HIA: SPMS Review

Review of the Specialist Personal Medical Service (SPMS) in Hounslow

Project Ref: 17246/001

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Executive Summary

Introduction

The review of the Specialist Personal Medical Services (SPMS) forms a small but significant part of some much wider thinking, discussion and debate that is starting to take place on the most cost-effective way to configure and structure primary care services under the responsibility of Hounslow Primary Care Trust (PCT). An external reviewer was commissioned to ensure that the review was impartial and objective.

The purpose of this review was five-fold:

- To evaluate the achievements of the SPMS in relation to its original objectives and underlying values (explicit and implicit).
- To identify the key learning points from the process of setting up and implementing the SPMS.
- To assess the SPMS's 'fitness for purpose' in light of the new 'Patient-led NHS' proposals.
- To assess the extent to which the SPMS provides value for money.
- To develop options for the future of the SPMS and, depending on the findings, make recommendations on the best way forward.

Review Design

The time frame for this review was extremely tight involving six weeks work over a two and half month period between November 2005 and January 2006.

There were also significant data constraints which meant that a full comparison of the achievements and value for money of the SPMS in relation to both the structure that was in place before it was set up as well as the other providers of primary care in Hounslow could not be undertaken. However, enough information was available to provide reasonably robust answers to the objectives of this review.

Frontline staff have important insights into the success or otherwise of a reconfiguration and change management process both on themselves and the users of the services that they provide.

The first strand of the review was therefore to bring out their views, perspectives and experiences of the SPMS. This was done through a staff workshop that had already been planned and a questionnaire sent to all the staff of the SPMS as well as key external stakeholders.

The second strand of the review was to attempt to analyse the achievements in terms of routinely collected outcomes measures e.g. global sum equivalent allocations; provision of enhanced services; prescribing practice; referrals to hospital and accident and emergency rates.

The third strand of the review was to carry out a content analysis of the key documents relating to the SPMS.

The final strand was to undertake a literature review on research into SPMSs. Unfortunately, due to the lack of literature on SPMSs a focussed and limited literature review on the strengths and weaknesses of past and present approaches to re-structuring and re-configuring primary care was undertaken.

Questionnaire Findings

50% (35 out of 70) of respondents described the current SPMS arrangements as better than those prior to October 2004. Doctors had more negative views

of the SPMS arrangements than other professional groups. 40% (28 out of 70) described the change process to the new SPMS arrangements as being well or very well managed, though here as well doctors had more negative views of the change process than other professional groups. On a scale between 0 and 100, where 0 = Totally Unsuccessful and 100 = Totally Successful, the average rating of how successful the SPMS has been was 60% (of the 57 respondents who answered this question). 65% (45 out of 70) of respondents described the SPMS as being either probably or definitely worth carrying out if we were to start again; with doctors having more negative views of its worth than the other professional groups.

The aspects of the SPMS that worked well or very well were: multidisciplinary team-working within respondent's own SPMS service; personal training and development; risk management and quality control; relations between management and staff; multidisciplinary working between SPMS services; and partnership working between SPMS and other health and social care organisations.

The aspects of the SPMS that worked less well or poorly were: finance functions; IT functions; human resources functions; and building and facilities functions.

The aspects of the setting of the SPMS that worked well or very well were: multi-disciplinary team-working within respondent's own SPMS service; relations between management and staff; personal development and training; communication of SPMS strategy; communication to affected staff; risk management and quality control; transfer of staff; and human resources functions [See Figure ES1].

The aspects of the setting up of the SPMS that worked less well were: finance functions; building and facilities functions; and IT functions [See Figure ES 1].

The objectives and principles of the SPMS that were described as significantly or fully achieved were: access to primary health care that is local; clear

leadership of the SPMS; processes and procedures in place that ensure care is safe and provided to a high standard; common standards and service requirements for all Out of Hours care providers; patient-centred services; access to primary health care that is quick; access to primary health care that is equitable; clear lines of accountability; and high quality services.

Review Of The Specialist Personal Medical Service (SPMS) In Hounslow

Figure ES1: In your judgement, compared to the arrangements in place before October 2004, which aspects of the SPMS have worked well and which poorly?

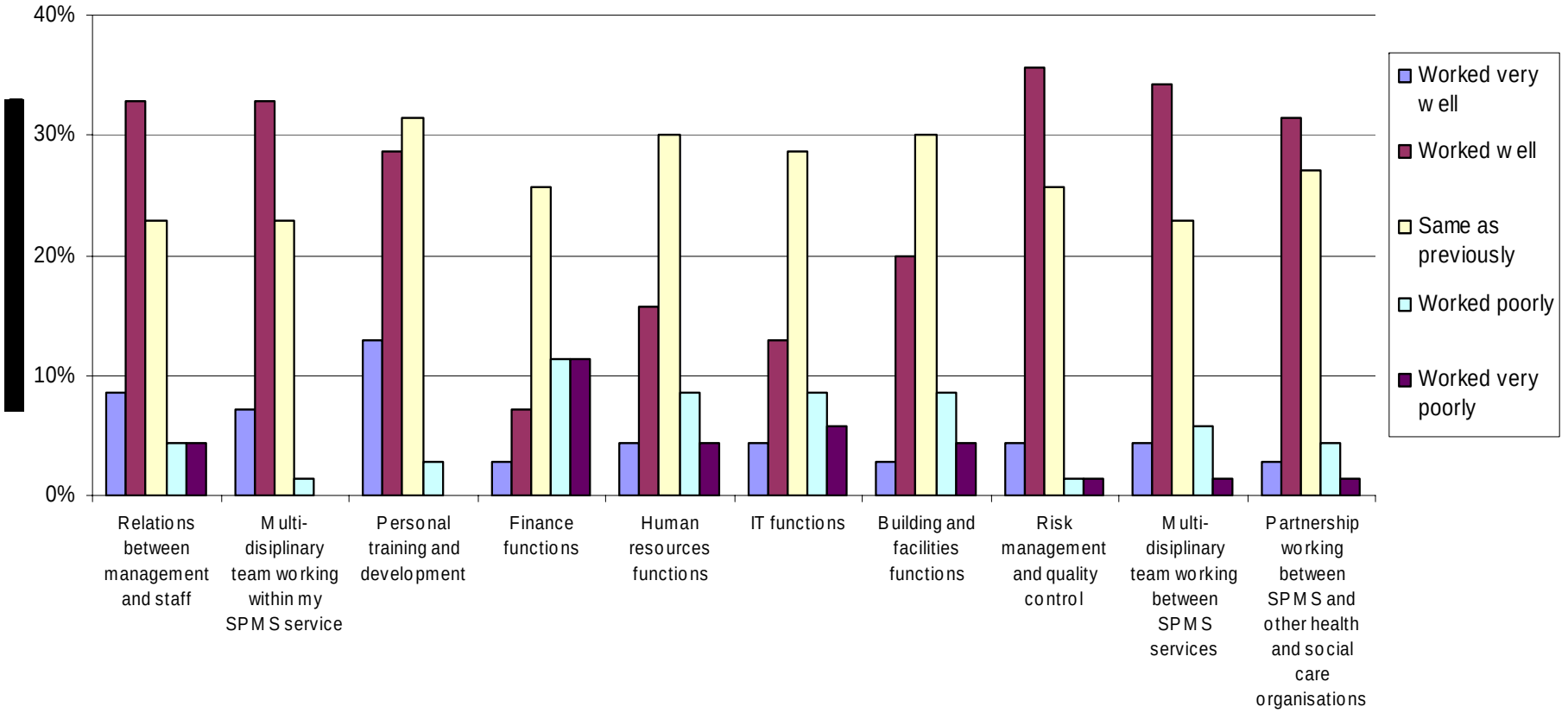
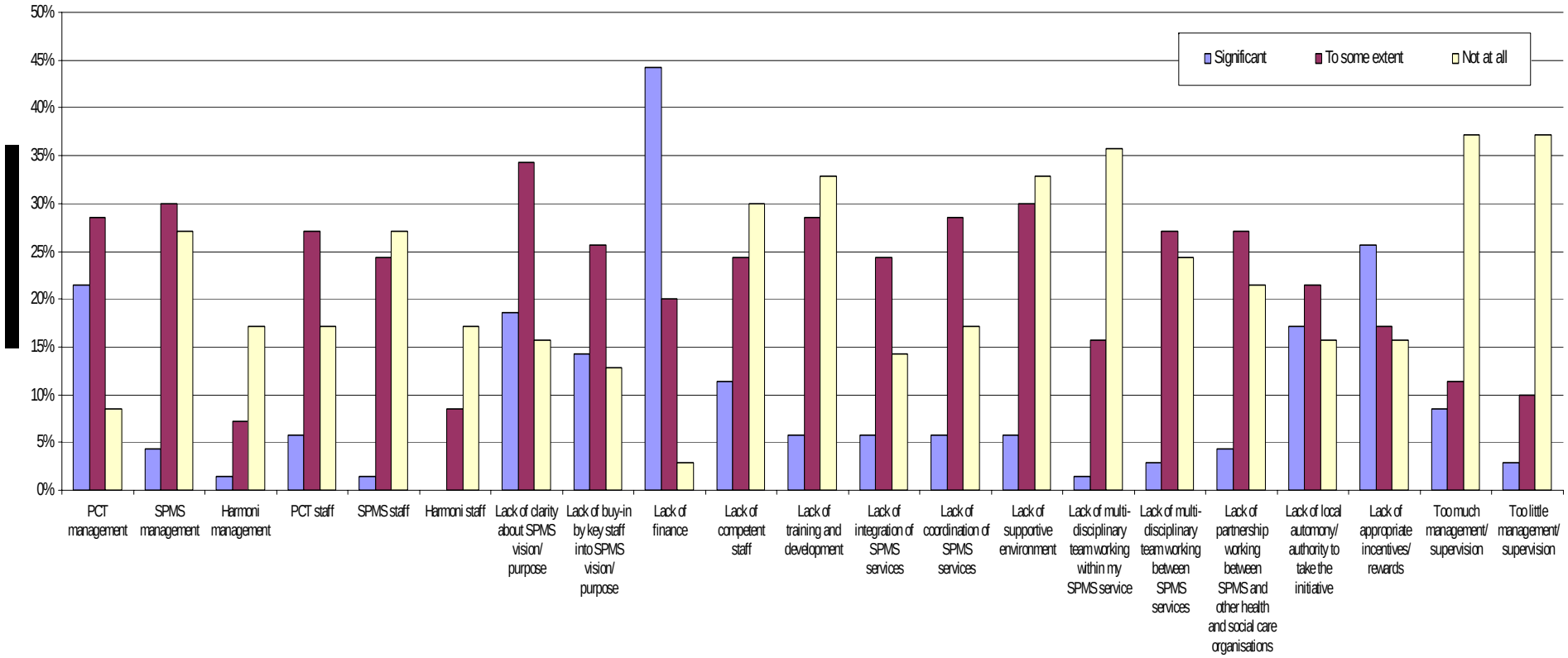


Figure ES2: In your judgement, which of the following have been barriers to the achievement of the SPMS's objectives/principles?



The objectives and principles of the SPMS that were described as only partially or not achieved were: opening up of the local primary health care market for better patient choice; infrastructure in place to support sharing of patient information between primary health care professionals; integration of the practices and services within the SPMS; value for money services; less conflict of interest; and sharing of patient information between primary health care professionals.

The values that the SPMS significantly or fully demonstrated were: commitment to providing services to the best professional standards; being a learning organisation; and being an exemplary employer that values staff.

The values that the SPMS only partially demonstrated or did not demonstrate were: focussed and responsive – offering local people a seamless service; open – working to bring together health and social care; achieving best value; and being an innovative organisation that recognises the needs and diversity of its local community.

The top ten barriers to the achievement of the objectives of the SPMS as identified by respondents were: lack of finance; lack of appropriate incentives/rewards; PCT management; lack of clarity about SPMS vision/ purpose; lack of autonomy/ authority to take initiative; lack of buy-in by key staff into SPMS vision/ purpose; lack of competent staff; too much management/ supervision; lack of supportive environment; and lack of coordination of SPMS services [See Figure ES2].

The criteria of a patient-led NHS which respondents described as being significantly or fully addressed were: securing safe services; reducing inequalities; improving health; securing high quality services; and improving engagement of GPs.

The criteria of a patient-led NHS which respondents described as being only partially or not addressed were: improving coordination with social services; delivering reduction in management/ administrative costs; improving public

involvement; improving management of financial risk; improving commissioning; and improving effective use of resources.

Overall Findings

The SPMS, in its first year, has been partially successful in achieving its objectives and a number of factors have contributed to and worked against the achievement of those objectives. Given that the first year of any change process tends to be the most disruptive and difficult this is a significant achievement.

The SPMS, depending on context, seems to be a good to excellent transitional model to move services or a set of services which a PCT is obliged to support for a time, from a lower level of service delivery to a higher level of service delivery, and then divest to other providers at a later stage.

The working arrangements between the PCT and SPMS have not been very successful and this has largely been due to the creation of a virtual 'arms-length' entity within the PCT that is trying to be an independent organisation within an organisation.

The SPMS has overspent its budget and while the quality of its services have been good to very good they have been within the range encompassed by other more cost-effective providers of primary care e.g. the GMS and PMS general practices. On balance, given the diversity of objectives the SPMS had it was the best model to enable these objectives to be tackled within a single framework.

Finally, Hounslow PCT and the Hounslow health community are moving towards the vision of a patient-led NHS. The development and implementation of the SPMS, albeit with some drawbacks, has overall supported and facilitated the changes that needed to take place to move closer towards achieving the vision of a patient-led NHS.

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1. Introduction

This review forms a small but potentially significant part of some much wider thinking, discussion and debate that is starting to take place on the most cost-effective way to configure and structure primary care services under the responsibility of Hounslow Primary Care Trust (PCT).

The review of the Specialist Personal Medical Service (SPMS) offers the opportunity to examine a small part of the Hounslow primary health care system and determine what lessons it has for the Hounslow health economy as a whole.

The SPMS is a microcosm of the tensions and challenges that are playing themselves out across the whole of primary care in Hounslow. The SPMS has tackled these tensions and challenges in a new and innovative way and therefore can provide an indicator of which approaches work well and which do not in the context of the Hounslow health economy. An external reviewer was commissioned to ensure that the review was impartial and objective.

The purpose of this review was five-fold:

- To evaluate the achievements of the SPMS in relation to its original objectives and underlying values (explicit and implicit).
- To identify the key learning points from the process of setting up and implementing the SPMS.
- To assess the SPMS's 'fitness for purpose' in light of the new 'Patient-led NHS' proposals.
- To assess the extent to which the SPMS provides value for money.
- To develop options for the future of the SPMS and, depending on the findings, make recommendations on the best way forward.

To put this review and the local health economy and community in context a number of local and national driving forces need to be understood.

At the local level, three key drivers are of note: firstly, the historic financial deficit of Hounslow PCT and the continuing financial pressures that make the existing provision of health care unsustainable if the current configuration of health services is retained; secondly, the needs of the diverse and relatively deprived community that the Hounslow health system serves; and thirdly, a desire among some service providers to further separate the commissioner and provider functions within Hounslow PCT and become service providers that are outside and independent of the PCT.

At national level, four major drivers are relevant: firstly, the imperative that local health economies manage their budgets in a sustainable way (achieving financial balance within each financial cycle and eliminating any past deficits); secondly, the need for local health systems to be cost-effective (achieve the highest level of quality of care for every pound of health expenditure); thirdly, the desire that the NHS is more responsive to patients and able to provide access to a wider choice of health care providers both within and outside of patient's localities; and fourthly, the need to separate out the commissioning and regulating functions of PCTs from their service and staff provider functions (so that commissioning and provision are more effective as conflicts of interest and conflicts in priorities within PCTs are eliminated).

This review takes as its benchmark the two reviews carried out by Derek Wanless: *Securing our Future Health: Taking the Long-Term View* and *Securing Good Health for the Whole Population (1,2)*. These two reports provide this review with its overarching health system framework and perspective. The rationale for this is simple, they are the only two major governmentally approved reports that tackle head-on the dilemma faced by all health care providers at local, national and international levels – how to secure the health of every community member without having health expenditure of such unsustainable proportions that it cannot be afforded by present or future

generations. One that is consistent with the NHS's core philosophy of fair access and free treatment at the point of use. These two reports are crucial benchmarks because the first was completed in April 2002 and the second in February 2004. An extract from the 2002 report illustrate the continuing relevance of its themes with regard to the configuration and structure of future primary health care services.

"THE HEALTH SERVICE IN 2022

2.10 Patients are at the heart of the health service of the future. With access to better information, they are involved fully in decisions – not just about treatment, but also about the prevention and management of illness. The principle of patient and user involvement has become ever more important and the health service has moved beyond an 'informed consent' to an 'informed choice' approach.

2.11 The health service is able to recruit and retain the staff that it requires with the right levels of skills. No longer do chronic shortages among key staff groups act as a constraint on the timely delivery of care. Health care workers are highly valued and well motivated as a result of better working conditions and the opportunity to develop their skills to take on new and more challenging roles for which they are appropriately rewarded.

2.12 Modern and integrated information and communication technology (ICT) is being used to full effect, joining up all levels of health and social care and in doing so delivering significant gains in efficiency…

2.13 In this vision, patients receive consistently high quality care wherever and whoever they are. It is appropriate, timely and in the right setting. Different types of care are effectively integrated into a smooth, efficient, hassle-free service. With support from the NHS, people increasingly take responsibility for their own health and wellbeing....

2.14 When patients need to see their GP, or seek other forms of primary care, they get appointments quickly with staff who are pro-active in identifying what care is required and who is best placed to deal with it. Primary care delivers an increasingly wide range of care, including diagnosis, monitoring and help with recovery. There is a focus on lifestyle, disease prevention and screening… Current service innovations such as NHS Direct, walk-in centres and telemedicine are commonplace, enabling people to receive an initial diagnosis in a variety of settings, moving beyond the traditional visit to the GP surgery."

While criticisms can be made of the two Wanless reports, especially with regard to their lack of emphasis on the wider determinants of health - the social, economic and environmental structures and factors that influence individual and community health and wellbeing - they do provide the most robust assessment to date of the future scenarios that are likely to emerge within the health care and the health of the UK population.

This review therefore starts with a basic assumption embedded within the Wanless reviews that only a long term perspective on health care system re-configuration and re-structuring is likely to be successful and sustainable. Short term priorities at local and national levels should not distract from the main task of Hounslow PCT to secure the long term health and wellbeing of the community of Hounslow whilst eliminating the PCT and wider health economy's financial deficit in the short to medium term.

Ultimately, it is not the restructuring of the local health system or the model that is used to do this that is important but the people who work within the system and the vision, courage and qualities they have to take the more difficult path to build a local health economy that is fit for purpose not just for today and tomorrow but for 2022. Health care delivery is above all dependent on the productivity, commitment, skill and vision of the people who work within it. This is because committed, skilled, productive and visionary people can make a bad health care model work while a de-motivated, unskilled,

unproductive group of people, who lack vision, can turn a successful model into a failure.

Finally, the ethos of this review is to identify and analyse what was successful and unsuccessful during the first year of the SPMS in a spirit of openness and learning that informs and supports future decision-making with regard to the SPMS and the wider health economy encompassed by Hounslow PCT.

This report is therefore made up of twelve chapters:

- Chapter 1 is an introduction to this report and the SPMS review.
- Chapter 2 provides details of the review methodology and the strengths, constraints, and limitations of this review.
- Chapter 3 provides a background introduction to the SPMS and the context within which it was created.
- Chapter 4 provides a brief overview of the current policy context.
- Chapter 5 provides an overview of the literature on the effectiveness of primary care and the value of the current approaches to reconfiguration to deliver national policy objectives in primary care.
- Chapter 6 describes the findings from the review workshop with SPMS staff.
- Chapter 7 presents the findings from the review questionnaire sent to SPMS staff and key external stakeholders.
- Chapter 8 presents an analysis of the available outcome data on the SPMS.
- Chapter 9 presents an analysis of key documents relating to the SPMS.

- Chapter 10 presents the overall findings of the review and the similarities and differences between the different types of data.
- Chapter 11 presents a SWOT analysis (Strengths, Weaknesses, Opportunities, Threats analysis) of the way forward options for the SPMS.
- Chapter 12 presents the external reviewer's conclusions on the SPMS, its achievements and the future.

2. Review Methodology

2.1 Introduction

This review uses a methodology called 'realistic evaluation'[1] which argues that the question for evaluators is not whether a plan, programme or project and its implementation were a success or failure but what aspects were successful and what aspects unsuccessful and why this should be so. This is because no plan, programme or project is ever a total success or a total failure, each has successful and less successful achievements and outcomes. A good evaluation therefore aims to draw out the lessons of why this should be, so that these insights can be used to develop and implement future plans, programmes and projects more successfully than past ones.

The time frame for this review was extremely tight involving six weeks work over a two and half month period between November 2005 and January 2006.

There were also significant data constraints which meant that a full comparison of the achievements and value for money of the SPMS in relation to both the structure that was in place before it was set up as well as the other providers of primary care in Hounslow could not be undertaken. However, enough information was available to provide reasonably robust answers to the objectives of this review.

2.2 Key review questions

The objectives of this review were turned into eight key questions:

1. What are the SPMS's objectives and to what extent have these been achieved?

[1] Pawson, R. and Tilley, N. (1997). Realistic Evaluation. Thousand Oaks, California, Sage.

2. What factors contributed to or worked against the achievement of these objectives?

3. What are the key learning points for the PCT from their commissioning of the SPMS?

4. How successful have the working arrangements been between the commissioner and the providers and what are the key learning points from the implementation of the SPMS?

5. Has the SPMS provided value for money one year on compared to carrying on with the arrangements in place before it was set up as well as in comparison to the other current providers of general practice? What have the costs and benefits been from financial, staff, service delivery, patient and organisational perspectives?

6. Could these objectives have been better achieved through a strategy and approach different from that used to develop the SPMS?

7. How does the objectives and underlying values of the SPMS measure up with the requirements for the 'patient-led NHS' agenda?

8. What does the review data tell us about the future of the SPMS and its core business?

2.3 Review Design

Frontline staff have important insights into the success or otherwise of a reconfiguration and change management process both on themselves and the users of the services that they provide.

The first strand of the review was therefore to bring out their views, perspectives and experiences of the SPMS. This was done through a staff

workshop that had already been planned and a questionnaire sent to all the staff of the SPMS as well as key external stakeholders.

The second strand of the review was to attempt to analyse the achievements in terms of routinely collected outcomes measures e.g. global sum equivalent allocations; provision of enhanced services; prescribing practice; referrals to hospital and accident and emergency rates.

The third strand of the review was to carry out a content analysis of the key documents relating to the SPMS.

The final strand was to undertake a literature review on research into SPMSs. Unfortunately, due to the lack of literature on SPMSs a focussed and limited literature review on the strengths and weaknesses of past and present approaches to re-structuring and re-configuring primary care was undertaken.

2.4 Methods

This review used a number of different methods: a workshop, questionnaire, content analysis, some unstructured interviews, routine outcome data analysis and a rapid literature review.

2.4.1 Workshop

A workshop for SPMS staff had already been planned and the review took this opportunity to undertake a series of focus groups on the achievements of the SPMS and the options for its future in light of the current national and local context. The workshop involved the participants sitting in small groups and discussing and writing their ideas and issues in individual workbooks (see Appendix). They also discussed them through short plenary sessions so that ideas from each of the seven groups could be shared with the others. A ‘world

café' session was also undertaken at the end to allow participants to explore one particular option of their choice in greater detail.

2.4.2 Questionnaire

A questionnaire was developed to elicit responses from SPMS staff and key stakeholders on the major themes of this review (see Appendix). This was sent to all 137 SPMS staff as well as 24 external stakeholders from the Joint Consultative Committee, Professional Executive Committee, the PCT Trust Board, Hounslow PCT, Harmoni, London Ambulance Services (LAS), Local Medical Committee (LMC), Patient and Public Involvement Forum (PPIF) and West Middlesex University Hospital (WMUH).

2.4.3 Content analysis

The key documents of the SPMS were reviewed and an analysis of the rationale for it being set up, its purpose and its implementation was carried out. The documents included the proposal document, the working arrangement document, a media article, minutes of the Trust Board and the PCT's strategic plan documents.

2.4.4 Informal interviews

Some informal interviews were undertaken with key informants to broaden the reviewer's understanding of the SPMS.

2.4.5 Literature review

A rapid literature review on the policy context, research on SPMSs as well as the effectiveness of primary care was undertaken and relevant research and its conclusions are presented in this report.

2.4.6 Routine outcome data analysis

Available outcome data on the SPMS and other primary care providers was reviewed and where possible and appropriate these were analysed to assess the quality and value for money of the SPMS. There were considerable constraints in the availability, accessibility and appropriateness of routinely collected datasets that could be used either as direct or proxy measures of the quality of the SPMS and its value for money particularly when comparing the SPMS practices with the General Medical Service (GMS) and Personal Medical Service (PMS) general practices.

2.5 Participant Selection

All SPMS general practice staff and managers of other SPMS services were invited to attend the workshop and all SPMS staff were sent a questionnaire. In total forty-five members of staff from a range of professional backgrounds (doctors, nurses, practice managers, receptionists, etc.) attended the workshop and seventy people (SPMS staff and external stakeholders), out of one-hundred and thirty-seven, completed and sent back the review questionnaire. Five informal interviews/conversations[2] were undertaken with key informants who had particular insights into the SPMS, its development, implementation and operation.

[2] There were the Deputy Director of Finance, Head of Performance, Quality and Outcomes Framework Facilitator, and Director of the SPMS Director of Clinical Development.

2.6 Data collection and analysis

Workshop data was collected through individual participant workbooks and whole group comments were written down on easel paper during the plenary sessions. A systematic manual analysis was undertaken by the reviewer using Microsoft Excel. Similarly, the questionnaire data was collated into Microsoft Excel and descriptive statistics and graphical output was developed which was then manually analysed.

For both the workbooks and the questionnaires statistical analysis beyond descriptive statistics was felt to be inappropriate, and potentially misleading, given the self-selected nature of the respondent sample and the significant number of non-respondents. However, reasonably robust conclusions can be drawn given the range of datasets analysed.

2.7 Rigour

As respondents were asked for their personal perspectives and selected themselves, there was a potential for both recall bias and the Hawthorne effect, the desire to present a more positive picture than respondents actually felt. Recall bias is difficult to eradicate however given that the SPMS was only 12-18 months old there was a strong likelihood that participant's recall was good. As for the Hawthorne effect (or a potential anti-Hawthorne effect), the analysis scrutinised the way respondents answered individual questions and the questionnaire as a whole. While there were a few examples where respondents seemed to be presenting a wholly positive picture - by consistently ticking items as good or very good across all question items - which was at odds with the majority of respondents, these have not biased the overall results of the questionnaire findings.

Given the complexity of the concepts and issues that participant's were asked to comment on for example risk, quality, equity and conflicts of interest there is

a strong potential for a lack of face validity i.e. that the respondents viewed these concepts and issues in such different ways that the aggregated answers were meaningless and not valid. This issue was raised by one of the respondent's to the questionnaire.

"This questionnaire is really badly designed. Lots of sections where I didn't understand the questions, this questionnaire does not have face validity."

This is a valid concern but the fact that the respondent did complete the questionnaire does show that while there may not be complete congruence between each of the respondent's understandings of key concepts, such as quality and equity, there is likely to be a significant overlap given that the majority of respondents have worked in the Hounslow health economy for many years and have been hearing, reading and discussing these issues in the context of their work.

A second point highlighted by another respondent was the lack of knowledge about other SPMS services and hence an inability to answer, appropriately or fully, the state of the SPMS as a whole.

"Question[s] in this paper not relevant as one does not know in detail how other SPMS are doing."

This again is a valid point each respondent is describing their experience of their service and the SPMS and other services they have come into contact with but what we are interested in is not the individual answers but what these answers tell us as a whole. When aggregated these collective responses provide a rounded picture of most aspect of the SPMS and how it has worked.

Finally, the use of a range of data sources including a workshop, questionnaire, informal interviews, and analysis of routine data ensured that the overall findings of the review are as rigorous and robust as possible given the time and data constraints. Similarly, attendance and presentations at SPMS steering group and Professional Executive Committee meetings; a review progress meeting and the feedback of comments on the draft review

report by the SPMS steering group ensured that reviewer bias in terms of misinterpretation and over-interpretation of the data was also reduced. An internal quality check on the report was also undertaken by a senior colleague within Peter Brett Associates.

2.8 Ethics

Each workshop workbook and questionnaire had a front page coversheet that provided all the key details of the review as well as the voluntary, anonymous and confidential nature of respondent's answers to them. This ensured that though signed informed consent was not taken, all the participants who responded to the workbooks and the questionnaires were fully informed about both the nature and purpose of the review.

Workbooks were taken by the reviewer at the end of the workshop and respondents had the opportunity to send their questionnaire directly to the reviewer by post, fax and email.

All workbooks and questionnaires were collated, read and analysed solely the reviewer.

All findings including personal comments written in the workbooks and questionnaires were vetted to ensure that they were anonymous and did not identify particular individuals either as authors or as the subject of comments made by respondents.

2.9 Summary

Given the short timescales, significant data constraints, and the need to undertake a rapid review of the SPMS to inform and support future decision-making the review attempted to use the best methods available to enable a fully rounded and robust picture of the strengths and weaknesses of the SPMS during its first year to emerge.

3. Background to SPMS

3.1 Introduction

In this chapter, the key background statements with regard to the SPMS, its rationale and the context within which it was developed are presented.

Four key documents were reviewed: the proposal for the SPMS; the SPMS – Hounslow paper; the MedEconomic article; and the SPMS – proposed working arrangements report.

All the statements presented in the following sections, apart from those in this introduction and the summary, are taken directly and verbatim - without interpretation on the part of the reviewer - from the original source documents as provided to the reviewer.

The key points to note are that the objectives of the SPMS were to develop more innovative solutions to delivering local primary care services; to separate the commissioner and provider functions of the PCT; to create a new and more integrated primary care provider and to do all this in a cost-effective manner.

The SPMS, in its final form, had the following services: seven general practices, family planning, night nursing, phlebotomy, central booking, the referral management centre and the SAFE project.

3.2 Proposal to develop a Specialist PMS in Hounslow (Paper 3B - February 2004)

The Specialist Personal Medical Services (SPMS) was conceived as

"…an innovative and holistic solution which will equip the PCT to improve the delivery of primary care in the near future and beyond. The solution needs to incorporate a long term vision with an interim solution to some immediate problems."

It was a response to three key factors[3]:

1. The concern that a single high cost monopoly provider of Out of Hours Services would emerge as GPs exercised their right to opt out of the responsibility to provide Out of Hours Services from December 2004.

2. The fact that the PCT was managing eight[4] general practices under PMS contracts, a much higher average than other PCTs, and blurring the boundaries between commissioning and providing.

3. The fact that the PCT was providing staff to a number of general practices again confusing the commissioning/regulatory role with the provider/ employment agency role.

"Twelve principles underpinned the development of the SPMS

a) Unscheduled care to develop in an integrated fashion, including:

   i. NHS Direct;
   ii. OOH services;
   iii. The communications hub for the sector (managed by Harmoni co-operative);
   iv. GP care;
   v. London Ambulance Service including the emergency care practitioner scheme;

[3] At the time the PCT made the decision there were two out of hours providers and this was so up till 30 December 2004.
[4] There were in fact nine practices managed by the PCT however the proposal document mentions eight practices; seven of which came into the SPMS.

vi. Accident & Emergency and other acute provision;
vii. Intermediate care provision including RADIATE;
viii. Social Services provision;
ix. Night Nursing service;
x. Voluntary sector care;
xi. Other services which support accident prevention; health promotion; self managed care and patients information provision.

b) Clear leadership for the development of high quality integrated unscheduled care.

c) Services to be developed in line with the Carson report standards and in a fashion complementary to the agreed model within the North West London Sector for Out Of Hours service development.

d) Services to be patient-centred and ensure that their wider needs – for information, explanation, support etc – are met through a co-ordinated multi-agency approach.

e) Wherever possible, patients are to be seen in a primary/community setting with referral to more specialist services as appropriate.

f) Access to the services to be quick, local and equitable.

g) Information on patient diagnoses and treatment to be shared by the relevant health professionals as appropriate; for example to the patient's GP, and the infrastructure to be in place to support this.

h) Services to be cost-effective with the need for clear leadership being complemented with a partnership approach to minimise financial risk.

i) Clear accountabilities without conflict of interest to be developed.

j) Establish ways of working which can increase opportunities for the future to improve services.

k) Enable the market to be opened to allow for better patient choice in line with the national direction.

l) Common standards and service requirements for all OOH providers in Hounslow, including those which may be commissioned by opting in GPs."

The SPMS represented:

"…a unique opportunity…to establish a Specialist SPMS to deliver a range of services which would be sensibly linked to enable improved co-ordination and support whilst reducing conflicts of interest and boundary blurring across the PCT and practices."

The unique set of circumstances that allowed this opportunity to be available were:

1. Already commissioned GP "safety net" booked appointments on the WMUH site.
2. A well developed primary care provider function within the PCT.
3. A high standard of Out of Hours services.
4. The need to develop unscheduled care services within the primary care setting.
5. A PCT run night nursing service which can be developed to provide home visiting for unscheduled care.
6. The opportunity to develop emergency care practitioner services with London Ambulance Service.
7. The opportunity to set common standards and requirements for all out of hours service providers.

8. A LIFT partnership about to be formed.

Five services that could be provided within the SPMS were identified;

1. Coordination and provision of out of hours services and a lead role in developing and co-ordinating the provision of integrated unscheduled care on a 24/7 basis.

2. The emergency care practitioner service being developed by the London Ambulance Service playing a central role in the service and complemented by an emergency walk-in centre.

3. The existing provision of primary care services managed by the PCT.

4. The 'employment agency' function of the PCT.

5. Partnership link to the LIFT partner, Building Better Health, West London.

The proposal describes the implications for commissioning primary care in the following way:

"The nGMSc requires PCTs to have a clearer commissioning role regarding primary care… The challenge has been set for senior managers and clinicians in PCTs to establish how services should be commissioned across the primary/secondary sectors and to shift resources to enable services to be developed in a more appropriate, patient centred, local and cost effective manner.

"The commissioning of primary care needs to be delivered through the commissioning function of the PCT and the providing of primary care needs to be delivered through a function which is at "arms-length" in order to reduce conflict of interest, develop a consistent approach to all primary care providers and to enable a more open market approach to develop."

"The commissioning of care needs to focus in particular on:

- Identifying services to be commissioned.
- Commissioning these services.
- Identifying where there is need for new primary medical services.
- Advertising for Greenfield (new) primary care sites and brownfield (existing practices becoming vacant) sites.
- Setting standards for primary care contractors and monitoring their achievement.
- Issuing notification of contract breaches to contractors as appropriate.
- Quality monitoring of clinical care and performance monitoring clinical care."

"PCTs are expected to strengthen their primary care commissioning function to "open up the market" so as not to be constrained in primary care development by existing providers who may not wish to use the opportunities for growth and development being made available. In doing so, this leaves a PCT managing a number of practices more open to being accused of conflict of interest. The DoH does recommend that PCTs establish PCT Medical Services (PCTMS) practices in order to, for example, ensure there are always some lists open for patients. The DoH does not, however, want to see primary care "nationalised" with PCTs providing all the local medical services as this would not "open up the market". By developing an "arm's length" Specialist PMS to provide the PCT PMS alongside other services there would be the opportunity to reduce this conflict of interest and still open the market".

3.3 SPMS – Hounslow Paper (September 2004)

"Many PCTs were feeling frustrated in the last couple of years in that they wanted to develop PMS practices which could provide services to patients of other practices as well as their own such as intermediate care services but the old PMS regulations prevented this. An SPMS contract allows a provider to provide a personal medical service to patients from beyond a registered practice list."

The real opportunities with SPMS include more innovative solutions to local problems, especially where the current service providers are unable or unwilling to deliver them.

"Hounslow PCT is in a unique position in that it has developed a primary care provider function within the PCT to a point beyond most PCTs and to a point where it has a conflict of interest within the PCT in terms of being commissioner and supporter of local primary care as well as a significant provider."

"By choosing an SPMS contract we could integrate the primary care services we run into one single provider, bringing together the 7 practices, the salaried professionals' scheme, OOH services and some other PCT run services which we see as primary care or naturally falling into the SPMS such as family planning services, phlebotomy and night nursing."

"The arrangement is to be at arms length from the PCT so the staff will be employed by the PCT and seconded into the arms length entity: the SPMS."

"This allows the PCT to have a strong partnership with Harmoni to build a robust primary care provider in Hounslow to enable more rapid growth of primary care in the area – something still badly needed with list sizes much higher than average. The scheme will enable positive collaboration with local GPs to provide more services traditionally provided in secondary care by

having a strong primary care provider able to play a key role in kick starting negotiations."

"…there is considerable interest in establishing it as a membership mutual."

"As well as continuing to provide the award [winning] salaried professionals scheme we aim for the SPMS to:

Provide gold standard General Practice

Integrated out of hours services based round Harmoni GPs and the SPMS night nursing service.

Family Planning and an innovative young peoples' health improvement project SAFE."

3.4 MedEconomics Article (October 2004)

This article was written by Hounslow PCT explaining the rationale behind the SPMS.

"Integral to the Hounslow SPMS is a new NHS organisation that will provide general practice services at vacant practices and deliver out-of-hours services across the PCT to opted-out GP's patients."

"PCTs with several gaps to fill may follow Hounslow's example by setting up a catch-all SPMS organisation."

"Hounslow SPMS will take over five vacancy practices that the PCT is already running and staffing. As well as the out-of-hours service for opted-out GPs' patients, the SPMS scheme will provide an urgent care centre based at West Middlesex University Hospital A&E"

"The advantage of SPMS over APMS is keeping service provision within the NHS. Hounslow SPMS activities will be commissioned by PCT staff; frontline

clinical services switching to SPMS will also be delivered by NHS professionals."

"Most practices were solo or small and had outdated premises. Consequently the PCT encountered severe problems recruiting independent contractor GPs."

"Hounslow PCT is in a unique position, as a commissioner, supporter and provider of primary care, it had developed the PCT's primary care provider function beyond most PCTs and to a point where it had a conflict of interest."

"…the PCT currently hosts a salaried professional scheme...an employment agency, only better. It arose because practices had difficulties recruiting and retaining these groups of staff to the capacity and calibre needed."

"As to what happens after two years…a review of the operation will probably take place after 18 months. By then, who knows what type of organisation it may have become? We will not be able to make decisions about the longer term until we get to that point."

"The options being considered are a non profit-making company limited by guarantee, an industrial provident society (also non profit making) and a community interest company."

"The SPMS needs to be cost-neutral; there is no increase to the PCT's recurrent allocation and no pump-priming cash."

"The new body will have an SPMS contract with the PCT, managed by the PCT commissioning directorate, in a partnership between Harmoni Ltd (a company owned by the co-operative) and Hounslow PCT.

3.5 SPMS – Proposed working arrangements report (April 2005)

"Whilst it is recognised that the SPMS is, in reality a contractual arrangement it has become widely used in Hounslow as the term to describe the organisation that manages the group of practices and other primary care and community services…"

"The recommendation is that the organisation remains part of the PCT but is established with its own management structure and decision making powers within the PCT. Whilst it is envisaged that in the longer term the SPMS could become an independent entity and this paper highlights a number of areas of weakness in remaining part of the PCT…"

"We believe that the arrangements proposed allow:

- The PCT to focus largely on commissioning of healthcare and management of the overall heath community.
- The SPMS to focus on improving effectiveness and efficiency whilst improving the working practice and service that it offers to patients.
- Sufficient control for good managers at the heart of the SPMS to rein in overspend whilst continuing to develop and integrate the services and operations of all the components being placed within the SPMS thereby improving the performance of the organisation in meeting patients' needs."

"Two workshops and a number of interviews and discussions were held in 2004 to discuss the options for the SPMS. The first workshop involved staff from different areas of the SPMS. The second was with the SPMS Project Team. Interviews were held with key people in the SPMS and PCT. Participants were invited to identify issues and strengths with the current and SPMS arrangements."

The issues and strengths stated in the *Proposed Working Arrangements Report* that were identified in the consultation workshop in early 2005 were;

Issues:

Too many people – changing staff and roles

- Too many teams and managers. Difficult to know what different people do and who they are. Too many mana[gers][5].
- Middle grade PCT staff – rate of change

Flexibility of working arrangements

- Development of portfolio careers
- Flexible working

Poor interface with PCT, poor quality staff

- Poor interface with PCT staff
- PCT staff – poor quality
- Poor management support
- What is the Trust doing to retain staff
- Lack of communication between managers

IT systems

- No communication network – N3

Size of practice

- Too small, single-handed

Confusion over what the SPMS means & implications of GMS/QoF

- Confused understanding of what SPMS means
- QAF – enormous task and no clear guidelines
- Too little information about GMS contract

[5] Items in square brackets [ ] have been added as words were cut off from the original document.

- Lack of vision for SPMS from the PCT

Financial deficit, financial management, conflict between need to save money and inve[stment]

- All SPMS practices should be treated equally
- Hidden agenda to save money, yet almost all practices need real investment
- Worry over financial deficit and what it means for us – will deficit be reduced by taking a pound of flesh from fro[ntline]
- Budget in view of rapidly growing list – how will it be relieved
- Lack of time/equipment
- Having to work harder to stand still – baseline budget includes QuOF aspiration money
- Cut to practice budget

PCT procedural mind-set rather than problem-solving

- Slow in implementation
- Procedure based rather than problem solving (in PCT)
- Slowness of response in recruiting GPs receptionists

Buildings and facilities

- Lack of room/space especially consulting rooms
- Premises need expansion to meet predicted population growth
- Very leaky building
- Very poor accommodation limits scope
- Building – lack of space

Too few staff in practices

- Lack of reception and admin staff
- Language barrier – shortage of interpreters

- We have been waiting for months for a receptionist

Quality of care not understood

- No appreciation of what quality of care is and how long it takes to provide it

Local autonomy

- Potential loss of practice autonomy and practice manager support

Strengths:

Good teamwork within the practice

- Loyal close-knit, efficient practice team
- Motivated and interested staff/workforce
- Good team-work
- Providing service in NHS framework at point of care. Teamwork to achieve the targets
- Integrated care, nurse led clinics, diabetes, asthma, tissues viability, referral system based on practice team [working together]
- Good communication within surgery staff
- Good team-work

IT systems

- In house part time IT manager delivered path link, coding, scanning, NHS net all in 6 months

Good cross practice support for GPs and staff

- Clinical supervision
- SPMS manager support
- Peer group support for salaried GPs
- Education, personal development opportunities and protected times

Secure permanent contract for staff

- Permanent contract for staff and GPs

Buildings and facilities

- The building that I work in is nice

Table 3.1 shows the key values that staff involved in the consultation thought that the SPMS should uphold.

3.6 Summary

This chapter presented the background context to the SPMS. It highlights the drivers that led to the creation of the SPMS and the various objectives that could be achieved through creating the SPMS.

As stated in the introduction the three key reasons that the SPMS was created were: to develop more innovative solutions to delivering local primary care services; to separate the commissioner and provider functions of the PCT; and create a new primary care provider.

There were a range of reasons as to why the SPMS was judged to be required and a range of objectives that the SPMS was seen to be able to deliver.

The development of the SPMS also included some consultation with staff that highlighted a number of existing strengths of the services that were proposed to become part of the SPMS and some concerns about the implications of the SPMS.

A detailed analysis of these documents is undertaken in Chapter 9.

Table 3.1 Values identified in the workshop, interviews and discussions undertaken in early 2005 presented in Appendix 3 the Hounslow SPMS 'Proposed Working Arrangements' document prepared by the SPMS Team in April 2005 (the categories have been created by the reviewer but the phrases are from the original results)

Organisation-focussed	Staff-focussed	Patient-focussed
• Quality managers • Mechanisms to implement agreed recommendations • Accountability – responsibility for services provided is clarified • Clarity of resources and ring fencing • Ownership and delivery • Efficient • Clinical governance • Deliver of goals • Problem solving • Open – support/environment • Local empowerment • Multidisciplinary team working and training • Professional boundaries • Leading not following • Taking risks before the risks take you • Getting clinicians and managers to buy into the same set of goals • Clarity of purpose • Autonomous financial decision making. • Open communication • Clear mission statement/philosophy • Organic organisation • Financially secure	• Communication • Flexibility • Capacity for services • Incentives to encourage work especially OOH • Autonomy to make decisions in practice – option to opt-out • What are the benefits, clearly defined, of being part of SPMS • Cross cover within practices – incentives • Computer literacy • Reward for results – not length of service • Opportunity at individual, team and organisational level • Caring (staff and services) • Clarity of roles • Supportive of staff development	• Responsiveness to patients • Efficient and effective • Quality • High Standards • Caring (staff and services) • Listening – response to local community • Creative, inventive ways to deliver healthcare to reach population/community

4. Policy Context

4.1 Introduction

This chapter summarises the key national and local policy documents that are relevant to the SPMS.

All the statements presented in the following sections, apart from those in this introduction and the summary, are taken directly and verbatim - without interpretation on the part of the reviewer - from national and local policy documents.

Key points of note at national level are:

- the requirement that PCTs meet a set of strict criteria to enable them to become patient-led and commissioning-led NHS organisations;
- the need to increase contestability and develop a wider choice of providers for patients; and
- the need for PCTs to provide comprehensive coverage of practice-based commissioning.

Key points of note at local level are:

- the significant financial deficit;
- the need to obtain greater efficiency and effectiveness of services;
- the need to increase prevention, assessment and treatment activities in primary care and community settings; and
- the need to reduce inappropriate referrals to hospital.

4.2 National context (Extracts from *Commissioning a patient-led NHS*)

Commissioning a patient-led NHS will require:

- Better engagement with local clinicians in the design of services.
- Faster, universal roll-out of Practice-Based Commissioning.
- Developing PCTs to support Practice-Based Commissioning, and take on the responsibility for performance management through contracts with all providers, including those in the independent sector.
- Improvements in commissioning, the determination to make progress on working with Local Authorities on *Choosing Health*, and the commitment to make £250 million of savings in overhead costs, require NHS organisations to change and develop.
- These changes in functions will mean that the NHS will want to reconsider the optimal configuration of PCTs, and where appropriate Care Trusts, and SHAs and their fitness for purpose. This will be done alongside the reform in the provision of ambulance services described in *Taking Healthcare to the Patient*.
- The pace of change will be for local consideration and consultation. However, the Department expects that PCTs will make arrangements for universal coverage of Practice-Based Commissioning to be in place by December 2006, that PCT changes will be in place by October 2006 and that SHA changes will be complete by April 2007. Changes in PCT service provision will be complete by December 2008. Some areas may choose to go faster. However, the Department will not approve proposals for restructuring unless proposals satisfy the criteria set out in *Commissioning a patient-led NHS*.
- The purpose of these changes is to see improvements in health and in services. Reconfiguration is not an end in itself. This process is about

ensuring organisations are properly configured and fully prepared for their new role. The Government's main priorities remain the delivery of Public Service Agreements (PSA) targets for this year and looking forward to 2008; and effective implementation of a patient-led NHS, so that improvement becomes embedded in the fabric of the NHS.

- It is important that as we make these changes we support the people who will be affected and ensure continuity of service for the public.

The programme of developing the commissioning process falls into two stages:

- The first stage is about getting the right configuration for commissioning and the right people in the right places. This will involve a review, coordinated by the SHAs and engaging PCTs, and other stakeholders including local government and NHS staff.
- The second stage is about enhancing the ability of Practices, PCTs and SHAs to do their job.
- Proposals will be assessed against the following criteria of the PCT's ability to:
    - secure high quality, safe services;
    - improve health and reduce inequalities;
    - improve the engagement of GPs and rollout of Practice-Based Commissioning with demonstrable practice support;
    - improve public involvement;
    - improve commissioning and effective use of resources;
    - manage financial balance and risk;

- improve coordination with social services through greater congruence of PCT and Local Government boundaries; and
- deliver at least 15% reduction in management and administrative costs.

- Most PCTs currently provide services. As PCTs focus on promoting health and commissioning services, arrangements should be made to secure services from a range of providers – rather than just through direct provision by the PCT. This will bring a degree of contestability to community-based services, with a greater variety of service offerings and responsiveness to patient needs.
- In some types of services, there may be a range of providers – for instance, in the voluntary sector – already able to deliver. In other areas, no obvious alternative providers may exist. One of the purposes of the forthcoming consultation and White Paper on health and care services outside hospital will be to consider how to develop a wider variety of local services and models of provision in response to patient needs.
- The White Paper will undoubtedly explore different service models. This may mean that SHAs and PCTs will want to refine these proposals on service provision. However, the direction of travel is clear: PCTs will become patient-led and commissioning-led organisations with their role in provision reduced to a minimum.
- The second stage is about identifying the development support that organisations will need to be successful in future.
- This second stage will focus on internal capacity and capability to discharge new functions, and particularly leadership ability. It will be as rigorous as that for NHS Trusts applying for NHS Foundation Trust status where strengthening the composition of Boards and improving governance

systems have featured strongly. It should also learn from the experience of local government as it has developed its role as a commissioner of social services.

- As part of this process, PCTs and SHAs across the country will undergo an independent diagnostic and benchmarking assessment, which will ensure that the resultant development programme will be appropriately targeted and consistently applied.

Practice-Based Commissioning

- The Government is committed to Practice-Based Commissioning as a way of devolving power to local doctors and nurses to improve patient care. It is also a way of aligning local clinical and financial responsibilities.

- Under Practice-Based Commissioning, GP practices will take responsibility from their PCTs for commissioning services that meet the health needs of their local population. Commissioning practices, or groups of practices will have the following main functions:

    - designing improved patient pathways;

    - working in partnership with PCTs to create community based services that are more convenient for patients;

    - responsibility for a budget delegated from the PCT, which covers acute, community and emergency care; and

    - managing the budget effectively.

- Under Practice-Based Commissioning GPs will not be responsible for placing and managing contracts. That will be done by PCTs on behalf of practice groups, with back office functions including payment administered by regional/national hubs. GP Practices will also receive management

support, the size of which will be dependent on the numbers of practices involved.

- There is a strong desire in general practice to make rapid progress in rolling out Practice-Based Commissioning more rapidly. In line with this desire, and given the strategic importance of commissioning to the system reform agenda, the Department can confirm that it expects to see PCTs make arrangements for 100% coverage of Practice-Based Commissioning by no later than the end of 2006. Individual practices will have the option to take on commissioning to a greater or lesser extent depending on their wishes and their capabilities.

Primary Care Trusts

- PCTs will ensure access and choice to a range of high quality health services and ensure that the Government's commitments to health, reducing health inequalities and health services are delivered for local people.

- As custodians of their population's health budget, they are responsible for ensuring prioritisation and value for money in ways which have maximum impact on health and secure all necessary health services.

- Their functions, which can be provided by external agencies, partners and consortia working on their behalf, will remain as follows:

    - improving the health of the community and reducing health inequalities;

    - securing the provision of safe, high quality services;

    - contract management on behalf of their practices and public;

- engaging with local people and other local service providers to ensure patient views are properly heard and coherent access to integrated health and social care services is provided;
- acting as provider of services only where it is not possible to have separate commissioning from provider management; and
- emergency planning.

- As proposed in paragraph 3.20 of Creating a Patient-led NHS, the need for PCTs to be involved in contract negotiation will be reduced by the development of national and regional standard contracts, with the ability to tailor locally. This will allow them to focus on health improvement and securing high quality services and reduce costs.

4.3 Local context (*Extracts from Hounslow Health Delivery Plan*)

The statements below are direct quotations from the Hounslow Health Delivery Plan. The Plan uses the term 'we' to talk about the Hounslow health community as a whole.

- The situation of the whole health economy is extremely serious. At the end of 2004/05 the Primary Care Trust is facing an end of year deficit of £6.5 m; WMUH is forecasting a deficit of £5.6m; West London Mental Health Trust a deficit of £1.5m; Ashford& St Peter's £3m; and Hammersmith Hospitals £3.5m.

- 2005/06 is therefore going to be particularly difficult, with a massive increase in our expected debt repayments along with the withdrawal of the final elements of our recent support. The Primary Care Trust is being asked to deliver services within its target funding at a time when significant inefficiencies across the wider health economy have still to be addressed fully. If we are unable to achieve an in-year balance, our debts in 2006/07

will mean that the additional funds available will still not be sufficient to repay these debts.

- We have some prospect of achieving recurrent balance and paying off our debts in 2007/08, but only if we are able to achieve reductions in hospital activity. In the meanwhile, we are unable to put additional cash into delivering priorities. In this context steady improvement is not enough, we need to implement radical change, and swiftly.

- To achieve [our targets and financial recovery] we must concentrate our efforts on:

    - obtaining greater efficiency and effectiveness across all services, ensuring that services are available to those who need them;

    - increasing prevention, assessment, treatment and care in primary and community settings; and

    - reducing the flow of activity to hospitals.

- We need to ensure that we allocate the resources we have towards delivering these programmes, and not dissipate the energies of our staff nor our limited funds too widely, expounding much energy to little effect. We need to speed up our efforts in certain areas, which may mean slowing down in others. This will mean that some of the national priority areas and local targets will not be achieved within the set timescale.

- The PCT has established a savings plan across all parts of the organisation, including our clinical services, clinical development, public health, information, finance, human resources and corporate affairs. The savings plan for these areas is covered elsewhere. However, savings in these areas alone cannot deliver financial balance. The main area for action is in the commissioning of external services, where 70% of the PCT's budget is spent.

- Better preventative and long term care should reduce the demand for planned and emergency care. But in order to invest in preventative care and long term care we need to release funds from planned and emergency hospital care…the government's policy initiatives should enable us to do this, if we use them appropriately and get them to work together in the right way. Getting it wrong, however, means we end up with double costs – not acceptable in our current financial position.

- A Primary Care Infrastructure Strategy is being prepared which brings together our programmes of investment in primary and community care to ensure that they maximise the capacity of these services and contribute to the achievement of reduced hospital activity. The strategy encompasses the development of estates, workforce and information technology and investment in enhanced services in primary care.

- One factor in Hounslow's slow pace of delivery is the continuing weaknesses in primary care infrastructure. Of our 62 practices many are working in substandard accommodation and/or have low levels of staffing within their practice teams. However, the latest QuOF (Quality and Outcome Framework) assessments show a high standard of service delivery, in spite of these barriers, and this bodes well for the future. We need to continue to drive up standards.

- Our LIFT programme will deliver considerable improvements for practices involved. However, some of these are not due to be completed until 2007/2008 so the impact will be gradual. The programme also represents a major financial risk, since the revenue costs of services provided in better buildings increases. We will need to ensure that we are using our new premises effectively.

- The National Programme for Information Technology (NpfIT) is crucial for the effective delivery of these programmes. Unfortunately it has been delayed and we are constantly having to review the impact of these delays

on delivery of both specific indicators and the wider infrastructure to deliver the changes set out above.

- We face considerable workforce challenges in Hounslow – there is low unemployment and a high cost of living here which militates against recruitment and retention. In addition our historically low staffing levels and high caseloads cannot compete with our more affluent neighbours in Richmond and Surrey. In order to deliver the changes highlighted above our service providers need to be able to recruit and retain staff, in particular staff from the local community who can provide a more responsive staff to our diverse population. We need to take a whole system approach to workforce planning and training and development.

- The new General Medical Services contract provided for the investment of funds in Local Enhanced Services to enable primary care (GPs and pharmacies) to provide a wider range of services, thus reducing referrals to hospital. However, no additional funds were provided to do this, so the mechanism relies on the transfer of funds from the acute sector. We will ensure that we link this to the wider programme of work to direct the limited resources available to those areas which make a significant contribution to national or local priorities.

- We will also ensure that our implementation of the new Pharmacy Contract fully engages local pharmacists in the programme of work. There is enormous potential to develop more effective prescribing for the benefit of both individual patients and the wider health economy.

- Over the last few years both self-referrals (people arriving at A&E) and GP referrals to hospital have increased. While this is a national trend it is replicated in Hounslow. This has coincided with (and may be partly the result of) the steady reduction in waiting times for A&E, outpatients and inpatients.

- Although progress has been made in a number of areas, there is still much to do. Weaknesses which have contributed to this are a lack of top level engagement (clinical and managerial); a lack of ownership by the clinicians (both primary and secondary care); a lack of defined targets and milestones; a lack of information to establish baselines and monitor progress and a lack of intensive project management capacity to drive them forward.

- We need to be clear of our baseline and of past trends and future prospects, we need to set ourselves specific targets and timescales for implementation and have top level commitment to deliver. We need to set our targets for delivery of a reduction in hospital activity in partnership with local GPs and other parts of the whole system as we will only achieve the reduction by working together.

- To address these weaknesses and drive forward our plans we have brought our work together under the oversight of five high level, whole system, groups: the Preventative Care Group; the Planned Care Strategy Group; the Urgent Care Network; the Long Term Care Strategy Group; the Infrastructure Group.

- Ultimately, however, if no external assistance can be found, the Primary Care Trust will have to scale down further the healthcare which we commission and deliver in order to achieve financial balance. In doing this we will have to revise our plans in each of the areas identified above, either stopping or slowing down, and in the process we cannot expect to meet the targets set. We will spell out clearly what we are not able to do, to ensure that the issues do not get lost, nor the timetable slip too far. We will report regularly both on performance against national targets and delivery of financial balance.

- Preparing the [Hounslow Health Delivery] Plan is only the first step in delivering improved health. Implementation is what counts, and we need to

make sure that everyone owns the plan and knows their role in implementation. We will be developing a business plan for the Primary Care Trust, and feeding into the business plans of our provider services and partners, to ensure that the action identified is taken forward by all those involved.

4.4 Summary

There are significant challenges facing Hounslow PCT and the wider Hounslow health economy in achieving local and national objectives and priorities.

Progress is being made in the delivery of these objectives and priorities though the pace of change could be seen as slow.

Strategic planning has taken place that provides a vision, direction and clear statement of intent for the next three years. This identifies key strengths and weaknesses within the Hounslow health system and outlines a plan for building on the strengths and addressing the weaknesses.

The options for the future of the SPMS in Chapter 11 are discussed within this local and national context.

5. Evidence Base

5.1 Introduction

This review did not find any research or evaluation literature on SPMSs. Therefore a focussed and limited literature review on the effectiveness of primary-care led commissioning and other newer forms of primary care service delivery and commissioning was undertaken.

All the statements presented in the following sections, apart from those in this introduction and the summary, are taken directly and verbatim without interpretation on the part of the reviewer from the research reports identified as relevant. The only exception to this is the bold highlighting of certain statements that the reviewer judged particularly noteworthy.

This chapter describes the key conclusions of a number of relevant pieces of research over the last three years by the Health Foundation, Kings Fund and National Economic Research Associates (NERA) Economic Consulting.

This research shows that:

- Re-structuring and reconfiguring primary care is a complex process that generates both intended and unintended consequences.
- Innovation, improved responsiveness and enhanced quality of care can be achieved but costs tend to rise.
- Choice, contestability and competition can occur but these are likely to work against efficiency, cost containment, cooperation and integration.

- Where models for improving quality and reducing cost have been piloted they have shown improvements in quality and widespread practitioner acceptance but little or no evidence of cost effectiveness.

- General practice is likely to be the best driver for improved quality at reduced cost, given its high levels of general patient satisfaction and historical experience of balancing cost and quality, however the take-up of practice-based commissioning especially where PCT's have deficits is likely to difficult to implement fully or effectively.

- The creation of a market of primary care providers where there is enough spare capacity likely to generate competition is likely to be difficult to achieve in the short to medium term.

5.2 Review of the effectiveness of primary care-led commissioning and its place in the NHS[6]

Key conclusions on the impact of commissioning were:

- There is little substantive research evidence to demonstrate that any commissioning approach has made significant or strategic impact on secondary care services.

- Primary care-led commissioning (where clinicians have a clear influence over budgets) can however secure improved responsiveness such as shorter waiting times for treatment and more information on patients' progress, as was seen within GP fundholding.

- There is research evidence to show that primary care-led commissioning made its greatest impact in primary and intermediate care, for example in developing a wider range of practice-based services, stimulating new

[6] Smith J, Mays N, Dixon J, et al; A review of the effectiveness of primary care-led commissioning and its place in the NHS; The Health Foundation; London; September 2004.

forms of peer review and quality assessment within and across practices, enabling new forms of specialist primary care, and building new community-based alternatives to hospital care.

- Given an opportunity to innovate, highly determined managers and clinicians are able to use their commissioning role to change longstanding working practices in the local health system, as demonstrated by many of the innovations secured by total purchasing projects.
- Primary care commissioners can effect change in prescribing practice, with financial incentives playing a key role, as demonstrated through GP commissioning and fundholding.
- Primary care-led commissioning increases transaction costs within commissioning.

Key conclusions on facilitating effective commissioning were:

- There is no 'ideal' size for a commissioning organisation – different population bases are needed for commissioning different services.
- Adequate levels of management support are vital to the success of commissioning, as was vividly demonstrated by the experience of total purchasing, where schemes with higher levels of support were seen to be more effective in terms of outcomes.
- Timely and accurate information is required for commissioning – NHS routine data could be exploited to a much greater degree as a source of analysis of patient flows and pathways.
- Real and meaningful clinical engagement in commissioning is crucial, the power of this is demonstrated by the experience of Bradford North

practice-based commissioning scheme, NHS Collaboratives and Independent Practitioner Associations (IPAs) of New Zealand.

- There is a careful balance to be struck between ensuring clinical engagement and assuring public and management accountability for commissioning decisions.
- Primary care-led commissioning organisations have struggled to engage patients and the public in a meaningful way.
- Local health commissioning/ funding bodies face a difficult challenge in enabling primary care-led commissioners to have the headroom to commission according to local as well as national priorities.
- Whilst commissioners need to have effective strategic relationships with providers, they also need to have the ability to shift activity elsewhere – 'contestable collaboration'.
- Commissioning organisations need a degree of stability in the wider policy context – they have never been given a sustained chance to prove their worth.
- A single organisational solution to commissioning is neither possible nor appropriate.

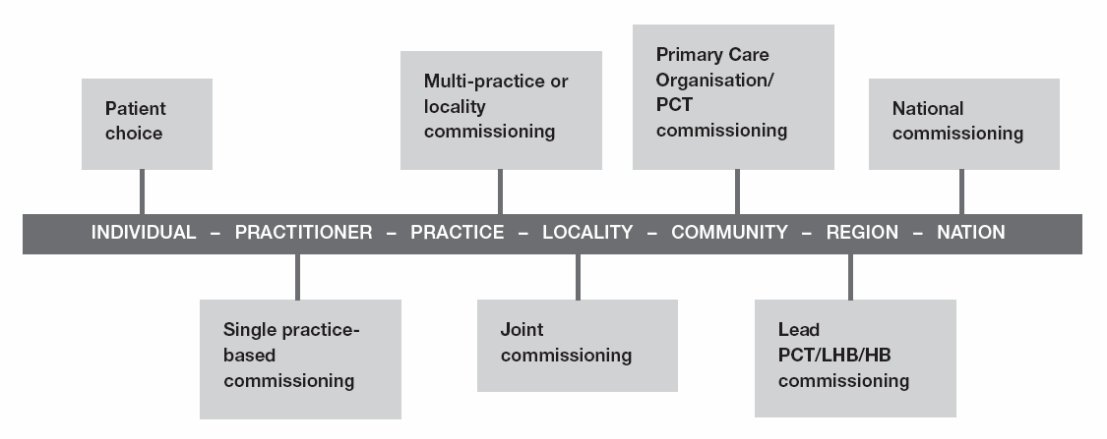
Key messages for policy makers and managers:

- There is little evidence to show that any primary care-led (or other) commissioning approach has made significant impact on the way hospital care is delivered, except in relation to waiting times for treatment. This challenges health funders and planners to find more powerful and sophisticated ways of exerting required changes from health providers.

- Primary care-led commissioning has been shown to be effective in the area of primary and intermediate care and in encouraging greater responsiveness in elective hospital services. There is significant potential to build on this experience of service development and innovation, this time within a stronger framework of public accountability and national health priorities.

- Primary care-led commissioning may be effective as part of a continuum of commissioning models [See Figure 5.1], and particularly appropriate for 'simple' and community-based chronic disease management and primary care services. Other models of commissioning are required for more specialised and complex services, including the development of more integrated forms of service provision based on managed care techniques and approaches together with care pathways. The challenge for funding organisations is rigorously to select an appropriate blend of approaches and to be clear about how, and for what reasons, that selection has been made.

Figure 5.1 The continuum of commissioning levels in the UK[7]



- There is a need for more systematic assessment of the impact of models of health commissioning, including the examination of their ability to achieve specific service and patient quality objectives which can be monitored in a rigorous manner.

- To achieve this, commissioning organisations need a degree of organisational stability. Providers have had relative stability for some 15 years whereas commissioners have been subject to numerous major imposed reorganisations.

- Commissioners need new and more advanced forms of support, in particular in developing a range of skills and competences such as the stratification of patients according to risk, commissioner-led advanced case management, predictive modelling of high user patients, handling and analysis of routine data, and more refined assessment of service quality and outcomes.

- Clinical engagement and the appropriate use of incentives are crucial to effective primary care-led commissioning and service development at all points along the commissioning continuum, and in particular within those approaches closest to the patients.

- The legitimacy and accountability of commissioning organisations needs to be made clear within whatever blend of models is applied within a health economy, and needs to be balanced with the necessary engagement of clinicians.

[7] Smith J, Mays N, Dixon J, et al; A review of the effectiveness of primary care-led commissioning and its place in the NHS; The Health Foundation; London; September 2004.

5.3 The future of primary care (NHS market futures series)[8]

- Primary care will be particularly central to any strategy to manage demand – something that is increasingly preoccupying the NHS as budgets run out despite record increases in resources. There are several reasons for this central position. The generalist role of the GP and the long-term relationships that are often formed with patients give the primary care team a unique view of the performance of the health system as a whole. In addition, the delivery of primary care is intimately related to the delivery of specialist services; what GPs and primary care teams do in their surgeries impacts on the role of and demand for hospital care. Therefore, the 'commissioning' of much hospital care is a reflection of the practice of primary care.

- Whatever the merits of this rapid and substantial programme of reform, it is clear that there are obvious strengths and weaknesses in primary care at present, which will have an impact on the degree to which the government is successful in its aims. With respect to provision, on the one hand, public satisfaction with family doctors and care by general practices is consistently high. Furthermore, GPs have recently achieved 92 percent of the wide range of quality targets under their contract. On the other hand, the quality of primary care (although on average high) is variable on a practice-by-practice basis, and quality has been poor, particularly in parts of some inner cities, for some decades. However, there have been only limited ways of identifying and addressing poor practice available to PCTs and their predecessor bodies.

- With respect to commissioning, the prevailing consensus is that this activity is underdeveloped in PCTs; this needs to change urgently if commissioners are going to provide an adequate counterweight to new incentives for acute and foundation trusts to admit patients (such as the new NHS 'payments by results' system) and for foundation trusts to meet

[8] Lewis R, Dixon J; NHS Market Futures: The Future of Primary Care; Kings Fund; 2005.

the exacting financial requirements set by Monitor (the independent regulator for NHS foundation trusts).

- New providers will increasingly enter the primary care market (under 'alternative provider medical services', 'specialist PMS' and the new GMS contracts). It seems likely that an increasing number will be from the independent sector or from NHS hospital or foundation trusts. Some will offer comprehensive care, whereas others ('third party providers') may offer only niche services such as chronic disease management or urgent and out-of-hours care services. Recent guidance has emphasised the requirement to offer contestable community health services and instructs PCTs to divest themselves of provider responsibilities in all but exceptional circumstances.

- The policy to encourage practices to hold budgets was developed partly to engage more clinicians in commissioning in the hope that they would contain health care costs. The ability of practices to hold commissioning budgets provides an opportunity for an expansion of community-based services. Practice-based commissioners (PBCs) will face the classic 'make or buy' business decision and may increasingly choose to provide services in-house (or contract with new providers) rather than continuing to refer to established hospitals. As in the past, commissioners currently face obstacles in transferring care out of hospital because only marginal, not full, costs are released by providers and there are only weak incentives for commissioners to seek to prevent avoidable admissions – for example, with respect to care of patients with long-term conditions. Both of these obstacles are likely to disappear once payments by results has been implemented across the NHS.

5.4 Commissioning in the NHS: challenges and opportunities[9]

Emergency and elective commissioning

- A significant challenge for commissioners is patients accessing emergency care unnecessarily. While routinely utilising A&E as a first point of contact with the health care system is universally regarded as inefficient, there are dangers that this may be increasing.

- Accessibility difficulties in primary care, in some areas exaggerated by perceived difficulties in accessing out-of-hours care following the introduction of the new GMS contract, together with significant improvements in A&E waiting times, are increasing the risk that a patient will access A&E directly. Further, the 4 hour A&E wait target, and Payment by Results incentives create both push and pull incentives for patients to be admitted following presentation at A&E, as hospitals risk being penalised for missing the 4 hour wait target but will be able to generate revenue as a result of admitting the patients. This has been demonstrated in sites where *Payment by Results* has been piloted, which have shown higher rates of short stay emergency admission.[10] This results in a situation that is inefficient and risks placing significant pressure on PCT emergency care budgets, but in a way over which commissioners have limited direct control.

- A related difficulty is the existence of patients who may be ill and require fairly intensive support, but may not be ill enough to require treatment in an acute setting. Again, *Payment by Results* provides incentives for providers to admit patients in such a category rather than seeking a more cost-effective setting for that care, as passing to an alternative provider would also pass on the revenue for the care of that patient.

[9] NERA Economic Consulating; Commissioning in the NHS: Challenges and opportunities; NERA Economic Consulting; 2005.
[10] Dr Foster's Case Notes; British Medical Journal; 12 March 2005.

- A Strategic Health Authority recently undertook a 5 day review of all patients admitted as emergencies and all patients that had occupied an acute bed for 5 days, against Interqual® criteria that assess the need for admission or occupancy of an acute bed.[11] This found that 35 per cent of admissions were inappropriate (in the sense that they could have been managed in a more appropriate and cost-effective setting if available) and that 60 per cent of patients with 5 day occupancy could have been discharged to a cheaper setting if available.

Choice

- One driver of the early stages of the choice programme may have been to place additional pressure on cutting waiting times. However, its lasting importance will be in the way it places the patient at the centre of the treatment decision. In a sense the patient is being given control of a significant part of the purchasing element of commissioning. Viewed in this way the effects of choice will be fundamental.

- Significant onus will be placed on providers to compete to attract patients. Since price will not form part of this purchasing decision, patient choices will reflect the dimensions of quality that patients find to be important. These could be clinical quality, timeliness of treatment or possibly other "patient experience" factors.

- Significant levers will be taken away from health service bodies that are undertaking commissioning. In particular, it will become very difficult to shape the volumes of care commissioned from different providers. In turn this could risk the financial instability of a provider even if the commissioner is relying on it for e.g. emergency services.

[11] The Interqual® criteria are evidence-based, widely used in the USA and authorised by Medicare there.

Practice-based commissioning

- Practice-based commissioning raises a number of difficult questions. These include how practice-level budgets will be set, and what allocation would be “fair”. Guidance suggests using historical norms and moving towards a fair-shares allocation, under which resources are allocated according to a formula reflecting population size and characteristics such as age that influence their need for health care. This is known as weight capitation.

- Other issues include the question of asymmetry in managing the practice budget. Individual practices will be allowed to reinvest savings from their budgets into developing services. PCTs will be responsible for overspends (although practices will be expected to balance the budget over a three year period and their right to hold the budget will be suspended if they fail to achieve this). PCTs will generally need to hold a topsliced contingency fund for such purposes, but this creates something of an imbalance in the incentives that practices face. Importantly, while budgets and the ability to reinvest savings may incentivise cost containment, it is less obvious how they incentivise the delivery of quality services.

- More broadly, there are questions about whether indicative budgets, against which savings can only be reallocated to other forms of patient care, will be enough of an incentive for practices to engage fully with practise-based commissioning. Given that there is no guarantee that savings will be achieved, there may be limited investment in the resources required to establish and manage practice-based commissioning (although reasonable administration costs can be met through indicative savings).

- Many other practice activities do carry direct financial incentives, such as those associated with the Quality and Outcomes Framework and this is reflected in the importance attached to achieving in these areas. Firm rather than indicative savings would provide stronger incentives and might

be required to ensure that practices fully engage with practice-based commissioning.

Some challenges

- On the one hand, practice-based commissioning provides genuine opportunity for commissioners to design new community-based service models. In particular, this may allow cost-effective and accessible care to be provided to the chronically ill, through the kinds of models described above.

- However, there are a number of possible drawbacks that may make it difficult to realise these benefits, namely that:

- Practices may be too small to establish and deliver such schemes on their own. Substantial investments in new facilities or services to allow such a transformation could need to be made in co-operation between several practices, and would likely require the involvement of the PCT and PEC.

- The full benefits of practice-based commissioning require competition and the availability of alternative providers. To be effective this could require some underutilised capacity in the system which may risk driving up costs and hence prices across the system as a whole although not specifically in that locality. This risks partially offsetting the incentives for efficiency in the new financial framework.

- Such competition may also make it more difficult for care to be delivered in a properly integrated fashion, since providers may seek to retain control of patients once they access the acute sector. In turn this risks bringing commissioners into conflict with providers, and raises issues about the circumstances in which it is desirable to split a tariff

between providers that are not vertically integrated but both deliver parts of a pathway.

- Practice-based commissioning will benefit from greater clinical engagement in commissioning and service redesign. However, this needs to be set against shortages in primary care treatment capacity in some localities and the benefits of using pathways that have been shown to represent evidence-based best practice. It may also be the case that incentives for efficiency, as opposed to responsiveness, would be greater if pathways were determined at a more strategic level. For example the effectiveness of service redesign at practice level may be compromised by the fact that the tariff for the hospital element of the pathway may remain at tariff, or only move in steps if and when the coded HRG changes, making it difficult for practices to benefit from certain changes in pathways.

- A further issue will also need to be addressed under practice-based commissioning is financing hospital care, and targeting the preventive care of any unregistered patients.

- Capacity management – there are difficulties associated with "managing the market". In particular if the choices of some commissioners for some services create financial difficulties for a provider that commissioners are relying on for other services there is a risk of instability. One popular approach is to develop a co-operative solution between commissioners and such a provider, perhaps brokered by a PCT. But in this case the need for co-operation across practices must again be acknowledged, and if a number of practices are unwilling to co-operate the solution may become unstable.

- Broader difficulties that commissioners face with the new financial framework relate to the prompt availability of data on activity in hospitals and the difficulty in ensuring the appropriateness of care that

is delivered, especially to emergency patients where the provider, broadly speaking, controls the decision. Reviewing the accuracy of data, to ensure that providers are not gaming the system is a task that is both difficult to undertake at a local level and likely to promote conflict with providers. In terms of planning services, information is also needed at practice level on demography, incidence and prevalence.

- It is straightforward to understand how some of the potential benefits of practice-based commissioning may be realised. It is intended to allow those closest to patients to design services that respond better to the needs of the locality, as well as incentivising cost-effective behaviour by referrers. It may also help by unifying responsibility for many elements of a practice's budget, facilitating improved resource allocation.

- However, it remains difficult to understand how pro-actively it is possible for a relatively small practice to engage in practice-based commissioning. Prioritising, budgeting, managing need, contracting and monitoring are all functions to which PCTs have devoted substantial dedicated resources. Clearly it will not be realistic for all of that work to be replicated in every practice, even if this can be helped somewhat through collaborative approaches such as buddying arrangements.

5.5 Summary

This chapter has presented the evidence and thinking to date on the present and future of primary care and primary care commissioning in particular.

The key points of note are that:

- There is little evidence for any model of primary care being able to deliver enhanced choice, quality and equity as well as reductions in costs.
- Radical change may be needed to deliver on the government's agenda but undertaking it will take considerable time particularly with regards to the creation of a market of providers.
- Practice-based commissioning will form an important part in creating a more responsive, effective and efficient primary care system but it is unlikely to deliver this on its own or in the short term.
- There are considerable resource and capacity issues that are likely to need addressing if commissioners are to move in the direction of a patient-led NHS.

6. Workshop findings

6.1 Introduction

The review workshop was attended by 45 participants ranging from doctors and nurses to allied health professionals and administrative staff from the SPMS services. Participants were grouped around seven tables and at the beginning of the workshop some context setting in terms of the policy drivers currently at work within Hounslow and the SPMS was undertaken.

In all, 36 workbooks were returned and the answers from these workbooks were used to create the rankings and options tables presented in this chapter. To aid the review process participants were each given a workbook so that they could write down their comments, issues and discussions concerning the key questions, posed during the workshop, directly into the workbooks (see Appendix). Participants also had the opportunity at the end of the workshop to explore the option that they were most interested in through a 'world café' session where they could form a group discussing in more depth one or other of the seven options for the future of the SPMS.

All the issues raised including the achievements and non-achievements, the aspects that worked well and did not work well, as well as the advantages and disadvantages of the options were developed by the participants themselves without prompting from the reviewer, facilitator or senior SPMS management.

The key findings are that the SPMS has achieved notable successes particularly with regard to training and development, recruitment and retention, internal team-working, patient care, development of new services and flexible working. However these have not been universal with recruitment and retention, in particular, also being an aspect that did not work well and was not achieved in some of the SPMS services. Of the aspects that were not achieved and did not work well finance (lack of and clarity of), premises and

facilities, recruitment and retention, responsive management, not being independent and external team-working between SPMS services are of note.

In terms of the options, participants saw the advantages and disadvantages of each of the options. Their top three options from the workbooks were becoming a troubleshooting and turn-around team; having the option of choosing when to become independent and letting the SPMS general practices become independent; and merging the remaining services with the PCT's existing clinical services. These were also the top three options identified in the 'world café' session though the order of the options is different with choosing when to become independent being first; the SPMS general practices becoming independent and the remaining SPMS services merging with the PCT's existing clinical services being second; and the SPMS as a turn-around troubleshooting team being third.

6.2 What was achieved by the SPMS and what aspects of the SPMS worked well?

The participants identified a range of different achievements of the SPMS and the aspects that worked well [See Table 6.1]. As participants did not always clearly separate or see the need to separate the achievements, as many achievements were also aspects that worked well, the aspects that worked well and the achievements have been grouped together. The major achievements and aspects that worked well can be placed into three categories: patient-centred; staff-centred and organisation-centred.

The patient centred achievements and aspects that worked well were: patient care, the development of new services, the commitment and hard work of staff, improvement in quality, extension of services and the out of hours service.

Table 6.1: The achievements of the SPMS and the aspects that worked well

Rank	Achievements of the SPMS and aspects that worked well	Number of respondents (out of 36)	Percentage (% out of 36)
1	Training and development	23	64%
2	Recruitment and retention	16	44%
3	Internal team-working – within their SPMS service area	13	36%
4	Patient care	11	31%
5	Development of new services	11	31%
6	Flexible working	10	28%
7	Commitment and hard work of staff	10	28%
8	External team-working – with other SPMS services	8	22%
9	Communication between staff	8	22%
10	Process change within their service	8	22%
11	Buying of necessary equipment	8	22%
12	Support for staff	7	19%
13	Improvement in quality	7	19%
14	Extension of services	7	19%
15	Out of Hours service	5	14%

Table 6.2: The non-achievements of the SPMS and the aspects that did not work well

Rank	Non-achievements of the SPMS and the aspects that did NOT work well	Number of respondents (out of 36)	Percentage (% out of 36)
1	Finance – higher budgets to invest (14), clarity of budgets (5), financial balance (2)	19	53%
2	Improvement in facilities	18	50%
3	Recruitment and retention	16	44%
4	Responsive management	12	33%
5	Not being independent	11	31%
6	External team-working - with other SPMS services	10	28%
7	Communication between staff	9	25%
8	Effectiveness of PCT functions	9	25%
9	Development of new services/ processes	8	22%
10	Support	7	19%
11	Lack of protected learning time	6	17%
12	Training and development	5	14%
13	Internal team-working – within their SPMS service area/discipline	5	14%
14	Security	3	8%
15	Buying needed equipment	3	8%

The staff-centred achievements and aspects that worked well were: training and development, flexible working, support for staff, internal team-working within some individual SPMS services and external team-working between some SPMS services.

Finally, the organisation-centred achievements and aspects that worked well were: recruitment and retention, buying of necessary equipment and enabling of process change within individual services e.g. the streamlining of administrative activities.

6.3 What was not achieved by the SPMS and what aspects of the SPMS did not work well?

The participants also identified a range of things not achieved by the SPMS and aspects that did not work well [See Table 6.2].

The major non-achievements and aspects that did not work well can also be placed into the three categories mentioned earlier: patient-centred; staff-centred and organisation-centred.

The patient centred aspect that did not work well or was not achieved was the development of new processes/ services in some SPMS services.

The staff-centred aspects that did not work well or were not achieved were: communication between staff within some SPMS services, internal team-working within some SPMS services, external team-working between some SPMS services and the security of some premises.

Finally, the organisation-centred aspects that did not work well or were not achieved were: finance, facilities and premises, recruitment and retention, responsive management, not being independent, the effectiveness of PCT functions, support for staff, lack of protected learning time, training and development and buying of necessary equipment.

6.4 Workshop options appraisal

In all, seven options were discussed by the participants of the workshop:

Option 1: The SPMS continues as it is.

Option 2: The SPMS general practices become independent and the remaining SPMS services continue within a smaller SPMS.

Option 3: The SPMS general practices become independent and the remaining SPMS services merge with the PCT's existing clinical services.

Option 4: The SPMS general practices become independent and the PCT's remaining clinical services join the remaining SPMS to create a new SPMS.

Option 5: All SPMS services become independent.

Option 6: SPMS becomes a troubleshooting and service turn-around team.

Option 7: Each SPMS service has the choice of when to go independent.

A number of other options were also identified but these were not discussed by participants in any detail.

The tables that follow show the advantages and disadvantages identified by participants for each of the above options. For all the options participants identified both potential advantages and disadvantages (pros and cons).

Ranking the options in terms of the numbers of people who identified more advantages (pros) than disadvantages (cons) we have:

- Option 6: SPMS becomes a troubleshooting and turnaround team (7 participants identified advantages compared with 3 who identified disadvantages)

- Option 7: SPMS staff and services have the choice of when to become independent (5 participants identified advantages compared with 3 who identified disadvantages)

- Option 3: SPMS general practices become independent and the remaining SPMS services merge with the PCT's existing clinical services (20 participants identified advantages compared with 21 who identified disadvantages)

- Option 2: SPMS general practices become independent and the remaining SPMS services continue as a smaller SPMS (17 participants identified advantages compared with 21 who identified disadvantages)

- Option 4: SPMS general practices become independent and the PCT's existing clinical services joining the remaining SPMS services to create a new SPMS (13 participants identified advantages compared with 18 who identified disadvantages)

- Option 1: SPMS continues as it is (15 participants identified advantages compared with 21 who identified disadvantages)

- Option 5: All SPMS services become independent (9 participants identified advantages compared with 24 who identified disadvantages)

Table 6.3: The advantages and disadvantages identified by workshop participants for Option 1 – the SPMS continuing as it is

Option 1: **SPMS continues as it is**	
Advantages identified	**Disadvantages identified**
Stability/ 'comfort zone'/continuity (with NHS)/ safe Train up more primary care nurses to improve patient care in poorly run practices There would be a service to local people Could carry on if became arms-length Good in some areas Working at the moment and providing excellent patient care Ethos	Not an option/ Not allowed/policy and political direction No evolution, no growth/ no improvement/ growth restricted Financial constraints/ need more financial independence May continue to run inefficiently Not achieving aims Will be more expensive/financially not viable/ cost implications Morale will suffer Could a failing service 'drag' down whole SPMS Not achieving in all areas Constraints on recruitment Pensions very important Fear for job – not certain about future No control over policies/ regulations already set
No of participants who identified at least one advantage for this option	**No of participants who identified at least one disadvantage for this option**
15	22

Table 6.4: The advantages and disadvantages identified by workshop participants for Option 2 – the SPMS general practices becoming independent and the remaining SPMS services continuing within a smaller SPMS

Option 2: SPMS general practices become independent and the remaining SPMS services continue within a smaller SPMS	
Advantages identified	**Disadvantages identified**
Independence (practices) Improve patient care in practices that run well/ delivering better care Team of nurses can bid and be partners with GPs More control setting standards Independent GPs have more power Effective management Financial control/better control More managerial responsibilities sorted out at local levels/ quicker decisions	Smaller SPMS non-viable Could attempt independence only to lose tender Asset stripping (cherry picking) Redundancies Loss of ethos If forced practices may not work May not be viable for practices not running well Finance not guaranteed More managers and assistants Would not work and change would be difficult Existing practices have no incentive to improve failing practice GPs call the shots PCT and SPMS conflicts of management Loss of jobs Fear of unknown
No of participants who identified at least one advantage for this option	**No of participants who identified at least one disadvantage for this option**
17	21

Table 6.5: The advantages and disadvantages identified by workshop participants for Option 3 – the SPMS general practices becoming independent and the remaining SPMS services merge with the PCT's existing clinical services

Option 3: SPMS general practices become independent and the remaining SPMS services merge with the PCT's existing clinical services	
Advantages identified	**Disadvantages identified**
Modernise Better 24 hour care Better retention All practices have to become independent Staff can remain in PCT (NHS terms, conditions and pension) Nurse-led PMS practices may be attractive Other SPMS services may sit better with clinical services One large provider service ensuring all services provided for local community/more integration Independence/Self-control Possible More efficient management costs More incentivisation More corporate feeling/sharing/informing/communication easier Merge with other disciplines, nature of work will be the same/team approach with other disciplines HV, school nurses, DN/better team cooperation/closer working relationship with other disciplines	Less seamless care May not be financially viable Concerns about NHS pension and conditions Other SPMS services will not be viable Some practices would not be viable as independents Less teamwork with practices/ Less multi-disciplinary Some practices may not want to become independent/forcing practices to become independent Penalised for not going. Them and us Loss of continuity Two-tier system No Communication problems/too wide Getting used to change, different base Management support/different management structures Fear of unknown
No of participants who identified at least one advantage for this option	**No of participants who identified at least one disadvantage for this option**
20	21

Table 6.6: The advantages and disadvantages identified by workshop participants for Option 4 – the SPMS general practices becoming independent and the PCT's existing clinical services joining the remaining SPMS services to form a new SPMS

Option 4: SPMS general practices become independent and PCT clinical services join remaining services to become a new SPMS	
Advantages identified	**Disadvantages identified**
Same as Option 3 Communication shouldn't be a problem if infrastructure set up right Only if SPMS becomes an independent organisation PCT would be fulfilling ethos to split commissioning and providing Allow those practices not wanting independence to stay in SPMS One large provider service ensuring all services provided for local community More efficient management costs More incentivisation More corporate feeling Practice would become independent Still SPMS or PCT taking over Having longer work history	Same as Option 3 Poor communication between managers of these services SPMS could become too big Could change aim of SPMS Hard to say whether quality will improve Has to go out to "tender" Lose 'our' voice Some practices may not want to become independent Clinical services may not want to join SPMS Cannot compete with Boots/BUPA The lead having a longer history Fear of unknown
No of participants who identified at least one advantage for this option	**No of participants who identified at least one disadvantage for this option**
13	18

Table 6.7: The advantages and disadvantages identified by workshop participants for Option 5 – all the SPMS services becoming independent

Option 5: All SPMS services become independent	
Advantages identified	**Disadvantages identified**
Independence/in charge Beneficial – financially Only if offered to teams first Save management costs May be better off Smaller organisation	Management costs Business case likely to be poor Expensive/cost Independent provider would not provide quality service in high demand non-financially viable areas (cherry pick) Training option for all GPs lost Loss of economy of scale SPMS may be less financially orientated than private company Loss of ethos/ More about money less about patient care Too small/Too small to survive private bids Not cost-effective No coordination/loss of coordination Would work at odds with 'sister' services No choice / Time Not all practices want to become independent Can lose out to other 'private' companies On tender teams would not be able to compete Contrary to wishes of team Job security/ NHS pensions Viability/independent team too small to survive financially Difficult to raise business independently
No of participants who identified at least one advantage for this option	**No of participants who identified at least one disadvantage for this option**
9	24

Table 6.8: The advantages and disadvantages identified by workshop participants for Option 6 – the SPMS becomes a troubleshooting and turnaround team

Option 6: SPMS becomes a troubleshooting and turnaround team	
Advantages identified	**Disadvantages identified**
SPMS is a 'turn-around' team that improves services which can then be tendered to private providers. 50:50 split between salaried GP and SPMS – incentivised Excellent GP output Practices have choice Dedicated bank of nurses to turn around poorly performing surgeries Freelance/ more opportunities	Financial burden Could fail More confusion, division and expenditure (all options)
No of participants who identified at least one advantage for this option	**No of participants who identified at least one disadvantage for this option**
7	3

Table 6.9: The advantages and disadvantages identified by workshop participants for Option 7 – each SPMS service within the SPMS has the choice of when to become independent

Option 7: Each service within the SPMS has the choice of when to become independent	
Advantages identified	**Disadvantages identified**
Practices have choice to remain in SPMS Turnaround option (6) fits this choice Developmental model allows progression and autonomy Team choice, allows for different development and motivations Increase of team morale/loyalty Local services to local people – with merger of clinical services into SPMS Allows greater investment Incentivisation Easier to form local relationships	Not complete option for all services Business risk (for SPMS) Managing maternity and sick leave
No of participants who identified at least one advantage for this option	**No of participants who identified at least one disadvantage for this option**
5	3

6.5 'World café'

In the 'world café' session where participants were allowed to explore a specific option that they were particular interested in the options that were chosen were as follows [See Table 6.10]:

- 13 chose to look at Option 7 – the SPMS services and staff should decide when they become independent.
- 7 chose to look at Option 3 – the SPMS general practices becoming independent and the remaining SPMS services merging with the PCT's existing clinical services.
- 4 chose Option 6 - the SPMS becomes a troubleshooting and turnaround team.
- 4 chose Option 5 – all the SPMS services become independent.
- 4 chose Option 1 – the SPMS continues as it is.
- 2 chose to look at Option 4 – the SPMS general practices becoming independent and the PCT's existing clinical services joining the remaining SPMS services to form a new SPMS.

Table 6.10 World Café options and the number of workshop participants who chose to explore a particular option and the additional comments they made on the options.

Option	No of participants who chose to explore this option	Advantages identified	Disadvantages identified
Option 7: SPMS services and staff choose when they become independent.	13	Choice of independence or to stay in the SPMS Independence for teams would occur at suitable stages of their development. This would increase morale	
Option 3: SPMS general practices become independent and the remaining SPMS services merge with the PCT's existing clinical services.	7	No separate comments returned	No separate comments returned

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Option	No of participants who chose to explore this option	Advantages identified	Disadvantages identified
Option 6 SPMS becomes a troubleshooting and turnaround team.	4	Strengths: Improve failing practices across Hounslow. Give PCT commissioner an option to commission from other options when negotiating with private providers. Providing service is not an alternative. Opportunities: New challenge for experienced doctors.	Weaknesses: No incentives to take on failing practices. Recruiting staff who like continual change. Financial rewards for GPs would be less than for PMS £120,000 Threats: Possibility of change Costs Maternity leave

Review Of The Specialist Personal Medical Service (SPMS) In Hounslow

Option	No of participants who chose to explore this option	Advantages identified	Disadvantages identified
Option 5: All SPMS services become independent.	4	Save management costs. Some may prefer to be independent. Long term business partnership. May buy services in. May be able to sell services to other practices. May communicated better with other independent practices. Independent with finances (more control of the budget) and ultimately better patient care!!	Some SPMS services too small to be viable No choice Cost implication to becoming independent No stability of staff
Option 1: SPMS continues as it is.	4	Haven't been given long enough to evaluate the model. Two years not long enough. Market research. Less upheaval for staff re. job security, if continue.	Could disrupt team dynamics.

Option	No of participants who chose to explore this option	Advantages identified	Disadvantages identified
Option 4: SPMS general practices become independent and the PCT's existing clinical services join with the remaining SPMS services to create a new SPMS.	2	Some SPMS services e.g. phlebotomy could benefit from joining clinical services.	
Option 2: SPMS general practices become independent and the remaining SPMS continue as a smaller SPMS	0	NA	NA

6.6 Summary

From the workbooks, the achievements and aspects that worked well in the SPMS, over the last year, were: training and development, recruitment and retention, internal team-working, patient care, development of new services and flexible working.

The things that were not achieved and did not work well were: finance, facilities and premises, recruitment and retention, responsive management, not being independent and external team-working between SPMS services.

However, the successes have not been universal with recruitment and retention, in particular, also being cited as an aspect that did not work well and was not achieved in some of the SPMS services.

In terms of the options, most participants identified both advantages and disadvantages for each of the options. Their top three options from the comments on the workbooks were the SPMS becoming a troubleshooting and turn-around team, having the option of choosing when to become independent and letting the SPMS general practices become independent and merging the remaining SPMS services with the PCT's existing clinical services. These were also the top three options identified in the 'world café' session though the order of the options was different with choosing when to become independent being first; the SPMS general practices becoming independent and the remaining SPMS services merging with the PCT's existing clinical services being second; and the SPMS as a turn-around troubleshooting team being third.

Option 3, to make the SPMS general practices independent and merging the remaining SPMS services with the PCT's existing services, was the one option where the largest number of participants identified at least one advantage.

7. Questionnaire findings

7.1 Introduction

The questionnaire was sent to a total of 161 respondents of these 137 were SPMS staff with the remaining 24 being key external stakeholders involved with the SPMS.

In total, 70 completed questionnaires were returned (43% out of 161). Of these, 55 (79% out of 70) were from the SPMS; 10 (14%) were from Hounslow PCT; 3 (4%) were from Harmoni; 1 (1%) was from the London Ambulance Service; and 1 (1%) was from the West Middlesex University Hospital.

In terms of professional groups, 19 (27% out of 70) were from nurses; 13 (19%) from administrative staff; 12 (17%) were from doctors; 11 (16%) were from managers; 8 (11%) were from directors; 2 (3%) were from allied health professionals; 3 (4%) ticked 'other'; and 2 (3%) did not tick any professional group.

In terms of the SPMS teams, 13 (19%) were from the Family Planning Service; 7 (10%) from the Referral Management Centre/ Central Booking Service; 5 (7%) from the SPMS management; 5 (7%) from Broadwalk general practice; 5 (7%) from the Isleworth general practice; 4 (6%) from Bedfont general practice; 3 (4%) from Heston general practice; 3 (4%) from Manor general practice; 2 (3%) from Chinchilla general practice; 3 (4%) from the Night Nursing Service; 2 (3%) from the Phlebotomy Service;
1 (1%) from the SAFE project; 1 (1%) worked at a number of practices; 2 (3%) had not ticked any of the SPMS teams and 14 (20%) were not part of the SPMS.

Of the 70 respondents, 26 (37%) had worked in the Hounslow health economy for 5 years or more; 20 (29%) had worked for between 2-5 years; 16 (23%) had worked for between 1-2 years; 4 (6%) had worked for less than 1 year

and 4 (6%) had not ticked any year category. In terms of employment status, 33 (47%) were full-time and 33 (47%) were part-time with 4 (6%) not having ticked a category. In terms of gender, 9 (13%) of respondents were male and 61 (87%) were female. In terms of ethnicity, 45 (64%) were White British; 10% were Asian Indian; 5 (7%) were Other Asian; 3 (4%) were White Irish; 3 (4%) were Chinese; 1 (1%) was from a mixed background; 2 (3%) ticked Other and 3 (4%) did not tick any category.

7.2 SPMS arrangements compared to service delivery arrangements in place before October 2004

Of the 70 respondents, 35 (50%) of respondents described the SPMS arrangements as better (good or very good) than those in place before October 2004. 21 (30%) described it as neither good nor bad when compared to the previous arrangements and only 2 (3%) described the current SPMS arrangements as worse (bad or very bad) than the previous arrangements [See Figure 7.1].

In terms of professional groups, only some of the doctors described the arrangements as worse than previously; with 2 describing the arrangements as bad, 4 as good and 6 as neither good nor bad. Nurses, administrative staff and directors (within and outside the SPMS) had only positive views with the majority in these groups ticking either good or very good while half of the managers thought that it had been good or very good with the other half feeling that it had been neither good nor bad when compared to the previous arrangements [See Figure 7.2].

Figure 7.1: What do you think of the SPMS arrangements currently in place compared to the service delivery arrangements in place before October 2004?

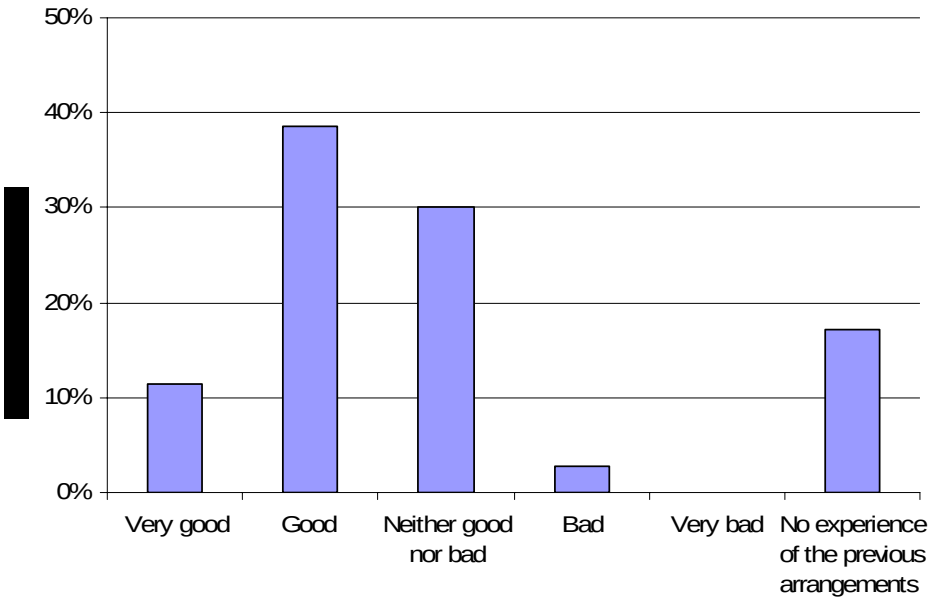
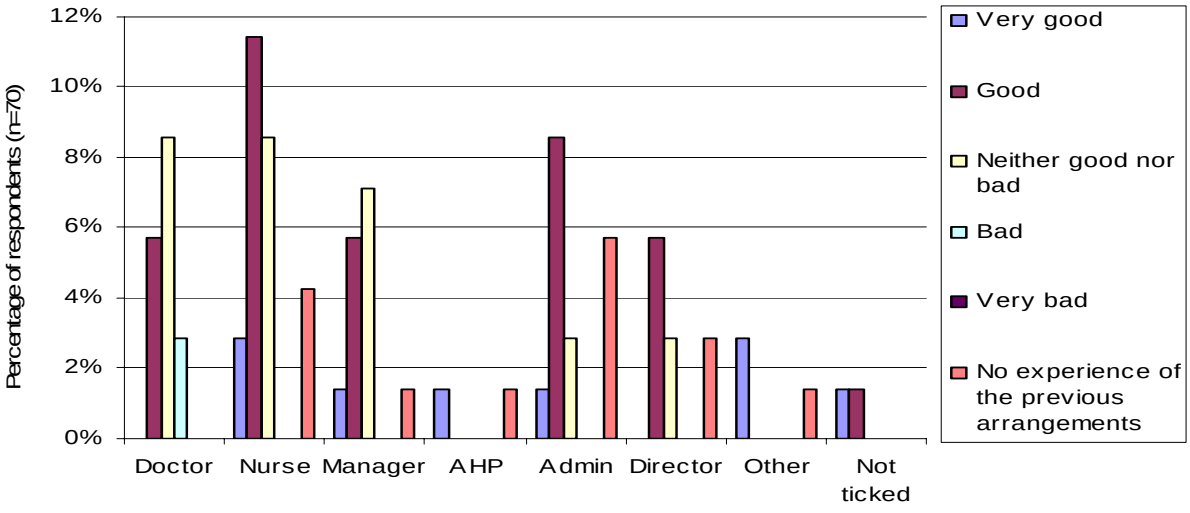


Figure 7.2: What do you think of the SPMS arrangements currently in place compared to the service delivery arrangements in place before October 2004? by professional group

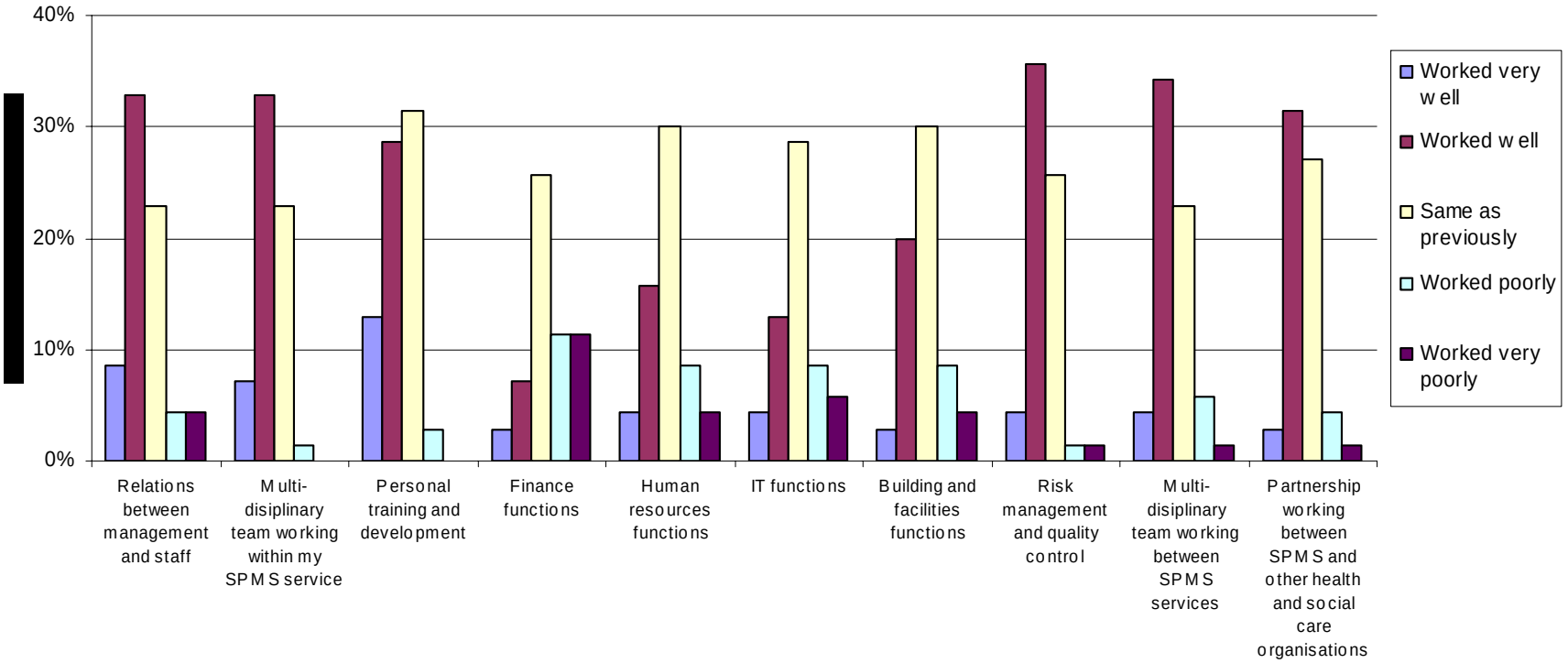


7.3 Aspects of the SPMS that have worked well or worked poorly

The aspects of the SPMS that worked well or very well were [See Figure 7.3]:

- multidisciplinary team-working within respondents own SPMS service (40% described this as working well or very well with only 1% describing this as working poorly or very poorly);
- personal training and development (42% described this as working well or very well with only 3% describing this as working poorly or very poorly);
- risk management and quality control (40% described this as working well or very well with only 2% describing this as working poorly or very poorly);
- relations between management and staff (42% described this as working well or very well with only 8% describing this as working poorly or very poorly);
- multidisciplinary team-working between SPMS services (38% described this as working well or very well with only 7% describing this as working poorly or very poorly); and
- partnership working between SPMS and other health and social care organisations (34% described this as working well or very well with only 5% describing this as working poorly or very poorly).

Figure 7.3: In your judgement, compared to the arrangements in place before October 2004, which aspects of the SPMS have worked well and which poorly?



The aspects of the SPMS that worked less well were:

- finance functions (22% described this as working poorly or very poorly with only 10% describing this as working well or very well);
- IT functions (17% described this as working well or very well with 15% describing this as working poorly or very poorly);
- human resources functions (20% described this as working well or very well with 13% describing this as working poorly or very poorly); and
- building and facilities functions (23% described this as working well or very well with 13% describing this as working poorly or very poorly).

7.4 Management of the change process carried out to move to SPMS arrangements

Of the 70 respondents, 28 (40%) described the management of the change process to the new SPMS arrangements as well or very well managed with 12 (17%) describing it as poorly or very poorly managed. 23 (33%) described the change process as neither well nor poorly managed (this includes those who wrote don't know or didn't put an answer down) [See Figure 7.4].

In terms of professional groups, more doctors described the change process as having been poorly or very poorly managed compared to other professional groups (4 thought this compared to only 1 who thought the arrangements were well managed). In contrast, 9 nurses described the change process as having been well managed compared to only 4 who described it as being poorly managed; similarly 4 managers described it as being well managed compared to only 2 who described it as being poorly managed; the 2 allied health professional viewed the process positively; as did 5 of the administrative staff compared to only 1 who described it as being poor; and 4 directors described

the change process as having been well managed compared to only 1 who described it as being poorly managed [See Figure 7.5].

Figure 7.4: How well managed was the change process to move to the SPMS arrangements?

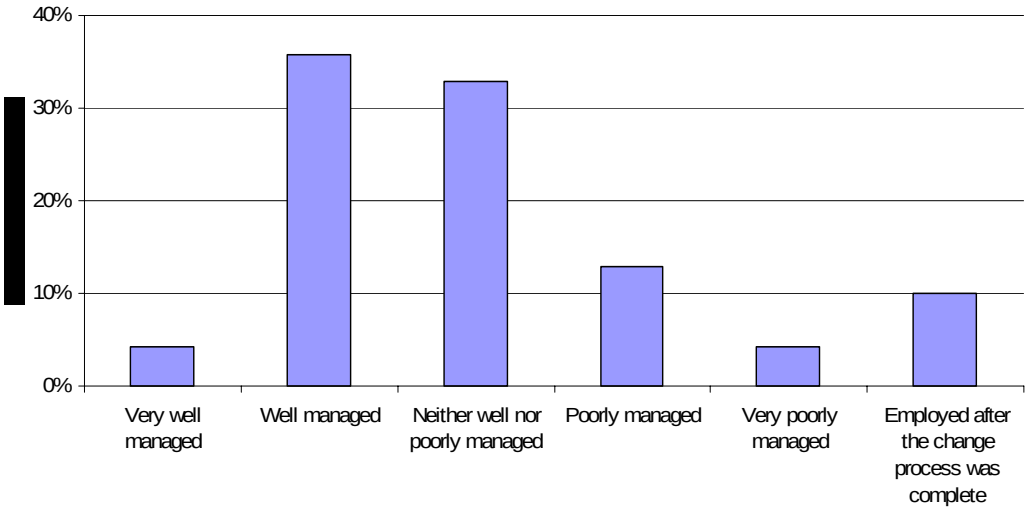
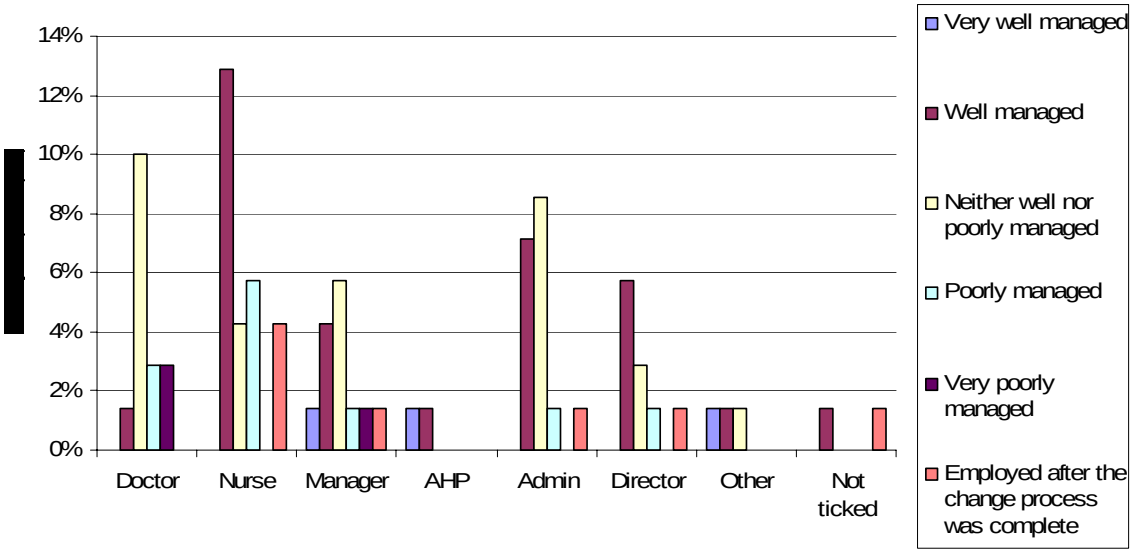


Figure 7.5: How well managed was the change process to move to the SPMS arrangements by professional group

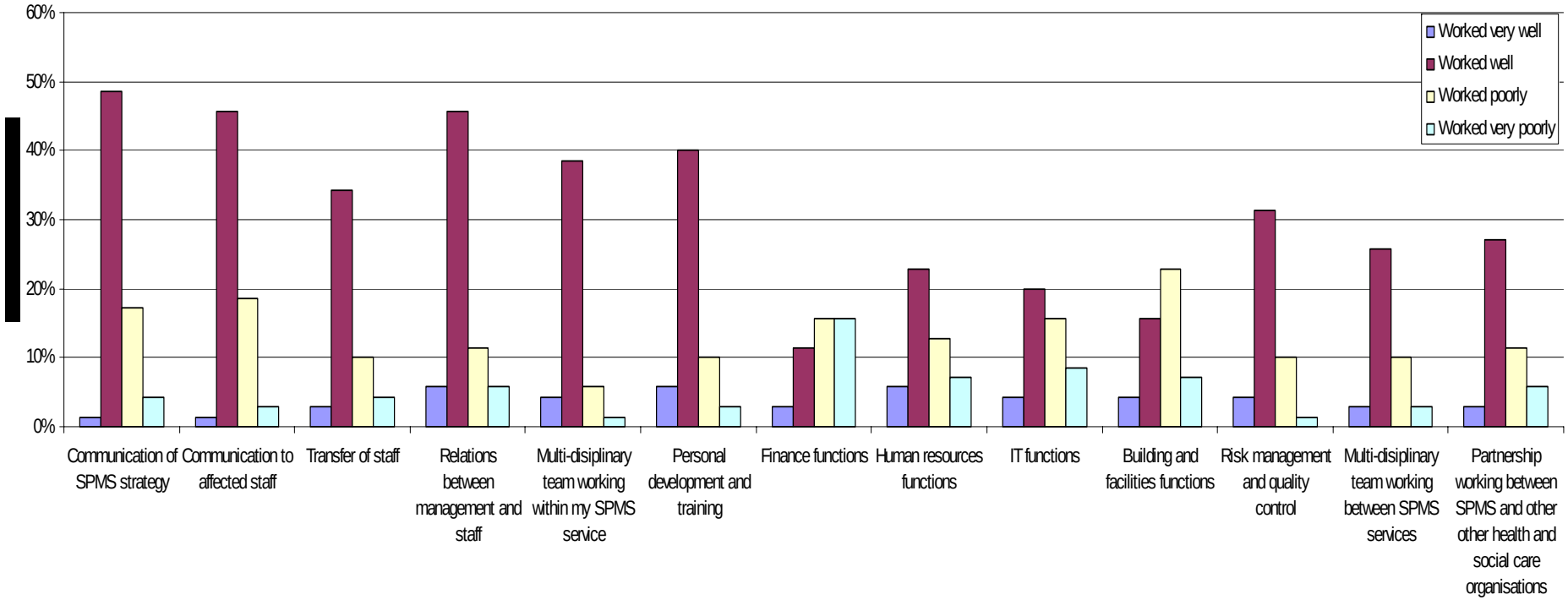


7.5 Aspects of the setting up of the SPMS that worked well and those that worked poorly

The aspects of the setting up of the SPMS that worked well or very well were [See Figure 7.6]:

- multi-disciplinary team-working within respondent's own SPMS service (43% described this as working well or very well with only 7% describing this as working poorly or very poorly);
- relations between management and staff (52% described this as working well or very well with 17% describing this as working poorly or very poorly);
- personal development and training (46% described this as working well or very well with 13% describing this as working poorly or very poorly);
- communication of SPMS strategy (50% described this as working well or very well with 21% describing this as working poorly or very poorly);
- communication to affected staff (47% described this as working well or very well with 22% describing this as working poorly or very poorly);
- risk management and quality control (35% described this as working well or very well with 11% describing this as working poorly or very poorly);
- transfer of staff (37% described this as working well or very well with 14% describing this as working poorly or very poorly); and
- human resources functions (29% described this as working well or very well with 20% describing this as working poorly or very poorly).

Figure 7.6: In your judgement, during the setting up phase of the SPMS, which aspects worked well and which poorly?



The aspects of the setting up of the SPMS that worked less well were:

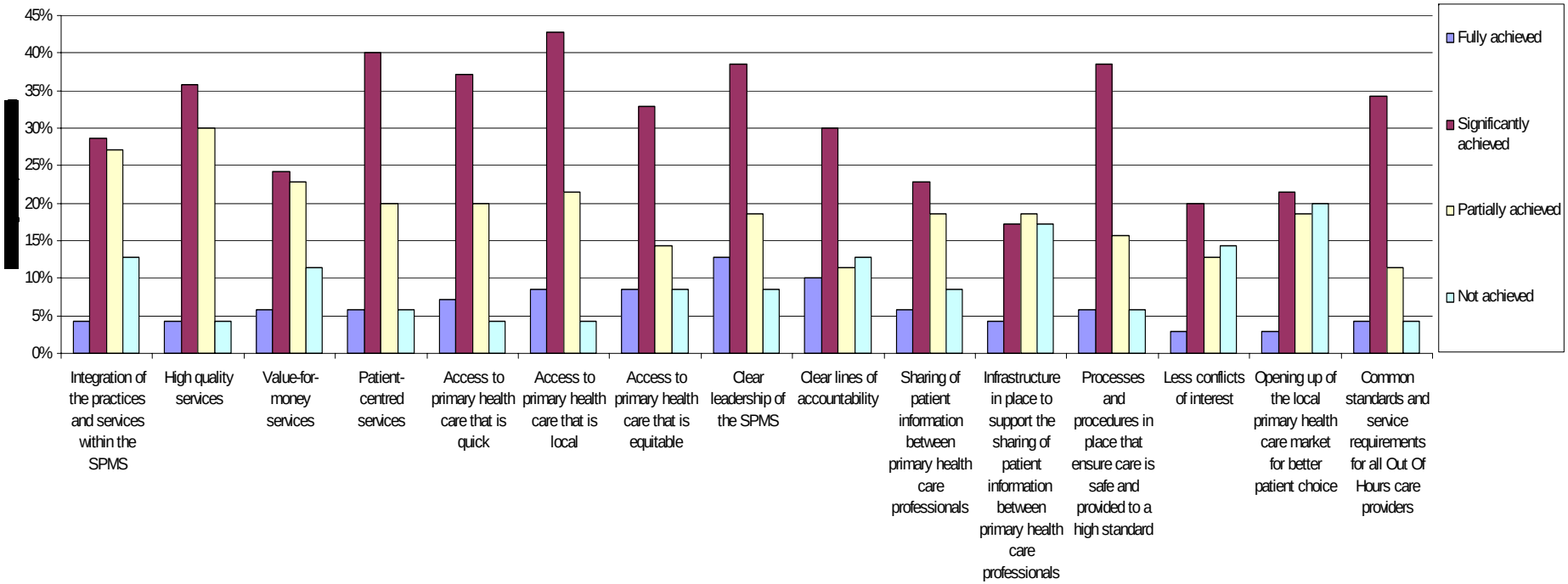
- finance functions (32% described this as working poorly or very poorly with 14% describing this as working well or very well);
- building and facilities functions (30% described this as working poorly or very poorly with 20% describing this as working well or very well); and
- IT functions (25% described this as working poorly or very poorly with 24% describing this as working well or very well).

7.6 Objectives/principles achieved due to the SPMS

The objectives and principles of the SPMS that were described as significantly or fully achieved were [See Figure 7.7]:

- access to primary health care that is local (52% described this as being fully or significantly achieved compared to 25% who described this as partially or not achieved);
- clear leadership of the SPMS (52% described this as being fully or significantly achieved compared to 28% who described this as partially or not achieved);
- processes and procedures in place that ensure care is safe and provided to a high standard (45% described this as being fully or significantly achieved compared to 22% who described this as partially or not achieved);
- common standards and service requirements for all Out of Hours care providers (38% described this as being fully or significantly achieved compared to 15% who described this as partially or not achieved);

Figure 7.7: In your judgement, over the last year, to what extent have the following objectives/principles been achieved due to the SPMS?



- patient-centred services (46% described this as being fully or significantly achieved compared to 26% who described this as partially or not achieved);
- access to primary health care that is quick (44% described this as being fully or significantly achieved compared to 24% who described this as partially or not achieved);
- access to primary health care that is equitable (42% described this as being fully or significantly achieved compared to 23% who described this as partially or not achieved);
- clear lines of accountability (40% described this as being fully or significantly achieved compared to 24% who described this as partially or not achieved); and
- high quality services (40% described this as being fully or significantly achieved compared to 34% who described this as partially or not achieved).

The objectives and principles of the SPMS that were described as only partially or not achieved were:

- opening up of the local primary health care market for better patient choice (39% described this as being only partially or not achieved compared to 24% who described this as significantly or fully achieved);
- infrastructure in place to support sharing of patient information between primary health care professionals (36% described this as being only partially or not achieved compared to 21% who described this as significantly or fully achieved);

- integration of the practices and services within the SPMS (40% described this as being only partially or not achieved compared to 33% who described this as significantly or fully achieved);

- value for money services (34% described this as being only partially or not achieved compared to 30% who described this as significantly or fully achieved);

- less conflict of interest (27% described this as being only partially or not achieved compared to 23% who described this as significantly or fully achieved); and

- sharing of patient information between primary health care professionals (28% described this as being only partially or not achieved compared to 29% who described this as significantly or fully achieved).

7.7 Values that have been demonstrated by the SPMS

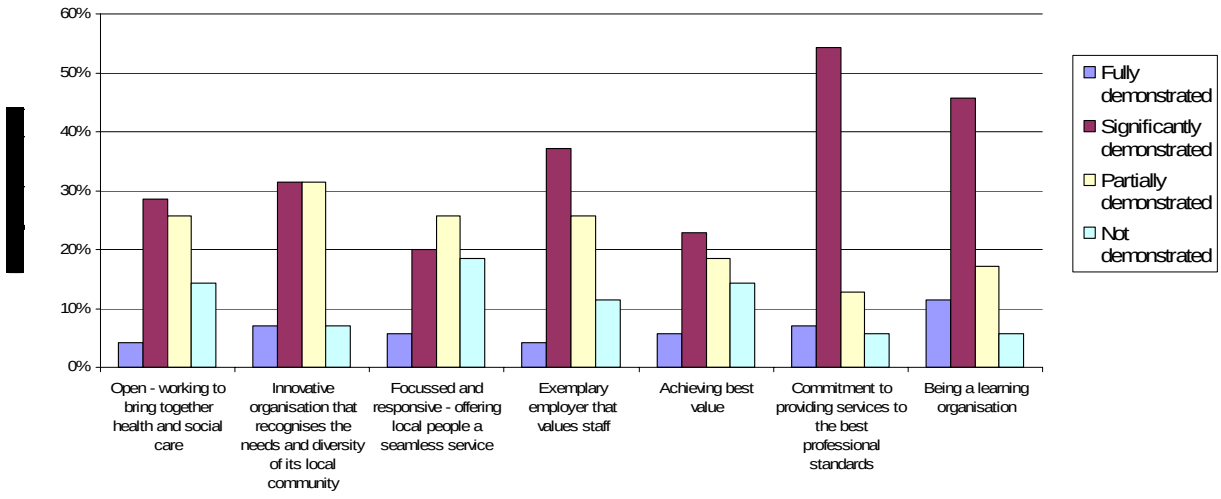
The values that the SPMS significantly or fully demonstrated were [See Figure 7.8]:

- commitment to providing services to the best professional standards (61% described this as being significantly or fully demonstrated compared to only 19% who described this as being partially or not demonstrated);

- being a learning organisation (57% described this as being significantly or fully demonstrated compared to 23% who described this as being partially or not demonstrated); and

- being an exemplary employer that values staff (41% described this as being significantly or fully demonstrated compared to 37% who described this as being partially or not demonstrated).

Figure 7.8: In your judgement, over the last year, to what extent have the following values been demonstrated in practice by the SPMS?



The values that the SPMS only partially demonstrated or did not demonstrate were:

- focussed and responsive – offering local people a seamless service (45% described this as being only partially or not achieved compared with 26% who described this as being significantly or fully demonstrated);

- open – working to bring together health and social care (40% described this as being only partially or not achieved compared with 33% who described this as being significantly or fully demonstrated);

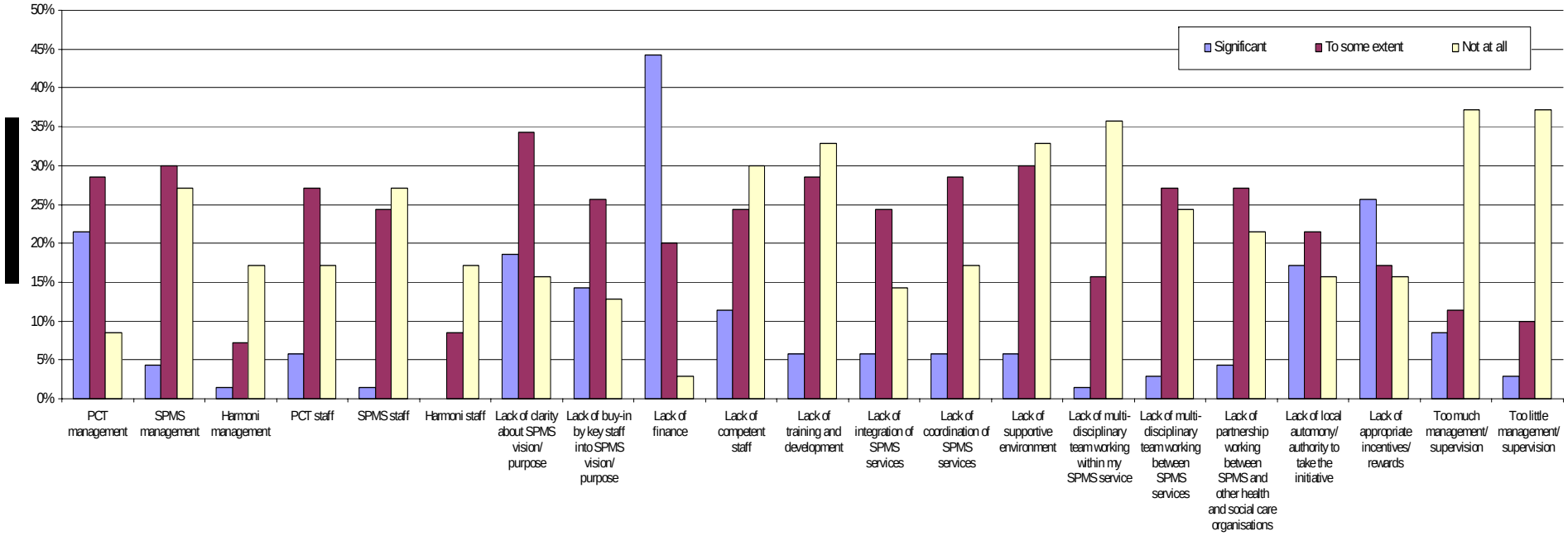
- achieving best value (33% described this as being only partially or not achieved compared with 29% who described this as being significantly or fully demonstrated); and
- innovative organisation that recognises the needs and diversity of its local community (38% described this as being only partially or not achieved compared with exactly the same percentage 38% describing this as being significantly or fully demonstrated).

7.8 Perceived barriers to the achievement of the objectives of the SPMS

The top ten barriers identified by respondents were [See Figure 7.9]:

- lack of finance (44% describe it as significant and 22% as to some extent);
- lack of appropriate incentives/rewards (26% describe it as significant and 17% as to some extent);
- PCT management (21% describe it as significant and 29% as to some extent);
- lack of clarity about SPMS vision/ purpose (19% describe it as significant and 34% as to some extent);
- lack of autonomy/ authority to take initiative (17% describe it as significant and 21% as to some extent);
- lack of buy-in by key staff into SPMS vision/ purpose (14% describe it as significant and 26% as to some extent);
- lack of competent staff (11% describe it as significant and 24% as to some extent);

Figure 7.9: In your judgement, which of the following have been barriers to the achievement of the SPMS's objectives/principles?

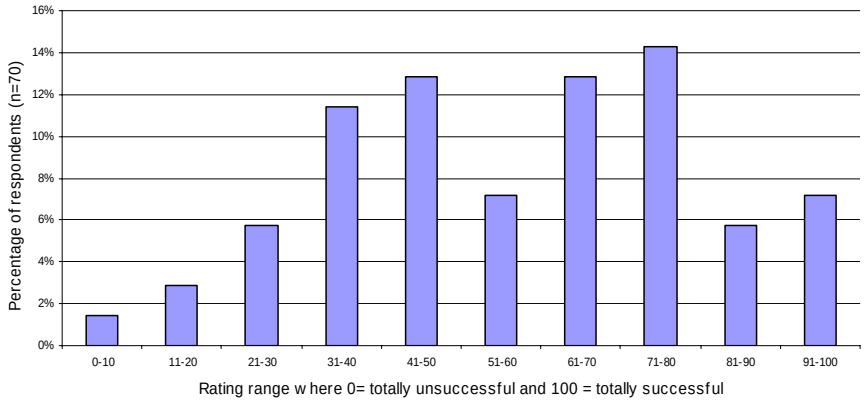


- too much management/ supervision (9% describe it as significant and 11% as to some extent);
- lack of supportive environment (6% describe it as significant and 30% as to some extent); and
- lack of coordination of SPMS services (6% describe it as significant and 29% as to some extent).

7.9 Success of the SPMS on a rating scale of 0-100

Overall, on a scale between 0 and 100, where 0 = Totally Unsuccessful and 100 = Totally Successful, the average rating of how successful the SPMS had been was 60% for the 57 respondents who answered this question [See Figure 7.10].

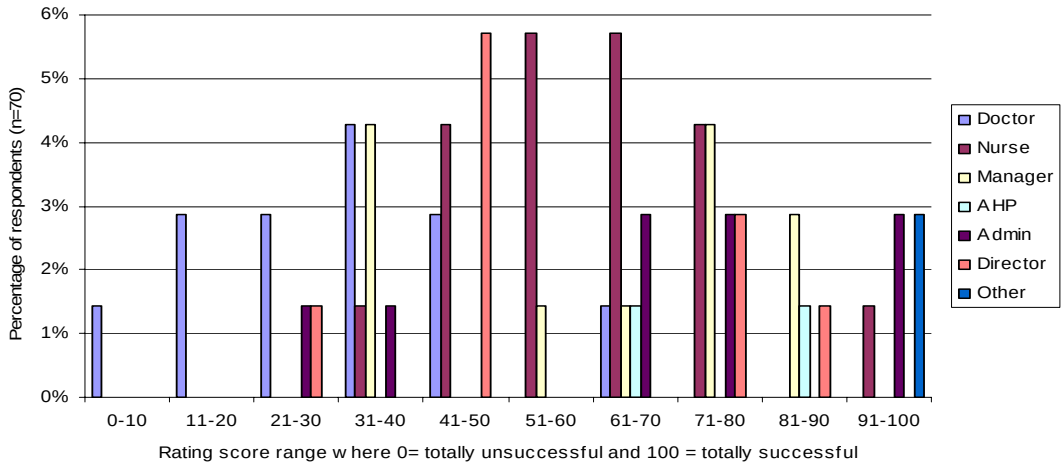
Figure 7.10: On a scale between 0 and 100, where 0 = Totally Unsuccessful and 100 = Totally Successful, how successful has the SPMS been?



Analysing the data by professional group, doctors gave the lowest scores, with scores ranging between 0-70, compared with nurses whose scores ranged

from 31-100; managers whose scores ranging between 31-90; allied health professionals whose scores ranging between 61-90; administrative staff whose scores ranging between 21-100; and directors whose scores ranging between 21-90 [See Figure 7.11].

Figure 7.11: On a scale between 0 and 100, where 0 = Totally Unsuccessful and 100 = Totally Successful, how successful has the SPMS been by professional group



7.10 Value of implementing the SPMS all over again

Of the 70 respondents, 20 (29%) felt it was definitely worth carrying out again and 25 (36%) felt it was probably worth carrying out again. Only 7 (10%) thought that the SPMS was probably or definitely not worth carrying out again [See Figure 7.12].

In terms of professional groups, an equal number of doctors described the SPMS as worth and not worth carrying out again; 4 describing the SPMS as worth carrying out and 4 describing the SPMS as not worth carrying out again. Nurses, managers, allied health professionals, administrative staff and

directors (within and outside the SPMS) had largely positive views with only 1 nurse, and 2 directors saying it was not worth carrying out again; compared to 14 nurses and 5 directors saying it was worth carrying out again [See Figure 7.13].

Figure 7.12: If we were to start again would the SPMS still be worth carrying out?

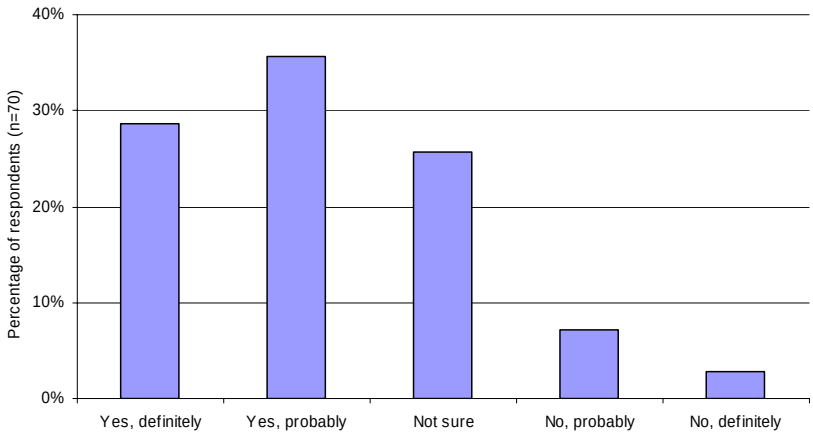
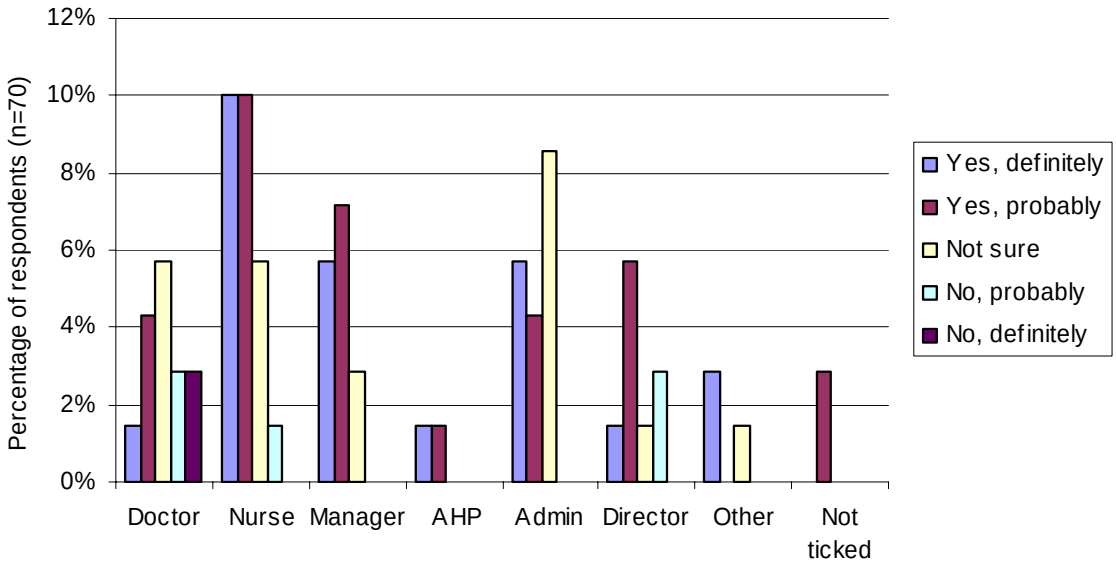


Figure 7.13: If we were to start again would the SPMS still be worth carrying out by professional group



7.11 Extent to which SPMS addresses the criteria of a patient-led NHS

The criteria of a patient-led NHS which respondents described as being significantly or fully achieved were [See Figure 7.14]:

- securing safe services (53% described this as being significantly or fully addressed compared with 27% describing this as being partially or not addressed);
- reducing inequalities (47% described this as being significantly or fully addressed compared with 22% describing this as being partially or not addressed);
- improving health (50% described this as being significantly or fully addressed compared with 27% describing this as being partially or not addressed);
- securing high quality services (49% described this as being significantly or fully addressed compared with 28% describing this as being partially or not addressed); and
- improving engagement of GPs (36% described this as being significantly or fully addressed with 35% describing this as being partially or not addressed).

The criteria of a patient-led NHS which respondents described as being only partially or not addressed were:

- improving coordination with social services (36% described this as being only partially or not addressed compared with 14% describing this as being significantly or fully addressed);

- delivering reduction in management/ administrative costs (38% described this as being only partially or not addressed compared with 17% describing this as being significantly or fully addressed);

- improving public involvement (37% described this as being only partially or not addressed compared with 19% describing this as being significantly or fully addressed);

- improving management of financial risk (37% described this as being only partially or not addressed compared with 20% describing this as being significantly or fully addressed);

- improving commissioning (37% described this as being only partially or not addressed compared with 20% describing this as being significantly or fully addressed); and

- improving effective use of resources (43% described this as being only partially or not addressed compared with 27% describing this as being significantly or fully addressed

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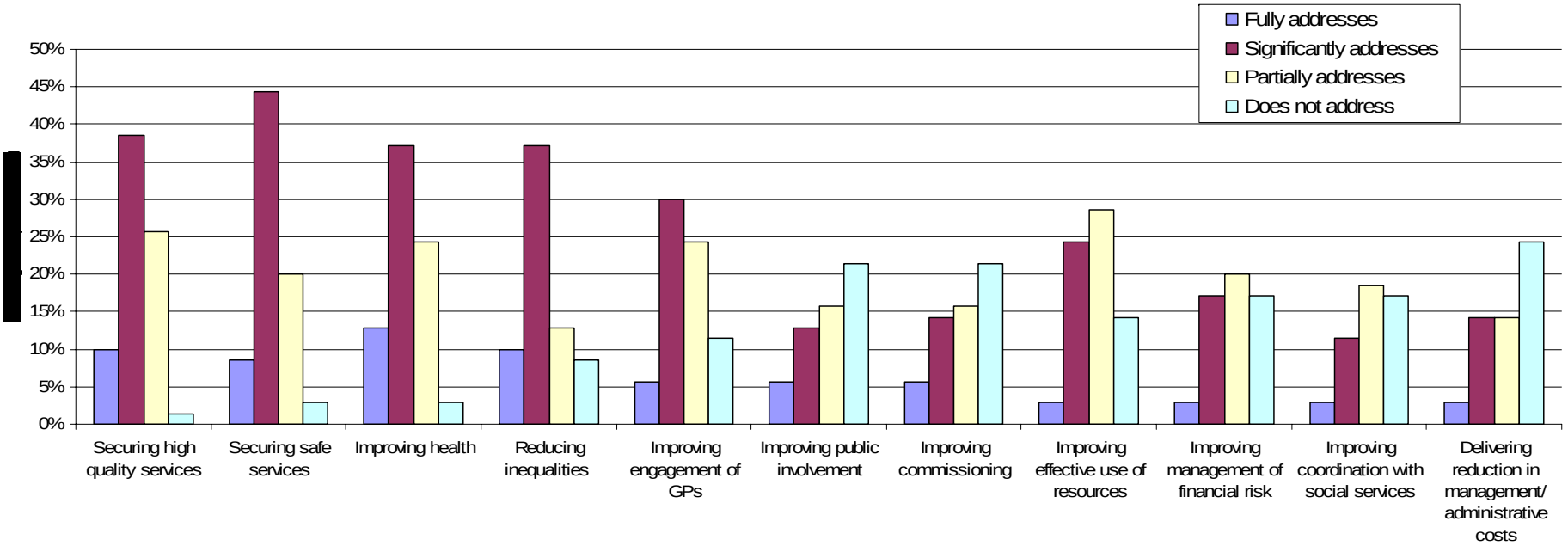
Figure 7.14: In your judgement, to what extent does the SPMS, as it is currently set up, address the following issues?



7.12 Summary

50% (35 out of 70) of respondents described the current SPMS arrangements as better than those prior to October 2004. Doctors had more negative views of the SPMS arrangements than other professional groups. 40% (28 out of 70) described the change process to the new SPMS arrangements as being well or very well managed, though here as well doctors had more negative views of the change process than other professional groups. On a scale between 0 and 100, where 0 = Totally Unsuccessful and 100 = Totally Successful, the average rating of how successful the SPMS has been was 60% (of the 57 respondents who answered this question). 65% (45 out of 70) of respondents described the SPMS as being either probably or definitely worth carrying out if we were start again; with doctors having more negative views of its worth than the other professional groups.

The aspects of the SPMS that worked well or very well were: multidisciplinary team-working within respondent's own SPMS service; personal training and development; risk management and quality control; relations between management and staff; multidisciplinary working between SPMS services; and partnership working between SPMS and other health and social care organisations.

The aspects of the SPMS that worked less well or poorly were: finance functions; IT functions; human resources functions; and building and facilities functions.

The aspects of the setting up of the SPMS that worked well or very well were: multi-disciplinary team-working within respondent's own SPMS service; relations between management and staff; personal development and training; communication of SPMS strategy; communication to affected staff; risk management and quality control; transfer of staff; and human resources functions.

The aspects of the setting up of the SPMS that worked less well were: finance functions; building and facilities functions; and IT functions.

The objectives and principles of the SPMS that were described as significantly or fully achieved were: access to primary health care that is local; clear leadership of the SPMS; processes and procedures in place that ensure care is safe and provided to a high standard; common standards and service requirements for all Out of Hours care providers; patient-centred services; access to primary health care that is quick; access to primary health care that is equitable; clear lines of accountability; and high quality services.

The objectives and principles of the SPMS that were described as only partially or not achieved were: opening up of the local primary health care market for better patient choice; infrastructure in place to support sharing of patient information between primary health care professionals; integration of the practices and services within the SPMS; value for money services; less conflict of interest; and sharing of patient information between primary health care professionals.

The values that the SPMS significantly or fully demonstrated were: commitment to providing services to the best professional standards; being a learning organisation; and being an exemplary employer that values staff.

The values that the SPMS only partially demonstrated or did not demonstrate were: focussed and responsive – offering local people a seamless service; open – working to bring together health and social care; achieving best value; and being an innovative organisation that recognises the needs and diversity of its local community.

The top ten barriers to the achievement of the objectives of the SPMS as identified by respondents were: lack of finance; lack of appropriate incentives/rewards; PCT management; lack of clarity about SPMS vision/ purpose; lack of autonomy/ authority to take initiative; lack of buy-in by key staff into SPMS vision/ purpose; lack of competent staff; too much

management/ supervision; lack of supportive environment; and lack of coordination of SPMS services.

The criteria of a patient-led NHS which respondents described as being significantly or fully addressed were: securing safe services; reducing inequalities; improving health; securing high quality services; and improving engagement of GPs.

The criteria of a patient-led NHS which respondents described as being only partially or not addressed were: improving coordination with social services; delivering reduction in management/ administrative costs; improving public involvement; improving management of financial risk; improving commissioning; and improving effective use of resources.

8. Outcome data analysis

8.1 Introduction

A review of outcome data can take two forms, a longitudinal assessment in time of the performance of a provider or a comparison between one provider and other similar providers.

The assessment of interest was one between the SPMS services and other similar services. This narrowed the outcome assessment data to the SPMS GPs and the General Medical Service (GMS) and Personal Medical Service (PMS) GPs given that they were the most similar provider services and had a range of routinely collected data about them.

However, despite this there were significant data constraints given that much of the financial and staffing data about GMS and PMS practices was not available for this review.

A discussion with the SPMS steering group and other key stakeholders on the kind of outcome data analysis that would be most useful was undertaken. This identified a number of interesting areas that could be explored:

1. Assess the budgets and capitations of GMS/PMS practices they provide versus the overall budgets and capitations provided by the SPMS practices.

2. Compare the baseline and change in absolute Quality Outcome Framework (QoF) values and the rate of improvement in QoF between GMS/PMS and SPMS practices.

3. Assess in detail the nature of the enhanced services provided by SPMS practices compared to GMS/PMS practices.

4. Compare the prescribing practice between GMS/PMS and SPMS practices.

5. Compare the patients' surveys from the last 2 years for SPMS and GMS/PMS practices.

6. Compare Referral Management Centre activity between GMS/PMS and SPMS practices.

7. Compare emergency admission rates between GMS/PMS and SPMS practices.

8. Levels of maternity leave, sick leave, and vacancies between GMS and SPMS practices.

Of these an assessment and comparison of the patient survey reports between GMS/PMS and SPMS practices was not feasible given the size of the task to analyse and compare individual questions from sixty plus practices.

In addition a full assessment of maternity, sick leave, and vacancies between GMS/PMS and SPMS practices could not be carried out given the lack of readily available data.

8.2 Cost-effectiveness and value for money

For 2004-05 the SPMS had a full year budget of just over £3.55 million it had an overspend of just over £576,000. This is 16.2% of its 2004-05 budget.

For 2005/6 it has a budget of £3.9 million and is predicted to have an overspend of £611,000. This is 15.5% of its 2005-06 budget.

The majority of the SPMS's overspend has occurred in the salaried professionals' service and SPMS general practices and this has been concentrated on the costs of locum cover for GP maternity leave. Therefore

not all services within the SPMS have overspent with some, most notably the night nursing service, Isleworth practice and the SPMS management, having made savings.

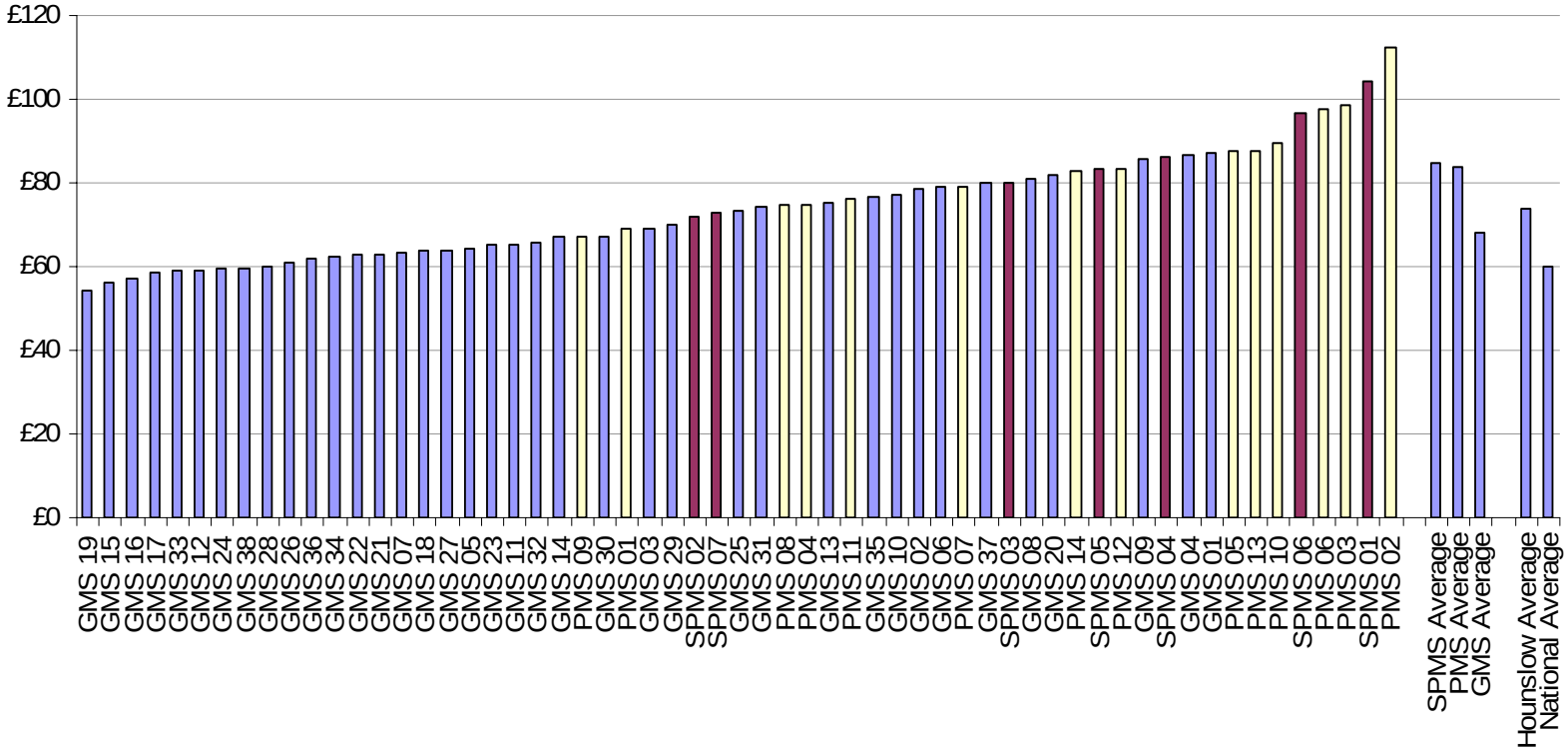
Most of the SPMS practices are less cost-effective than GMS/PMS practices given that they are overspending and this overspend is being picked up by the PCT (this is assuming that GMS/PMS practices are staying within their Global Sum Equivalent (GSE) allocations at least in terms of not coming to the PCT and asking it for more money to cover the core services they provide through their GSE).

Global Sum Equivalent (GSE) is a fair shares allocation of health care monies that is based on the needs of a GP practice population and two other key factors; relative to the UK population as a whole. The weighted factors are age and sex; patients in nursing/residential homes; list turnover for new patients; additional needs - measured through standardised limited long-standing illness and the standardised mortality ratio; staff market forces; and rurality. This means that GPs who are cost-effective will keep to the GSE budget and those that are not will overspend given that the practices compared provide the same level and quality of services. The most cost-effective, of course, would be saving money and actually delivering services below their GSE allocation whilst maintaining and even improving quality and performance.

Figure 8.1 shows a graph of the annual GSE per patient (GSE per P) for all the practices that Hounslow commissions. There is considerable variation between practices but what this variation shows is that the GPs with low GSEs per patient have a healthier and younger adult practice population with less patient turnover compared to those with higher GSEs per patient who have a more ill, very young and very old population with higher levels of patient turnover.

The national average GSE per P is £60 and the Hounslow average is £74 (based on the data that was provided for 7 SPMS practices, 14 PMS practices and 38 SPMS practices). This shows that Hounslow GPs serve a more needy

Figure 8.1 Global sum equivalent income allocations per patient by GMS, PMS and SPMS practices.



population compared to England as a whole. Within Hounslow the SPMS practices serve the most needy practice populations as their average GSE is £85 compared to a PMS average of £84 and a GMS average of £68.

However, these figures need to be understood in the context of the minimum practice income guarantee (MPIG) which ensures that GP's do not get paid less than previous earnings. This therefore has a significant influence on GSE totals and is likely to continue historical inequalities in funding between practices. GSE may therefore be more usefully seen as a measure of the variation and inequality in the historical funding of GPs.

8.3 Enhanced services

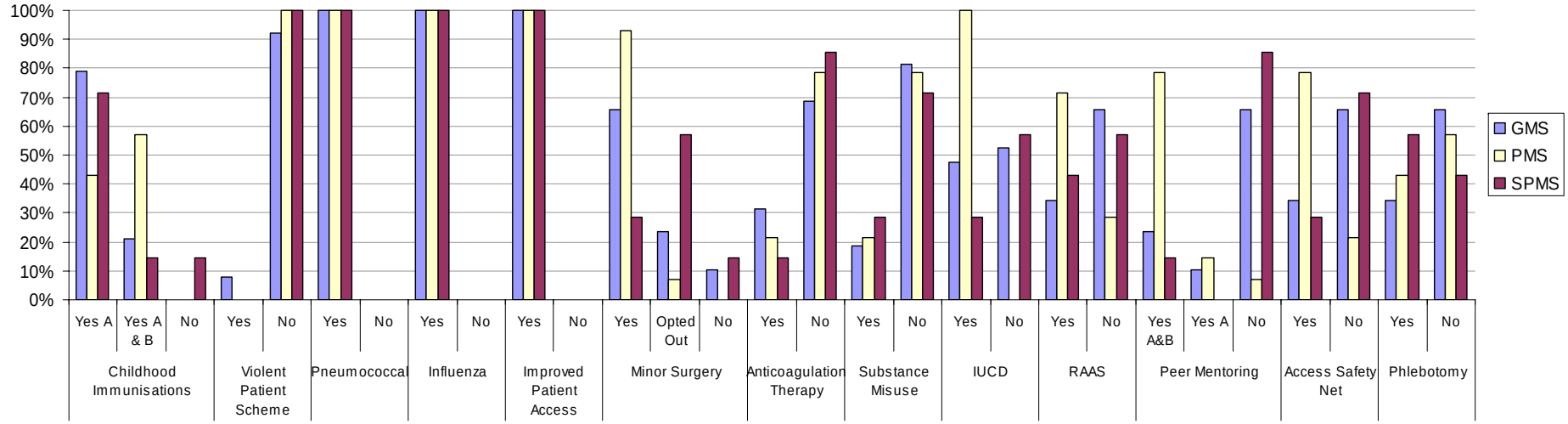
Thirteen enhanced services were reviewed in terms of whether and to what level they were being provided by SPMS, PMS and GMS practices [See Figure 8.2]

All SPMS, PMS and GMS practices provide the pneumoccocal, influenza and improved patient access services.

5 (71%) SPMS practices deliver Option A of the childhood immunisation enhanced service with 1 (14%) delivering both Option A and B and another 1 (14%) not currently delivering it. 6 (43%) PMS practice deliver Option A with 8 (57%) delivering both Option A and B; while 30 (79%) GMS practices deliver Option A with 8 (21%) delivering both Option A and B. Therefore only a majority of PMS practices currently deliver both Option A and B of the childhood immunisation enhanced service compared to both SPMS and GMS practices.

None of the SPMS or PMS practices and only 3 (8%) of GMS practices deliver the violent patient scheme enhanced service.

Figure 8.2 Range and level of enhanced services provided by SPMS, PMS and GMS practices



2 (29%) SPMS practices deliver the minor surgery enhanced service with 4 (57%) having opted out and 1 (14%) not currently delivering it. In contrast, 13 (93%) PMS practices deliver minor surgery with only 1 (7%) having opted out; while 25 (66%) GMS practices deliver minor surgery with 9 (24%) having opted out and 4 (11%) not delivering this service.

1 (14%) SPMS practice delivers the anticoagulation therapy enhanced service with 6 (86%) not delivering this. 3 (21%) PMS practices deliver anticoagulation therapy with 11 (79%) not delivering it; while 12 (32%) GMS practices deliver this service with 26 (68%) not delivering it.

2 (29%) SPMS practices deliver the substance misuse enhanced service with 5 (79%) not delivering it. 3 (21%) PMS practices deliver the substance misuse service with 11 (79%) not delivering it; while 7 (18%) GMS practices deliver this service with 31 (82%) not delivering it.

3 (43%) SPMS practices deliver the IUCD enhanced service with 4 (57%) not delivering it. All 14 (100%) PMS practices deliver the IUCD service; while 18 (47%) GMS practices deliver it with 20 (53%) not currently delivering it.

3 (43%) SPMS practices deliver the RAAS enhanced service with 4 (57%) not delivering it. 10 (71%) PMS practices deliver the RAAS service with 4 (29%) not delivering it; while 13 (34%) GMS practices deliver this service with 25 (66%) not delivering it.

1 (14%) SPMS practice is delivering both Parts A and B of the peer mentoring enhanced service with the remainder not delivering either Part A or Parts A and B. 11 (79%) PMS practices deliver both Parts A and B of the peer mentoring service with 2 (14%) delivering just Part A and 1 (7%) not delivering this service; while 9 (24%) GMS practices deliver both Parts A and B of the peer mentoring service with 4 (11%) delivering just Part A and 25 (66%) not delivering this service.

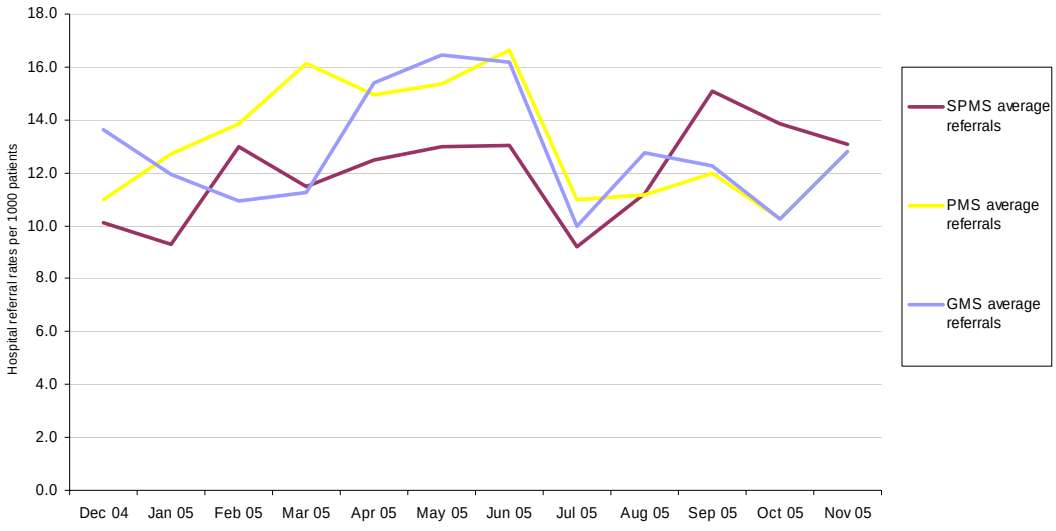
2 (29%) SPMS practices deliver the access safety net enhanced service with 5 (71%) not delivering it. 11 (79%) PMS practices deliver the access safety net service with 3 (21%) not delivering it; while 13 (34%) GMS practices deliver this service with 25 (66%) not delivering this service.

Lastly, 4 (57%) SPMS practices deliver the phlebotomy enhanced service with 3 (43%) not delivering it. 6 (43%) PMS practices deliver the phlebotomy service with 8 (57%) not delivering it; while 13 (34%) GMS practices deliver this service with 25 (66%) not delivering it.

8.4 Referral management centre activity

Analysing the referral management centre (RMC) data for 55 practices from December 2004 to November 2005 shows no differences between SPMS, PMS and GMS practices they are each referring similar number of patients for hospital referrals via the RMC [See Figure 8.3].

Figure 8.3 Number of hospital referrals per 1000 patients by the SPMS, PMS and GMS practices



8.5 Prescribing practice

Analysing the data for fifty-seven practices found some differences in prescribing practice.

The average percentage of generic items prescribed out of total items prescribed (excluding dressings etc) is 81% for SPMS practices, 82% for GMS practices and 78% for PMS practices against a Hounslow PCT average of 80%.

Reducing antibiotic use is important in preventing the antibiotic resistance of illness-causing micro-organisms. The average antibiotic items usage per 1000 STAR-PU (Specific Therapeutic Group Age-Sex Related Prescribing Units) for SPMS practices is 116, for GMS practices is 135 and for PMS practices is 120 against a Hounslow PCT average of 127.

Reducing benzodiazepine and Z drug prescribing is considered a priority by the PCT given the guidance from the National Institute of Clinical Excellence and the Committee on the Safety of Medicines. The average benzodiazepine average daily quantity (ADQ) per 1000 STAR-PUs for SPMS practices is 873, for GMS practices is 646 and for PMS practices 481 against a Hounslow PCT average of 626.

The average annual projected variance in the prescribing budgets of SPMS is forecast to be 4%, that for GMS to be -2% and that for PMS practices to be -4% against a Hounslow PCT average of -2% (a negative percentage indicates an overall forecast underspend and a positive percentage an overall forecast overspend).

8.6 Emergency admission rates

Analysing emergency admissions data for fifty-eight practices (7 SPMS, 13 PMS and 38 GMS practices) the average attendance rates at accident and

emergency for the first six months of 2005-06 to the three key hospitals that serve the SPMS practices was 137 per 1000 patients, for GMS practices it was 130 per 1000 patients and for PMS practices it was 115 against a Hounslow average of 128.

There also seem to be no correlation between an increase in contact with Harmoni, the out of hours service provider, and reductions in attendances at accident and emergency.

8.7 Summary

Given that the SPMS practices overall are overspending they are less cost-effective than the GMS and PMS practices which stay within their core GSE allocations. However they are serving a more needy patient population compared to GMS and PMS practices given that there average GMS allocation per patient is higher than that for PMS and GMS practices[12].

The SPMS practices provide a similar range of enhanced services as GMS and PMS practices.

The SPMS practices refer similar numbers of patients to hospital, via the referral management centre, as GMS and PMS practices.

The SPMS practices seem to have a higher level of antibiotic and benzodiazepine prescribing though its generic prescribing is in line with GMS and PMS practices. The SPMS is also projected to overspend its prescribing budget compared to GMS and PMS practices which are projected to underspend.

[12] Though this needs to be seen in the context of historical funding and the protection of general practice funding through the minimum payment guarantee it is unlikely that historical funding levels were high only for the SPMS practices.

The SPMS practices, over the last six months, also seem to have a higher level of accident and emergency attendances compared to the GMS and PMS practices.

There were significant data constraints as well as some discrepancies in the GPs and GP practices listed within the various datasets which has caused some difficulties in analysis. The relative differences between the practices is likely to be accurate but the absolute numbers are subject to correction given that some practices have not been included in the analysis.

9. Content analysis

9.1 Introduction

This chapter analyses the key documents relating to the SPMS and in particular the rationale of the SPMS and its structure.

Key themes emerging from this are:

- The range of diverse, differing and, in some instances, contradictory objectives that emerged between the first development of the SPMS, the decision to set it up and its implementation.
- The tension between creating a new independent provider versus one that was still part of the PCT and hence whose vision was in line with that of the PCT.
- The underlying tension between reducing overspending versus improving poorly performing services and developing new and innovative ones.
- The lack of an explicit exit strategy for the SPMS to deal with changing national and local circumstances.
- The lack of a detailed assessment of the implications and consequences of creating the SPMS and alternative options available to the PCT.

9.2 Rationale for the SPMS

The rationale of the SPMS was to create a new and innovative provider that would develop more innovative solutions to delivering primary care within Hounslow and separate some of the provider functions from the PCT.

The *Proposal to develop SPMS in Hounslow* paper, of February 2004, puts it like this:

"…an innovative and holistic solution which will equip the PCT to improve the delivery of primary care in the near future and beyond. The solution needs to incorporate a long term vision with an interim solution to some immediate problems."

"…a unique opportunity…to establish a Specialist SPMS to deliver a range of services which would be sensibly linked to enable improved co-ordination and support whilst reducing conflicts of interest and boundary blurring across the PCT and practices."

The key theme emerging from this paper is that though the SPMS would influence commissioning by splitting some, but not all, provider functions from the PCT, it was primarily an approach to develop provider services, specifically a new independent provider whose vision was more in line with that of the PCT compared to existing providers which would develop better services and fill the service gaps left by existing providers. One aspect that the SPMS was not developed to tackle was an explicit objective to develop more cost-effective primary care services.

By the time of the *SPMS – Hounslow* paper, of September 2004, the rationale has been further worked up to state:

"By choosing an SPMS contract we could integrate the primary care services we run into one single provider, bringing together the 7 practices, the salaried professionals' scheme, OOH services and some other PCT run services which we see as primary care or naturally falling into the SPMS such as family planning services, phlebotomy and night nursing."

"This allows the PCT to have a strong partnership with Harmoni to build a robust primary care provider in Hounslow to enable more rapid growth of primary care in the area – something still badly needed with list sizes much

higher than average. The scheme will enable positive collaboration with local GPs to provide more services traditionally provided in secondary care by having a strong primary care provider able to play a key role in kick starting negotiations."

"As well as continuing to provide the award [winning] salaried professionals scheme we aim for the SPMS to:

- *Provide gold standard General Practice*
- *Integrated out of hours services based round Harmoni GPs and the SPMS night nursing service.*
- *Family Planning and an innovative young peoples' health improvement project SAFE."*

The first quoted paragraph identifies the key services that would be, and were, incorporated into the SPMS and the rationale for including these in one organisational framework was that they were 'services which we see as primary care or naturally falling into the SPMS'. There is no further assessment or justification of why the services were chosen and what the potential advantages and disadvantages of including them would be.

The MedEconomics article, of October 2004, which was written by the PCT and included the quotes from the SPMS Director and the PCT Chief Executive, goes on to elaborate some further objectives of the SPMS:

"Integral to the Hounslow SPMS is a new NHS organisation that will provide general practice services at vacant practices and deliver out-of-hours services across the PCT to opted-out GP's patients."

"PCTs with several gaps to fill may follow Hounslow's example by setting up a catch-all SPMS organisation."

"Hounslow SPMS will take over five vacancy practices that the PCT is already running and staffing. As well as the out-of-hours service for opted-out GPs' patients, the SPMS scheme will provide an urgent care centre based at West Middlesex University Hospital A&E"

"The advantage of SPMS over APMS is keeping service provision within the NHS. Hounslow SPMS activities will be commissioned by PCT staff; frontline clinical services switching to SPMS will also be delivered by NHS professionals."

The article highlights that the SPMS would: provide general practices services at vacant practices, something not explicitly described in the previous two documents; act as a general catch-all structure through which any kind of service gap could be filled; and significantly enable service provision to be kept within the NHS. This latter statement is significant as it contradicts the notion that SPMS would split some provider functions from the PCT and reduce conflict of interest and boundary blurring.

The Medarticle does though discuss the issue of cost-effective by stating that:

"The SPMS needs to be cost-neutral; there is no increase to the PCT's recurrent allocation and no pump-priming cash."

The first theme that emerges from a reading of the key proposal documents is that the SPMS was set up to deliver a range of quite complex and in some instances contradictory objectives. Key to this has been the notion that it is better to deliver a range of objectives within a single diverse organisational and contractual entity than to create a number of smaller and more coherent entities each delivering one or a few of these objectives. The second theme was the ambiguity about whether the SPMS was a long term model for creating new providers of primary care services, that delivers services independently of the PCT, or a transitional model within the PCT, that improves poorly performing services or undertakes other remedial work and

then enables these services to pass on to another provider or achieve independence.

9.3 Design of the SPMS

The SPMS – proposed working arrangements document of April 2005 highlighted a number of key issues relating to the final design of the SPMS.

"The recommendation is that the organisation remains part of the PCT but is established with its own management structure and decision making powers within the PCT. Whilst it is envisaged that in the longer term the SPMS could become an independent entity and this paper highlights a number of areas of weakness in remaining part of the PCT…"

"We believe that the arrangements proposed allow:

- *The PCT to focus largely on commissioning of healthcare and management of the overall heath community.*
- *The SPMS to focus on improving effectiveness and efficiency whilst improving the working practice and service that it offers to patients.*
- *Sufficient control for good managers at the heart of the SPMS to rein in overspend whilst continuing to develop and integrate the services and operations of all the components being placed within the SPMS thereby improving the performance of the organisation in meeting patients' needs."*

In this document the objectives of the SPMS are restated focusing: first, on enabling the PCT to focus more on its commissioning role; second, on improving the effectiveness and efficiency of the services within the SPMS; third, on reining in overspending at the same time as further developing and integrating services to improve the performance of the services within the SPMS.

Two questions arise from the objectives as stated above. First, how was the SPMS, as now structured, going to enable the PCT to focus more on its commissioning function given that the PCT had not actually divested these services but had just created an internal quasi-departmental separation. Second, given the difficulty in improving any type of service whist also reducing costs within that service, how would the tension be resolved between the objective of improving and innovating services and that of reducing costs.

The original rationale was to a) create a new provider that would be independent of the PCT and b) integrate these service with, or within, Harmoni. This was not realised and instead the SPMS became an internal contractual arrangement within the PCT whose aim was to provide greater flexibility whilst still being a part of the PCT.

Given that the original SPMS design was predicated on a model of independence any approach that did not lead to this was unlikely to be fully satisfactory in terms of the SPMS achieving its aims and objectives.

The organisational structure given that the SPMS services stayed within the PCT meant that the role of Harmoni, originally seen as equal co-partner, was small and limited.

Finally, the virtual nature of the separation between the PCT and the SPMS has led to a blurring of the lines of responsibility and accountability, some elements of blame-laying and finger-pointing between the SPMS and the PCT, and heightened sense of ‘us and them’ between the SPMS and the PCT. This latter issue is significant because the greater the sense of team cohesion within the SPMS as a separate organisational entity the less team cohesion and conflict that seems to have been generated between the PCT and the SPMS.

9.4 Implementation and monitoring of the SPMS

Staff consultation was undertaken to identify the views and perspectives of staff on the SPMS but this was undertaken at a late stage in the planning process. Staff and other stakeholders were not consulted and involved in the early stages of the design of the SPMS approach. This would have been useful both to gauge staff and stakeholder support and opposition but also to develop a more robust design and wide support for the final design and approach chosen.

No specific outcome or performance indicators were identified nor were specific monitoring measures or mechanisms put in place to assess the quality, effectiveness and value for money of the SPMS when compared to the previous arrangements or to other similar existing primary care providers e.g. GMS and PMS practices, Harmoni, etc. Very little of the current routine data seen by the reviewer is categorised by the SPMS services, individually and collectively, and other providers.

9.5 Future of the SPMS

The SPMS strategy did include a review of the SPMS in October 2006 but no explicit long term strategy was developed which considered what would happen, who would decide and what steps would need to be taken if the SPMS became unviable or if the circumstances under which it was created changed and this necessitated a change, major reconfiguration or evolution of the SPMS.

9.6 Assessment of the implications and consequences of the SPMS

There was no detailed assessment of the implications and consequences of the SPMS and there was no development and consideration of other options.

This is a crucial task when developing and implementing a new and innovative approach which has no existing good practice guidelines or pilot sites to learn from. As a minimum such an assessment would have highlighted the issues identified in this chapter and would have helped to develop answers and approaches to constructively deal with them.

9.7 Summary

Bearing in mind that it is always easier to identify weaknesses in the rationale and design of a project in hindsight than it is when the project is first developed, nevertheless a rapid content analysis of the key documents relating to the SPMS has identified a number of key weaknesses in the rationale and design of the SPMS:

The SPMS had a range of diverse, differing and, in some instances, contradictory objectives that emerged between the first development of the SPMS and its implementation. There was a tension between creating a new independent provider and one that was still part of the public sector NHS. There was also a tension between reducing overspending versus improving existing services and developing new ones. The SPMS lacked an explicit exit strategy to deal with changing national and local circumstances or potential unviability. Lastly, there was no detailed assessment of the implications and consequences of creating the SPMS and no detailed consideration of the alternative options available to the PCT.

10. Overall findings

10.1 Introduction

This chapter presents the overall findings in relation to the eight review questions described in Chapter 3.

The SPMS, in its first year, has been partially successful in achieving its objectives and a number of factors have contributed to and worked against the achievement of those objectives. Given that the first year of any change process tends to be the most disruptive and difficult this is a significant achievement.

The SPMS, depending on context, seems to be a good to excellent transitional model to move services or a set of services which a PCT is obliged to support for a time, from a lower level of service delivery to a higher level of service delivery, and then divest to other providers at a later stage when feasible.

The working arrangements between the PCT and SPMS have not been very successful and this has largely been due to the creation of a virtual 'arms-length' entity within the PCT that was and is trying to be an independent organisation within an organisation.

The SPMS has overspent its budget and while the quality of its services have been good to very good they seem to have been within the range encompassed by other more cost-effective providers of primary care e.g. the GMS and PMS general practices.

On balance, given the diversity of objectives that the SPMS had it was the best model to enable these objectives to be tackled within a single framework.

10.2 What are the SPMS's objectives and to what extent have these been achieved?

The major objectives of the SPMS were to develop more innovative solutions to delivering local primary care services; to separate the commissioner and provider functions of the PCT; to create a new and more integrated primary care provider and do all this in a cost-effective manner.

Though, overall, respondents to the questionnaire described the SPMS as not being an innovative organisation it has been successful in delivering primary care services that provide:

- access to primary health care that is local;
- processes and procedures in place that ensure care is safe and provided to a high standard;
- common standards and service requirements for all Out of Hours care providers;
- patient-centred services;
- access to primary health care that is quick;
- access to primary health care that is equitable; and
- high quality services.

However, it has not separated any provider functions from the PCT, has been less successful at integrating services and being cost-effective. Specifically, it has not been successful in:

- opening up of the local primary health care market for better patient choice;

- putting infrastructure in place to support sharing of patient information between primary health care professionals;
- integrating the practices and services within the SPMS;
- providing value for money services;
- creating less conflict of interest; and
- enabling the sharing of patient information between primary health care professionals.

10.3 What factors contributed to or worked against the achievement of these objectives?

The top five factors that have contributed to the achievements of the SPMS have been:

- multidisciplinary team-working within respondents own SPMS service;
- personal training and development;
- risk management and quality control;
- relations between management and staff; and
- multidisciplinary team-working between SPMS services

The top five factors that worked against the achievements of the SPMS were[13]:

[13] These top five factors are from the questionnaire results and no additional information is available as to what specific aspects of PCT management worked against the achievements of the SPMS.

- lack of finance;
- lack of appropriate incentives/rewards;
- PCT management;
- lack of clarity about SPMS vision/ purpose;
- lack of autonomy/ authority to take initiative;

10.4 What are the key learning points for the PCT from their commissioning of the SPMS?

The key learning points for the PCT are that:

- Hounslow PCT can develop and implement new and innovative models of primary care quickly, successfully and with reasonably wide staff support.
- The SPMS, depending on context, seems to be a good to excellent transitional model to move services or a set of services which a PCT is obliged to support for a time, from a lower level of service delivery to a higher level of service delivery, and then divest to other providers at a later stage.
- It less clear how good a model the SPMS is for making services independent from the PCT. The SPMS in itself is a legal contract and not a legal entity such as a charity, not-for-profit company or co-operative and hence to move services to independence requires the services bound by the SPMS to collectively transform themselves into such an entity. This reverses the traditional model where a provider already exists or is created first and this provider then signs up to an

SPMS or other contractual arrangement to take on existing primary care services or develop new ones.

- It is vitally important that objectives are explicitly stated and changes to objectives explicitly justified when models like the SPMS are developed. This would ensure that the model is both able to achieve its stated objectives as well as still being the best model when these objectives change as they inevitably do as a project or plan is worked up and refined.

- It is not always better to achieve a range of differing and diverse objectives or to fit a range of services within a single SPMS. It can be better to split objectives and services into smaller subsets and use a number of SPMS's to enhance accountability, coherence and integration. Avoiding the temptation to have a 'one size fits all' SPMS model is also likely to concentrate minds on the likely benefits and disbenefits of going down this route as a whole.

10.5 How successful have the working arrangements been between the commissioner and the providers and what are the key learning points from the implementation of the SPMS?

The working arrangements between the PCT and SPMS have not been very successful and this has largely been due to the creation of a virtual 'arms-length' entity within the PCT that is attempting to be an independent organisation within an organisation. This has led to a sense of 'us and them', which while understandable between a commissioner and an external provider, has been damaging in terms of facilitating shared objectives, responsibility and accountability as well as possibly team-working between the PCT and SPMS.

Key areas that have, to a greater or lesser extent, worked less well are the core support functions provided by the PCT: finance, IT, building and facilities and human resources. These functions have understandably, and inevitably, been PCT and PCT Trust Board focused rather than SPMS and SPMS services focused. The priorities of these support functions have been those of the PCT and not those of the SPMS. This has been exacerbated by a lack of skills and experience within the SPMS services in taking on and managing basic aspects of these support functions within their services. For example, at the level of individual SPMS services, there seems to have been some significant lack of skills, experience and confidence in dealing with financial information that was exacerbated by a lack of advisory and practical support from the PCT's financial function.

If services are to be made independent or quasi-independent then significant resources need to be expended up-front in training service staff in these four core support functions within their service unless separate dedicated personnel are assigned in these areas to support these services full-time.

10.6 Has the SPMS provided value for money one year on compared to carrying on with the arrangements in place before it was set up? What have the costs and benefits been from financial, staff, service delivery, patient and organisational perspectives?

The SPMS has overspent its budget and while the quality of its services have been good to very good they have been within the range encompassed by other more cost-effective providers of primary care e.g. the GMS and PMS general practices.

However, the SPMS has, overall, improved service delivery and been seen in a positive light by SPMS staff as a model and approach that has provided significant benefits both to patients and staff.

Organisationally, the virtual separation of the SPMS within the PCT and the PCT-focus of key PCT functions have not worked as well as intended.

10.7 Could these objectives have been better achieved through a strategy and approach different from that used to develop the SPMS?

As stated earlier there were a range of quite challenging objectives, principles and values that the SPMS was set and some were unclear and contradictory. On balance, given this context, the SPMS was probably the best model to enable such diverse objectives to be tackled within a single framework.

The other options available would have been to have an SPMS with just the general practices, plus the salaried professional scheme, and an SPMS with the other clinical services. This could have increased management costs but by having a smaller set of strongly aligned services these could have been held more directly accountable, more integrated and potentially more cost-effective.

The other major criticism was for the PCT to have carried out a more explicit options assessment that included all the potential strengths, weaknesses, opportunities and threats; consideration of a range of possible other options; as well as more early involvement and consultation of service staff and other stakeholders in the development of the available options and the design of the final chosen option.

10.8 How does the objectives and underlying values of the SPMS measure up with the requirements for the ‘patient-led NHS’ agenda?

The PCT values that the SPMS significantly or fully demonstrated were:

- a commitment to providing services to the best professional standards;
- being a learning organisation; and
- being an exemplary employer that values staff.

The PCT values that the SPMS only partially demonstrated or did not demonstrate were:

- focussed and responsive – offering local people a seamless service;
- open – working to bring together health and social care;
- achieving best value; and
- innovative organisation that recognises the needs and diversity of its local community.

As for the criteria of a patient-led NHS, respondents described the following as being significantly or fully achieved:

- securing safe services;
- reducing inequalities;
- improving health;
- securing high quality services; and
- improving engagement of GPs.

The criteria of a patient-led NHS which respondents described as being only partially or not addressed were:

- improving coordination with social services;
- delivering reduction in management/ administrative costs;
- improving public involvement;
- improving management of financial risk;
- improving commissioning; and
- improving effective use of resources.

The SPMS, in its first year, therefore significantly addresses only half the criteria that need to be fulfilled for a service to be fully patient-led.

10.9 What does the review data tell us about the future of the SPMS and its core business?

In its first year, the SPMS has been a successful model in helping to improve the quality of the services within it. It has significant support from staff and has created a good working environment with training and development, flexibility and good morale. Key improvements have been achieved within the individual services and while all of these are not directly attributable to the SPMS framework itself it was achieved within the SPMS framework.

The SPMS has been less successful at integrating services and in fostering team-working between services. Many of its successes have also not been across the board with some services not feeling the benefits of enhanced training and development or recruitment and retention.

The SPMS could continue as it is and build on its successes but its current structure as being within the PCT and yet at 'arms-length' is not an optimal organisational configuration for the long term. For the medium to long term it either needs to move to independence, either as a whole or in part, or be 're-absorbed' back into the PCT, again either as a whole or in part.

10.10 Summary

In summary, the SPMS, in its first year, has been partially successful in achieving its objectives and a number of factors have contributed to and worked against the achievement of those objectives. Given that the first year of any change process tends to be the most disruptive and difficult this is a significant achievement.

The SPMS, depending on context, seems to be a good to excellent transitional model to move services or a set of services which a PCT is obliged to support for a time, from a lower level of service delivery to a higher level of service delivery, and then divest to other providers at a later stage.

The working arrangements between the PCT and SPMS have not been very successful and this has largely been due to the creation of a virtual 'arms-length' entity within the PCT that is trying to be an independent organisation within an organisation.

The SPMS has overspent its budget and while the quality of its services have been good to very good they have been within the range encompassed by other more cost-effective providers of primary care e.g. the GMS and PMS general practices.

On balance, given the diversity of objectives the SPMS had it was the best model to enable these objectives to be tackled within a single framework.

11. Options

11.1 Introduction

This chapter analyses the possible future options for the SPMS. The options considered are:

- The SPMS continuing as it is.
- The SPMS becomes independent as originally envisioned.
- The SPMS general practices become independent and the remaining SPMS services continue as a smaller independent SPMS.
- The SPMS general practices become independent and the remaining SPMS services merge with the PCT's existing clinical services.
- The SPMS general practices become independent and the PCT's existing clinical services join the remaining SPMS services to create a new SPMS.
- All the SPMS services become independent.
- The SPMS becomes a turn-around troubleshooting team.
- Each service within the SPMS has the choice of when to become independent

This chapter does not re-state the advantages and disadvantages identified by participants of the review workshop but describes potential strengths, weaknesses, opportunities and threats that – in the reviewer's judgement - are likely to emerge should an option be progressed.

Three points are worth bearing in minding when considering the options. First, all the options involve certain risks, uncertainties and challenges in terms of negative impacts on staff, service delivery and costs. Second, the crucial question therefore becomes which option is likely to have the most positives and fewest negatives in relation to the local and national context and the findings of this review. Third, regardless of the option progressed, how it is worked up and implemented will be critical to its overall success.

11.2 Option 1: SPMS continues as it is

In the reviewer's judgement, the strengths of continuing the SPMS, as it is, are the continuity and stability that it affords to staff and service delivery. There would be no resource expenditure – financial, human or time – on designing and implementing any change. From the workshop and the questionnaire a significant number of staff seem to be happy with the SPMS structure. The SPMS has had important successes in creating a structure that provides a greater degree of flexibility for, at least, some staff and services to develop and extend their activities.

This provides the key opportunity of pursuing this option namely to build on the successes of the first year of the SPMS.

The weaknesses of this option are firstly, the SPMS is currently overspending and the factors which are causing the overspending are likely to remain. Secondly, the flexibility and room for manoeuvre that some staff and services have experienced has not been felt uniformly across all the services within the SPMS. Thirdly, the SPMS as it currently works does not fully address all the criteria for a patient-led NHS service. Fourthly, some SPMS staff may not like this option.

The major threats of pursuing this option are firstly, the strong policy driver that PCTs should divest themselves of provider services which is likely to

mean that this option is unlikely to be a long term sustainable solution. Hence, the security, certainty and continuity that staff will gain is likely to be only temporary. So, while initially morale may remain high this is likely to fall as staff realise that change has only been postponed and not fully resolved. Secondly, concerns and tensions from some SPMS staff who do not like this option.

In the reviewer's judgement therefore, pursuing this option therefore builds on the strengths of the SPMS and provides the opportunity to deliver services more innovatively as well as providing a structure that enables the rescue of failing practices (and services). But its weaknesses in doing nothing to take forward the requirement to split provider functions from the PCT, continuing the SPMS's overspending and some SPMS staff not liking this option could threaten to exacerbate the financial pressures on the PCT, reduce the room for manoeuvre of the SPMS and needing to manage the concerns and tensions among some SPMS staff.

11.3 Option 2: SPMS goes independent as originally envisioned

In the reviewer's judgement, the strengths of this option would be firstly, that it progresses the original vision of the SPMS. Secondly, there is support from some SPMS staff for greater freedom and autonomy from the PCT.

The opportunities this presents are firstly, that it would give the SPMS greater autonomy which could allow it to deliver better and more cost-effective services. Secondly, it would achieve a split between the PCT and some its provider functions enabling it to focus more on its commissioning role. Thirdly, it would reduce some of the overspending within the PCT. Fourthly, the SPMS could in this form provide a model by which the existing clinical services within the PCT could also be split from the PCT.

The weaknesses of this option are firstly, the SPMS is currently overspending and the factors which are causing the overspending are likely to remain. Secondly, the process of becoming a not-for-profit charitable company or co-operative is likely to take some time, given the scarcity of examples where NHS services have become independent, particularly with regard to negotiating staff transfer, the annual budget, etc. Thirdly, some SPMS staff may not like this option.

The threats therefore of making the SPMS independent are firstly, though some of the overspending within the PCT would be reduced, in terms of the PCT being directly responsible for the SPMS's overspending, there is a potential for the independent SPMS to become, for whatever reason, unviable which could force the PCT to step in and take over the SPMS given the range, diversity and significance of the services that are being delivered by it. Secondly, concerns and tensions from SPMS staff who do not like this option.

In the reviewer's judgement therefore, pursuing this option therefore builds on the original vision and the current strengths of the SPMS; provides the opportunity to create a new provider that through its newly acquired autonomy becomes better and more cost-effective; split some provider functions from the PCT enabling it to focus more on its commissioning role; reduce some of the overspending within the PCT; and develop a model of how the PCT might divest its remaining clinical services. But its weaknesses in terms of its current overspending threaten and some SPMS staff not liking this option threaten to still leave the PCT with the possibility of having to step in and support the SPMS if, for whatever reason, it should become unviable and managing and needing to manage the concerns and tensions from some SPMS staff who do not like this option.

11.4 Option 3: SPMS general practices go independent and the remaining SPMS services continue as a smaller independent SPMS

In the reviewer's judgement, the strength of this option is that there is a willingness on the part of some general practice staff to go independent.

The opportunities would be firstly, the greater autonomy could enable the independent SPMS general practices and services to deliver better and more cost-effective services. Secondly, that the PCT would divest itself of some of its provider functions enabling it to focus more on its commissioning role.

The weaknesses of this option are firstly, the lack of experience and expertise within many of the SPMS services to manage the financial and clinical risks of running these services outside the public sector. Secondly, the remaining services are to a greater or lesser extent dependent on the SPMS general practices for using their services. There is a potential therefore that they will not be viable because the independent SPMS general practices either commission services from a non-SPMS provider or bring these services in-house. Thirdly, the PCT would lose an in-house 'back-up' GP service that could deliver services at short notice. Fourthly, some SPMS staff may not like this option.

The threats of this option are firstly, the non-GP SPMS clinical services become unviable in a smaller independent SPMS without the general practices. Secondly, concerns and tensions from staff who do not like this option. Thirdly, the PCT would lose an in-house 'back-up' GP service that could deliver services at short notice. Fourthly, some of the SPMS general practices may not become independent, either because they are seen to be difficult to run or less financially attractive, leaving the PCT to continue managing them. Fifthly, concerns and tensions from some SPMS staff who do not like this option

In the reviewer's judgement therefore, pursuing this option therefore provides the opportunity to make the SPMS general practices and services

independent enabling them through their newly acquired autonomy to become better and more cost-effective; split some provider functions from the PCT enabling it to focus more on its commissioning role; and reduce some of the overspending within the PCT. But its weaknesses in terms of the dependency of the SPMS's non-GP clinical services on the SPMS general practices; the potential for only the well run and more financially attractive general practices to become independent; and some staff not liking this option threaten to still leave the PCT having to step in and support these services should they, for whatever reason, become unviable; either the loss of an in-house 'back-up' GP service or still continuing to run a number of GP practices; and needing to manage the concerns and tensions from some SPMS staff who do not like this option.

11.5 Option 4: SPMS general practices go independent and the remaining SPMS services merge with the other clinical services provided by the PCT

In the reviewer's judgement, the strength of this option is that there is a willingness on the part of some general practice staff to go independent and some SPMS clinical services staff to merge with the other clinical services provided by the PCT.

The opportunities would be firstly, that the PCT would divest itself of some of its provider functions enabling it to focus more on its core commissioning role. Secondly, the merger of clinical services could lead to better integration of these services and potentially greater cost-effectiveness. Thirdly, the greater autonomy could enable the independent GPs to deliver better and more cost-effective general practice services. Fourthly, skills and expertise developed through the SPMS are retained within the PCT's existing clinical services.

The weaknesses of this option are that firstly, some of the non-GP SPMS services are overspending and this is likely to continue to be the case. Secondly, some SPMS staff may not like this option.

The threats of this option are firstly, it still leaves the PCT with a significant number of provider services some of which are likely to continue to overspend though as the SPMS general practices generate some of the overspend this is potentially less than when these services were all in the SPMS. Secondly, the PCT would lose an in-house 'back-up' GP service that could deliver services at short notice. Thirdly, some of the SPMS general practices may not become independent, either because they are seen to be difficult to run or less financially attractive, leaving the PCT to continue managing them. Fourthly, concerns and tensions from some SPMS staff who do not like this option

In the reviewer's judgement therefore, pursuing this option therefore provides the opportunity to make the SPMS GP practices independent enabling them through their newly acquired autonomy to become better and more cost-effective; split some provider functions from the PCT enabling it to focus more on its commissioning role; reduce some of the overspending within the PCT; and integrate the non-GP SPMS clinical services with the PCT's clinical services potentially making them better and more cost-effective. But its weaknesses in terms of the PCT retaining some services that are likely to continue overspending; the loss of an in-house 'back-up' GP service and some SPMS general practices not becoming independent; and some staff not liking this option threaten to leave the PCT with continuing overspending, less flexibility; either the loss of a in-house 'back-up' GP service or still continuing to run a number of GP practices; and needing to manage the concerns and tensions from some SPMS staff who do not like this option.

11.6 Option 5: SPMS general practices go independent and the other clinical services provided by the PCT merge with the remaining SPMS services to form a new SPMS

In the reviewer's judgement, the strength of this option is that there is a willingness on the part of some general practice staff to go independent and possibly some SPMS clinical services staff to see the other services provided by the PCT join them in a new SPMS.

The opportunities would be firstly, that the PCT would divest itself of all of its provider functions, if the new SPMS is made independent, enabling it to focus totally on its commissioning role. Secondly, the merger of clinical services could lead to better integration of these services and potentially greater cost-effectiveness. Thirdly, the greater autonomy could enable the independent GPs and clinical services to deliver better and more cost-effective services.

The weaknesses of this option are that firstly, this would be a major and complex change process to implement with few, if any, other examples from which to learn from. Secondly, some SPMS and PCT staff may not like this option.

The threats of this option are firstly, the new SPMS could, for whatever reason, become unviable and this could force the PCT to step in and support the SPMS if, for whatever reason, it should become unviable. Secondly, some of the SPMS general practices may not become independent, either because they are seen to be difficult to run or less financially attractive, leaving the PCT to continue managing them. Thirdly, concerns and tensions from some SPMS and PCT staff who do not like this option.

In the reviewer's judgement therefore, pursuing this option therefore provides the opportunity to make the SPMS GP practices and the SPMS's and PCT's clinical services independent enabling them through their newly acquired autonomy to become better and more cost-effective; split all the provider functions from the PCT enabling the PCT to focus totally on its commissioning

role; and reduce much of the overspending within the PCT. But its weaknesses in terms of implementing a large and complex change management process and some SPMS and PCT staff not liking this option staff and a very difficult transition threaten to still leave the PCT having to step in and support the new SPMS if, for whatever reason, it should become unviable; either the loss of a in-house 'back-up' GP service or still continuing to run a number of GP practices; and needing to manage the concerns and tensions from some SPMS and PCT staff who do not like this option.

11.7 Option 6: All SPMS services become independent

In the reviewer's judgement, the strength of this option is that there is a willingness on the part of some general practice staff to go independent. There is also willingness on the part of some SPMS staff for greater autonomy and freedom from the PCT.

The opportunities would be firstly, that the PCT could divest itself of some of its provider functions enabling it to focus more on its commissioning role. Secondly, the greater autonomy could enable the independent general practices and services to deliver better and more cost-effective services.

The weaknesses of this option are firstly, the SPMS are likely to be too small in scale individually to cope with the financial and clinical risks in managing their services independently. Secondly, these services individually are currently inexperienced in managing these services outside the public sector. Thirdly, some SPMS staff may not like this option.

The threats of this option are firstly, the non-GP SPMS services could quickly become unviable forcing the PCT to step in and support these services. Secondly, not all the SPMS general practices or services may become independent either because they are seen to be difficult to run or less financially attractive, leaving the PCT to continue managing them. Thirdly, the

PCT would lose an in-house 'back up' GP service. Fourthly, concerns and tensions from some SPMS staff who do not like this option.

In the reviewer's judgement therefore, pursuing this option therefore provides the opportunity to make the SPMS general practices and the SPMS's clinical services independent enabling them through their newly acquired autonomy to become better and more cost-effective; split some provider functions from the PCT enabling it to focus more on its commissioning role; and reduce some of the overspending within the PCT. But its weaknesses in terms the independent non-GP clinical services threaten to make the transition process difficult and still leave the PCT with having to step in and support these services if, for whatever reason, they should become unviable; either losing an in-house 'back-up' GP service or still continuing to manage a number of SPMS services; and needing to manage the concerns and tensions from SPMS staff who do not like this option..

11.8 Option 7: SPMS becomes a turn-around troubleshooting team

In the reviewer's judgement, the strengths of this option are that it builds on the achievements and skills of the SPMS and there is support among some SPMS staff for this option.

The opportunity of this option is that it enables the Hounslow health economy to retain key skills in remediating poorly performing and failing practices (and services).

The weakness of this option are firstly, that it is not clear how this will be structured and whether all the SPMS general practices and clinical services would have a role in turning around and troubleshooting other primary care services. Secondly, the SPMS is currently overspending and this option does not resolve this issue. Thirdly, some SPMS staff may not like this option.

The threat of this option is that firstly, it does not address all the objectives and services of the SPMS, as it is currently set up, and hence may require some restructuring and change in vision and direction within the SPMS. Secondly, it does nothing to tackle the factors that are causing overspending within the SPMS. Thirdly, concerns and tensions from some SPMS staff who do not like this option.

In the reviewer's judgement therefore, pursuing this option builds on one of the strengths of the SPMS. But its weakness in being unclear about what would happen to many of the SPMS's current services; not resolving the SPMS's current overspending; and some staff who may not like this option threatens to move the SPMS and the PCT away from their main objectives and priorities and needing to manage the concerns and tensions from some SMPS staff who do not like this option.

11.9 Option 8: Each service within the SPMS has the choice of when to become independent

In the reviewer's judgement, this option has similar strengths, weaknesses, opportunities and threats as Option 1, the SPMS continuing as it is, as this is what this option implies.

This option is not so much an option as a value statement that whatever the future of the SPMS its staff should have the final say in how each of the services within it change and develop.

In the reviewer's judgement therefore, the PCT would therefore need to highlight that this important value will be taken into account and balanced alongside the PCT's and SPMS's other equally important values of delivering responsive, equitable, high quality and cost-effective services to local people in developing the way forward for the SPMS.

11.10 Summary

In the reviewer's judgement, Option 1 - the SPMS continues as it is, builds on the original vision and the current strengths of the SPMS; provides the opportunity to create a new provider that through its newly acquired autonomy becomes better and more cost-effective; split some provider functions from the PCT enabling it to focus more on its commissioning role; reduce some of the overspending within the PCT; and develop a model of how the PCT might divest its remaining clinical services. But its weaknesses in terms of its current overspending threaten and some SPMS staff not liking this option threaten to still leave the PCT with the possibility of having to step in and support the SPMS if, for whatever reason, it should become unviable and managing and needing to manage the concerns and tensions from some SPMS staff who do not like this option.

In the reviewer's judgement, Option 2 - the SPMS as whole becomes independent, builds on the original vision and the current strengths of the SPMS; provides the opportunity to create a new provider that through its newly acquired autonomy becomes better and more cost-effective; split some provider functions from the PCT enabling it to focus more on its commissioning role; reduce some of the overspending within the PCT; and develop a model of how the PCT might divest its remaining clinical services. But its weaknesses in terms of its current overspending threaten and some SPMS staff not liking this option threaten to still leave the PCT with the possibility of having to step in and support the SPMS if, for whatever reason, it should become unviable and managing and needing to manage the concerns and tensions from some SPMS staff who do not like this option.

In the reviewer's judgement, Option 3 - SPMS general practices go independent and the remaining SPMS services continue as a smaller independent SPMS, provides the opportunity to make the SPMS general practices and services independent enabling them through their newly acquired autonomy to become better and more cost-effective; split some

provider functions from the PCT enabling it to focus more on its commissioning role; and reduce some of the overspending within the PCT. But its weaknesses in terms of the dependency of the SPMS's non-GP clinical services on the SPMS general practices; the potential for only the well run and more financially attractive general practices to become independent; and some staff not liking this option threaten to still leave the PCT having to step in and support these services should they, for whatever reason, become unviable; either the loss of an in-house 'back-up' GP service or still continuing to run a number of GP practices; and needing to manage the concerns and tensions from some SPMS staff who do not like this option.

In the reviewer's judgement, Option 4 - SPMS general practices go independent and the remaining SPMS services merge with the other clinical services provided by the PCT, provides the opportunity to make the SPMS GP practices independent enabling them through their newly acquired autonomy to become better and more cost-effective; split some provider functions from the PCT enabling it to focus more on its commissioning role; reduce some of the overspending within the PCT; and integrate the non-GP SPMS clinical services with the PCT's clinical services potentially making them better and more cost-effective. But its weaknesses in terms of the PCT retaining some services that are likely to continue overspending; the loss of an in-house 'back-up' GP service and some SPMS general practices not becoming independent; and some staff not liking this option threaten to leave the PCT with continuing overspending, less flexibility; either the loss of a in-house 'back-up' GP service or still continuing to run a number of GP practices; and needing to manage the concerns and tensions from some SPMS staff who do not like this option.

In the reviewer's judgement, Option 5 - SPMS general practices go independent and the PCT's existing clinical services merge with the remaining SPMS's clinical services to form a new SPMS, provides the opportunity to make the SPMS GP practices and the SPMS's and PCT's clinical services independent enabling them through their newly acquired autonomy to become

better and more cost-effective; split all the provider functions from the PCT enabling the PCT to focus totally on its commissioning role; and reduce much of the overspending within the PCT. But its weaknesses in terms of implementing a large and complex change management process and some SPMS and PCT staff not liking this option staff and a very difficult transition threaten to still leave the PCT having to step in and support the new SPMS if, for whatever reason, it should become unviable; either the loss of a in-house 'back-up' GP service or still continuing to run a number of GP practices; and needing to manage the concerns and tensions from some SPMS and PCT staff who do not like this option.

In the reviewer's judgement, Option 6 - all SPMS services become independent, In the reviewer's judgement therefore, pursuing this option therefore provides the opportunity to make the SPMS general practices and the SPMS's clinical services independent enabling them through their newly acquired autonomy to become better and more cost-effective; split some provider functions from the PCT enabling it to focus more on its commissioning role; and reduce some of the overspending within the PCT. But its weaknesses in terms the independent non-GP clinical services threaten to make the transition process difficult and still leave the PCT with having to step in and support these services if, for whatever reason, they should become unviable; either losing an in-house 'back-up' GP service or still continuing to manage a number of SPMS services; and needing to manage the concerns and tensions from SPMS staff who do not like this option..

In the reviewer's judgement, Option 7 - the SPMS becomes a turn-around troubleshooting team, builds on one of the strengths of the SPMS. But its weakness in being unclear about what would happen to many of the SPMS's current services; not resolving the SPMS's current overspending; and some staff who may not like this option threatens to move the SPMS and the PCT away from their main objectives and priorities and needing to manage the concerns and tensions from some SMPS staff who do not like this option.

In the reviewer's judgement, Option 8 - each service within the SPMS has the choice of when to become independent, is not so much an option as a value statement that whatever the future of the SPMS its staff should have the final say in how each of the services within it change and develop. The PCT would therefore need to highlight that this important value will be taken into account and balanced alongside the PCT's and SPMS's other equally important values of delivering responsive, equitable, high quality and cost-effective services to local people in developing the way forward for the SPMS.

12. Conclusion

The SPMS is an important step in the evolution of primary care services in the Hounslow health economy. It shows as research elsewhere has suggested that primary care staff and managers can plan and implement rapid change that overall is positive for both patients and staff.

However, it also shows the difficulties of PCTs taking the lead in creating new providers from existing NHS services and in tackling a wide range of objectives within a single provider model. Research suggests that, though size and financial strength are important for provider stability and their management of financial and clinical risk, no single provider or commissioning model is likely to fulfil all the health care requirements of a local community.

The patient-led NHS agenda aims to use choice to drive up both the quality and cost-effectiveness of primary and secondary care. Given the research evidence to date this is likely to be a longer term achievement and not something that will be achievable in the short term.

When Hounslow PCT looks to develop new models of delivering primary care establishing a clear vision is crucial. In the case of the SPMS the vision was not as clear as it could have been because of the range of diverse objectives that it was given.

The Trust Board has to formally lead, direct and have a firm grip on such change processes particularly with regard to ensuring that all the options have been fully considered and the potential positive and negative consequences adequately addressed. Greater consultation both with staff, patients and the local community – both through formal consultative bodies and directly – while risking critical comment and opposition has the benefit of generating wide support for the final chosen option as well as ensuring that the resulting option is more robust and successful. This consultation and involvement should

involve stakeholders in actively exploring the potential benefits and disbenefits of potential options and how they can be made to work better.

Given the complexity of creating an independent provider outside of the public sector, and the lack of expertise and experience within the public sector of working with unyielding financial constraints, there is a need to tap into the formal and informal experience and expertise from the private and, importantly, the voluntary sector when such options are developed. Public sector services can learn a lot, at little cost, from voluntary sector organisations delivering health and social care services as they have a very similar ethos to the public sector but deliver reasonably high quality services on what can at times be very insecure income flows.

Allied to this is the danger of PCTs trying to create NHS-like or PCT-like independent providers given the inherent contradiction of creating an independent public sector provider. Health care providers can be public sector, private sector or voluntary sector (charity, co-operative or not-for-profit company limited by guarantee). They cannot be public and private sector or public and voluntary sector in their legal and organisational framework, though they can and must be NHS in the values and ethos that they uphold and can be part of public-private, public-voluntary and public-private-voluntary sector partnerships and collaborations.

Undertaking a detailed options assessment followed by a detailed assessment of the potential strengths, weaknesses, opportunities and threats of the best option, using staff and other stakeholders to brainstorm and analyse the options through a scenario-based assessment approach, is likely to highlight the potential dangers that would be faced when an option is implemented, suggest possible solutions to overcome these dangers and build widespread support among staff, patients and the local community for the final chosen option. This type of consultation and involvement is far removed from the ritualised and formalised forms of consultation that the NHS in general tends to carry out.

The need for a stronger information collation and analysis function is important if the PCT and its provider services are to become fully patient and commissioning-led. This is wider issue within the NHS as a whole but integrating the different datasets that the PCT currently has – finance, human resources, prescribing, referral management centre, accident and emergency - so that all data for a particular provider can be accessed and analysed against other similar providers will be crucial to enabling a robust assessment of quality and performance.

The creation of a market in health care and of new providers is likely to be an evolutionary process that will take time to emerge. This is because it will require the emergence of providers who do not have guaranteed work and income streams in the beginning and hence will need to have the financial resources to pay out some or all of their fixed costs whilst lacking enough income to cover these costs. The research on primary care, at times, seems to favour radical experiments in developing and creating new forms of primary care provider but the reality, at local level, is that the failure of a new model involving existing services with the potential for, but not the guarantee of, significant improvements in cost-effectiveness must be balanced against the paramount need to provide continuity in health care provision as the potential adverse effects on the health of local people as well as the negative impacts on staff morale and reputation can be enormous. Changes in the market for primary care services are therefore more likely to be evolutionary and incremental, as providers gain experience of working within the new environment, than revolutionary and radical.

Practice-based commissioning is an attempt to build on the longevity and broad success of the general practice model by further enabling and pushing GPs to lead and manage the development and creation of newer and more responsive forms of primary and secondary care services. The small amount of research evidence to date suggests that determined, proactive and visionary GPs can develop and create responsive, high quality and cost-effective primary care services. This is not to downplay or disparage the

commitment, skill and vision of nurses, practice managers, administrative staff and allied health professionals in co-creating and co-delivering responsive, high quality and cost-effective primary care services but GPs are, and will continue to be, the crucial professional group in determining whether local health economies are able to move rapidly and successfully to a patient-led NHS. The PCT needs to recognise and acknowledge the need to move from a directing and controlling role to a strong informing, supporting and facilitating role that is balanced, but not overshadowed, by its monitoring and regulatory role within local health economies.

Additionally, a patient-led NHS will require GPs, individually and collectively, as explicit and implicit practice-based commissioners to acknowledge and own the responsibility of creating financially viable local health economies. Research points to the need for all providers in a health economy having to take a significant share of the responsibility to eliminate deficits and to manage, individual and collective, overspends on sustainable three year cycles. This is likely to mean income flows moving up and down more rapidly in response to the numbers of people and characteristics of the population that are being served than has been the case in the past. This process of financial balance within a health economy is also likely to mean that the deep-rooted variation in the amounts allocated to registered patients of different practices, after taking into account key demographic and health variables, should narrow thereby reducing the inequalities in primary care financial allocations resulting from historical funding norms.

Finally, Hounslow PCT and the Hounslow health community are moving towards the vision of a patient-led NHS. The development and implementation of the SPMS, albeit with some drawbacks, has overall supported and facilitated the changes that needed to take place to move closer towards achieving the vision of a patient-led NHS.

Bibliography

Securing our Future Health: Taking the Long-Term View. HMSO, London, 2002.

Securing Good Health for the Whole Population. HMSO, London, 2004.

Proposal for Specialist PMS (Paper 3B). Directorate of Primary Care Development. Hounslow PCT. February 2004.

Health Delivery Plan 2005/6 – 2007/8. Hounslow PCT. March 2005.

Developing Health Services in West Hounslow 2005-2008: implementing the Hounslow Health Delivery Plan in Feltham, Bedfont and Hanworth. Hounslow PCT. October 2005.

Commissioning Intentions for 2006/07. Hounslow PCT. October 2005.

Annual Public Health Report 2003-04. Hounslow PCT. February 2004.

Incentives for Reform in the NHS: an assessment of current incentives in the south-east London health economy. Jenny Grant. King's Fund Working Paper. London. September 2005.

NHS Market Futures: exploring the impact of health service market reforms. Richard Lewis and Jennifer Dixon. King's Fund NHS Market Futures Series. London. September 2005.

The Future of Primary Care: meeting the challenges of the new NHS market. Richard Lewis and Jennifer Dixon. King's Fund NHS Market Futures Series. London. 2005.

A Review of the Effectiveness of Primary Care-led Commissioning and its place in the NHS. Judith Smith, Nicholas Mays, Jennifer Dixon et al. The Health Foundation. London. September 2004.

Commissioning in the NHS: challenges and opportunities. A Report for Norwich Union Healthcare by NERA Economic Consulting. NERA Economic Consulting. London. June 2005.

Appendix: workbook and questionnaire

Special Personal Medical Service (SPMS)

1 Year On - Review Workshop Worksheets

Background to the review

Just over a year ago, Hounslow PCT set up a specialist personal medical service (SPMS or Specialist PMS) to provide a range of primary care services as well as support some of the corporate work of the PCT. The SPMS is unique both locally and nationally.
One year on, the PCT would like to evaluate the operation of the SPMS in terms of its original objectives and underlying values. Key questions include:

- *To what extent have the SPMS's objectives and values been achieved?*
- *What factors contributed to or worked against the achievement of these objectives and values?*
- *What are the key learning points from the implementation of the SPMS?*
- *How successful have the working arrangements been between the commissioner and the providers?*
- *Has the SPMS provided a high quality and value for money service one year on?*
- *Could these objectives have been better achieved through a strategy and approach different from that used for the SPMS?*

Review process

The review will take place over November and December 2005 and the final report will be produced by the end of January 2006.

We will be aiming to disseminate a draft version of the report for you to comment and critique so that the final version will be as credible and useful a report as it can be.

Review Focus Group – Workshop Group Work

Your views on the SPMS and the arrangements in place over the last year are crucial to understanding what was good and what was bad about the implementation and operation of the SPMS.

We are therefore using this workshop and the groups work within them to gain some in-depth understanding of the SPMS and its achievements, strengths and weaknesses and any ideas you have about the way forward.

Filling out these groupwork sheets is entirely voluntary and your answers will be kept confidential and anonymous.

By asking participants to write down their thoughts on the discussions they have in their groups we aim to capture more useful insights and more information than just our own facilitator notes and discussions during and after the workshop.

Please will you therefore write as much as you can on these worksheets. We will collect them at the end and feed your issues, thoughts and ideas into the final review report.

For further information or if you have any questions please contact:

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Salim Vohra, External Reviewer, **on 07 876 576 288 or at svohra@pba.co.uk**

Q1: What has the SPMS achieved?

What has worked well?

What has helped us?

Q2: What have we not achieved?

What has not worked well?

What has hindered us?

Q3a: The Way Ahead - Option 1:

SPMS continues as it is

What are the pros and cons?

Q3b: The Way Ahead - Option 2:

SPMS GP practices become independent and the remaining SPMS services continue within a smaller SPMS

What are the pros and cons?

Q3c: The Way Ahead - Option 3:

SPMS GP practices become independent of the SPMS & PCT and the remaining SPMS service merge with the other clinical services provided by the PCT

What are the pros and cons?

Q3d: The Way Ahead - Option 4:

SPMS GP Practices become independent & PCT Clinical Services join remaining services to become new SPMS

What are the pros and cons?

Q3e: The Way Ahead - Option 5:

All SPMS services become independent

What are the pros and cons?

Q3f: The Way Ahead - Option 6:

What other option can your group think of?

What are the pros and cons?

Review Of The Specialist Personal Medical Service (SPMS) In Hounslow

Thank you for taking the time to fill out this questionnaire. Your help is very much appreciated. 👍 ☺

Special Personal Medical Service (SPMS) 1 Year On - Review Questionnaire

Background to the review

Just over a year ago, Hounslow PCT set up a specialist personal medical service (SPMS or Specialist PMS) to provide a range of primary care services as well as support some of the corporate work of the PCT. The SPMS is unique both locally and nationally.
One year on, the PCT would like to evaluate the operation of the SPMS in terms of its original objectives and underlying values. Key questions include:

- *To what extent have the SPMS's objectives and values been achieved?*
- *What factors contributed to or worked against the achievement of these objectives and values?*
- *What are the key learning points from the implementation of the SPMS?*
- *How successful have the working arrangements been between the commissioner and the providers?*
- *Has the SPMS provided a high quality and value for money service one year on?*
- *Could the objectives have been better achieved through a strategy and approach different from that used by the SPMS?*

Review process

The review will take place over November and December 2005 and the final report will be produced by the end of January 2006.

We will be aiming to disseminate a draft version of the report for you to comment on and critique so that the final version will be as credible and useful a report as it can be.

Review questionnaire

Your views on the SPMS and the arrangements in place over the last year are crucial to understanding what was good and what was bad about the implementation and operation of the SPMS.

Answer the questions the best you can and don't worry if you put down 'don't know' or 'not sure' for some or all of the questions.

This questionnaire is entirely voluntary and your answers will be kept confidential and anonymous.

The background data we have asked for will help us to analyse the views and perspectives of the different professional groups and teams who have experience of the SPMS. To see what similarities and differences in perspectives there are between and within the different groups and teams.

We need you to help us by 1) filling out this questionnaire and 2) sending it back to us by Friday 2nd December.

Questionnaires should be sent to **Nicola Green, SPMS, The Isleworth Centre, 146 Twickenham Road, Isleworth, Middlesex, TW7 7DJ** by your organisation's **internal or external mail** system or you can send them directly to **Salim Vohra, Peter Brett Associates, Caversham Bridge House, Waterman Place, Reading, Berkshire, RG1 8DN**.

For further information or if you have any questions please contact:

Kirsty McLachlan, SPMS Director, **on 07 976 732 238 or at kirstie.mclachlan@hounslowpct.nhs.uk**

Salim Vohra, External Reviewer, **on 07 876 576 288 or at svohra@pba.co.uk**

Review Of The Specialist Personal Medical Service (SPMS) In Hounslow

General Background

1. What organisation do you belong to? (please tick only one item)

- ☐ SPMS
- ☐ Hounslow PCT
- ☐ Harmoni
- ☐ Patient & Public Involvement Forum (PPIF)
- ☐ London Ambulance Service
- ☐ West Middlesex Hospital
- ☐ Hounslow Council
- ☐ Other – please give details:

……

2. What professional group do you belong to? (please tick only one item)

- ☐ Doctor
- ☐ Nurse
- ☐ Manager
- ☐ Allied Health Professional
- ☐ Admin staff
- ☐ Other – please give details:

……

Review Of The Specialist Personal Medical Service (SPMS) In Hounslow

SPMS Background (SPMS staff only)

3. What professional team within the SPMS do you belong to? (please tick only one item)

☐ Bedfont GP ☐ Isleworth GP ☐ SPMS Management Team
☐ Broadwalk GP ☐ Manor GP ☐ Night Nursing Service
☐ Chincilla GP ☐ Oasis GP ☐ Phlebotomy service
☐ Heston GP ☐ Family Planning Service ☐ SAFE project
☐ Referral Management Centre/ Central Booking Service
☐ Not part of SPMS

4. How long have you worked in primary care services in Hounslow?

0-11 months (less than 1 yr) ☐ 24-59 months (2yrs or more but less than 5 yrs) ☐
12-23 months (1 yr or more but less than 2 yrs) ☐ 60 months plus (5 yrs and over) ☐

5. What type of employment do you have: (please tick all that apply)

Full-time? ☐ Part-time? ☐
Permanent? ☐ Temporary? ☐
☐ Other – please give details:
……

6. Are you: male ☐ female ☐

7. What is your ethnic origin?

White		**Black**		**Asian**		**Chinese and other**		**Mixed**	
British		African		Bangladeshi		Chinese		Asian & white	
Irish		Caribbean		Indian				Black african & white	
Any other white background		Any other black background		Pakistani					
								Black caribbean & white	
				Any other asian background					
						Any other		Any other mixed background	
						background			

Review Of The Specialist Personal Medical Service (SPMS) In Hounslow

Specialist Personal Medical Service Arrangements

8. What do you think of the SPMS arrangements currently in place compared to the service delivery arrangements in place before October 2004?

☐ Very good	☐ Good	☐ Neither good nor bad	☐ Bad	☐ Very bad	☐ No experience of the previous arrangements

9. In your judgement, compared to the arrangements in place before October 2004, which aspects of the SPMS have worked well and which poorly?

Aspects	Worked very well	Worked well	Same as previously	Worked poorly	Worked very poorly	Don't know
Relations between management and staff	☐	☐	☐	☐	☐	☐
Multi-disiplinary team working within my SPMS service	☐	☐	☐	☐	☐	☐
Personal training and development	☐	☐	☐	☐	☐	☐
Finance functions	☐	☐	☐	☐	☐	☐
Human resources functions	☐	☐	☐	☐	☐	☐
IT functions	☐	☐	☐	☐	☐	☐
Building and facilities functions	☐	☐	☐	☐	☐	☐
Risk management and quality control	☐	☐	☐	☐	☐	☐
Multi-disciplinary team working between SPMS services	☐	☐	☐	☐	☐	☐
Partnership working between SPMS and other health and social care organisations	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐
Please state what:						

Other comments?

……

Review Of The Specialist Personal Medical Service (SPMS) In Hounslow

10. How well managed was the change process to move to the SPMS arrangements?

☐	☐	☐	☐	☐	☐
Very well managed	Well managed	Neither well nor poorly managed	Poorly managed	Very poorly managed	Employed after the change process was complete

11. In your judgement, during the setting up phase of the SPMS, which aspects worked well and which poorly?

Aspects	Worked very well	Worked well	Worked poorly	Worked very poorly	Don't know
Communication of SPMS strategy	☐	☐	☐	☐	☐
Communication to affected staff	☐	☐	☐	☐	☐
Transfer of staff	☐	☐	☐	☐	☐
Relations between management and staff	☐	☐	☐	☐	☐
Multi-disiplinary team working within my SPMS service	☐	☐	☐	☐	☐
Personal development and training	☐	☐	☐	☐	☐
Finance functions	☐	☐	☐	☐	☐
Human resources functions	☐	☐	☐	☐	☐
IT functions	☐	☐	☐	☐	☐
Building and facilities functions	☐	☐	☐	☐	☐
Risk management and quality control	☐	☐	☐	☐	☐
Multi-disciplinary team working between SPMS services	☐	☐	☐	☐	☐
Partnership working between SPMS and other health and social care organisations	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐
Please state what:					

12. In your judgement, over the last year, to what extent have the following objectives/principles been achieved due to the SPMS?

Objectives/principles	Fully achieved	Significantly achieved	Partially achieved	Not achieved	Don't know
Integration of the practices and services within the SPMS	☐	☐	☐	☐	☐
High quality services	☐	☐	☐	☐	☐
Value-for-money services	☐	☐	☐	☐	☐
Patient-centred services	☐	☐	☐	☐	☐
Access to primary health care that is quick	☐	☐	☐	☐	☐
Access to primary health care that is local	☐	☐	☐	☐	☐
Access to primary health care that is equitable	☐	☐	☐	☐	☐
Clear leadership of the SPMS	☐	☐	☐	☐	☐
Clear lines of accountability	☐	☐	☐	☐	☐
Sharing of patient information between primary health care professionals	☐	☐	☐	☐	☐
Infrastructure in place to support the sharing of patient information between primary health care professionals	☐	☐	☐	☐	☐
Processes and procedures in place that ensure care is safe and provided to a high standard	☐	☐	☐	☐	☐
Less conflicts of interest	☐	☐	☐	☐	☐
Opening up of the local primary health care market for better patient choice	☐	☐	☐	☐	☐
Common standards and service requirements for all Out Of Hours care providers	☐	☐	☐	☐	☐

13. In your judgement, over the last year, to what extent have the following values been demonstrated in practice by the SPMS?

Values	Fully demonstrated	Significantly demonstrated	Partially demonstrated	Not demonstrated	Don't know
Open - working to bring together health and social care	☐	☐	☐	☐	☐
Innovative organisation that recognises the needs and diversity of its local community	☐	☐	☐	☐	☐
Focussed and responsive - offering local people a seamless service	☐	☐	☐	☐	☐
Exemplary employer that values staff	☐	☐	☐	☐	☐
Achieving best value	☐	☐	☐	☐	☐
Commitment to providing services to the best professional standards	☐	☐	☐	☐	☐
Being a learning organisation	☐	☐	☐	☐	☐

14. In your judgement, which of the following have been barriers to the achievement of the SPMS's objectives/principles *(as stated in Question 12)* and values *(as stated in Question 13)*?

(Tick all the items that you think apply)

Barriers	Significant	To some extent	Not at all	Don't know
PCT management	☐	☐	☐	☐
SPMS management	☐	☐	☐	☐
Harmoni management	☐	☐	☐	☐
PCT staff	☐	☐	☐	☐
SPMS staff	☐	☐	☐	☐
Harmoni staff	☐	☐	☐	☐
Other management	☐	☐	☐	☐
Please state which:				
Other staff	☐	☐	☐	☐
Please state which:				
Lack of clarity about SPMS vision/purpose	☐	☐	☐	☐
Lack of buy-in by key staff into SPMS vision/purpose	☐	☐	☐	☐
Lack of finance	☐	☐	☐	☐
Lack of competent staff	☐	☐	☐	☐
Lack of training and development	☐	☐	☐	☐
Lack of integration of SPMS services	☐	☐	☐	☐
Lack of coordination of SPMS services	☐	☐	☐	☐
Lack of supportive environment	☐	☐	☐	☐
Lack of multi-disciplinary team working within my SPMS service	☐	☐	☐	☐
Lack of multi-disciplinary team working between SPMS services	☐	☐	☐	☐
Lack of partnership working between SPMS and other health and social care organisations	☐	☐	☐	☐
Lack of local autonomy/authority to take the initiative	☐	☐	☐	☐
Lack of appropriate incentives/rewards	☐	☐	☐	☐
Too much management/supervision	☐	☐	☐	☐
Too little management/supervision	☐	☐	☐	☐
Other	☐	☐	☐	☐
Please state what:				

Review Of The Specialist Personal Medical Service (SPMS) In Hounslow

15. Overall, on a scale between 0 and 100, where 0 = Totally Unsuccessful and 100 = Totally Successful, how successful has the SPMS been? ☐

16. If we were to start again would the SPMS still be worth carrying out?
    Yes, definitely ☐ Yes, probably ☐ Not sure ☐ No, probably ☐ No, definitely ☐

    If No, how could we have done/do things differently?

    ……

    ……

17. In your judgement, to what extent does the SPMS, as it is currently set up, address the following issues?

Issues	Fully addresses	Significantly addresses	Partially addresses	Does not address	Don't know
Securing high quality services	☐	☐	☐	☐	☐
Securing safe services	☐	☐	☐	☐	☐
Improving health	☐	☐	☐	☐	☐
Reducing inequalities	☐	☐	☐	☐	☐
Improving engagement of GPs	☐	☐	☐	☐	☐
Improving public involvement	☐	☐	☐	☐	☐
Improving commissioning	☐	☐	☐	☐	☐
Improving effective use of resources	☐	☐	☐	☐	☐
Improving management of financial risk	☐	☐	☐	☐	☐
Improving coordination with social services	☐	☐	☐	☐	☐
Delivering reduction in management/ administrative costs	☐	☐	☐	☐	☐

18. Are there any other comments you would like to make about the SPMS and/or the future of primary care services in Hounslow?

    ……

Thank you for taking the time to fill out this questionnaire. Your help is very much appreciated. ☺