

IS THE LOCAL IMPROVEMENT FINANCE TRUST (LIFT) PROCUREMENT INITIATIVE DELIVERING THE EXPECTED ECONOMIES OF SCALE? – RESULTS FROM THREE CASE STUDIES

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The UK Department of Health (DoH) introduced the Local Improvement Finance Trust (LIFT) initiative in 2000 to reverse the declining state of primary healthcare facilities. The initiative involves partnerships between diverse organisations from public and private sectors working together to deliver improvements in facilities that will be suitable for modern primary and social care services. However, recent evaluations of the performance of some schemes under the initiative show mixed results. This paper examines three LIFT case studies to investigate whether the LIFT procurement strategy supports the delivery of facilities for improved primary and social care services that meet local needs whilst providing value for money. The investigations, which involved senior managers, revealed significant differences in the maturity levels of the schemes evaluated in terms of appropriate systems, processes and structures in the planning and implementation of the schemes. Although there is potential for more improvements, the pattern of progress made generally confirmed an evolving system, with considerable evidence of performance improvement from project-to-project. Whilst suggesting some potential ways for securing long-term improvements and sustained value for money, this paper concludes that there is considerable evidence that the LIFT initiative is delivering the expected economies of scale in providing modern facilities for the provision of integrated primary and social care services.

Keywords: economies of scale, primary care, procurement, value for money.

INTRODUCTION

Until recently, investments targeted at providing facilities to support the provision of modern and integrated primary and social care in the UK have been fragmented and piecemeal (National Audit Office (NAO) 2005). The Department of Health (DoH) announced the establishment of the Local Improvement Finance Trust (LIFT) initiative in 2000 as part of the 'NHS Plan'. The vision of the NHS Plan is a health service designed around the patient and includes, amongst other things, better partnerships and team-working. The LIFT initiative aims to deliver a step change in the quality of the primary care estate, remedy some of the deficiencies in the existing arrangements and contribute to delivery of the investment targets identified within the

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NHS Plan (DoH 2000). According to NAO (2005), the objectives of the LIFT initiative include:

- bringing significant improvements to the GP premises;
- supporting co-location of healthcare professionals;
- forging links between primary and social care;
- indirectly resolving GP recruitment and retention problems;
- shifting services away from the secondary care level;
- assisting in achieving good chronic disease management; and
- enhancing “Patient Choice” by providing patients with more choice over how, when and where they receive treatment.

The execution of LIFT initiative involves consultations with diverse stakeholder groups in order to develop a 'Strategic Service Development Plan' (SSDP) that captures the requirements of the diverse interests in each LIFT locality. Each SSDP sets out the expected demand for services in ten years' time based on current knowledge of likely demographic, technological and clinical changes over the intervening period. Because the SSDPs are expected to be 'living documents', the 'LIFTCos.' (in collaboration with the local NHS, LAs and other relevant parties in each local health economy) share the responsibility for updating them annually to reflect changes and developments in strategy, objectives and priorities in each and all of the partner organisations. The SPBs on the other hand have the responsibility for ensuring good strategic fit with other local initiatives in related areas – for example in secondary, acute and social care.

Although the LIFT initiative has been portrayed by the NAO (2005) as an attractive way of securing improvements in primary and social care, other independent evaluations have revealed mixed results. For example, Hudson *et al.* (2003) used the NHS Environmental Assessment Toolkit (NEAT) to demonstrate that LIFT schemes are delivering more sustainable solutions compared to primary care facilities delivered through the traditional procurement routes. Similar procurement models are already being developed in other sectors based on the LIFT model – notably the Building Schools for the Future (BSF) programme. However, Holmes *et al.* (2006) established, from a case study involving two LIFT schemes, that because the bidding processes typically involves unequal struggles between large consortia and inexperienced clients, the demonstration of value for money had been difficult and consequently resulted in wasted opportunities in obtaining optimum designs and prices. Furthermore, although LIFT advocates cross-project and scheme-wide learning, the NAO (2005) revealed that there was little evidence of knowledge sharing between PCTs they evaluated and that subsequent projects are being embarked upon. These have created the need for greater interest in evaluating how LIFT schemes are set-up and the arrangements for ongoing value for money and accountability assessments.

Previous evaluations of LIFT schemes have not examined the specific project management practices in terms of their effectiveness and their transferability, nor have they identified the areas where improvements are needed. As a result, the research presented in this paper was undertaken to explore current key project management practices in the planning and implementation of the LIFT procurement strategy. The principal objective of the research was to examine whether or not the LIFT initiative supports the delivery of facilities for improved primary and social care services that meet local needs whilst providing value for money.

RESEARCH METHOD

A multiple case study methodology was adopted. The how/why nature of the research questions suggest, according to Yin (2003), that a case study research strategy was appropriate. The criteria for selecting the case study LIFT schemes were largely to have a scheme from each of the three waves that have so far opened facilities to the public and, importantly, the opportunity for access to the stakeholders and their archives. Hence, one scheme each was considered from the first, second and third waves. Much of the material requested could be classified as commercially sensitive. Case study selection was therefore purposive (Marans 1987) and evolved as fieldwork progressed.

The case study proposition was that “LIFT initiative is delivering the expected economies of scale in providing modern facilities for the provision of integrated primary and social care services that meet local needs whilst providing value for money”. The ‘unit of analysis’ in this study is a “LIFT scheme”, which typically comprises participants from public and private sector organisations.

Data were generally collected from secondary and primary sources: project archival research and interviews with stakeholders. Project archives held by the clients, consultants, the private sector partners and other public sector partners were examined. Semi-structured interviews were also conducted across a broad constituency of stakeholders with a prefigured list of questions. Interviewees were drawn from the following categories:

- public sector central lead Project Directors;
- public sector Directors of Primary Care representing the PCTs;
- public sector Project Managers;
- Chair and General Managers of the LIFTCos. (from private sector); and
- public sector independent technical consultants (from private sector).

The semi-structured nature of the interview technique allowed the interviewees to elaborate on any topic, but required all predetermined topics to be covered (Love *et al.* 2002). The diversity in the interviewees enabled a broad cross-section of views to be canvassed in relation to the efficacy of the LIFT procurement approach.

CASE STUDY RESULTS

The investigations revealed that in each case, the LIFT procurement process began with the redesign of the healthcare system to facilitate the necessary improvements in primary and social care services at each local level. A ‘hub’ and ‘spoke’ clinical model was used in the three schemes. Under this model, a ‘hub’, which represents a primary care centre where core and enhanced services (such as diagnostics, minor surgery and outpatient services) are provided will work with a network of ‘spokes’, which provides other services more locally in the community, for example at GP practices. Subsequently, the organisational structures that link the various partners were simultaneously defined as the relationships between the organisations and people involved were evolving over time. The design and construction processes were then defined and developed.

This research explored current practices used by the LIFT schemes examined, highlighting both good practices (that could be transferred across schemes and between projects) and poor practices (that require improvements). The specific practices evaluated include: the mechanisms for establishing/capturing and managing

stakeholders' requirements; procedures for defining and assigning roles, responsibilities and accountabilities; definition of project management processes; the processes of aligning project participants' values; and assessment of project performance. It should, however, be noted that the assessment of value in a complex environment such as healthcare, with diverse stakeholder groups that have distinct and particular requirements, concerns, goals and values, is highly problematic. This difficulty is further compounded by the inherent differences in the stakeholders' abilities in expressing and articulating their specific needs.

A summarised cross-scheme analysis of the LIFT schemes evaluated in this research is presented in Table 1 below.

It can be discerned from Table 1 that the pattern of progress made in the schemes reflects an evolving system, with the schemes announced in earlier waves making improvements as they move from one tranche of projects to the next. Further discussions on this pattern are discussed in the following section.

Table 1: Cross-scheme analysis

Criteria	Scheme 1	Scheme 2	Scheme 3
NHS LIFT wave	1st	2nd	3rd
Definition of project requirements	Initial stages were characterised with high staff turnover, inadequate understanding of project requirements and insufficient capacity to translate stakeholder requirements into design and construction terms. However, current SSDPs are more definitive and inclusive.	Initial stages were characterised with poor understanding of project requirements due to problems with engagement, incapability of in-house staff and erratic changes during implementation. Also, subsequent SSDPs are now becoming more definitive and inclusive.	Initial stages were characterised with poor understanding and translation of project requirements into design and construction terms and poor management of the delivery process. Initially resulted in facilities that were not fit-for-purpose. They've had to engage external consultants.
Definition of roles, responsibilities and accountabilities	Initially, had insufficient expertise for translating strategic directives to operational level. Now uses a project map that comprises defined roles and responsibilities of both core and project staff.	Initially, had insufficient expertise for translating strategic directives to operational level. Still do not have clearly defined roles, responsibilities and accountabilities. These have resulted in confusions and overlaps. Now taking steps to identify lead roles for the purpose of accountability.	Initially, had insufficient expertise for translating strategic directives to operational level. Still do not have clearly defined roles, responsibilities and accountabilities. These resulted in confusions and overlaps.
Definition of project management processes	Initially had no structured and clearly defined Project Management processes for their projects. However, they have now developed a defined project process called Project Assurance Framework (PAF) that sits at the heart of project governance, risk containment and continuous improvement.	Initially had no structured and clearly defined Project Management processes for their projects. However, they now rely on the project maps prepared by the external consultants.	Have no structured and clearly defined Project Management processes for their projects.
Alignment of stakeholders' values	Initially, there were lack of internal direction within the partner organisations, resulting in participants pulling towards different directions. There were also lack of effective coordination between strategic and operational levels of management. The scheme now operates a shared risk register and uses the PAF facilitate and nurture collaboration between partners.	Initially, the participants were pulling towards different directions because of lack of internal direction within the partner organisations. Although there is now some co-location, there is lack of effective coordination between strategic and operational levels of management.	Initially, the participants were pulling towards different directions because of lack of internal direction within the partner organisations. Although there is now some co-location, there is not harmonisation of their processes, organisational cultures and tools.
Assessment of performance	All projects have demonstrated higher performance compared to other public projects. The projects have also	All projects have demonstrated higher performance compared to other public projects. The projects have also	All projects have demonstrated higher performance compared to other public projects. The projects have also portrayed

Criteria	Scheme 1	Scheme 2	Scheme 3
	portrayed greater public satisfaction in meeting regeneration agenda of the local communities. Diverse criteria are being used for evaluating performance of projects. More definitive criteria are being advocated. Innovations are evolving e.g. procurement and legal times/expenses are reducing, innovative designs and adaptable materials are being used.	portrayed greater public satisfaction in meeting regeneration agenda of the local communities. Diverse criteria are being used for evaluating performance of projects. More definitive criteria are being advocated. Innovations are evolving e.g. multi-faith facilities are being provided, flexibility is being provided through equipment and workforce reconfiguration.	greater public satisfaction in meeting regeneration agenda of the local communities. Diverse criteria are being used for evaluating performance of projects. More definitive criteria are being advocated. Innovations are evolving e.g. multi-faith facilities are being provided, flexibility is being provided through creation of multi-purpose rooms and flexibilities in staff working hours.

DISCUSSION OF RESULTS

Mechanisms for establishing and managing project requirements

Although the PCTs generally have a commitment to stakeholder participation in the design and implementation of healthcare strategy, this investigation revealed that the processes of capturing and managing stakeholder values and requirements were fragmented, unstructured and incomprehensive in the three LIFT schemes. The engagements were largely restrictive in terms of participants, scope, timing and content. As a result, the interviewees suggested that the process of capturing and managing project requirements can be improved by giving more attention to the consultation and engagement of the key stakeholders (including the end-users) in the planning, design and monitoring of the projects by adopting a structured stakeholder engagement methodology.

Definition of roles, responsibilities and accountabilities

The case studies revealed that owing to apparent lack of specific expertise across the three schemes, there were difficulties in terms of translating directives and communicating updates from strategic leadership level to the operational level. Although one of the schemes uses a structured framework to identify and define the key deliverables and the sorts of issues that the board will need to satisfy itself on collectively, a more holistic assurance mechanism was emphasised. This would entail the development of a procurement process map that shows clear information flows, deliverables, approval and review points, and identify the roles and responsibilities and the appropriate skills mix that are required to satisfy each of the process stages at both strategic and operational levels. There is an increasing use of Cross-Functional Diagrams (CFDs) and the Responsible-Assist-Support-Consult-Inform (RASCI) charts in conjunction with jointly defined governance principles and operating guidelines (Ibrahim *et al.* 2006). The CFDs show who is responsible for specific tasks and decisions, and the sequence of those actions. On the other hand, the RASCI charts show for each task who is responsible for carrying it out, who is authorised to approve work or expenditures, who provides administrative or technical support, who should and can provide counsel, and who should be kept informed. Ibrahim *et al.* (2006) also recommended that the process maps should indicate the members of each team or community of practice responsible for delivering each task, the deliverables, the task duration and a unique identification number for easy reference in other

documentations and guidance notes. They further stressed that the underlying principle for allocating roles and responsibilities should ensure that each partner retains accountability for delivering the part of the project for which it has been selected (for example design, finance, construction, fabrication, etc) whilst at the same time signing up to the collective responsibility of successfully delivering each LIFT project. The advocated mechanism is expected to facilitate consistency and integration through the replication of the operating practices (activities, deliverables and functions) embedded in the generic process in all the projects handled by each LIFT scheme, thereby increasing the predictability of outcomes. In addition, it could also be used both as a learning tool for new employees and for monitoring relationships and performance of the members of the supply chain and projects. Other benefits of implementing process models at the project level include increased assurance of the product quality (Ulrich and Eppinger 2000), reduced circle times and costs (Kagioglou *et al.* 1998), and clearer definition of stakeholders' roles (Gray and Hughes 2001).

Definition of project management processes

The development of project management processes on the schemes evaluated follows similar trend as the definition of roles, responsibilities and authorities. SCRI (2005) had identified the skill sets required for effective management of LIFT processes to include a wide range of technical, managerial, behavioural and attitudinal competences. However, this investigation established that the LIFTCos. do not aggregate (combine) their competences in order to fully utilise the potential skills and competences available within the partner organisations, largely as a result of the ingrained culture of distrust and fragmentation in the construction industry. It was also established that collaboration between the project participants was done rather intuitively without the use of any formalised procedures. In order to maximise the effective utilisation of the current competences available within the partnerships, Chan and Cooper (2006) suggested the mapping of 'as is' skills mix so that the gaps can be identified and these should be subsequently filled preferably from within the partner organisations, and outsourced only when absolutely necessary and covering the three levels of human resources practices of recruitment, deployment and development at the partnership, project and team/individual levels respectively. In addition, while there were some forms of co-location between the participants in two schemes, no efforts had been made at harmonising their processes, cultures and tools in order to maximise the benefits of the partnerships. The third scheme, which had no physical co-location but used the 'Project Assurance Framework' (PAF) (a shared risk register and issue logs to facilitate collaboration between the project participants), did not harmonise their operational procedures, tools and documentations, thereby compromising the fundamental spirit of partnership. Also, the PAF does not emphasise the learning benefits realisable from an effective feedback function towards continuous improvement. It is, therefore, recommended that lessons (successes and failures) and project experiences captured during each of the stage/phase reviews be fed back to the framework for the benefits of the later phases and future projects. The creation, maintenance and use of a Legacy Archive had been suggested to be capable of aiding this process (Kagioglou *et al.* 1998).

Alignment of stakeholder values

This investigation has revealed that LIFT key stakeholders often had different priorities and drivers, largely resulting from differences in organisational values. For example, while public sector values are usually policy-driven, the private sector

values are often commercially driven. Yet, the success of project relationships (especially involving multiple parties from diverse sectors) has been found to fundamentally depend on the effectiveness of the relationships between the different participants, both at corporate level and within integrated cross-organisational project teams, and how these relationships are nurtured over the duration of the partnerships (Griffith and Gibson 2001). This, according to Bolton (2003), will require the project participants to: aggregate their resources and competences and jointly harmonise the objectives, strategy, processes and operational procedures for each project; and clearly communicate these to all participants. Bolton (2003) also suggested the aggregation and balancing of the approaches, methodologies, tools and techniques applied within the two “slightly different” sectors (public and private) whose missions and overall objectives may be similar but using different means for achieving them. The use of alignment mechanisms suggested by Bayliss *et al.* (2004) can strengthen the bond between the partners and their employees. Bolton (2003) further suggested that the harmonisation should extend to the development of the “basket of performance measures”, through a collaborative process so that the resulting measures are “owned” by those subjected to them. Equally important is the harmonisation of policies and practices of the project participants, the optimisation of which Evans and Jukes (2000) suggested can be achieved through the four key steps of process standardisation, knowledge sharing, alignment of existing practices, and continuous elimination of waste within the joint development cycles.

Assessment of performance of LIFT projects

This research has established that the project outcomes (in terms of delivery to budget, time and desired quality) of LIFT schemes are better than those obtained from traditional procurement processes. While a diverse variety of criteria have been used to evaluate the performance of the LIFT projects (such as public perception surveys, staff attraction and satisfaction surveys, benefits realisation surveys, Key Performance Indicators (KPIs) and benchmarking), it is being argued that they cannot comprehensively measure the objectives set out by the project participants or the drivers identified for implementing the projects. A paradigm shift is, therefore, advocated to develop criteria that can sufficiently measure the project objectives and/or drivers as agreed by the project participants.

Although the increasing involvement of the private sector in the delivery of public facilities and services is aimed at inject increased innovation, this research revealed that some of the LIFT schemes are still producing sub-optimal facilities that may be unable to cope with changing and evolving ways of delivering care in a cost-effective manner. This is not particularly limited to the LIFT initiative as Barlow and Köberle-Gaiser (2007) revealed that the PFI also yield less innovative hospitals that cannot grapple with future changes in demand. In order to ensure effective adaptability and flexibility of completed LIFT facilities over the facilities’ useful lives, Griffin and Roughan (2006) suggested that healthcare facilities’ designs adopt a ‘long-life, loose-fit’ approach that will yield a ‘universal’ building type. This system entails the use of ‘shell and core’ concept, by establishing reasonable and consistent structural bays (e.g. 9m x 9m) and locating vertical elements such as stairs, lifts and shafts on the perimeter so that the cores can maintain maximum flexibility. This way, the facilities can be adaptable to new function within the building shell (Griffin and Roughan 2006).

CONCLUSIONS

This paper examined whether the Local Improvement Finance Trust (LIFT) procurement initiative supports the delivery of facilities aimed at improving primary and social care services that meet local needs whilst providing value for money. The research also identified both good practices (that could be transferred across schemes and between projects) and poor practices (that require further strengthening) used by the LIFT schemes examined. The research employed a qualitative approach involving semi-structured interviews with senior managers working on three LIFT schemes. The results revealed that the processes of capturing and managing stakeholder values, requirements and expectations were fragmented, unstructured and incomprehensive. The engagements with stakeholders were found to be largely restrictive in terms of participants, scope and content, and in the selection of competing designs during the first tranche of projects in the three schemes that were investigated. This investigation also revealed that because the project processes were seldom sufficiently defined, the projects were plagued with lack of common understanding in the initial stages of the early projects, subsequently leading to some degree of confusion and overlaps with regards to roles and responsibilities.

The results indicated significant differences in the maturity levels of the schemes evaluated in terms of availability of appropriate systems, processes and structures in the planning and implementation of the schemes. It can be concluded that although further improvements in performance were possible, the pattern of progress made in the various schemes generally confirmed an evolving system that could ultimately meet the expected economies of scale. For example, more structured and inclusive approaches to stakeholder engagement, strengthening accountability and for driving innovation are recommended. In particular, the success of the schemes in meeting the requirements for continuous improvement to secure long-term value for money is predicated upon the development of a comprehensive framework for procuring LIFT facilities.

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