to overcome them.

1.1.3. Section 2 of this Report sets out the categories of Hurdles and Barriers affecting the delivery of Social Infrastructure against which consultees were asked to comment.

1.1.4. Section 3 sets out the method by which evidence was obtained to support the list of Hurdles and Barriers in each category.

1.1.5. Section 4 sets out the results of the process outlined in section 3 by listing the Hurdles and Barriers for each of the categories referred to in section 2.

1.1.6. Section 5 lists the Thames Gateway Social Infrastructure Framework "Criteria for Public Stakeholder Co-operation"

1.1.7. Section 6 describes in detail a number of the Hurdles and Barriers referred to in section 4, and makes recommendations as to how to overcome them.

1.1.8. Section 7 sets out conclusions and next steps.

1.1.9. Appendix 1 is a list of the sources for the evidence gained.

1.1.10. Appendix 2 contains the material gathered from the list of sources.

2. Categories of Hurdles and Barriers

2.1.1. In order to provide some structure to the information collated during the exercise, responses were captured under a number of generic headings. These are:

- Financial Barriers e.g. capital expenditure restrictions preventing NHS development on non NHS land
- Legal Barriers e.g. exclusivity clauses in LIFT/BSF documentation.
- Regulatory Barriers e.g. internal restrictions within the organisations or the regulatory regime within which they operate.
- Cultural Barriers e.g. in respect of working together with different stakeholders and/or gaining access to different stakeholders at the appropriate level at the appropriate time.
- Planning Barriers e.g. constraints/time delays placed by the planning regime, s106 regime, etc
- Public and Private Partnering Barriers e.g. to implementing solutions for closer coordination between the public and private sector
- Private Sector Barriers e.g. coordinating/ accessing private sector developers/ income streams
- Other Barriers

3. The Method Used to Obtain Evidence

3.1.1. As part of the creation of an evidence base for the Thames Gateway London Social Infrastructure Framework a wide ranging consultation exercise on barriers and hurdles to the delivery of social infrastructure was carried out.

3.1.2. Attached as Appendix 1 is a list of sources which covers telephone and face-to-face interviews with clients and recommended contacts, desktop and web searches of published data and applied knowledge of senior partners in the firm. Additional material has also been added from EDAW research and the Focus Groups of London stakeholders that contributed to the early stages of the project.

3.1.3. Attached as Appendix 2 are details of the responses.

3.2. PRINCIPAL PURPOSE

3.2.1. The interviews assumed that the principal purpose of the exercise was to identify what barriers are being encountered by the consultees:-

- in delivering the key goals/objectives which have been set for their organisation with regard to social infrastructure;
- to achieving an integrated (i.e. co-located in the same building) and/or coordinated (i.e. different stakeholders working together but not necessarily co-locating) approach for the delivery of social infrastructure; and
- in respect of the delivery mechanisms currently used for social infrastructure implementation

3.3. GENERIC THEMES

3.3.1. The following were the general themes and questions raised with consultees:

- Is multiple Public Stakeholder co-operation a realistic objective in particular taking account of the complex revenue and capital rules in place?
- At what level is policy co-operation appropriate and in what form?
- Where is service provision best procured separately and where is it best procured in association with facilities?
- Where is integration rather than co-ordination of service and/or facility provision appropriate?
- What scale of procurement makes operational sense and is likely to attract the best response from the public and private sectors?
- What level and type of public "interest" is appropriate in partnership procurement?
- What potential new markets for the delivery of social infrastructure might emerge in the light of experience of PFI and derived initiatives such as NHS LIFT, BSF and Strategic Partnerships? This includes direct public or private sector provision.
- What is the effect of the future uncertainty surrounding organisational and policy changes coupled with the proliferation of providers?
- To what extent can services be delivered from existing accommodation? Does the provision of services necessarily require new buildings and infrastructure?
- Can successful delivery mechanisms focus on how and who provides services rather than where they are provided i.e. the provision of services as opposed to facilities/buildings? How can buildings be made flexible enough – but still affordable – to cope with the inevitable changes in service provision and demand in the future?

- How can community facilities be maintained (both physically and legally) for community use in the future? Are existing means under S106 Agreements adequate?

3.4. SPECIFIC AREAS FOR EXPLORATION

3.4.1. The areas to be explored during the consultations were broken down into the following four main areas.

What Is Being Done Currently - Delivery of Social Infrastructure & Joined Up Working

- What are the key goals/deliverables which organisations are striving to achieve in respect of the delivery of social infrastructure?
- What barriers/hurdles are being encountered (either financial, legal, regulatory, cultural, planning etc) in moving towards those goals?
- Where has co-operation with other stakeholders etc achieved integrated and/or coordinated delivery of social infrastructure to date? What barriers have been encountered in trying to achieve this?

How is this being done - delivery mechanisms

- What delivery mechanisms are currently used to deliver social infrastructure and what limitations are you encountering in respect of these?
- What are the key factors influencing your choice of delivery mechanism?

When and with whom should engagement occur - ideal times for engagement & synergies between services

- How, at what level and at what point during the delivery of social infrastructure should engagement with other stakeholders, the wider community etc take place? What are the barriers to achieving this?
- Where are the real opportunities for delivering integrated and/or coordinated social infrastructure facilities i.e. where are the synergies with other stakeholders/services etc?
- What barriers/hurdles are being encountered (either financial, legal, regulatory, cultural, planning etc) in moving towards the integrated and/or coordinated delivery of social infrastructure?

What changes are needed?

- Generally, does the current government policy and initiative environment hinder or support the efficient delivery of social infrastructure and if not, what changes would improve the situation?
- Of the barriers/hurdles identified in the various categories which are more perceived than real? Which of the barriers identified can be solved by local action? Which of the barriers require departmental/government action in order to be resolved?

4. Results

4.1.1. The results of the various researches, set out in the categories listed in section 2 above, are summarised as follows:

4.2. FINANCIAL & INVESTMENT ISSUES

Funding Dimensions

4.2.1. Public investment constraints and cash flow issues, even with planning contributions being taken into account, are prohibitive especially in the early stages of a regeneration project where the market returns realised are only sufficient to service the private sector.

4.2.2. There needs to be some arrangement to secure Social Infrastructure funding when the need arises from new occupied development so as to ensure parity with existing development needs and their contribution through local taxes. This will be a mixture of capturing added value from the consented development and future local taxes on the occupier. The proposed Planning Gain Supplement may provide a solution but in deprived areas, values only grow after an early (riskier) phase has been completed, occupied and a market created. The planning system and associated timing of contributions must be configured to reflect where difficult market situations occur in these areas. See also section 6.2.1 for further details.

Joining up funding streams

4.2.3. Joined up capital investment is difficult to manage due to different lines of mainstream stakeholder and funding accountability and there are regulatory constraints regarding sharing of budgets. Funding incongruities should be replaced by incentive schemes to promote coordinated/integrated strategy, procurement and funding. See also section 6.3.2 to 6.3.8 for further details.

Revenue/Capital Alignment

4.2.4. Current arrangements for the recycling of funds/reinvestment of profits back into the services need to be extended by improved arrangements to incorporate public service provider interests in the delivery arrangements to allow more flexibility in responding to changing social infrastructure needs. See also section 6.4 for further details.

Public Risk and Reward

4.2.5. In return for a share in value uplift deriving from new development and public investment in social infrastructure but to take account of the timing of need for social infrastructure the public sector should expect to contribute more in the early stages of provision. This might take the form of bridging finance and rent free periods in return for overage or a dividend.

Pooling Resources

4.2.6. There is scope to operate planning contributions from multiple schemes towards a social infrastructure facility the demand for which derives from the combination of needs. This is more straightforward within one local authority boundary. Pooling of developer contributions and merging budgets is likely to be more difficult where social infrastructure impacts will occur across administrative boundaries and in particular in relation to the delivery of 'strategic' services. One possible way to overcome this is set out in Recommendation 7 in section 6.

4.3. REGULATORY & LEGAL

Co-operation Foundation

4.3.1. There is a need for a change in the regulatory and in some case statutory basis for some co-operative initiatives.

Performance Measures

4.3.2. Public performance indicators require simplification. Currently they can be too service provider specific and focus on particular facilities rather than on the wider outcomes for the community: they should not focus on narrow service goals and should instead look at the broader social outcomes for the community. In addition, the link between effective local delivery and the achievement of government objectives is unclear/confusing. Joint target setting may also provide a logical basis for co-operation.

Duplication of Responsibility/Overlapping Initiatives

4.3.3. A significant amount of duplication occurs through the proliferation of partnerships with overlapping responsibilities and different priorities.

Using Public Sector Land

4.3.4. The current process for generating public capital receipts from the disposal of "surplus" public assets at "best value" can remove the opportunity to deliver social infrastructure efficiently. Although there are examples of how to create sustainable communities as part of a disposal arrangement as well as evidence of relaxation of the best value obligations, this needs to be extended through the promotion of longer term relationships, public/public and public/private together with a recognition that best value needs to take account of the wider regeneration and social benefits and not to focus solely on financial return. As example 10 in section 6 suggests, this is potentially more of a problem for non-local authority public sector bodies.

LIFT/BSF Exclusivity

4.3.5. Current NHS Lift and DfES BSF schemes are sector specific and can militate against sharing with other service providers. This is discussed in more detail in sections 6.2.8 to 6.2.19.

LA/PCT Delegation Constraints

4.3.6. The constraints of local authorities/PCTs to delegate their statutory discretion to other public sector bodies can be problematical. Recommendation 7 in section 6 suggests ways in which this can be overcome.

4.4. CULTURAL

Co-operation Rationale

4.4.1. There are issues with regard to the devolution of funding and policy making powers to local authorities from Whitehall.

Need for improved communication

4.4.2. There is evidence of poor communication within service deliverers as well as between them. For higher levels of strategic co-operation to be translated down to facility provision and service delivery, a simpler and more effective delivery chain than exists currently will be required. The operating environment needs to be clearer. In a number of the examples set out in section 6, lack of communication between public sector bodies was a major problem.

Workforce Impacts

4.4.3. Delivery 'efficiencies' will involve broadening staff roles and combining jobs. This may in instances lead to job losses and invoke resistance.

4.5. COMMUNITIES

Community Engagement

4.5.1. The democratic deficit requires wider community engagement in strategy and needs assessment. The service processes vary from wide statutory obligations (planning) through area body (NDC) to inconsistent broad base (LSPs and LCSs) to negligible. The local authorities are charged with improving community engagement and there is scope to devise long term iterative processes that might capture a wide range of service/facility provision. There is scope to engage at various stages in the delivery chain – needs assessment, consequent individual and co-operative service provider strategy, facilities/services programme, performance monitoring, and delivery participation.

Existing and Emerging Communities

4.5.2. Engaging with new communities as they emerge is essential as they do not fit into existing democratic structures. This is difficult across the London Thames Gateway in terms of forecasting exactly 'who' will be living there in the future. There is scope to engage new residents in mixed tenure housing management processes especially where estate management services are provided and when major renewal exercises are undertaken such as LSVTs, ALMOs and PFIs.

Joint Community Engagement

4.5.3. Service providers should work together in community and use the consultation and commissioning processes to increase the effectiveness, give clarity to the consultees and also to reduce the costs incurred. The sharing of results from such processes will also inform the scope for service provider co-operation in social infrastructure delivery.

Community Facility Specification

4.5.4. The potential to introduce ethnic and sector specific facilities such as churches and mosques can motivate particular communities to participate in community facilities that serve multiple needs.

Varying Community needs

4.5.5. Different communities and individuals have different needs and different cultural and other requirements which need to be captured.

4.6. LEADERSHIP

Accountability

4.6.1. The delivery of social infrastructure can be through single, double or multiple groups of service providers. Once the case for co-operation has been established a lead body, individual and other accountable officers must be appointed. This arrangement needs to operate at the strategic and project level and teams must have decision taking powers. Strategy and Project leaders need to be incentivised to secure efficient co-operation.

Prioritisation

4.6.2. Ministers need to demonstrate commitment to a Social Infrastructure Framework evidenced by a co-ordinated and comprehensive policy and service provider investment programme. Against this background private contributions and investment may occur.

Operational Area Incongruity

4.6.3. Many operational areas are not the same whether at local/area or regional level. There are indications that Government intends to regionalise health and police service areas to reflect regional planning and housing areas and this would make co-operation and alignment easier. Similarly, if Local Authority boundaries were selected as the "local" boundary then alignment would be easier.

4.7. BUILDINGS

Specification

4.7.1. Any specific building specification needs to be flexible to allow different uses as needs evolve and change. There are clearly limits to this as fitness for purpose can and should be prescriptive for some facilities. However as much social infrastructure involves personal service then where integrated facilities are provided flexibility is achievable.

Managing Growth

4.7.2. The selection of growth points within Thames Gateway would allow more manageable social infrastructure provision albeit within an overarching framework. There is evidence that local authorities could provide a logical basis for much planning however, population growth will deliver cross boundary impacts and full strategic co-ordination will be required.

Building Use Life

4.7.3. Different service uses require buildings with different lives and maintenance/service requirements. Security of tenure is normally a pre-requisite of any public or private investor and as with vertical mixed use aspirations can lead to landlord and tenant problems for example where leases fall in at different times.

4.8. POLICY

Spatial Planning

4.8.1. The key role for the new spatial planning system needs to be capitalised upon to provide the common link through service planning activities.

Policy/Performance Alignment

4.8.2. Policy, service level agreement and performance standard alignment should be required at the national level. Without this existing and new co-operative mainstream funding streams are less likely to emerge and there is a consequent need to incentivise the application of different funding sources.

Strategy Alignment

4.8.3. Many service provider strategies are not subject to wide public scrutiny except through a mixture of primarily regional and local stakeholder consultation. However, the one function where there is a statutory obligation to consult at regional, local and development level is the planning process.

4.8.4. There is evidence that alignment between service provider strategies and spatial plans and local development frameworks is poor or non existent.

4.8.5. The current proposals to enhance the role of LSPs, Local Community Strategies and Local Area Agreements with the local authority to take the lead to bring together all public stakeholders provides another opportunity to bring social infrastructure into a broader public service context with associated Social Infrastructure strategy and delivery benefits. The interaction between the different strategies needs to be managed and in particular further consideration needs to be given as to how these can and should affect each other.

Plan Rationalisation

4.8.6. The production of fewer plans as supported by the ODPM rationalisation programme needs to be incentivised by offering it to poorly performing as well as good performing local authorities.

Inter Service Provider Agreement Timescales

4.8.7. There is a need for stakeholders to have the ability to enter longer strategic agreements with other stakeholders and this should be linked into funding availability. Many Social Infrastructure proposals require delivery over periods beyond the 4 year Expenditure Planning Rounds. To capture the private sector efficiently can require longer commitments to partnership.

5. TGSIF Criteria for Public Stakeholder Co-Operation

5.1.1. The review of issues, challenges and barriers has revealed the complexity of delivery. The operational and policy basis of Social Infrastructure providers does not (and in some cases cannot) lead to a co-operative approach that might most benefit the community.

5.1.2. There are often good reasons for an individual stakeholder approach but a set of criteria has emerged, against which justifiable co-operation might be addressed, at higher strategic/stakeholder and lower project/service levels whether through consultation, co-operation in procurement of parallel or integrated facilities and services or in the approach to engage the community.

5.1.3. These "Criteria for Stakeholder Co-operation" have arisen from the Hurdles and Barriers exercise.

"Criteria for Stakeholder Co-operation"

- Common data for calculating current and projecting future social infrastructure needs is available and can be shared.
- Common performance targets and measures: PSA performance targets and priorities for intervention are complementary or shared and can be established in a single commitment.
- Clear stakeholder roles: the roles and responsibilities of the public bodies can be clearly defined and distinguished.
- Common client characteristics: the client body or group is the same demographically, geographically and/or by reference to agreed levels of deprivation. E.g. schools in NDC areas and programmes seeking to resolve drug and alcohol abuse.
- Multiple public services needs: the client body or group has multiple needs.
- Phased services needs: the client group or body requires a phased approach to achieve a public service objective. This may be simply an issue of ageing e.g. from child, through student to employee or it may be a development in capability or skill level e.g. from illiterate/innumerate to competent.
- Interdependent or chronological service needs: the nature of the service follows naturally from one sector to another or is interdependent e.g. from social care of the elderly to health care.
- Service inter-relationship: the nature of the public service impacts upon another e.g. the statutory spatial planning process and the regional strategies for health, education and welfare; e.g. school absenteeism and neighbourhood policing.
- More cost effective: the funding of an integrated services is more cost efficient.
- Common service delivery location opportunity: the route to our supply of a public service might be managed from a common point.
- Speedier decisions: decision taking is managed to an optimum speed.
- Utilising existing processes: LSPs/LAAs, etc.

6. Examples of Key Barriers and Specific Recommendations

6.1. INTRODUCTION

6.1.1. It is evident from the general themes emerging from section 4 that there are many real and perceived barriers to the delivery of social infrastructure.

6.1.2. This section illustrates by way of specific examples barriers that are having an immediate and real impact on the delivery of actual schemes, together with specific recommendations as to how to overcome them.

6.1.3. It has become apparent that these "real" examples divide into three categories. First, barriers between the public sector and the private sector. Secondly, barriers between public sector organisations and, thirdly, barriers within individual public sectors.

6.1.4. These examples and recommendations should be seen as a key element in delivering a successful Social Infrastructure Framework through the Delivery Chain referred to in section 7 below. The Toolkit is part of a comprehensive process to arrive at the right solution for the delivery of social infrastructure in any part of the Thames Gateway. However, in order for that process to be successful the real live examples referred to in this section must be addressed and overcome.

6.2. BARRIERS BETWEEN THE PUBLIC SECTOR AND THE PRIVATE SECTOR

Negotiating Section 106 contributions

6.2.1. Planning contributions, through Section 106 Agreements, are fundamental to the affordability of new social infrastructure. In practice the process does not always operate effectively, as illustrated by the following two examples.

Example 1: Negotiating the Milton Keynes tariff

6.2.2. In Milton Keynes a tariff is being negotiated with a consortium of the principal developers and land owners in Milton Keynes. It should be noted that HM Treasury has agreed in principle to forward fund the provision of infrastructure on the basis that costs will be recouped when paid by the developers pursuant to the Section 106 agreement. The potential benefits of such an approach are clear: the public sector receives a set amount per dwelling or area of employment space at fixed dates and can use the contributions in an effective way area-wide to provide the strategic and local infrastructure required, rather than having to negotiate one off contributions on individual sites. The principal benefits for the private sector are equally clear: certainty in terms both of the amount required to be paid and that the required infrastructure will be delivered within a given time frame. This is so important to the private sector that it is likely to be preferable for the private sector to agree a slightly higher contribution than might otherwise be negotiated on an individual site basis because sites can be developed sooner with cost and delivery certainty. In practice, the negotiations have taken so long to conclude, (the public sector has lost credibility in shifting its ground on what had been agreed previously in principle; has changed personnel; missed deadlines; introduced new issues at a later stage; not had a co-ordinated approach; and officers have not secured authorisation form members/boards before negotiating a position etc) that there is considerable doubt as to whether the tariff will be seen as the solution to Section 106 delays which it was originally hoped it would be.

6.2.3. The negotiations have also emphasised a key barrier to all Section 106 negotiations, including area-wide negotiated tariff arrangements of this sort, namely timing of the private sector's contribution. It must be recognised that the private sector will be carrying the front end costs of site preparation, procurement, construction etc and will therefore be unwilling to frontload additional costs such as Section 106 benefits until it begins to receive income from the site e.g. via completed private housing units. This is particularly the case in relation to brownfield sites, on which, of course, the Government's policy is that

most new homes (target is 60% plus) should be built. This often leads to compromises being made in relation to the extent of health and education facilities built "up front". Instead of a full scale secondary school being constructed, contributions may only be sufficient for a specified number of additional school places. This leads to problems when population growth leads to further social infrastructure requirements.

6.2.4. **Key Recommendation 1: An effective means must be found for ensuring that, where suitable for use, area-wide negotiated tariffs are concluded quickly enough to justify the area-wide (as opposed to the individual site) approach. The awareness of the importance of this issue through this type of Report is itself a part of the solution.**

6.2.5. **Key Recommendation 2: In the absence of available private funding innovative means should be explored to enable the public sector temporarily to fund the necessary social infrastructure in advance of agreed planning contributions being made by the private sector upon completion of private housing units. Some of the delivery mechanisms explained in the Toolkit would be relevant to resolution of this issue.**

Example 2: The mismatch between what developers deliver through Section 106 Agreements and what social infrastructure is actually needed.

6.2.6. There are many examples around the country of cases where a local authority has negotiated a Section 106 Agreement with a developer for the provision of, or a financial contribution to, schools, health centres or leisure facilities, which turn out to be very far from what is useful or needed. Examples include facilities which are the wrong specification or size; which oblige the developer to build agreed facilities but then require the public sector to pay an (unaffordable) market rent; which require the public sector to pay an (unaffordable) open market value for the freehold and/or which results in the public sector paying capital charges. Although the consultation process revealed improvements to the co-operation between, say, health bodies and local authorities, particularly in areas of the Thames Gateway, the communication between public sector providers and the local planning authorities remains patchy. This is particularly concerning at a time when the requirements for health facilities in the community are rapidly changing as technological advances may now mean that financial contributions to addressing the treatment of long term conditions may be just as important as new bricks and mortar.

6.2.7. **Key Recommendation 3: Public sector stakeholders (particularly health bodies) must engage more closely and more regularly with local planning authorities to ensure that Section 106 negotiations deliver what is actually needed.**

Exclusivity clauses and procurement issues in NHS LIFT and Building Schools for the Future

6.2.8. NHS LIFT and BsF are new delivery mechanisms developed in the last five years for overcoming many of the problems that have beset the delivery of new schools, GP surgeries and health centres. The NHS LIFT initiative is significantly more advanced than BsF with 42 new LiftCos set up across England covering more than half the country's population and all England's major urban areas. It has been very successful in driving a step change in the provision of primary health care infrastructure and its importance is likely to increase as the initiative looks to deliver larger community style hospitals. One of the key advantages of NHS LIFT (and BsF) is the long term partnering arrangement between public and private sectors which enables schemes to be delivered without lengthy procurements and with consequential cost savings. Part of the commercial structure of NHS LIFT is that the private sector meets the cost of setting up the local "LiftCos", but in return the private sector naturally requires some element of certainty that it will be given first refusal on schemes that the local health bodies plan to carry out. Hence the so called "exclusivity" clauses. The issue for the delivery of co-ordinated social infrastructure is that when some public sector participants are caught by exclusivity provisions and some are not, this can make a joint scheme difficult or impossible to deliver.

6.2.9. The following two examples look at two related but contrary issues that have arisen for the development of LIFT schemes. Example 3 looks at problems which arise where one party (the local authority) considers that the proposed joint scheme is too expensive and both the local authority and the PCT wish

to procure the facility outside LIFT. However, LIFT has the right to prevent this though its "exclusivity" clause.

6.2.10. Example 4 looks at the situation which is becoming more frequent, where the local authority wants to deliver the scheme through LIFT (possibly because it has been given PFI credits specifically to do so), but problems arise because the scope at the proposed joint facility is outside the original OJ procurement.

Example 3: Problems with exclusivity clauses in East London.

6.2.11. Two schemes in East London, the Jo Richardson School development at Castle Green and the Barking Town Centre development have illustrated the potential problem. In the first confusion around whether the health element of the scheme was, or was not, caught led to time delays and ultimately the scheme was not delivered by a single provider. In the latter case, the problem was more fundamental. The proposed scheme involved the development of a new health facility as part of a larger building housing the local authority's new headquarters for 400 staff. However, the local authority did not believe that LiftCo's proposals represented value for money and was also concerned that there may be procurement issues in delivering a scheme with LiftCo without going out to a separate tender. In the end, the joint scheme did not go ahead and the local authority and the PCT developed separate buildings.

6.2.12. In our opinion many of these problems arose as a result of a number of factors. First an insufficient understanding of the complexities of the standard LIFT documentation and the means by which value for money can be demonstrated through the provisions of the Strategic Partnering Agreement and/or exclusively can be legitimately bypassed. For example, public sector bodies can specify the level of rent they can afford for any scheme. If LiftCo cannot meet that affordability cap or otherwise demonstrate value for money (which it is contractually required to do) then the public sector can procure the scheme outside LIFT provided no changes are made to the scheme after it has been offered to LiftCo. A practical approach is simply to ask LiftCo to waive exclusivity on a "one off" basis. Such an approach is likely to be successful where the partnering arrangements are working well (as they are in many parts of the country) but there will be an understandable reluctance on LiftCos to waive exclusivity when there is little prospect of other schemes being offered to them. (There are a number of other detailed provisions which are relevant here but a detailed explanation is beyond the scope of this paper and in any event depends strongly on scheme specific issues.)

6.2.13. The second reason (and probably more important reason) for jointly proposed LIFT schemes failing is the lack of the risk sharing and proactivity by the LIFT, private sector partner. There are a number of examples throughout the country of joint leisure and health facilities procured extremely successfully through LIFT. The Burnley Town Centre scheme was such an example where our consultation revealed a high level of trust between the public and private sector, caused in the past by the proactive approach of the private sector partner. In many cases the LiftCo partner will add value to the scheme by offering innovative development opportunities to enable schemes which would not otherwise be possible to be delivered. However, this proactive approach is not universal and there are examples of LiftCos that have reacted rather than innovated, leading to fewer, usually less affordable, schemes being developed.

6.2.14. In our view a number of the problems affecting exclusivity clauses are to a certain extent more perceived than real. LIFT is one of the few nationwide initiatives which has involved both health bodies and local authorities delivering social infrastructure schemes together. The structure is in place; but it is acknowledged that it must be combined with an effective culture by both public and private sectors.

6.2.15. The problem affecting Barking Town Centre however, is one which is more difficult to overcome. The nature of LIFT is that the lease arrangements entered into by the public sector are more expensive than conventional lease arrangements because the landlord (unlike a normal commercial lease) takes full responsibility and risk for repair and maintenance. Naturally this comes at a cost to the tenant. Where, as in Barking Town Centre, the local authority cannot afford the proposed rent, it can lead, as was the case in Barking, to a joint facility not going ahead. Although this may not have been the case in Barking, often value for money is demonstrated (because the public sector is getting guaranteed services accommodation), but affordability remains a problem.

6.2.16. **Key Recommendation 4: Greater awareness is needed by both local authorities and health bodies of the way the LIFT documentation works. A clear understanding by all the parties to a proposed LIFT transaction and the financial implications is essential at the outset of the scheme. A separate recommendation is that there is clarity between the public sector bodies as to who picks up aborted costs if schemes do not proceed. It is acknowledged that in some cases local authorities will choose not to provide a scheme through LIFT. However, in our opinion it is unreasonable for the private sector to be expected as a matter of course to allow health developments to be procured outside LIFT. Where the public sector is delivering a healthy number of schemes then we are aware of specific cases where LiftCo have been prepared to waive exclusivity.**

6.2.17. The second LIFT example relates to procurement issues.

Example 4: The problems of procuring joint health and leisure schemes through LIFT.

6.2.18. There are numerous examples of schemes across the country where local authorities and health bodies are working together to deliver joint social infrastructure schemes (e.g. health and leisure, health and social housing). However, potential barriers have arisen where the local authority has sought to deliver schemes which potentially fall outside the original OJ procurement. NHS LIFT principally was designed to deliver health and social care schemes,. Arguably, housing, leisure facilities, libraries and schools all fall outside this definition but we are aware of a number of examples, where such schemes have been developed through LIFT; the town centre health and leisure development in Burnley delivered by the successful East Lancs LIFT; a proposed community hospital and swimming pool in Bristol; a combined health and leisure facility in Sandwell; and a joint health and social housing scheme in Medway. There is no one simple answer to how these issues are overcome, but we believe that in all the cases referred to above, they have been overcome by careful consideration in advance of the issues arising; mitigation strategies; and in some cases changing the scheme to minimise the risk of challenge.

6.2.19. **Key Recommendation 5: NHS LIFT is potentially a dynamic tool to drive the delivery of social infrastructure. Rather than veering away from it as a procurement model it should be embraced to deliver as wide a variety of joint schemes as possible. Where procurement issues arise these can usually be addressed provided specialist advice is sought at an early enough stage.**

6.3. BARRIERS BETWEEN PUBLIC SECTOR BODIES

6.3.1. Section 6.2 above looks at barriers between the public sector and the private sector. This section 6.3 looks at barriers between public sector bodies. First 6.3.2 to 6.3.8 looks at a variety of financial barriers. Section 6.3.9 to 6.3.19 then goes on to look at some regulatory and legal issues.

Financial issues between public sector bodies

6.3.2. When public sector bodies seek to deliver schemes jointly, problems are often caused by the different funding regimes which apply to each

Example 5: Use of PFI credits for joint schemes

6.3.3. We are aware of a number of instances where joint procurement (usually health and leisure) schemes have encountered difficulties because of a lack of clarity around the extent to which PFI credits, available to the local authority for its leisure element, could be used for the joint health and leisure scheme. This occurred in a scheme in South London which led to significant delays and similar issues have arisen (now resolved) on a scheme in the Bristol area.

6.3.4. Another example relates to the passing of grant monies between government departments/bodies.

Example 6: Grant monies – giving with one hand and taken with another.

6.3.5. The Barking Town Centre development encountered a classic example of intra governmental financial regulations significantly delaying and ultimately having a serious detrimental effect on a joint procurement scheme. In this case £5m of grant monies were made available for the Barking Town Centre Scheme. However due to the way in which the grant monies were received by the Primary Care

Trust it was required to account for capital charges on the extent to which the grant monies were injected into the scheme. The effect was that the capital monies given by one government department were ultimately returned as revenue funding by the Department of Health through the PCT

6.3.6. Finally there is the example of the potentially detrimental effect of VAT decisions on lease rentals.

Example 7: The vagaries of VAT treatment on public sector bodies.

6.3.7. NHS bodies generally don't pay VAT on the services they procure. However where NHS bodies occupy premises under leases from third party landlords historically NHS bodies have been able to rely on an exemption which relied on the premises being leased being categorised as serviced accommodation rather than simply accommodation. For many years documentation was accepted which entitled health bodies to fall into this exemption. Last year a VAT decision rescinded this exemption and made many schemes which health bodies were intending to enter into almost 20% more expensive. This additional cost made many schemes unaffordable and could cause many others to be shelved.

6.3.8. **Recommendation 6: The myriad of inconsistencies affecting the financial regimes between public sector organisations and departments needs looking at on a case by case basis. Although the use of PFI credits has now benefited from greater clarity, the inflexible approach to treatment of grant monies should be addressed by government. The reinstatement of the previous approach to VAT treatment would also be greatly welcomed.**

Regulatory and legal barriers between different public sector bodies

6.3.9. One of the most crucial hurdles to overcome when providing joint schemes is the difference in the legal and regulatory powers of public sector bodies, particularly between local authorities, which generally have greater powers and are more autonomous, and other public sector bodies and government departments. Let us examine some further examples.

Example 8: The lack of suitable legal structures between local authorities and other local authorities

6.3.10. If local authorities want to procure schemes in partnership problems are often caused by the lack of suitable legal structures. Between local authorities the current possibilities are agency arrangements and Joint Committees. Agency arrangements involve one authority arranging for another authority to discharge its functions but they are unpopular because they involve a loss of sovereignty and are consequently unstable particularly where there is a change in political control of one of the authorities. Joint Committees can be set up as an alternative where two or more local authorities set up a Joint Committee and delegate their powers to the Joint Committee. However, the Joint Committee is not a separate legal entity so it is always necessary to have one of the local authorities as lead authority employing staff and holding land. This can lead to jealousies as such arrangements are very susceptible to a change in political control.

Example 9: The lack of suitable legal structures between local authorities and other public bodies

6.3.11. Between local authorities and NHS bodies there are Section 31 arrangements which work reasonably well, but they are limited to the specific social care arrangements to which Section 31 arrangements relate and have other limitations relating to the lack of a separate legal entity. This can particularly be seen when joint health and social teams under Section 31 arrangements need to enter into lease arrangements.

6.3.12. Even Section 31 arrangements have limitations, however. For example, there is no ability for local authorities and other public sector bodies jointly to own land or buildings. This was a particular problem on a scheme in Cornwall where a variety of different social infrastructure stakeholders including health bodies, local authorities and other voluntary bodies all had capital funds to invest in a scheme. However, because each organisation had individually to "receive" a legal interest in return for the capital payment, a highly artificial and complex legal structure had to be imposed to ensure that legal and financial

regulations were satisfied. This is exactly the type of scheme which would have been far easier to procure if there had been one public sector organisation which was both accountable to, and represented, the interests of the various stakeholders, and was also able to exercise (on behalf of its constituent bodies) all necessary powers, including, for example, the power to own land.

6.3.13. In addition to the lack of suitable legal structures, problems can arise because of the mis-match of different stakeholders' powers.

Example 10: The mis-match of stakeholders' powers: vires; equity investment; and sale of land.

6.3.14. Local authorities have useful "wellbeing" powers which enable local authorities to enter into arrangements which would be ultra vires for other public sector bodies. This is because, assuming the parameters for meeting the "wellbeing" powers are met, local authorities can proceed with a scheme unless there is a specific statutory provision which prevents them from doing so. This is different to, for example, health bodies, which must be able to justify any use of its powers by reference to specific statutory authority. If there is doubt about the existence, or exercise, of a power, it is likely that health bodies will be acting ultra vires if they proceed. There are other examples: local authorities can sell land at an undervalue of usually up to £2m. Health bodies are constrained by statute and the provisions of Estatecode to sell at market value (save in a number of limited circumstances). Local authorities can take shareholdings and companies. Health bodies have to be given express statutory authority to do so through primary legislation because the existing powers of health bodies are too limited to be of any use in jointly procured social infrastructure schemes.

6.3.15. **Key Recommendation 7: Examples 8 and 9 suggest that the lack of suitable legal structures is a major problem for the development of integrated or co-ordinated social infrastructure schemes, particularly in light of the mis-match of powers between local authorities and other public sector bodies, illustrated in example 10.**

6.3.16. We recommend that consideration be given to using the Joint Board model to deliver jointly procured social infrastructure schemes. In certain cases (transport and waste in the old metropolitan counties; planning in the national parks; and combined police and fire authorities), the government has provided in legislation for Joint Boards – new joint local authorities, established by statute to secure the joint provision of a service. These provide a model which could be used better to deliver social infrastructure in the Thames Gateway (and elsewhere).

6.3.17. Local authorities, health bodies, schools, colleges and other relevant stakeholders should be able to go to the Secretary of State and get him/her by order to set up a Joint Board comprising members of the constituent bodies. It would be a separate corporate entity, able to own land and employ staff. It would have certain powers devolved by statute, but the constituent bodies could also delegate voluntarily additional powers to it, and, as a statutory body it could have functions and discretions delegated to it. Because of its statutory basis, it would be much more stable than a voluntary arrangement or contractual framework, as it could only be dissolved by order of the Secretary of State rather than at the whim of one of the constituent bodies.

6.3.18. The model is equally applicable for a range of other functions such as collaborative working for town development, health promotion and joint procurement. Also, the availability of this model would make the size of the constituent bodies much less important.

6.3.19. This recommendation would require primary legislation but there is a golden opportunity in the Local Government Bill due in the Queen's speech this autumn.

6.4. BARRIERS WITHIN PUBLIC SECTOR BODIES

6.4.1. There are a number of examples where the internal regulations of individual stakeholders cause problems on schemes. Examples 11, 12 and 13 illustrate three specific issues that NHS bodies are encountering. The first and second are of general application, whilst the third is a problem encountered across the country on NHS LIFT schemes.

Example 11: The problem of impairment:

6.4.2. When NHS bodies sell land there are complicated and arguably artificial rules relating to the valuation of the land and whether it causes a profit or loss in the NHS body's profit and loss account. This is regardless of the fact that the land is being sold at a fair open market price in a contested auction. On a proposed scheme in the South West, the theoretical loss against a health body's balance sheet was very significant and enough to cause the scheme to be delayed. Indeed it is likely the scheme would have been stopped all together if it were not for further internal financial regulations which enabled the technical deficit on the profit and loss account to be covered by the NHS Bank. However, as there was a minimum threshold for seeking relief, the scheme was in serious danger of falling between creating a technical loss which was too high to allow the health body to proceed, but too low to obtain central relief. Although the problem was ultimately resolved, the solution was entirely scheme specific and leaves open the possibility of the same issue arising where NHS bodies sell land as part of the jointly procured social infrastructure scheme.

Example 12: Use of capital receipts on the sale of land.

6.4.3. This is a widespread problem throughout the NHS. When local NHS bodies sell land the usual position is that such capital receipts must be refunded centrally to the Department of Health rather then being used for the local health economy. There are exceptions to this rule, but even where capital receipts are retained by the local NHS body for specific purposes such as equipment purchases, the receipts are still subject to capital investment rules and may be clawed back by the strategic health authority.

Example 13: Use of enabling funds in NHS LIFT schemes.

6.4.4. In NHS LIFT, enabling funds were made available to assist the financial affordability of jointly procured health and social care schemes. However, Department of Health regulations require the monies to be used for capital purposes only rather than revenue, which is where it is needed most urgently. Although intended to ensure that such enabling funds are properly accounted for and spent, it can, and often does, lead to a situation where enabling funds are used to fund a much less cost effective "capital" solution (for example, purchase of a portacabin) rather than a much cheaper "revenue" solution such as renting third party space for the requisite period of time. This seems illogical.

6.4.5. These three examples taken together with some of the examples referred to in example 10 where NHS bodies have fewer powers than local authorities lead to our final recommendation.

6.4.6. **Key recommendation 8: Urgent consideration should be given to reviewing and revising the internal powers of, particularly, NHS bodies. These should include:**

- **relaxing the requirement to use enabling funds in NHS LIFT schemes for capital purposes only**
- **giving NHS bodies greater flexibility to use receipts from sales of land**
- **changing impairment rules to ensure that technical NHS accounting rules do not prevent schemes proceeding**
- **giving NHS bodies wellbeing powers similar to local authorities**
- **expanding the powers of PCTs to invest in joint venture companies in the same way as local authorities.**

7. Conclusions

7.1.1. There are five clear conclusions that can be drawn from the consultation process that has led to this Hurdles and Barriers Report, and the belated "Toolkit" and "Case Four" documents. These emerge from five key questions:

- Has Social Infrastructure historically been delivered in a co-ordinated/integrated way?
- Are there benefits to a co-ordinated/integrated approach?
- What are the reasons for the failure to co-ordinate the delivery of Social Infrastructure?
- What can be done to overcome the hurdles?
- Is there a willingness amongst key stakeholders to effect a step change in how Social Infrastructure is delivered?

7.2. HAS SOCIAL INFRASTRUCTURE HISTORICALLY BEEN DELIVERED IN A CO-ORDINATED/INTEGRATED WAY?

7.2.1. Generally the answer to this question is an emphatic "no". Exceptions have tended to be where quite specific local circumstances have led to a one-off integrated facility or co-ordinated approach to the delivery of Social Infrastructure. However, part of the reason for this is the comparatively recent recognition of the extent of the benefits that a co-ordinated approach to the delivery of Social Infrastructure can bring. See section 7.3.

7.3. ARE THERE BENEFITS TO A CO-ORDINATED/INTEGRATED APPROACH TO THE DELIVERY OF SOCIAL INFRASTRUCTURE?

7.3.1. The answer to this question is an emphatic "yes". Historically, the broadly individual approach by the health, education, leisure and emergency services sectors to the delivery of Social Infrastructure may have met the historic needs and expectations of the community. However, this is rapidly changing for the following reasons:

7.3.2. **Changes in the population**: particularly in the growth areas such as the London Thames Gateway (but the same is true to a lesser extent throughout the country) changes in population location and housing need have led to a requirement to ensure that such new housing needs are matched by the necessary Social Infrastructure.

7.3.3. **Changes in the way services are provided**: never before has there been such a rapid change in the way Social Infrastructure services are delivered. In particular, the development of new technology (such as telemedicine) means that the emphasis in the future is likely to be on the way services are provided rather than the facilities from which those services are provided. Flexibility will be the key: providing facilities that service providers are not tied to for a period of time but far exceeds the needs of the community in which the facility is based. Small, more flexible facilities, spread throughout a community can best be achieved (arguably, can only be achieved) through a co-ordinated approach to the delivery of Social Infrastructure.

7.3.4. **Recognition of the service benefits of the co-location of Social Infrastructure**: quite apart from the efficiency and financial savings (see below) there is clear evidence that the benefits of co-locating the provision of Social Infrastructure, whether at the basic level of improving access to services (for example, patients are more likely to go to a surgery if it is next to a leisure centre and single parents are more likely to take up training opportunities if they are located next to child care facilities), or because better outputs can emerge (for example GPs can more easily prescribe an exercise regime if a surgery is next to a gym and swimming pool).

7.3.5. Government is now openly acknowledging in particular the health benefits of co-locating health facilities with other Social Infrastructure. The recent White Paper "Our health, our care, our say" specifically refers to the benefits of co-location and this is taken up in more recent guidance on the additional £750 million funding for the new generation of community hospitals, which suggests that those areas that can demonstrate a co-ordinated approach for Social Infrastructure are more likely to win part of the new £750 million funding.

7.3.6. **Financial benefits**: last but not least, against a background of an increasing need to demonstrate value for money, the financial benefits of pooling funding and resources to deliver Social Infrastructure seem obvious, quite apart from the indirect financial benefits of improving service provision in the way outlined above.

7.4. WHAT ARE THE REASONS FOR THE FAILURE TO CO-ORDINATE THE DELIVERY OF SOCIAL INFRASTRUCTURE?

7.4.1. The answer to this question is what forms the basis of sections 4 and 6 of this Hurdles and Barriers Report.

7.4.2. Looking at each of the categories listed in section 4, we suggest that the overriding hurdles are as follows:

7.4.3. **Financial**: as explained above there may well be significant financial benefits to the Government in delivering Social Infrastructure in a co-ordinated way. However, there is no process in place to identify what these benefits would be across all the different Social Infrastructure sectors.

7.4.4. **Legal and regulatory**: there is an insufficient understanding of – and in addition some real barriers relating to (see section 6) – the legal and regulatory framework within which the different Social Infrastructure stakeholders operate.

7.4.5. **Cultural** there is no historic culture of communication between different Social Infrastructure providers (though there are many examples of the beneficial effects where this has happened.

7.4.6. **Leadership**: there are many champions of the co-ordinated approach for Social Infrastructure. However, inevitably, there is no existing structure in place which enables leadership of a co-ordinated approach to Social Infrastructure, and the resources that need to go with it.

7.5. WHAT CAN BE DONE TO OVERCOME THESE HURDLES?

7.5.1. Section 6 sets out 8 key recommendations dealing with the hurdles identified in section 7.4 above. The recommendations range from proposals for key policy and legislative changes (the introduction of Joint Boards) just specific legal and regulatory changes (looking at the way NHS bodies can use receipts from the sale of land). These recommendations are extensive, but not conclusive. Further recommendations will emerge as the process of delivering Social Infrastructure in specific areas (such as Barking Dagenham) develops.

7.6. IS THERE A WILLINGNESS BY STAKEHOLDERS TO EFFECT A STEP CHANGE IN HOW SOCIAL INFRASTRUCTURE IS DELIVERED?

7.6.1. This undoubtedly the case, not least because many stakeholders can see as a minimum the very real benefits of informing their own area of influence (whether it be responsibility for Local Area Agreements; delivering new fire facilities; negotiating a section 106 tariff – the list is endless) with how other stakeholders are approaching similar issues of co-ordination of Social Infrastructure. Excitingly, many stakeholders are beginning to see that a co-ordinated approach enables the much greater benefits set out in section 7.3 to be achieved.

8. Next Steps

8.1.1. Stakeholders are, we believe, excited by the opportunities that a Social Infrastructure Framework can bring.

8.2. BARKING AND DAGENHAM LOCAL SIF

8.2.1. However, the benefits need to be demonstrated in real life situations, which will then form an additional justification for further developing the process within the London Thames Gateway and beyond.

8.2.2. This is already happening in the London Borough of Barking and Dagenham where the "Toolkit" is, in effect, being used to put in place a process which will produce by September 2006 a list of specific recommendations, some of which will include the recommendations listed in section 6 above, as to how Social Infrastructure can best be delivered within the Borough.

8.2.3. The "input" will be:

- Consultation with key stakeholders and decision makers.
- An audit of Social Infrastructure needs and projected future needs.
- An audit of the existing policy, commercial and legal framework.

8.2.4. The "output" will be:

- Options for meeting projective Social Infrastructure needs taking into account spatial/asset opportunities within the LBBD area.
- Generation of specific delivery vehicles if required.
- Ideally creating an overarching framework within which stakeholders can continually update, modify and improve delivery of Social Infrastructure.

8.2.5. The benefits will be:

- The meeting of Social Infrastructure needs for existing and emerging communities.
- Maximising accessibility and uptake by those communities; and
- Increased efficiencies for service providers.

8.3. A NATIONAL APPROACH

8.3.1. Our hope is that this paper together with the SIF Toolkit, the "Case For SIF Planning" document and the LBBD pilot will result in a Government led drive for the effective delivery of Social Infrastructure throughout the country. The SIF should form a key element of the Local development Frameworks and as such be regularly monitored and reviewed. The development of Social Infrastructure Frameworks in individual locations usually but not exclusively at Local Authority level through partnership working, will reap the benefits of a more joined up co-ordinated approach, for both customers and providers of services, outlined in these reports.

A1. List of Evidence Sources

Accent Group
Barking and Dagenham PCT
Castle Green (including Jo Richardson extended school)
Chepstow Community Hospital Case Study
Citizen's Advice Bureau Cx2)
East Lancashire LIFT
Elizabeth Garrett Anderson School Case Study
English Partnerships (x3)
Evaluation of Local Government Modernisation Agenda: Progress Report on Stakeholder Engagement with Local Government
Gateway People - the attitudes and aspirations of prospective and existing residents of the Thames Gateway
Hengrove Park Case Study
Home Office - Crime and Disorder (x2)
Housing and Public Health Report; a Review of Interventions for Improving Health
Housing Corporation (x2)
Learning and Skills Development Agency
London Borough of Lewisham
London Borough of Tower Hamlets
Newham PCT
Ocean NDC
ODPM Local Area Agreements Team (x2)
OFSTED Review of Services for Children and Young People
Report on Process Evaluation of Plan Rationalisation: Formative Valuation of Community Strategies
Sandwell HMRP
Social Exclusion Unit Report
South East of England Development Agency
TGSIF Focus Groups
The Coram Community Campus Case Study
The Dalmellington Area Centre Case Study
Turning Point
Wythenshaw Forum Case Study

A2. Material gathered from Evidence Sources

CATEGORY
Financial & Investment Issues
1. Social Infrastructure delivery should coincide with new housing from which reciprocal contributions may be sought.
2. Similarly, securing, for example a new school to be provided alongside new housing, is difficult because of public investment constraints, even with a planning contribution form the developer.
3. Joint public capital investment programmes are extremely difficult to manage.
4. Lack of funding to develop community strategies and improve rationalisation within and outside local authority area inhibits effectiveness.
5. Different lines of accountability for funding and mis-aligned planning processes are an impediment.
6. Community facilities and conference/catering facilities attract revenue. Any revenue created by a project should be invested back into the project rather than the central pots of each service.
7. The withdrawal of the Housing Corporation's ability to offer support to Supported Housing removes an important cohesive solution.
8. There are issues surrounding whether some infrastructure such as community facilities and new hospital provision should be provided (and paid for) in advance of occupation or at some agreed period after occupation i.e. when is the need for infrastructure triggered?
9. Joint procurement should be considered as a way of demonstrating the vision of an integrated service provision. Different funding sources provide a current barrier to this.
10. Where a project is operated by a non profit distributing organisation, any profit it makes must be reinvested in the service rather than distributed to the shareholders.
11. It is difficult to agree the timing of contributions associated with new development - on planning permission, on completion of unit or phases on occupation of units.
12. Capturing S106 monies across borough boundaries is very difficult where Social Infrastructure is to be provided that serves more than one Local Authority need.
13. There is a need to configure base data on a consistent basis as there is an unnecessary disparity of data capture/retention across agencies
14. There is scope to access wider and potentially common sources of relevant data from Local Authorities, Police voluntary/community sectors and business
15. Local consultation needs service provider join-up to increase access and effectiveness, reduce the costs of consultation, share the results and reduce the burden on the public and provide appropriate feedback
16. In one scheme the council applied to the Government for PFI credits. Whilst waiting for a response in respect of its OBC the Authority did some work on its project and considered what it could do if it was unsuccessful in its bid for credits – how could it build the centre? The Authority looked at who would be an occupant within the accommodation and collated its partners and in-house teams together. A lot of work was done with an architect for a potential design of the facilities which forced all parties to think about what they wanted. Following this design concept study the Authority had a better understanding of the actual cost of the Scheme and was able to increase its application for credits by £2m due to the higher capital cost that would be required.
17. There is a need to free up restrictions on funding routes (for example where a council was advised that it would take 5 or 6 years to develop a joint service delivery point involving the collocation of a doctors surgery, a PCT and a school using LIFT).
18. It is not possible for PFI credits for a particular area simply to be pooled using the gate-keeping of a

Local Area Partnership or equivalent board to decide on priorities for the area within the pool of credits made available by different government departments.

19. Funding for 16-19 year old education should come back to the LEA (rather than go direct from the LSC to education institutions) to ensure joined up provision of places at local level.

20. Section 106 contributions often cover buildings which are usually offered at market rents only and therefore do not necessarily provide an affordable or public value for money solution

21. Where a project is a potential beneficiary of ODPM grant monies, internal Local Authority accounting regulations; VAT issues; and possible balance sheet issues can combine to raise concerns about the ability of the project substantively to benefit from the grant monies

22. Separate planning applications on separate and separately owned parcels of land in an area tend to be dealt with on their own merits. It is difficult for the Planning Officer and indeed the relevant education, health and other bodies to co-ordinate their requirements between two or more applications on large parcels of land because they have had no control on the timing of implementation of those schemes. This can result in delays, uncertainty and over-provision or excessive costs to the developer.

23. Section 106 Agreements attach to land which is the subject of planning application. Where a much larger overall site has been allocated for development or is expected to come forward for development over a ten year period, there is no mechanism for charging the later phases of land that have come forward with costs that it ought to share of infrastructure which the earlier phases have had to put in to serve the greater development.

24. Key issues relate to funding gaps where there is certain capital funding, but there is no revenue funding. Obtaining grants or any other funding for staff and other sorts of administrative costs can be a real challenge. This is a very complex area and to some extent the complexity tends to slow people up and slow or dampen the energy that some people put into the project.

Regulatory & Legal

1. Public Performance Management targets and process require substantial simplification. The overall local authority reporting process to Government is based on different data and a level of duplication and inconsistent requirements from different departments pertains.

2. Institutional Performance Indicators defined by Government do not address wider area policy outcomes which describe the performance of communities rather than individual schools.

3. The availability to local authorities of data from central government sources makes the achievement of their targets easier than locally derived targets. Accessing common data sources for strategy i.e. Data Sharing, strategy interpretation and join target setting is required.

4. The nature of government advice varies and is sometimes contradictory in how to achieve rationalisation. The link between effective local delivery and the achievement of government objectives is unclear.

5. Local discretion for community strategies is counter to the operation of local agencies working to different central and their centrally imposed target. Sharing budgets is a real problem.

6. Overload in relation to stakeholder engagement can be counterproductive.

7. Duplication through the proliferation of partnerships with overlapping responsibilities can be counterproductive.

8. An appropriate framework is required to avoid the dangers to corporate strategic priority setting from inappropriate stakeholder engagement.

9. Health and social care service provision is currently defined by the respective institutions of these sectors rather than by the needs of patients. Removal of this barrier, so there is no distinction between health and social care, should be a key step in developing an integrated social infrastructure. This will allow relevant commissioners to contemplate the use of the voluntary sector as a key provider of integrated services.

10. Local area partnerships/LSPs are already established - but differ substantially in different areas.
11. Service business plans need to be coordinated/joined up
12. Community strategies do not have a statutory status and suffer in relation to other service priorities. This also makes it difficult to attract other non-LA service providers. Community strategies are seen as an addition to the day job.
13. Public sector selling off land – there should be a remit to look at what can be achieved jointly/with regeneration in mind so that the land is sold for highest best value rather than for strategic use for public sector.
14. Projects are designed around broad social outcomes for the community, not narrow service goals. This can lead to the development of projects that are strongly focused on the needs of the community itself and not the providers encouraging each organisation to extend beyond the confines and perhaps constraints of its individual perspective and/or service to the user.
15. None of the Growth Areas or indeed the Communities Plan has any statutory status so there are institutional barriers to co-operation.
16. Alternative delivery mechanisms should be considered, such as housing associations, community interest companies or trusts holding capital assets on behalf of the community and taking responsibility for infrastructure generally. These bodies, with local representation on their boards, could replace local authorities as the traditional service delivery bodies. Instead, local authorities could have a role based more on scrutiny and overview.
17. Exclusivity provisions in NHS LIFT are a barrier to greater co-ordination of social infrastructure buildings and services
18. Having the right culture between organisations is absolutely essential. Existing delivery mechanisms can help this process. In one case without LIFT the scheme would have been impossible - but LIFT itself did not provide the sole answer - it enabled a legal solution to underlying mutually good relationships
19. Conflict and duplication of effort can arise out of overlapping operational boundaries
20. Procurement law renders difficult if not impossible the appointment of a LIFT Co to build a related swimming pool and leisure centre. The differing building life spans of a hospital and a swimming pool, together with their very different residual values in terms of building re-use and flexibility would in any event have made procurement of the two buildings together in one PFI or LIFT scheme quite difficult. The balancing of the shared unitary charge would have been tricky. However, the procurement of such a conjoined facility, otherwise than by one process would have been virtually impossible because the risk profile of either PFI or LIFT would have put an unacceptable level of risk on whichever provider was required to put in place the shared common parts being access, service infrastructure and car parks.
21. Barriers to meeting multiple needs include: having to start all over with each service provider; ineffective signposting of support beyond the individual stakeholders - poor referral and follow-up; lack of clarity of roles and responsibilities - some overlap of responsibilities.
22. Other barriers include: duplication and overlap; unrecognised service interdependency, inadequate recognition of the synergy between different services; "failure demand" - one service failure causing failure in another.
23. State aid restrictions cause particular issues when dealing with leisure/recreation projects.
24. There is certainly inadequate capacity at officer level so delivery took longer because officers were asked to do many other things in order to meet their objectives.

Cultural

1. Ties are closest at higher management level, where the organised structures appear to work more effectively.
2. A complex organisational structure can make integration more difficult as individual services attempt to retain their autonomy at the same time as establishing a collective identity. The central vision for the

centre is well received by senior managers but doesn't translate to changes in individual practice. There are also more opportunities for interaction at the senior level than lower level staff.

3. In one case the Project Team put in a great deal of time allowing staff to meet with each other and clearly explain their roles and process map their functions against each other. This enabled time for staff to both get to know one another, but also to understand the regimes of another organisation. This work resulted in a joint handbook for the Centre.
4. LAAs allow councils and their delivery partners to agree local priorities in Whitehall and receive certain freedoms over how they use government cash to meet these goals.
5. It is essential for all home visitors and other services providers for individuals to be made aware and refer other appropriate services/needs to other providers
6. Any cultural concerns about the use of private finance on social infrastructure delivery have to be shelved as there is no public capital funding available.
7. Setting up multi service project teams improves alignment of policy and delivery.
8. More manageable "Growth Points" within the Thames Gateway allows more manageable infrastructure frameworks to be established.

Communities

1. Tensions arise between existing deprived communities and "new" developments to which they do not have the resources to move into.
2. Competing priorities, for example, the Olympics, are disrupting a balanced approach to housing in the Thames Gateway and associated Social Infrastructure.
3. The voluntary sector has the greatest in-reach into communities at a local level. Charitable bodies can interact with local people and identify the needs of the local population. There is scope to build on community involvement
4. Communities find it difficult to understand why stakeholders do not point in the same direction
5. The move towards neighbourhood governance/management increases the chances of true service needs being addressed.
6. Except in LSVTs/ALMOs with a long term manager in place from inception there is little scope to engage new communities as they emerge.
7. It is important to provide a bespoke service to the different demographic areas in the Thames Gateway region. Health and social care provision, as well as the provision of other services such as policing and education, should be specifically tailored, for example, to a very poor area or to an area with lots of young Muslims. One size does not fit all.
8. There can be a mismatch between jobs in the area and occupations of locals
9. There needs to be identification of untapped talent e.g. public services colleges could attract/retain key workers – particularly where there are low skills areas
10. Understanding longer term workforce development agenda has to be synchronised.
11. Professional skilled staff should be paid sufficiently to support area working on an effective basis and to ensure appropriate level of participation in debate but avoid hijacking by pressure groups.
12. Any Social Infrastructure solution for the Thames Gateway taking account of both Growth and Olympic proposals will require a cohesive approach to the Social Infrastructure needs of migrant workers
13. There are benefits to accessing parts of the community which are traditionally harder to get to and use healthcare facilities less, and of being able to prescribe e.g. exercise treatments at an adjoining facility when patients come to the surgery
14. People from black and minority ethnic communities are frequently concerned about the lack of availability of culturally specific goods and services.
15. Greater priority should be given to community development and investment in increasing the capacity

and skills of local authorities and the community and voluntary sector to address community cohesion issues.

16. There should be engagement with and consultation with existing communities to ensure that the investment in the Growth Areas reflects their needs, as well as those of new residents.

17. There is scope to introduce a range of voluntary or third sector services in any solution to integrate other public/private services

Leadership

1. The lead partner must always be clear.

2. Strategic partnerships only work if a lead agency takes responsibility for the project in working with all other stakeholders, particularly the voluntary sector. Real accountability for the lead agency would incentivise it to collaborate with these stakeholders rather than competing with them. Lead agencies across the service sectors could then form a consortium to meet, share ideas and ensure an integrated approach on a long term basis.

3. In one case most service providers maintained an element of autonomy from the central management structure and remained, instead, only accountable to their own management bodies. This made it harder for the services to be integrated or to engage in joint working.

4. The internal structures of individual service providers are not always compatible with joint working.

5. Dedicated multi partner teams are needed.

6. Different geographical boundaries militate against joint working.

7. Stronger political leadership are required for community strategies.

8. Support from Government Organisations is variable for community strategies.

9. Individual roles and responsibilities, including for elected members, require clear definition.

10. The role of the voluntary and community sector requires enhancement.

11. Council leadership is essential but could also be a constraint because of community perception of the council and service provider perception of council domination.

12. Ownership and commitment at senior levels needs to be secured from strategy through implementation.

13. Clear lead from the top in terms of partnership working should be given for all organisations involved.

14. The proposed fragmentation of the joined up education provision currently overseen by the LEA as set out in the recent White Paper is extremely worrying and is a potential barrier.

15. There should be governance arrangements for locality groups which see small effective boards with real power and delegated decision making rather than unwieldy constitutions.

16. There is an absence of congruence in the administrative boundaries for various different providers of social infrastructure (education, health, police services, social services, transport). At a different level there is similar confusion between the boundaries of different initiatives set up for regeneration over the last ten years or so. Some administrative boundaries are inappropriately positioned for service provision.

17. There is frustration that carefully worked out Borough wide plans for improving education provision are being frustrated by policy changes giving more independence to schools and more influence to local communities who are not themselves accountable for the greater area wide plan.

18. There is no brief in either PCTs or SHAs to co-ordinate provision when a major development is proposed. They arise from the initiative of a particular officer of either a PCT or the SHA. It is not written into the structure and role of those bodies that they should be looking either to assess the health issues arising from the proposed redevelopment or to respond pro-actively to any initiative for cohesive and co-ordinated or co-location of social infrastructure facilities.

Buildings
1. Flexibility of Buildings is inhibited by financial/statutory hurdles.
2. Engagement with communities at the design stage is essential - design is a catalyst for change
3. There should be a focus on services and not facilities
4. Lifetime pathways to service delivery are required to specify buildings that will last and be effectively used.
5. Space must be flexible and the services need to be complementary.
6. Integration (not just co-location) makes particular demands and provides cost sharing opportunities.
7. There can be a mismatch between where facilities can go and where population is or is planned.
8. It is important to ensure that more decision making is devolved and that services are located nearer to local communities.
9. Lack of recreational and leisure facilities is an impediment to the health of children
10. Better collaboration is required between schools, colleges and work-based learning providers.
11. Best practice integrated approaches is required for care planning and working in Child and Adolescent Mental Health Services.
12. Best practice would be for a PCT to have a named director responsible for leading children's services and securing alignment with other public service providers.
13. There are service benefits of a co-located health and leisure facility.
Policy
1. Individual public stakeholder strategies do not have the same timeframe with associated cultural differences regarding needs and solutions. Regional governance structures in Holland and Germany overcome this problem.
2. Local Authority community strategies pay little regard to Regional Economic/Spatial Strategies, LDFs, HMRPs, and sub-regional or area initiatives.
3. The statutory LDF process should reflect the community strategy.
4. Managed interaction between plans is required to identify how targets affect each other.
5. The benefits of producing fewer plans should be incentivised by government in all local authorities not just "Excellent" ones.
6. The 4 year CSA process prohibits agreements for longer periods making the legal encapsulation of social infrastructure arrangements for Growth Areas and HMRPs beyond that period impossible.
7. A legal Framework solution with stronger public stakeholder engagement would provide a more flexible arrangement for both future public funding beyond the CSA 4 year period, and private commitment to coincide with development delivery.
8. An overarching commissioning strategy is required for children's social care services
9. Services are demand led, therefore it is not always possible to plan too far in the future.
10. Planning is a spatial system – but is increasingly influencing services delivery
11. A social infrastructure framework could be helpful publicising all plans that exist (including transport); and to detail responsibilities/acceptability too.
12. Few local authorities have embarked upon rationalisation process. This is despite considerable financial, government control and individual plan preparation advantages to "Excellent" LAs
13. There needs to be a culture of sharing thinking before policy set.
14. The London Plan provides a long term framework.

15. Integrated planning is absolutely key – and integration rather than necessarily co-location. The principles of integrated planning should be kept in mind from the start.

16. Sensible and consistent approaches are required both within each Borough and across Boroughs for the calculation of future school requirements given changing demographic circumstances.

17. There can be no coordinated approach to medium term planning. Often stakeholders focus on either the next couple of years - which directly affects the relevant individual - or in the future (say 15 years) which does not directly affect the relevant individual - but not for the important in between period.

18. There are clear benefits to a co-ordinated approach to joint service provision in health. Patients don't like "going round the system" so finding ways in which to reach groups that wouldn't normally be reached (by co-locating leisure and health facilities for example) has clear positive benefits

19. Health is only one aspect of making people healthy so interaction with other relevant agencies is essential. For example, the provision of school meals in a more healthy way would assist healthier outcomes but health bodies generally have little say over how such school meals are provided

20. When there is a major growth area planned, there are a number of statutory consultees who bring their response back into the Case Officer for the planning application. Consultees may be from within the Local Authority or outside. They are not however co-ordinated and it is not the job of the Case Officer to co-ordinate their responses and the delivery by the developer of the funds or facilities which are required to meet those responses. Thus, there can be a piecemeal and uncoordinated approach to the delivery of social infrastructure and indeed physical infrastructure pursuant to this process.

21. Strategic frameworks for the Growth Areas should be developed to guide local planning decisions, informed by a better understanding of the underlying demographic and migration drivers that will shape their future populations.

The London Thames Gateway Social Infrastructure Framework Partners:

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London Development Agency
Thames Gateway London Partnership
London Borough of Barking and Dagenham
London Borough of Tower Hamlets
North East London Strategic Health Authority
London Thames Gateway Development Corporation
NHS London Healthy Urban Development Unit

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