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# Managing cultural diversity in healthcare partnerships: the case of LIFT

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## Abstract

**Purpose** – The National Health Service (NHS) Local Improvement Finance Trust (LIFT) programme was launched in 2001 as an innovative public-private partnership to address the historical under-investment in local primary care facilities in England. The organisations from the public and private sector that comprise a local LIFT partnership each have their own distinctive norms of behaviour and acceptable working practices – ultimately different organisational cultures. The purpose of this article is to assess the role of organisational culture in facilitating (or impeding) LIFT partnerships and to contribute to an understanding of how cultural diversity in public-private partnerships is managed at the local level.

**Design/methodology/approach** – The approach taken was qualitative case studies, with data gathering comprising interviews and a review of background documentation in three LIFT companies purposefully sampled to represent a range of background factors. Elite interviews were also conducted with senior policy makers responsible for implementing LIFT policy at the national level.

**Findings** – Interpreting the data against a conceptual framework designed to assess approaches to managing strategic alliances, the authors identified a number of key differences in the values, working practices and cultures in public and private organisations that influenced the quality of joint working. On the whole, however, partners in the three LIFT companies appeared to be working well together, with neither side dominating the development of strategy. Differences in culture were being managed and accommodated as partnerships matured.

**Research limitations/implications** – As LIFT develops and becomes the primary source of investment for managing, developing and channelling funding into regenerating the primary care infrastructure, further longitudinal work might examine how ongoing partnerships are working, and how changes in the cultures of public and private partners impact upon wider relationships within local health economies and shape the delivery of patient care.

**Originality/value** – To the authors' knowledge this is the first study of the role of culture in mediating LIFT partnerships and the findings add to the evidence on public-private partnerships in the NHS.

**Keywords** Public-private partnerships, Primary care funding, Organizational culture, National Health Service, United Kingdom, Partnership, Strategic alliances

**Paper type** Research paper

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## Introduction

Although the majority of all patient contact in the English NHS occurs in general practice, financial investment in frontline primary care facilities has historically been

underdeveloped, piecemeal and poorly targeted according to need (Appleby, 2001; House of House of Commons, 2006). This has led to a situation whereby many primary care premises are of poor quality and not fit for purpose. This particularly applies in deprived inner city areas, which suffer from a disproportionately high number of sub-standard facilities (Holmes *et al.*, 2006). Against this background of chronic under-investment, in 2001 the government launched a new financial vehicle for stimulating a the market for developing the primary care estate – the Local Improvement Finance Trust (LIFT).

LIFT operates at both national and local levels. At the national level a new public private partnership has been established – Partnerships for Health (PfH), which is a formal collaboration between the Department of Health and Partnerships UK (itself a joint venture between the Treasury and the private sector) to oversee and invest in the establishment of local LIFT companies. At the local level, LIFT companies comprise joint ventures between private sector property development agencies, NHS organisations, local social services departments and central government. Around 50 LIFT schemes are currently in operation with responsibility for developing and channelling more than £1bn of private investment into the regeneration and refurbishment of local primary care premises.

The design of the LIFT programme reflects concerns with the traditional financial models developed under the public financial initiative (PFI) introduced by the Conservative government in 1992, in particular the lack of suitability of PFI funding for small-scale projects and the relative financial investment inexperience of public sector partners (Beck *et al.*, 2009; Broadbent *et al.*, 2008). Thus, LIFT differs significantly from traditional PFI procurement in a number of important ways. First, unlike standard models of PFI, LIFT involves a significant public sector shareholding, both in the form of local trust share ownership and PfH share ownership. Local Primary Care Trusts (PCTs) are therefore shareholders in the local NHS LIFT and act to protect the public interest. Second, the governance of a LIFT company includes a public sector director and mandates close collaboration between the LIFT and local NHS partnering boards. These measures are meant to ensure a closer working relationship between local Trusts and LIFT than is typical of the arm's-length relationship between trusts and special purpose vehicles (SPVs) established under traditional PFI arrangements. Finally, while traditional PFI procurement mandates the calculation of a public sector comparator (PSC) as part of the value-for-money exercise, there is no such requirement for LIFT projects. The key stages in setting up a LIFT scheme are detailed in the Appendix.

Following the completion of four waves of LIFT schemes the Department of Health announced in 2008 its intention to replace LIFT with a new Express LIFT. This framework envisaged the creation of a list of approved private sector, each of whom were expected to have had demonstrated a track record of delivering the services required of a successful LIFT company. A key stated objective of Express LIFT is to accelerate the procurement process and reduce costs to bidders. There is an expectation that the new process will reduce the length of time for the completion of bids, with local procurements being completed within about four to six weeks rather than two years, as was the case with LIFT. Following an initial shortlist, in March 2009 the Department of Health announced a list of seven successful bidders.

The partnering organisations which taken together comprise a local LIFT company each have their own distinctive norms of behaviour, professional values and acceptable

working practices – ultimately different organisational cultures. Previous research into the effectiveness of public-private partnerships has highlighted the various ways in which culture can create barriers to effective inter-organisational collaboration and yet how at the same time the knowledge and repertoires embodied in cultures can serve as a valuable resource for building relationships and facilitating co-operation (Bates, 1997; Birnie, 1999; Beck *et al.*, 2009; Child and Faulkner, 1998) Given the central role of LIFT in funding the development of primary care delivery and the need to establish effective long-term relationships within LIFT companies, it is important to understand the factors, including cultural issues, that serve to facilitate or impede successful partnership working. The rest of this article is given over to addressing these concerns and draws on organisational culture theory and freshly gathered empirical evidence. It is organised as follows: the next section unpacks what is meant by organisational culture and introduces some of the key concerns with using a cultural approach to understanding inter-organisational relations. We then draw on qualitative interviews and case study evidence to explore how culture and cultural diversity are managed in LIFT partnerships in the English NHS. Finally, we draw out the implications of our study for policy and practice and look forward at the emerging research agenda in this area.

## Organisational culture and inter-organisational relations

Organisational culture is frequently invoked by policy makers, managers and health professionals alike as a lever for improving organisational performance and service quality in the NHS (Darzi, 2008). Questions then arise as to whether this is empty rhetoric, a convenient shorthand for radical change – or whether this framing of organisations and inter-organisational relations in cultural terms offers a useful means of understanding and managing, with the potential for improvements in the processes and outcomes of health care (Mannion *et al.*, 2005). Notwithstanding its widespread use by researchers, managers, and policymakers, the concept of organisational culture has no fixed or broadly agreed meaning and is far from being conceptualised universally (Alvesson, 2002). Indeed there is a wide spectrum of definitions of organisational culture in the literature. For example, Ott (1989) lists 74 elements of organisational culture that have been put forward by various authors, while a review of the organisational culture literature by van der Post *et al.* (1997) identified over 100 dimensions associated with the notion. Any such definitional problems are confounded by the fact that there is little agreement on the meaning of either of the underlying concepts, "organisation" and "culture". For example, a critical review of dimensions associated with the term "culture" by Kroeber and Kluckhohn (1963) identified 164 unique definitions of the term, the overall number almost reaching 300.

Whatever cultural model adopted, in broad terms, the study of organisational culture highlights what is shared between people within organisations, for example:

- beliefs, values, attitudes and norms of behaviour;
- routines, traditions, ceremonies and rewards; and
- meanings, narratives and sense-making.

These shared ways of thinking and behaving in organisations help define what is legitimate and acceptable; they also serve as the social glue that holds an organisation together, and in colloquial terms it is "the way things are done around here".

Dimensions of organisational culture identified in the literature as being important mediating factors in facilitating (or impeding) successful strategic alliances, partnerships and joint ventures, include:

- attitudes towards cooperation, relationship building and team working;
- beliefs about the motivations and working practices of partners;
- perceptions regarding the trustworthiness of partners;
- assumptions concerning the competence and skills of partners;
- attitudes to risk taking and how change and uncertainty are accommodated;
- the influence of professional norms, codes of conduct and acceptable working practices;
- values relating to ethical and moral aspects of work; and
- views regarding to appropriate and acceptable arrangements for conflict resolution and dispute settlement.

Meyerson and Martin (1987) have developed a typology for categorising different approaches to organisational culture that is useful to understanding the cultural issues associated with partnership working in health and social care (see Peck and Dickinson, 2008). The first approach identified by Meyerson and Martin (1987) assumes an integration model, whereby cultures are conceived as mini societies with similar beliefs and values that are shared by the majority of members in an organisation. Here culture is conceived as something an organisation possesses and which can be manipulated towards managerial ends. Thus from this perspective partnering organisations may have divergent cultures which can inhibit cooperation, require managerial intervention to ensure cultures are made compatible. The second approach adopts a difference model of culture in which organisations are assumed to be made up of many different sub-cultures, possibly demarcated along occupational and professional lines that may cohere, interact and compete at different levels in the organisation. Again different cultures may attenuate effective interaction and from this perspective need to be purposefully managed to facilitate joint working. The third and more radical approach identified by Meyerson and Martin (1987) is the *ambiguity* model, which conceives of culture as contingent and dynamic and continuously being created and recreated and reproduced locally through ongoing social relations. This model offers managers fewer levers for shaping and manipulating cultures in predictable and desirable ways.

Whatever the model of culture adopted it is clear that culture is an important aspect of organisational life and as previous research attests, deserves serious attention when considering inter-organisational relations, including the study of ongoing relationships within public-private partnerships (Broadbent *et al.*, 2008). It is in this regard that Child and Faulkner (1998) have developed a useful typology to explore approaches to managing inter-organisational relationships and partnership working in the face of cultural diversity. Their analysis is structured by two fundamental choices. The first concerns whether one organisation's culture should dominate, as opposed to striving for a balance of contributions from the contributory cultures. The second relates to the decision to either integrate different organisational cultures (in order to derive synergy between them) versus a preference segregating the various cultures within the partnerships (with the aim of avoiding conflict or efforts devoted to culture

management). These strategic partnership choices give rise to four possible bases for accommodating cultural diversity:

(1) synergy;
(2) domination;
(3) segregation; or
(4) breakdown.

The first three offer some scope for establishing a cultural fit, whilst the fourth may give rise to serious dysfunctional consequences (see Table I).

## Methods

The foregoing conceptual frameworks for understanding cultural diversity in inter-organisational alliances informed the empirical phase of the project. This had two broad aims:

(1) to assess the role of organisational culture in facilitating (or impeding) LIFT partnerships; and
(2) to contribute to an understanding of how cultural diversity in public-private partnerships is managed at the local level.

Data gathering comprised two key elements:

(1) In-depth, semi-structured "elite" interviews with 11 senior policy makers and managers with a range of functional responsibilities for implementing NHS LIFT across the English NHS, including staff from the Department of Health; Community Health Partnerships; Partnerships UK and the Public Finance Unit.

| Domination by one subculture? | Integration between cultural groups? Yes | No |
|---|---|---|
| No | (1) Synergy<br>Here the objective of collaboration is to meld both partners' cultures and to achieve the best possible fit between the two. The best elements are combined with the objective of making the whole greater than the sum of its parts | (2) Segregation<br>Here the aim is to strike an acceptable balance between different cultures by virtue of maintaining separation rather than seeking integration |
| Yes | (3) Domination<br>This is based on recognition that integrating organisational cultures may prove impossible and accepts the right of dominance of one sub-group's culture | (4) Breakdown<br>This occurs when one culture seeks domination, integration or mutually acceptable segregation but fails to secure the acquiescence of the other organisational culture |

**Note:** Four possible bases for accommodating cultural diversity within inter-organisational relations can be identified depending on whether there is integration between organisational cultures and/or whether there is domination by one of the cultures
**Source:** Derived and expanded from a classificatory scheme on strategic alliances developed by Child and Faulkner (1998)

**Table I.** The meeting of cultures: achieving a cultural fit

(2) Case studies of three local LIFT companies, involving documentary analysis and interviews with senior managers from partnering public and private organisations involved in the partnership.

To focus our data gathering and analysis we structured the interviews with LIFT partners around the key issues identified in the Child and Faulkner Framework and used this understanding the role of culture in mediating LIFT relationships (see the Appendix). The case studies were selectively purposefully to represent a range of key background factors (see Table II). Data collection and analysis were based on both deductive and inductive enquiry, using pattern matching and replication methods to draw out key themes within and across the case study sites (Yin, 1984).

## Public and private cultures in LIFT partnerships

In recent years a number of researchers have explored the cultural implications of partnership working (Peck and Dickinson, 2008; Noble and Jones, 2006; Broadbent *et al.*, 2008). These studies have highlighted key differences in the shared values and beliefs of public and private sector managers. In our study we found there was general agreement across the elite interviews that public and private organisations had very different value orientation, incentives and motivations for being involved in a LIFT Partnership. PCTs and other public sector organisations were characterised as being motivated by the opportunity to develop a range of innovative services that would improve quality and access for the local community to health and community care premises. Private sector providers, on the other hand, were believed to be primarily motivated by the opportunity to make a short-term profit from the company, with the implication that the interest of shareholders would take precedence over the needs of the local populations. Notwithstanding these differences there was a broad consensus among the elite interviewees that although public and private interests differed, they could in successful partnerships be aligned in the pursuit of developing high-quality local premises that would benefit the local community. It was also noted that general practitioners, as independent contractors, operated small businesses and that as such their commercial culture and motivations may not be that far removed from those of private-sector partners:

> I think there are complete differences in public sector values and private sector values, so the challenge is to ensure there is sufficient alignment of interest for those interests not to matter. So the private sector' s job is to earn a return for their shareholders; no public sector have no such aspiration, but actually what both want is to deliver high quality new facilities and there is a total alignment of interest there [. . .] The challenge for LIFT is to get the private sector to recognise that they are in a partnership and that if they go for short term win in terms of profit, that's going to damage the partnership and what they should be looking for is a win/win when the private sector makes a return but recognises that a fair and reasonable return over the long tem is better than going for a quick buck because they're never going to get another deal (Senior Manager, Partnerships UK).

## Case study evidence

Although the elite interviews generally painted a somewhat favourable picture of LIFT partnerships, our three case studies revealed more dynamic, complex and sometimes more troubled LIFT relationships. In the condensed case studies below we focus on

| | | | | |
|---|---|---|---|---|
| Urban Northeast (UNE) | Urban: city of 250,000 | Financial close end 2003; second wave | Investments of £17m + | Six completed schemes, three in construction, one with planning permission |
| Rural East Midland (REM) | Rural county: population of 730,000 | Merger between LIFT and non-LIFT PCTs October 2006; third wave | Investments of £42m | Three completed schemes, one in construction |
| Urban Southwest (USW) | Urban: city of 400,000 | Financial close mid-2004; third wave | Investments of £28m + | Four completed schemes, two in construction |

**Table II.** Characteristics of the three LIFT case studies

how local cultural differences between public and private partners are managed and accommodated.

*Urban North East (UNE) LIFT case study*

UNE LIFT is a second-wave scheme with private sector capital investment in excess of £17m. The involvement of UNE in LIFT was, from the public sector perspective, primarily driven by a history of chronic underinvestment in local primary infrastructure despite several attempts to secure alternative sources of public finance. Indeed, there was initial reluctance to seek private sector finance. In terms of Table I, staff at UNE LIFT positioned themselves somewhere in the top half (i.e. no dominance by one organisational culture) between Area 1 (Synergy) and Area 2 (Segregation). There was a belief on the part of PCT staff that following an initial phase of misunderstandings and subsequent learning and renegotiations that their private sector partner was now quite sensitive to the value and ways of working in the health service and that this had enabled a strong bond to be forged between LIFT partners. There was a general feeling among PCT staff that there had developed a degree of trust between public and private partners and that both recognised that the success of the project depended upon them working together and following a common agenda, although it was felt that there did remain some suspicion about each other's motives which formed a backdrop to negotiations. Overall the PCT staff were very happy with the relationship that had developed with their private sector partner, and during the interviews LIFT project was frequently cited as a model that other projects should follow:

> I don't think that there's one dominant culture. I think we are probably between box 2 and box 1 (relating to Figure X). I wouldn't say we've got absolute synergy, but I'd probably say that we've got more synergy than segregation if that makes sense [. . .] I don't think there's much in terms of breakdown" (Senior manager, UNE LIFT).

> There's a level of trust now and if any thing went horribly wrong we would have to help each other out – one party wouldn't leave the other to flounder as it wouldn't do either of us any good. So if something major happened we would try to help each other out and not just turn to the legal documents (Senior manager, UNE LIFT).

*Urban South West (USW) LIFT case study*

USW LIFT is a third wave LIFT company set up in 2004 with a capital investment of almost £30m in new integrated health centres. A high proportion of primary care infrastructure in USW is owned by the PCT, and the primary focus of the LIFT investment has been the replacement and refurbishment of PCT-owned facilities. The private partner chosen to be part of the LIFT company was a partnering organisation rather than a building company who had a large construction firm in their supply chain. Interviewees in the USW case study reported that their LIFT Partnership could be best represented a being in Area 2 (Segregation) in Table I, although at times (and also perceived as the ideal situation to be in) the partnership could be characterised as being in Area 2 (Synergy). It was noted by the private sector partner in the interviews that there had been specific times when they thought the public sector had dominated the relationship because they had forced through initiatives (or suspended them) because of wider political considerations that the private sector partner found difficult to challenge. Yet there was also a feeling that relationships in the LIFT company were

dynamic and fluid and at different times either the public or private sector had been the stronger partner in deciding how the LIFT project was run:

> In [name of city] where we have been on the whole is segregation. Synergy is the ideal, but segregation is as good as its likely to get because there are different entities involved. If you were applying this to one organisation with different partners it would be easier to arrive at synergy. We've been aiming at segregation, where there is a balance between the needs of different parties. We have different legal entities so there is a difference, and it is necessary to maintain a sense of independence, in a commercial, legal and business sense (Senior Manager A, USW LIFT).

> Within our activity the relationship could change at different times – and could be stronger or weaker depending on which stakeholder we are talking about. We're dealing with lots of stakeholders who represent other cultures, and the relationships aren't fixed, for every individual for every organisation (Senior Manager B, USF LIFT).

### *Rural East Midlands (REM) LIFT case study*

REM LIFT is a third wave LIFT scheme, which, following merger with the PCT, received ongoing capital investments of almost £43m. On establishment the new PCT was faced with an ongoing procurement process that was not of their choosing. This was thought to have caused problems in that several capital projects were already part way through the planning and procurement process at the point of restructuring. Staff from the PCT believed that REM LIFT was in the top half of Table I (i.e. no one organisation dominated the partnership) and was positioned somewhere between Area 1 (Synergy) and Area 2 (Segregation). There was a strong feeling that although there needed to be a melding of cultures between partners to manage the cultural diversity, there also needed to be some form of separation so that PCTs for example could focus on addressing the needs of their patients and the wider health community. Several of the interviewees believed that the ideal for the LIFT would be to move across to Area 1 (Synergy) although it was acknowledged that there would probably always be a degree of separation between public and private partners because each have fundamentally different values, objectives and operating practices.

> I would say that we are in the top half between segregation and synergy. I say were between the two. We wouldn't have got to financial close with (name of private partner) if there was any degree of melding cultures, and get the best combination out of the team. But there's a slight feeling within the PCT about difficulties. We are partners in LIFT but also we're a customer of them (the private partner) so that's where there's separation, but still a feeling that there needs to be a degree of separation because we need to make sure that the PCT's interests are safeguarded (REM manager).

> For me it's about understanding each other's values. And in some areas there are clear overlaps and similarities but there are some things where there are fundamental differences, generating surpluses and being part of a profit making chain somewhere along the line [. . .] So I think it's about recognising the common purpose, but also understanding that to some extent we have got different value bases (REM managers).

## Discussion

LIFT was established by the government as an innovative public-private financial vehicle for channelling major investment into transforming the stock of primary care

premises in the NHS. In this article we have used culture as a lens to explore the functioning of LIFT partnerships. Our study identified a gap between the rather optimistic perspective on cultural integration within LIFT partnerships held by senior policy makers and the reality on the ground. Indeed, we identified a range of key difference in the value orientation, working practices and cultures of public and private sector organisations which influenced the nature of partnership working in our case study sites. In some LIFT projects different assumed motives had created a degree suspicion and of lack of trust between partners, with public organisations sometimes uncomfortable when faced with the underlying profit motive of private sector organisations, and private sector organisations worried about the perceived bureaucracy, "red tape", lack of financial acumen and political interference under which public organisations laboured. The aspiration for most of the LIFT partners in our case studies was to aspire for "synergy" in inter-organisational relations; however, in practice existing relationships were reported to be positioned closer to "segregation", with none of the LIFT partnerships characterised by a full integration of cultures. This difference between the views of senior policy makers and the reality on the ground suggests that central government strategies to support LIFT need to be alert to possible tensions between LIFT partners and be designed in such a way as to support and nurture cooperative working relationships.

Nevertheless, on the whole partners appeared to be working well with none of the LIFT partnerships in case studies described by public and private managers as a "breakdown" in relations. Indeed we found that differences in culture were being managed and accommodated as LIFT partnerships matured and partners grew to trust each other and develop a better understanding of each others strengths, weaknesses and particular ways of working.

Our case studies also identified two factors that appeared to be related with local LIFT projects ability to move towards synergistic relations. The first relates to good ongoing personal relationships between senior staff from partner organisations. Where there were good personal relationships between partners, trust could be nurtured more easily with the corollary that when difficulties between partners arose, these were more likely to be resolved amicably and without recourse to prolonged and costly legal action. The second relates to how open partners were with each other in terms of signalling their intentions and any internal difficulties they were experiencing. It was especially important from a public sector perspective that private-sector partners were open about their internal affairs and ways of operating, although it was recognised that it was not as easy to be open in terms of making public commercially sensitive information.

As with all studies our findings should be tempered with a degree of caution. First, we only undertook three case studies and although we selected cases with a range of background and operating factors, they will not fully reflect the range of experience of LIFT companies in the NHS. Second, the cases are based on only a limited number of interviews over a relatively short timescale, during the formative years of LIFT partnerships. Whether our findings hold in the medium to longer term remains unanswered – to assess this would require protracted longitudinal study. Third, organisational culture is an essentially contested concept with a range interpretations based around different epistemological and ontological assumptions (Alvesson and Sveningsson, 2008). We adopted an integration model of culture to guide our fieldwork

and analysis (Meyerson and Martin, 1987) and had we adopted a different model or theoretical framework perhaps our findings would have been different. Finally, we are aware of the distinction between espoused cultural values and those beliefs and values that organisational members use on a day-to-day basis to guide their work activities (Brown, 1996). Although we triangulated our data and cross-references accounts, if our case studies tapped largely espoused values – or the way organisations would like to portray themselves in a normative sense rather than how they actually are in practice, then this may misrepresent the reality of joint working and make LIFT partnerships appear successful than they are in practice.

## Concluding remarks

Culture resonates with a variety of LIFT stakeholders and forms an intuitive way for them to understand inter-organisational dynamics. Thus a key overall finding is that organisational culture matters, and is seen to matter in the formation and maintenance of LIFT partnerships. Managers at all levels in the public and private organisations recognised the significance of culture and were either actively interested in shaping it or in some instances felt constrained by its pervasive influence on inter-organisational relations. Our findings relating to culture have important implications for the expansion of LIFT that deserve further attention. As LIFT develops and becomes the primary source of investment for managing, developing and channelling funding into regenerating the primary care infrastructure, further longitudinal work might examine how ongoing partnerships are working and how changes in the cultures of public and private partners impact of upon wider relationships within local health economies and influence the delivery of patient care.

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## Appendix. Key stages in implementing a LIFT project

- At the initial stage involves agencies and organisations with responsibility for planning for a local health economy in developing a joint Strategic Service Development Plan. Participants involved in formulating the plan typically include PCTs, acute trusts, ambulance trusts, local authorities and mental health trusts.
- The local health economy decides to seek a private sector partner with whom it will establish a LIFT company. The company is owned in part by the private sector and partly by public-sector participants.
- The company is charged with delivering the Strategic Development Plan as well as partnering services. This involves responsibility for building, maintaining and leasing local primary care premises to PCTs, GPs, dentists, pharmacists, opticians and local

authorities. The local PCT is made shareholder of the LIFT company to protect the public interest.

- Private partners are selected on the basis of a competitive procurement process and a joint venture is established between local health bodies, Partnerships for Health and the private sector partner.
- The local health economy supervises the performance of the LIFT company through a Strategic Partnering Board, which also approves new projects from the Strategic Development Plan.

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