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The methodological development of a Benefits Realisation Management Process (BRMP) in the case of Manchester, Salford and Trafford (MaST) Local Improvement Finance Trust (LIFT)

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Abstract:

In recent years the UK government has made huge capital investment into the public sector in particular healthcare. One such initiative occurred in 2001 in the form of LIFT (Local Improvement Finance Trust) for primary care settings through a Public Private Partnership (PPP). LIFT has enabled a large amount of private spending to take place in primary care settings in deprived areas. However, LIFT has been subject to much criticism in areas such as overall costs, over-capacity, and lack of utilisation of spaces. Therefore there is a need for past, current and future government initiatives to be assessed on their benefit. HaCIRIC has started to address this first issue through a case study within the MaST LIFT. The findings of this case study aim to assess and review the degree to which the original planned benefits have been realized and what the actual benefits have been. This paper will present how the processes within the initial phases of the case study will be undertaken. As well as presenting the literature in the area of benefits management and related areas through a literature review of key texts.

Keywords:

Benefits Management, Primary Care, LIFT, Policy, methodology

1. Introduction

This paper is presenting one part of a larger project being undertaken by HaCIRIC Salford called 'BRMP in Healthcare'. It is presenting in detail the development of the methodology and the initial stages of the case study taking place with MaST LIFT. LIFT is a procurement route for primary care services, which was introduced in 2001. It is a partnership jointly owned, 50% by Department for Health (DoH) and 50% by Partnerships UK (PUK). PUK is a joint venture Public Private Partnership owned 49% by HM Treasury and 51% by private organisations including the Scottish executive. Community Health Partnerships (CHP) (originally known as Partnerships for Health - PfH) is fully owned by the DoH and is responsible for the delivery of LIFT. LIFT has delivered the following (CHP website, 2008):

- Improvement in primary and social care services and facilities.
- Generated over £1500m in investment to develop more than 210 new integrated community.
- Bought a number of services to one location, integrated them quickly, particularly to disadvantaged areas, these are specific to a community and its requirements
- Inspired partnerships between different agencies enabling innovation and new and different community care models.
- Promotes links between the NHS and social care as well as primary and secondary healthcare.

The aim of the case study is to assess what degree MaST Local Improvement Finance Trust (LIFT) is realising its intended aims and benefits, through undertaking a BRMP. This is needed as LIFT has been criticised for a number of things including (Baggott, 2004, Ibrahim et al 2006):

- The bureaucracy and complexity which causes confusion and delays,
- Private companies are profiting from tax payers
- little evidence that it will be more cost-effective than those funded entirely of public resources
- Distrust and lack of mutual understanding between the stakeholders
- Culture clashes
- Different time frames
- Lack of clarity and communication
- Lack of appropriate skills and competencies
- Expensive and time consuming

The paper will give the reader an understanding of what would be involved in the evaluation of a LIFT scheme, and guidance into the methodology involved within the BRMP. An overview of the wider project will be explained so that the relevance of the case study is understood.

1.1. The Bigger Picture: Benefits Realisation Management Process Project

The BRMP Project aims to develop a tool that will assist in managing projects driven by benefits through action research. Action research follows a cycle of planning a change, acting, observing the consequences, planning further action and repeating (Kemmis and Wilkinson, 1998). The process can also be used to assess past, current and future government initiatives in relation to the benefits they were set out to achieve in the original LIFT plan and individual SSDPs (Strategic Service Development Plans), LDPs (Local Development Plans) and Business cases. This assessment will take place through case studies at different stages of the lifecycle of a LIFT building, those stages are:

1. Policy Development
2. Programme Development
3. Business Case
4. Post Project
5. Post Occupancy
6. 5yrs, 10yrs

The findings from the different stage case studies will assist in better future planning, so that policy setting can be adequately informed by evidence with a fuller appreciation of potential outcomes and impacts. It will also feed into the development of the BRMP being developed by HaCIRIC. This BRMP aims to promote the use of knowledge sharing for successful monitoring of the benefits as they were originally conceived throughout the programme and manage new/reviewed outcomes (Sapountzis et al, 2007). The project is based upon the underlying assumption that that benefits planned at the business case stage of LIFT procurement are not routinely monitored throughout the project. It is necessary for the tool to be flexible enough that it is able to effectively capture the anticipated and unanticipated impacts that have an effect on actual benefits through a continuous improvement (CI) benefit review cycle.

In section 2 a review of what exists already in terms of literature on benefits realisation in general and within healthcare infrastructures as well as the related areas will be explored; this will identify the need for the Benefits Realisation Project to take place. Section 3 goes into

detail about the MaST LIFT case study methodology on the basis of the protocol that was developed for this Post Occupation scheme. The conclusions are set out in Section 4.

2. BRMP Literature Review

2.1. A definition

It is important to have a full understanding of what is meant by the term Benefits Realisation Management Process. The term has been generated by HaCIRIC through the project, when a fuller understanding of benefits and realisation was gained.

A benefit is a noticeable improvement, advantage gained from an outcome (Payne, 2007, OGC, 2007 and Oxford English dictionary, 2006). Realisation is an adjective of realise, described as ‘become fully aware of as a fact; understand clearly’ and ‘cause to happen. Achieve (something desired or anticipated); fulfil’ (Oxford English dictionary, 2006, pp. 1197). Farbey et al (1999) keeps in mind that it is a process that realises the benefits that are achieved as well as managing the unexpected ones. Payne’s (2007) definition of benefits management focuses on the harder outcomes of a business, the process he believes identifies manageable business benefits and the required financial impact at the beginning of a project and through the process makes sure that these are actually achieved. Bradley (2006) defines the process of benefits realisation in 5 steps as illustrated in table 1.

Table 1. Benefits realisation process (adapted from Bradley, 2006)

Step	Process
1	Conceive benefit as real
2	Get more detail on the benefit so it is fully understood
3	The benefit’s dependencies are mapped, taking changes required and earlier benefits into consideration so it becomes more realistic
4	The changes are made making the benefit actual
5 (not always)	Benefit is transformed into money

Therefore benefits realisation could be defined as one becoming fully aware of the positive impact as a result of a change. From these plus much more analyses into the subject area HaCIRIC consider the Benefits Realisation Management Process (BRMP) to “*To increase the predictability of realising maximum benefits for all stakeholders of healthcare infrastructure programmes and projects through the utilisation of a robust benefits realisation process.*”

2.2. A Background

Benefits Realisation Management has been discussed in terms of finance and IT since the late eighties, early nineties (Farbey et al, 1999). It is only recently that the topic has been theoretically linked to healthcare through writers such as OGC (2007) and Bradley (2006). There have been some attempts by the government to use related tools for managing projects and their performance within the healthcare sector, such as:

- Gateway Review Process - 2001
- 18th Week Pathway - 2004
- The Integrated Service Improvement Programme (ISIP) road map for ‘Transformation Change’ - 2005

- PCT Fitness for Purpose and Development Programme - 2006
- Benefits Realisation Plan (BRP) for all of the 'integrated change programmes proposed in their ISI Plan' - 2006
- NHS Integrated Service Improvement Plan web page - 2007

However these tools do not drive projects through benefits, many occur at the end of a project acting only as an evaluation, from which lessons are not learnt. As presented in Sapountzis et al (2007) there is a need in the healthcare sector for a process that is integrated into business planning as well as:

- Appropriate for those who operate it and those that use the information produced;
- Robust enough to withstand change;
- Balanced in its assessment of hard and soft benefits;
- Cost effective by producing performance information that realises benefits in proportion to the investment required to collect it;
- Simple to Implement

The need of such a process is being addressed through the development of a BRMP, through a review of literature, consultation with a multi stakeholder group related to healthcare procurement, case studies and action research. Section 3 goes into detail about the methodology being undertaken within the case studies, providing guidance for those undertaking an evaluation of a LIFT scheme in terms of benefits.

3. MaST LIFT Case Study

3.1. Protocol Development

To develop the protocol for this study and to help advise and steer the project, MaST Project and Steering Group meetings have taken place. Both groups gave HaCIRIC access to all stakeholders involved in the MaST schemes from the top level Partnership Director to the operational level such as Centre Managers. Both of these groups and the different stakeholders within them had the same key objective, to evaluate the LIFT schemes. This helps the groups to be successful and effective, having conflicting objectives within a team can cause problems for a project (Barnard, 1938, Ayuso, 2006,). The Groups undertook the following activities and exercises:

- Through their own experience the original LIFT proposal and MaST business case they identified the benefits that were planned and not planned for the scheme.
- Identified the most appropriate method to be used to measure the benefits; a section of this is shown in table 2.
- Undertook a benefits relationship mapping exercise, which is a key exercise in a BRMP in identifying the dependencies and relationships between the different benefits (OGC, 2007).

Table 2: Methods and Measures table

Ref	Strategic Benefits	Outcome or further benefit	Method of measurement Q = questionnaire				Secondary Data Collection/ Analysis
			Patient Q	Centre-user Q	Staff Q	Interview	
A	Improved Patient Services						
A1	Product	Improved patient experience	X				
A2		Better Access to facilities	X	X		X	
A3		Greater Privacy	X		X		
A4		More services in 1 place (Co-location)	X	X		X	X
A5	Service	Improved health outcomes					X
A6		Greater access	X	X		X	X
A7		Less waiting	X				X
A8		New services	X	X		X	X
A9		Care closer to home				X	X
A10		Increased patient choice	X	X		X	X

Both groups have been consulted and will continue to be consulted to advise and ensure the research being undertaken is addressing the need of the healthcare industry.

The information for the project will be gathered through multiple case studies. Multiple case studies allows findings to be compared between the different cases, which allows the study to be more robust than if a single case study were to be used (Herriott and Firestone, 1983). The case studies will take place within three schemes in MaST LIFT: The Energise Healthy Living Centre Douglas Green in Salford, The Partington Health Centre in Trafford and The Wythenshawe Forum Health centre in Manchester. The findings from each post occupancy case study will be used to enhance the development, implementation and evaluation of a BRMF across and within different primary care settings. This multi-site approach enables the transferability of the BRMP to be measured at the same time as capturing wider user perspectives (Yin, 2003 and Kagioglou et al, 2000).

Inside of the three case studies a variety of quantitative and qualitative methods will be adopted, these include questionnaires, interviews and focus groups. These will be used to develop, implement and evaluate the BRMP from the perspective of both service providers and users. It is anticipated that the combination of techniques will capture the perspectives of the case study target population and the activity inside of the case study site to measure the effectiveness of the BRMP implemented. The advantages of using two methods known as polarity of methods is that claims for the validity of conclusions are improved if the findings support one method can be counterbalanced with the strengths of the other another (Bryman, 1988, Punch, 2005).

Douglas Green's Energise Healthy Living Centre has been chosen to be the pilot case study site. A Pilot study is the pre-testing of a tool or method or scaled down version of a full scale study (Teijlingen and Hundley 2002). It is necessary to undertake a pilot to determine the effectiveness of the research method chosen and to test and refine the methods and data collection tools (Yin, 2003). This is accomplished by analyzing the significance of questions and/or hypothesis testing, using non-parametric/parametric statistics in Statistical Package for

the Social Sciences (SPSS) for closed questions, and Non-numerical, Unstructured Data Indexing, Searching and Theorising (NUD*IST) software to explore the validity of comments provided within open questions. The outcome of these will aid in finalising the questionnaire and interview methodology for rolling out to the other case study schemes; this is why the pilot is so important and that more resources in terms of time and money are often spent to this stage than any other of the other case studies (Yin, 2003). How the questionnaires, interview and patient/community forums will be undertaken and why, will now be discussed.

3.2. Questionnaires

The main bulk of the data collection for the case studies will be done through questionnaires one for the staff of the schemes and one for the patients. The bulk of the data being obtained through quantitative methods are that these “have the ability to use smaller groups of people to make inferences about larger groups” (Holton and Burnett, 1997, p. 71).

Questionnaires are tools used to collect quantitative data, they gather numerical data through which patterns and causal relationships are discovered, the findings are seen to have high reliability. Questionnaires are a good way to gain an insight into ‘characteristics, attitudes, and beliefs’ of many people (Marshall and Rossman, 1999). In this case the questionnaires will gather an insight and assess the different groups’ views and perceptions of the services, facilities and overall effects of the LIFT scheme. The questions will be addressing benefits identified through earlier meetings that are specific to the group as illustrated in table 2. The AUDE (Association of University Directors of Estates) and CABE (Commission for Architecture and the Built Environment) best practice guidance has been used for developing an effective questionnaire involved in Post Occupancy Evaluation. Within the best practice guidance are recommendations of the kind of questions that should be used when addressing client satisfaction. This is relevant to the work being undertaken within the case studies as a large focus of the studies is on the experience of the staff and patients. Through analysis of the questionnaire findings it will be possible to see if the MaST has delivered these benefits in the view of the staff, patients and community.

3.3. Interviews

Interviews are the most important qualitative methods to provide information to a case study (Easterby-Smith et al., 2002, Yin 2003). Therefore semi structured interviews will be used to collect qualitative data from the staff for these case studies. Semi structured interviews have some predetermined questions, but these can change dependant on the answers given and how the researcher interprets the conversation (Robson, 2003). They are used to provide guided but open discussion (Yin, 2003). Due to this openness interviews discover new areas that should maybe looked into. There will be multiple interviewers for this study, each will undergo training before the interviews begin to ensure they understand how to obtain consent, the approach, purpose and strategy, they will also receive a guide to follow as this is a way in which the interviewer can be sure that they are following the same lines of inquiry (Patton, 2002). Throughout the period of interviewing interviewers will meet regularly to discuss both the data collection and analytical techniques to make certain that researchers are not bringing their own interpretations on the data but rather an objective view that they all share making the results more valid and holistic.

3.4. Patient/Community Forums/Focus groups

Some of the schemes use patient and public forums to communicate with the patients and centre users. Patient and public involvement forums were set up officially to (Department of Health website, 2008):

- Monitor and review NHS delivery
- Seek the views of the public about those services
- Make recommendations to the NHS accordingly
- Other issues relevant to organization

Therefore these forums will be an ideal setting to gain the views of the patients and discuss their perceptions of the service, facilities and knock on effect of LIFT in their area. Focus groups provide information that may not be obtained through other tools as they give attendees opportunities to disagree or develop a shared perspective (Hakim, 2000). They will also give those with low literacy unable to complete the questionnaires an opportunity to be involved in the study. The discussions will be tape recorded and after which will be transcribed into detailed notes and the project representative will write a research summary directly following the forum, ensuring that specific details and key elements are recorded.

3.5. Data Analysis and Evaluation

From the different techniques there will be quantitative and qualitative data that needs to be analysed, both primary data (obtained from the questionnaires, patient/community forums and interviews) and secondary (obtained from the data collection of PCTs records). To save time and drudgery through many details (Robson, 2003) analytical software will be used for the analysis. The qualitative data will be analysed using NUD*IST (Non-numerical, Unstructured Data Indexing, Searching and Theorising) software. This software is based on a code-and-retrieve facility, which means that the data it holds can be coded and then from this retrieved through using 'Boolean, context, proximity, and sequencing searches' from these searches qualitative matrices, relationships and patterns can be discovered (Richards and Richards, 1994). NUD*IST can also be used to develop and influence new ideas and hypothesis. SPSS (Statistical Package for the Social Sciences) would also be used for statistical analysis. This is a computer package used by market, education and health researchers, survey companies, the government and more. This analysis will be undertaken by members of the research team at the University of Salford.

Data will be compared and contrasted on different levels, both within and across case study sites to identify similarities and differences which inform the BRMP. The methodology will be applicable and transferable to primary care settings where schemes are at different stages of implementation. The findings will help LIFT schemes to identify criteria needed to achieve the benefits.

The methodology for the case studies will also be subjected to an extensive evaluation once completed e.g. was the mapping exercise a success? How could it be improved if repeated? From this lessons learnt will be identified, and this will aid to refine the process and methodology for the future projects.

3.6. Ethical approval

A paper on the process of case studies being undertaken within a healthcare setting cannot be done without mention of the different ethical approval processes that need to be obtained:

- NHS Ethical approval
- University of Salford Ethical Approval
- Research Governance from Salford PCT
- NHS Research Passport
- PIAG
- Pan Manchester

These are all necessary as the research involves developing a new tool through consultation with NHS staff and patients, both of whom have not agreed to be contacted by independent bodies such as ourselves.

4. Conclusion

The evaluation of the original MaST LIFT business case, project and steering group meetings, a review into research methodologies and Benefits Realisation literature resulted in the protocol and methodology presented in this paper. This methodology informs the BRMP, where part of the process is the identification of required benefits, appraisal and evaluation throughout the lifecycle of a project or programme (Farbey et al, 1999). It will also feed into the development of a BRMP Framework which aims to promote the use of knowledge sharing for successful monitoring of the benefits as they were originally conceived throughout the programme and manage new/reviewed outcomes even through times of change.

The next step for this research is to begin the research and use the findings to not only inform the BRMP and BRMP framework, but also to evaluate if MaST LIFT has realized its intended benefits and how, and if not, why? This will help MaST LIFT to take any necessary action where the benefits are not being realised. Where planned or unanticipated impacts and benefits and dis-benefits have occurred the research will be able to evaluate why, feeding into recommendations for future LIFT projects and acting as guidance for future evaluations of similar projects. They will also help to identify any unanticipated benefits and dis-benefits that have occurred. These findings will ultimately assist in better future planning so that policy setting can be adequately informed by evidence with a fuller appreciation of potential outcomes and impacts of using LIFT.

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