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Making trouble for the NHS?

Entrepreneurs and innovators
in primary care,
and the barriers they face

"I encourage you in primary care and the NHS Alliance to make trouble – to root out bad deals and bad services"

David Nicholson
NHS Chief Executive
(NHS Alliance conference 2006)

NHS Alliance

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This report expresses the opinions of the authors and those involved in the research.

This report was written and edited by Andy Cowper, editor of *British Journal of Healthcare Management* and *Commissioning Health.*

Appendix A 'New ownership forms for entrepreneurial provision' was written by Dr David Carson.

Contents

"The innovator makes enemies of all those who prospered under the old order, and only lukewarm support is forthcoming from those who would prosper under the new order.

"Their support is lukewarm partly from fear of their adversaries, who have the existing laws on their side, and partly because men are generally incredulous, never really trusting new things unless they have tested them by experience."

Niccolo Machiavelli, '*The Prince*'

Executive summary

The development of entrepreneurial provision in primary care is a vital aspect of improving patient care closer to home. It is also an exciting opportunity. Increasing the diversity of provision in primary care is a key policy goal of NHS reform. Primary care delivers 80% of NHS patient care in England.

NHS Alliance fully supports the principle of allowing entrepreneurial provision to complement - and where necessary, challenge - existing provision. The main gaps in existing primary care provision are in poorer areas. Entrepreneurial provision has the potential to help to address these health inequalities.

Entrepreneurial provision in primary care is still in its early stages. The signals from the Department of Health so far are permissive –to allow the front line to get on and innovate, rather than telling people what to do and how to do it.

Entrepreneurial provision will mean change. Change can be seen as difficult by some NHS staff used to the 'usual' ways of working. It may also be seen as threatening by PCTs and commissioning consortia / groups. Changes will need to be handled with care.

For entrepreneurial provision to improve patient care, it will be essential to avoid the creation of *de facto* local monopolies under practice-based commissioning.

There is a market-making role to be played in primary care. It remains to be decided (or at least, to be made explicitly clear) to what extent this is a role for primary care trusts (PCTs), strategic health authorities (SHAs) or the Department of Health.

There is little doubt that the ultimate direction of policy travel is for PCTs to become almost purely commissioners of services and managers of the local NHS market. For commissioners of primary care services to work effectively and even-handedly, it seems unlikely that they should also be providers of services

Current NHS staff who want to provide new entrepreneurial services have been expected to set themselves free: a contrast with the Monitor-&-subsidy approach for aspirant foundation trusts. Freedom could, however, be a powerful motivating tool – a useful carrot to lure staff who may be disenchanted with the frequent NHS organisational restructurings of recent years.

Obstructive, disruptive and protectionist behaviours from the 'NHS family' have been repeatedly reported by those interviewed for this report. People currently trying to provide new services do not feel that they have access a level playing field, and that the degree of

preference shown to ‘NHS family’ providers is unfair. There is a clear risk of oblique obstruction preventing the development of entrepreneurial provision.

This needs to be addressed. However, it seems contrary to the spirit of entrepreneurialism to suggest that the remedy needed is a complex new bureaucracy - a ‘heavy’ regulatory system.

Instead, we recommend that a flexible, fast-moving ‘unblocking’ system should be created to support entrepreneurs who can show that they are being obstructed.

This set-up should have a ‘light’ and temporary structure. The need for its existence should be reviewed annually as the market in primary care develops. Ideally, the organisation should aim to make itself redundant within a few years.

A small group of staff with good, recent experience of primary care should be contracted or seconded, whose role would be to assess complaints from would-be providers who are being obstructed. Their recommendations should have formal influence on PCTs and commissioning clusters.

Foreword

British primary care has much reason to be proud, but no service can afford to be complacent. Improving cost-effectiveness, extending choice and redesigning services will require a new breed of entrepreneurs in primary care - clinicians and managers who can think, act and provide in bold and original ways. That much is certain. Indeed, it is an absolute premise of current Government policy and the successful devolvement of some PCT provider functions.

Who will be these new entrepreneurs in primary care? What forms will they take, and how can we support and encourage them? This document is based on the views and discussions of leading primary care entrepreneurs. It is an attempt to answer those questions. More than that, it is also a guide for those who would like to join the ranks of primary care entrepreneurs and for those whose job is to enable their development.

Full of detailed examples of different primary care entrepreneurs who are leading the way, this should be read by all front-line clinicians and managers on their journey to becoming future potential front-line entrepreneurs themselves. It is a worthy sequel to the NHS Alliance January 2006 document '*The Nuts And Bolts Of Primary Care Provision*'.

The words "public service" and "entrepreneur" may seem odd bedfellows, particularly within the traditional management arrangements of the NHS. Indeed, change and challenge are not necessarily good in themselves. Yet they are more likely than not to bring about improvement where services are currently poor or there has been a historical monopoly.

Many of those already championing change as entrepreneurs are still developing. They may need some initial encouragement, and even protection, before they are mature enough to withstand the full force of open market competition.

Yet, it is particularly important at present that an invigorated and optimistic entrepreneurial spirit should pervade primary care and its frontline clinicians. That is not to say that every front-line clinician should be an entrepreneur; but that each should be working within a dynamic, fast-moving and free-thinking organisation where front-line clinicians feel fully engaged. It is equally important that such organisations should put their local population and patients first, and aim to ever improve our strong reputation as providers of integrated, holistic, continuing and personal care.

In the new world of primary care entrepreneurs, values, clinical leadership and local ownership will be ever more important. For

leading clinicians and managers in primary care, the challenge will be to further develop the entrepreneurial spirit without losing the NHS's fundamental ethos. For entrepreneurs, who have not traditionally worked in the health service, the challenge will be to ensure that entrepreneurialism does not become an end in itself but a means of improving and building upon strengths of current primary care.

These are challenging days. Fortune favours the brave. Primary care, with its history of innovation and adaptability, is well placed for the entrepreneurialism of the new world.

Dr Michael Dixon
Chairman, NHS Alliance

Introduction

The reform programme of the English NHS aims to deliver better patient care faster. To achieve this will require the NHS's ways of working to be reviewed and, where necessary, revised.

Primary care is patients' first port of call. It is where the NHS delivers over 80% of patient care, as DH primary care czar David Colin Thome's recent report 'Keeping It Personal' (2007) points out: "Out of every 10 people using NHS services, … eight are being treated by the country's 32,000 GPs … all this frontline care is delivered for just under £8 billion a year … a fraction of the £90 billion annual NHS budget".

And primary care is not just delivered in GP surgeries – important though these are. It includes the vital allied health professionals - physiotherapists, occupational therapists, speech therapists etc. as well as such vital primary care practitioners as pharmacists, dentists and optometrists.

The current policy initiative to increase the diversity of providers in primary care offers exciting opportunities for those who wish to provide more entrepreneurial services.

Entrepreneurial provision in primary care is in its early stages of development. This report aims to look at some of the key issues in existing practice, and outline both some potential problems and possible solutions to the emerging issues.

Good as primary care in the UK is, we should not pretend that it is uniformly perfect. Data from the Quality and Outcomes Framework and the Healthcare Commission have shown that not only is the supply of GPs worse in poorer areas, on average, poorer patients get a worse quality of care. Equitable and high-quality patient care must remain the primary focus in primary care. NHS chief executive David Nicholson exhorted delegates at the NHS Alliance conference last autumn, "I encourage you in primary care and the NHS Alliance to make trouble – to root out bad deals and bad services".

NHS Alliance fully supports the principle of allowing entrepreneurial provision to complement - and where necessary, challenge - existing provision. As commissioning develops in sophistication, the local knowledge of existing primary care providers will be a vital tool in improving patient care. The many good and excellent GP practices already have a good story to tell, and this can offer them new opportunities.

Change can seem threatening (as Machiavelli pointed out), yet NHS Alliance believes that if the potential pitfalls are kept under close review and the appropriate checks and balances are introduced,

entrepreneurial provision can make an important contribution to improving patient care. Change management will be crucial, and the skill sets required for this will need to be hired if they are not available.

For entrepreneurial provision to improve patient care, it will be imperative to avoid the establishment of *de facto* local monopolies under practice-based commissioning. There is a market-making role to be played. It remains to be decided (or at least, to be made explicitly clear) whether this is to be done by primary care trusts (PCTs), strategic health authorities (SHAs) or the Department of Health.

If existing NHS services are simply re-created as 'entrepreneurial businesses', staffed by the same people and working in exactly the same way, a real opportunity for genuine innovation in primary care will have been missed.

Greater diversity of provision in primary care is another step towards an NHS 'market', both internal and external. Markets require regulation in order to limit anti-competitive behaviour.

If no new entrepreneurial businesses (whether 'for profit' or 'social enterprise') fail within the first two years, then what has been created will be far from an effective entrepreneurial market. A clear majority of new businesses fail within the first few years of start-up. If this emerging market works properly, there will be failures to be coped with as well as successes to be celebrated

Along with the risks that change of this kind can bring, new freedoms to work differently are on offer. This represents an opportunity to bring in some real change and to deliver better services for patients. We support the development and progress of this agenda to improve patient care.

Key points for consideration

For aspiring entrepreneurs
Be clear why you want to work entrepreneurially – what is the difference you want to make?

Be clear about what services you want to deliver, at what scale, and whether there will be a sustainable market for what you want to offer.

NETWORKING AND INTEGRATION AND CO-OPERATION TO SEE PATIENTS GET GOOD INTEGRATED CARE

Be clear about whether you want to offer the NHS pension – it is possible (but expensive) to do so in certain organisational forms.

Be clear about the scale at which you want to operate – and be aware that operating at large scale is very different from running a relatively small business such as a general practice (think Tescos and corner-shop).

Be clear about the importance of back-office functions. Bigger organisations have the scale to do vital training, HR and finance functions. If your organisation would be too small for this, how can it be done?

Consider how you can use the ideas of 'freedom from control', 'our ethos' and 'ownership' as positive attractors for staff.

Once you have devcided on the function you wish to deliver, consider which organisational form (see Appendix A – p. xx) is most appropriate for your business.

For PCTs
What is your role in making and managing the emerging market in primary care, including provider development? Do you have the right skills for this?

How engaged are you in the management of relationships in primary care?

NETWORKING AND INTEGRATION AND CO-OPERATION TO SEE PATIENTS GET GOOD INTEGRATED CARE

How are you ensuring that the emerging provision market is not just a re-creation of the old NHS monopoly under new names?

How will you manage the contracts? What systems / structures are in place?

Can you prove your commitment to the development of entrepreneurial provision in primary care?

Are you going to 'invest to save' in new entrepreneurial services?

If a practice make substantial savings on its budget (drug and others) for the PCT, can the PCT remunerate a percentage for development and investment of that practice?

Will you release existing monies tied up within PMS contracts and MPIG sums where there is no demonstrable value for money being provided by practices for this extra funding?

How are you going to react when new businesses fail?

For policymakers
Is policy support for entrepreneurial provision sufficiently explicit?

Will pump-priming funding be forthcoming?

Will you instruct PCTs to support local GP leaders and entrepreneurial practices with no-strings attached business and management support?

How will you enforce PBC groups / commissioning consortia not to set up local monopolies in all but name?

Will you revisit the concept of supporting pilot schemes to generate outcome-based evidence for innovations to change policy?

Will you make resources available around financial and activity information to those trying to develop services in an easily accessible form?

If a practice make substantial savings on its budget (drug and others) for the PCT, can the PCT remunerate a percentage for development and investment of that practice?

Will you release existing monies tied up in PMS contracts and MPIG sums where there is no demonstrable value for money being provided by practices for this extra funding?

Will you stop the culture of carrying debts into new financial years but not allowing savings to be carried over?

What is the definitive, final position relating to whether APMS providers in primary care have to have all their shareholders eligible to hold an NHS list in order to be able to provide an NHS pension for their employees - or can it just be some shareholders?

Is it legitimate to do commercial commuter clinics as an NHS organisation?

What is the latest GPC guidance on charging patients?

How are you going to react when new businesses fail?

Policy context

A key driver in the current reform strategies of the English NHS is the introduction of greater choice into the system. This 'contestability' strategy was introduced in such key policies as *The NHS Plan* (DH 2000), *Shifting The Balance Of Power* (DH 2002), *The NHS Improvement Plan* (DH 2004), *Creating A Patient-Led NHS* (DH 2005) and *Commissioning A Patient-Led NHS* (DH 2005).

Contestability was intended to increase the efficiency and effectiveness of NHS services, by bringing new providers in to the system. This was partly to increase the available capacity of the system, to help the NHS with meeting Government objectives on patient waiting times. By introducing new providers with new ways of working, offering new options to commissioners and referrers, it was also hoped to help established NHS providers reconsider whether they needed to improve the ways in which they deliver patient care.

This began via the DH's Commercial Directorate procurement of NHS and independent sector treatment centres, bringing contestability to the acute sector. Treatment centres focus on high-throughput of a limited range of surgical procedures (such as joint surgery or opthalmic surgery, later expanded into diagnostic and other services).

Critics of this programme argue that:

- independent sector treatment centres were subsidised by the NHS to enter the market (which is true – their payments were higher than the NHS tariff to cover their set-up costs)
- their clinical quality was less than the NHS's (a criticism that seems to have been more anecdotal than based on published research evidence)
- treatment centres simply cherry-pick relatively uncomplicated cases (likewise true, but slightly irrelevant, since the business model of treatment centres rests on high-throughput of low-complexity cases)
- treatment centres destabilise local NHS acute providers by taking away some of their 'bread-and-butter' work (again true, though likewise this is the 'contestability' aspect of what they were intended to do)

Supporters of the treatment centre programme point out that NHS acute waiting times reduced fastest in those areas to have experienced 'contestability' from a nearby treatment centre, suggesting that treatment centres played a significant role in getting NHS acute providers to re-appraise and raise their activity rates.

This was allied to the creation of NHS foundation trusts (FTs) - existing NHS trusts who had performed highly on a range of quality

indicators and shown a sound financial footing. Once approved to operate by the FT regulator Monitor, FTs became able to retain surpluses for re-investment in patient care and were allowed greater freedoms from Whitehall control. Many FTs increased their activity in order to increase their income under Payment By Results, and it has been a complaint of primary care trusts (PCTs) that these increases in activity have created or worsened PCT deficits. PCTs have also complained about 'up-coding' of cases by FTs, to attract higher payments.

Foundation trusts have shown higher-than-NHS-average levels of financial performance, while retaining good scores for clinical quality. The freedoms FTs have earned have not so far resulted in major crises affecting patient care. However, a few FTs have already required regulatory intervention due to departures from their financial plans, and others have had payment disputes with their local PCTs.

Until recently, in operational terms the 'contestability' agenda mainly affected the acute sector. However, primary care is where the NHS delivers 90% of its patient care. With this in mind, *Commissioning A Patient-Led NHS* (DH 2005) stated that "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." Confusion followed the publication of this policy, with many PCT staff nervous that their jobs would be 'privatised', until the Health Secretary announced that PCTs would not be compelled to divest their provision of primary care services "unless and until" they decide to do so.

The recent policy statement *Health Reform in England: Update And Next Steps* (DH 2006) listed as a supply-side reform "more diverse providers, with more freedom to innovate and improve services.

The emphasis on development of commissioning, allied to the 2006 restructuring of PCTs from 302 to 152, focused attention on the need to encourage or develop new providers in primary care (see NHS Alliance 'Providing For The Future' 2007).

However, the 2006 PCT restructuring, combined with the DH's fitness for purpose reviews of the new PCTs 2006-7, had a paradoxical effect: development of new services, divesting provision and encouraging entrepreneurs in primary care has been on the back burner operationally for PCTs, just when it has been emerging as a policy goal.

There is little doubt that the ultimate direction of policy travel is for PCTs to become almost purely commissioners of services and managers of the local NHS market. For commissioning of primary

care services to work effectively and even-handedly, it seems unlikely that they should also be providers of services. This would create clear conflicts of interest and also raise questions of anti-competitive behaviours, which may prove to be illegal under competition law and European law if the NHS becomes regarded as a true 'marketplace' of provision.

THE BIG ISSUES

Control

Participants in the entrepreneurs event at the Kings Fund in January 2007 felt that APMS had not made any significant inroads in primary care because direct control doesn't tend to work with highly-paid groups of professionals such as GPs. They also noted that it is hard to change working practices in such groups.

Control was also seen as an issue for PCTs. It was observed that the direction of policy travel could mean that not only may PCTs lose the provision of community services, but practice-based commissioning will (if successful) take away a significant amount of their remaining commissioning function. Another person pointed out that would-be entrepreneurs "need to quell their fear of GPs and primary care staff as 'bad guys', out to do the PCT down."

Data

One participant commented, "Using data to prove points, peer review and internal review is extremely powerful". However, financial and activity data were widely thought to be lacking at PCT level, and it was not understood how success would be measured under potential contracts.

Entrepreneurialism

'Entrepreneur (n) - the owner or manager of a business enterprise who, by risk and initiative, attempts to make profits'

Collins English Dictionary

Although the vast majority of primary care is provided by the small private businesses of general practice, it would be incorrect to suggest that this is entrepreneurialism in the conventionally-understood sense. Once a practice has secured its NHS contract, it has a high level of security. The annual reviews with the PCT very infrequently result in the loss of the practice's contract, which only follows from a very serious breach of the contract.

Although general practice and GPs in particular can be regarded as the 'risk sink' of the NHS (as their gatekeeping role relies on a relatively low level of diagnostic testing and a relatively high level of understanding of when they are seeing a patient who may be gravely ill), the business risks inherent in general practice are low. Demand is high; the NHS is a steady customer; and the majority of patients tend to register at the practice nearest their home. For all these reasons and because commissioning remains unsophisticated, external pressures on general practices to offer new or extended services are not high.

The new GP contract ties remuneration tightly to achievements on the 'points' system of the Quality and Outcomes Framework (QOF). High achievement of these targets, together with an increase in the amount of profit it is possible to take out of a practice annually, have meant that GPs have seen significant increases in their remuneration in recent years. Being well paid for the status quo situation seems unlikely to be a strong pre-condition for widespread development of entrepreneurial activity.

There is also a degree of suspicion in the NHS that entrepreneurial provision means putting profits before patients. As current entrepreneurial provision in primary care mainly exists in the relatively new market of out-of-hours cover, there is only a short period available on which to base judgements. It will remain to be seen whether there is a difference of attitude towards this between GPs (who are mainly self-employed small business owners) and other primary care staff (who are more used to being traditional employees). Employment status may also affect attitudes to risk.

One particularly interesting comment was made at the entrepreneurs' event in January 2007: "we need entrepreneurialism within practices as well as outside them".

Evaluation

As with any major policy initiative, evaluation is important. Without using a control group who do not go down this route, it will be difficult to know for sure whether (borrowing Sir John Oldham of the Improvement Foundation's concept) the provision of entrepreneurial services in primary care is an improvement, or simply a change.

Evaluation also raises the issue of what success would look like in process and outcome terms: are there equity goals; patient satisfaction measures; improvements in cost-effectiveness and value for money; end points that represent success? The method (the means) of this policy is based on the 'grit making the pearl in the oyster' theory of contestability. Do we know what the end is - and does it justify the means?

Failure

"Ever tried. Ever failed. No matter. Try again. Fail again. Fail better."

Samuel Beckett, 'Worstward Ho'

Because this is an emerging area of NHS policy, let alone delivery, it may appear grossly premature to talk about failure. Ideally, this should not be the case. If no new entrepreneurial businesses (whether 'for profit' or 'social enterprise') fail within the first two years, then we will be able to be quite clear that what has been created is far from an effective entrepreneurial market. A definitive

statistic is not available, but a clear majority of new businesses fail within the first few years of start-up.

Another issue clearly flagged by those involved in the research behind this report was that they would need to be able to learn from problems and failure: 'what not to do'. This may be problematic. Learning from problems and failure has not been a strong suit for the NHS in recent years, in large part because of the increased importance of achieving centrally-determined activity and access targets. In the recent media and political climate, bad news about the NHS has been increasingly high-profile. Serious consideration will be needed both on how the NHS will respond in the event of failure (contingency arrangements), and also on how the media impact of failure will be managed.

Financial resources

"It's a rich man's world."
Abba, 'Money, Money, Money'

Given the NHS 2006-7 financial position, it is unsurprising that this was regarded as a hindrance. PCTs' financial positions were frequently cited as a barrier to progress.

Pump-priming was, unsurprisingly, felt to be needed. In the words of one survey, "If PCTs could understand 'invest to save', we would get a lot further." In the words of another, "finance will be a great driver of entrepreneurial services".

Another survey observed, "There is no money in commissioning, only in provision."

Freedom

The message from the Department of Health's directorate of provider development has been that they do not wish to prescribe or proscribe too much of the agenda for entrepreneurs. There is, in short, plenty of freedom for the front line to innovate in their own way. It is not a case of waiting for permission from Whitehall.

There is an interesting comparison between the opportunity of freedom from direct NHS control (in the guise of employment) and the freedoms on offer through organisations achieving Foundation Trust status. In Monitor, FTs have an organisation dedicated to the process of getting NHS trusts out of Whitehall control and into 'the liberated zone' and to maintaining them in good working order once there. Finance is made available by DH to trusts who want to apply for foundation status.

Thus far, the process for current NHS staff who wish to provide new entrepreneurial services has, by contrast, been one of expecting them to set themselves free.

Freedom could, however, be a powerful motivating tool – a useful carrot to lure staff who may be disenchanted with the frequent organisational restructurings of the NHS of recent years.

Many participants in the research for this report raised concerns about the explicitness of policy support for entrepreneurial provision. More clarity would be helpful to the aim of leveraging local change.

While it currently looks unlikely that any potential government would significantly alter the health policy agenda (supply-side reforms to increase activity and move care into the community), some participants reported that GP colleagues were disengaged from the agenda, regarding this policy as only here for the next 2-3 years until the next reorganisation ('GP fundholding syndrome').

One survey stated, "If the DH really want PBC / GP entrepreneurs to take on extended primary care and move services out of hospital, they should give PCTs a clear signal of the direction of travel for the next 3 years and encourage them to facilitate credible GP entrepreneurial schemes to flourish".

Governance

Governance arrangements for more diverse provision in primary care will be crucial, and should be clarified as soon as practically possible. Entrepreneurs need to know with whom they will be negotiating contracts (and for what duration), and by whom they will be inspected. PBC guidance suggests that in all but exceptional circumstances, PCTs' role is to licence providers – not to agree contracts with identified cost and volume.

Although thinking is now emerging about community foundation trusts, it remains opaque. There are currently a few PCTs working with the DH on this – but the scale is small and timescale slow. Bill Moyes, executive chair of Monitor (who would licence such bodies if they emerge) revealed at the NHS Alliance conference in 2006 that the minimum turnover figure for community FT viability being examined is £30 million a year.

Clinical governance (inspection) is increasingly starting to go into primary care organisations – and more will be coming. Governance and control (or comfort level of control) are vital issues for GPs.

Legal matters and ownership structures were of significant interest to participants in our research (the latter tied in with the NHS pensions issue – see 'Risk' section below). TUPE regulation was also

raised. Other issues emerged in this area from the survey questionnaires, including protectionist behaviour and misinformation from one FT.

Obstruction and protectionism

Obstructive, disruptive and protectionist behaviour from the 'NHS family' have been repeatedly reported by those interviewed for this report. There were reports of one foundation trust writing to its consultants, forbidding them to talk to GPs about developing new services in future under PBC and insisting (wrongly) that this had to go through the FT's contracts department. There is clearly a risk of oblique obstruction preventing the development of entrepreneurial provision.

This needs to be addressed. However, it seems contrary to the spirit of entrepreneurialism to suggest that what is needed is a complex new bureaucracy or 'heavy' regulatory system to address the issue.

Instead, we recommend that a flexible and fast-moving unblocking system should be created to support entrepreneurs who can show that they are being obstructed.

This set-up should have a 'light' and temporary structure. The need for its existence should be reviewed annually as the market in primary care develops: ideally, the organisation should aim to make itself redundant within a few years.

A small group of staff with good, recent experience of primary care should be contracted or seconded, whose role would be to assess complaints from would-be providers who are being obstructed. Their recommendations should have formal influence on PCTs and commissioning clusters.

People currently trying to provide new services do not feel that they have access a level playing field, and that the degree of preference shown to 'NHS family' providers is unfair. One survey asked how the DH "will enforce PBC groups not to set up local monopolies in all but name?" Practice-based commissioning consortia / clusters were regarded in some places as re-establishing local NHS monopolies of primary care provision. Protectionism is a potential problem.

This charge of protectionism has been backed by recent research by Richard Lewis and colleagues from the Kings Fund. Writing in the February 2007 *British Journal of Healthcare Management* (Walsh, Maybin and Lewis 2007), they point out that their survey of the reconfigured PCTs (122 of 152 responded) found that "only 2 PCTs had awarded a contract to an organisation outside the 'NHS family'."

Lewis and colleagues also found that "the volume of alternative types of provider in primary care remains limited notwithstanding the Government's desire to increase the range of primary care providers, especially in deprived areas … GP-owned businesses continue to exercise a virtual monopoly over provision. Indeed we have found evidence that some PCTs had reversed their decision to provide alternative-run primary care services, preferring to use APMS to contract with traditional GP organisations."

They also concluded that "the introduction of an alternative model of primary care may be constrained by the interests of local providers, especially in the absence of any suitable new providers entering the market … PCTs are being cautious about using the flexibility of the APMS contract to commission alternative types of primary care provider from the commercial sector. The values of the PCT board and senior NHS managers may be influencing decision about the use of the independent sector. Alternatively, NHS managers may not have the knowledge or the courage to challenge local GPs."

Organisational development

All participants in our research agreed that business management skills and marketing skills will be needed by entrepreneurial providers. These are not currently widespread, in the small business world that is most of general practice.

One survey asked, "big organisations can do training and do back-office functions effectively; but how can smaller ones do so?" Another felt that "back office functions should be done properly, and at city-wide-type scale".

Practice-based commissioning

Guidance on the next wave of practice-based commissioning (PBC) has clearly indicated that PCTs should look to new entrants to the primary care market. As one person pointed out, "practice-based commissioning won't work without alternative providers".

Primary care trusts

PCTs' commitment to practice-based commissioning and to the entrepreneurial provision agenda was much questioned. One survey described "PCTs constantly repeating the what and the why of practice-based commissioning, but with little to no understanding of or commitment to the how". Another suggested that DH should "instruct PCTs as a part of their function to support local GP leaders and entrepreneurial practices in no-strings attached business and management support".

Provider-commissioner conflict of interest was repeatedly mentioned. Some PCTs are seen as reluctant to give away their provision activity – some participants outlined PCT managers' fears

of loss of control when community services go 'out-of-house'. Others felt that their PCT was not clear about the services they need / want.

The last round of mergers left many feeling that PCTs have changed from organisations who felt they 'owned' practices to now being managers of contracts who have data and are asking practices what they are to do about their referral rates etc.

Regulation

The move to more diverse provision of primary care is another step towards the creation of an NHS 'market', both internal and external. Markets require regulation in order to limit anti-competitive behaviour. No less a figure than the high priest of capitalism Adam Smith admitted in 'Wealth Of Nations' that merchants and manufacturers tend to conspire to distort markets unless they are prevented from so doing.

Risk

Entrepreneurialism inescapably involves risk to the business of the aspirant entrepreneur. In the context of healthcare, which is highly regulated and also highly newsworthy when things go wrong, risk is not the most welcome concept. Many of the people involved in the research and production of this report felt that in policy terms, there were not sufficiently clear guarantees and signals coming from the centre that entrepreneurial provision is 'here to stay' – and is to be encouraged and welcomed by PCTs and the NHS family.

To entice entrepreneurs into the market, the contracts on offer will need to be of sufficient duration and of manageable size for business start-up to be viable.

There will also be issues to be addressed around the cost of premises. Property prices in England continue to rise despite repeated interest rate increases. These rises, together with the effects on building costs of the Olympic development, are causing above-trend inflation in building costs. New primary care services will have to be delivered somewhere. The Government's new policy 'Fairness in Primary Care Procurement', which aims to see supermarkets partner with existing GP NHS providers to offer services in 'under-doctored' areas, offers one route to delivering new services.

Another aspect of risk raised repeatedly was NHS terms and conditions of employment – particularly the NHS pension. While it is clear that certain legal ownership forms will allow new organisations to offer the NHS pension, there is clearly a high financial cost of doing so. It will remain to be seen whether the NHS pension is a *sine qua non* for older and more experienced NHS staff in considering whether to join or form an entrepreneurial business.

Given that new entrepreneurial organisations will be looking to recruit from NHS staff, many specific questions were asked about how to make working for them attractive.

Another potential risk to the business plans of entrepreneurs will be the possibility of Foundation Trusts looking to move into the primary care market at scale. Assuming that FTs can prove to Monitor that such expansion will not jeopardise their financial viability and terms of licence, this would be permitted.

Several participants in our research mentioned 'threat of FT competition' as a driver to their interest in the entrepreneurial agenda. However, a dissenting voice argued that "the real enemy of general practice is not big corporations; it's the GP down the road who's not pulling his weight."

Sincere change?

"The secret of success is sincerity. Once you can fake that, you've got it made"
Jean Giradoux

One of the strongest-held views among the participants in the events and research for this report concerned sincerity of the change in moving to providing entrepreneurial services. There was almost universal wariness of the possibility that existing NHS services may simply be re-created as 'entrepreneurial businesses', staffed by the same people and working in the same way, as simply a solution to the divesting of provision by PCTs. It was felt that if this happens, the real opportunity in primary care to see genuine innovation will have been missed.

Case studies: towards entrepreneurial provision in practice

BriSDoc

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In BriSDoc, Ray Montague and colleagues have created a shareholding body that is also an NHS body and can deliver NHS pensions. Bristol had previously been served by a GP co-operative providing out-of-hours care – a non-profit company limited by guarantee (CLG) with GP ownership and control.

Montague and colleagues in the old co-op wanted to create something that they could extend which others could join. They wanted the new structure to offer:

- Local GP ownership
- Integrity and transparency
- Incentives to grow with the new NHS
- A 'can-do' mentality
- The NHS pension

They decided that a company limited by shares was more transparent than other options. The executive own a major (but not majority) share. All shareholders must be active in delivering the company's services. A shareholder agreement exists, and those who decide to leave must sell their shares on exit.

The new organisation is constituted as an NHS body, and so can offer the NHS pension. For the company to do good, interesting work, they felt that they needed to employ NHS people, who can keep their pension when they move (especially nurses and other staff who will be vital to innovative future service provision). Employees' need to access the NHS pension was a key point: they wanted the NHS ethos and affiliation. This introduced a competitive weakness into BriSDoc, in that funding the NHS pension costs 'an arm and a leg' and reduces competitiveness.

Montague had first established the possibility of BriSDoc offering the NHS pension from the NHS Alliance 'Nuts And Bolts Of Primary Care' (Davies 2005) guide, which said that using the NHS pension was possible if two criteria are met:

- All shareholders must already be involved in the provision of NHS services
- The company must hold an APMS contract

BriSDoc's operational parameters:

- 2 share types: member shares (70%) and director shares (30%)
- A minimal working commitment is needed to hold shares
- Annual transfer window

- Share value = book value at year end
- 70% majority is needed to alter the constitution if conditions change.
- Board of directors – 5 executive, 6 non-executive. Currently, all but one are GPs, but that is not the aim in future.
- Dynamic, incentivised executive
- Looking for opportunitiues
- Enfranchised GPs across Bristol
- Can-do attitude
- Attractive NHS employer. Independent, strong symbiosis with PCT (ticking their mandatory 15% private provision box?)

<u>Key steps in the creation of BrisDoc</u>

- Get a businessman on board
- Form a parallel shareholder company to the original GP co-op
- Apply for APMS contract in the joint company names (without getting this contract, the project would have been impossible)
- Developed GP stake in new company and shareholder agreement
- Confirm employment authority status
- Transfer employment
- Make old company dormant

BriSDoc has successfully won a tender to double in size, which is being delivered successfully. They had resolved the key issue of NHS employment and pension status, and also enjoy a good relationship with their PCT, who are now asking whether BriSDoc would be interested in other service provision. He speculated that their business model may be one that other GP co-operatives consider attractive to join.

Epsom Day Surgery Limited

Dr Tim Richardson and colleagues at his GP practice in Epsom, Surrey created a new business that treats up to 80 per cent of patients previously referred to hospital for routine care. The work is handled by GPs, nurses and consultants near or in these people's homes. Dr Richardson's practice owns and runs the Old Cottage Hospital, Epsom through their day surgery company Epsom Day Surgery Ltd (EDS).

EDS offers a range of day case surgery, diagnostic procedures and clinics normally associated with district general hospitals, and has been providing this service for 12 years. They are currently expanding, to help manage similar care for a network of 16 practices and 121,000 patients.

Together with other local GPs, the practice has also formed the first Specialist Personal Medical Services (SPMS) company called The Epsom Downs Integrated Care Services (EDICS). It has a contract with the local PCTto provide and manage all GP outpatient referrals, and has direct access to diagnostic tests and minor procedures undertaken by GPs with special clinical interests.

These services are provided within a fixed budget, but at far lower cost than the PCT or the practices previously paid. GPs with specialist skills in this area work alongside senior consultants from neighbouring hospitals to carry out the work in the cottage hospital and other primary care facilities. Patients benefit from an integrated one-stop service that can refer them to consultants who are literally down the corridor, carry out x-rays and other preliminary diagnostic investigations and perform operations like cataracts, hernia and endoscopies on site.

Because the process has fewer steps, waiting times are shorter. The quality is higher because patients are guaranteed to see experienced consultants who are paid a fee per case by Epsom Day Surgery. This approach, coupled with the reduction in appointments, means productivity is high and the costs are around 10 per cent cheaper than NHS tariffs for surgery and up to 25% cheaper for the outpatient services.

Dr Richardson's philosophy is to "do 100% of the work for 90% of the cost rather than 90% of the work for 100% of the cost. It's also the only way we will get back to financial balance, improve quality and access and deliver on waiting time targets without blocking our patient's ability to get expert care when they need it."
Sourced from material in David-Colin Thome's report 'Keeping It Personal' (DH 2007)

Impact - integrated medicine partnership
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Impact, created by Julie McKay and colleagues, is a social enterprise which provides acupuncture, chiropractic and homeopathy in primary care. It was set up in response to residents' requests for access to complementary medicine at a New Deal For Communitites consultation event in June 2001. Its ethos is not-for-profit.

A vital aspect of the business's success has been its effective local partnership working with the PCT, GPs, the patients forum, mental health trusts and local MPs. Impact has recorded outcome measures on all patients in the last three years, and has also tracked its effects on patients' needs for GP follow-up for the condition treated. McKay was clear that 'large amounts of money' have been saved, but admitted that it is difficult to track these savings under current tariff and cost systems. She also pointed out that the financial case for disinvesting in secondary care to invest in primary care will require a methodology to assess and price 'work avoided'.

Some of the major obstacles encountered by Impact

- The need for business acumen and the expense of getting outside help
- The difficulty of breaking into what seems to be a closed market in primary care: McKay feels that the 'entire spirit of the Government directive' is often being ignored, and that commissioners should be looking at new ways of working; not the same old ones under a different flag
- Slow progress of the commissioning timetable – PCT staff's confusion and fear about maintaining the current provision, and fear of change

Important opportunities taken by Impact

- Getting contracts with local GP clusters under practice-based commissioning
- Getting a local government contract to address incapacity benefit take-up (involved in muscuolo-skeletal and mental health)
- Work for the mental health NHS trust
- Consultancy work

Summary of advice for would-be entrepreneurs

- You need a strong sense of vision and mission: setting up can be hard work
- 'Don't ask, don't get'
- You need allies, champions and friends
- You need patient and user support

- Government policy around the choice agenda supports this kind of development
- Effective team working is vital

i4vision® Social Enterprise

Dinesh Verma
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This case study is not, unfortunately, a success story yet. It offers useful lessons in the potential obstructions encountered by a would-be entrepreneurial provider.

Dinesh Verma, an opthalmic consultant in the NHS, recognised the need for a new model of provision of ophthalmic services. The ageing UK population will see a 24% increase in over-65 year-olds by 2020. Over 50% of this group have vision <6/12 in one or both eyes. Projected incidence of visual impairment will rise by 35%, and by the age of 75, 25% have cataracts, 5% have glaucoma, 20% will have acute macular degeneration. Over two-thirds of those with visual impairment are over 65 years of age. Furthermore, a population which is more 'health aware' will demand instant access to quality care.

Having become frustrated with the cultural barriers to working differently in the NHS, Verma's business concept was a phased solution, starting with primary care. He wanted to establish selected optometrist practices & large GP practices ('super-surgeries'), supported by a central fixed site with a day surgery unit; a reading centre; diagnostics and laser facilities at a community hospital (all linked with high speed broadband secure connection through NHS Connecting For Health).

The various premises would offer a broad range of optometric services using the latest technologies and maximising the use of IT to deliver web-based direct booking for GPs and optometrists and e-mail discharge summaries and Hospital Eye Service notes. Working arrangements would maximise the use of ophthalmic assistants to deliver care under the supervision of consultants, enabling a higher throughput of patients.

The project originally started as a service for age-related eye disorders, with an eye clinic equipped with slit lamp, phoropter, Field Analyser, Optical Coherence Tomography (OCT) etc. This achieved Healthcare Commission registration as an independent sector provider in March 2005. The business then applied for Extended Choice Network – but was unsuccessful. It moved into a GP "super" surgery in July 2006, and Verma joined forces with a GP (ex-Medical Director of Crawley PCT) and a nutritionist to form i4vision Services, which is currently being registered as a Community Interest Company (a social enterprise).

Barriers to market entry

Verma and colleagues encountered a range of barriers to entering the local primary care market. These included:

- Being seen as a threat to local health economy
- Traditional referral patterns proving difficult to change
- The local eye care "market" being controlled by NHS consultants – leading to no real choice for patients
- Intimidation of healthcare workers currently working in NHS hospitals was experienced if they were seen to be keen to join an alternative provider
- Money – Verma invested £50,000 of personal savings. He applied for Pathfinder funding from DH's Social Enterprise fund, but was unsuccessful – the feedback received was that his plans "do not correspond to need identified by Strategic Health Authority". i4vision applied for a 'Futurebuilders' grant / loan – but in a classic Catch-22, they need evidence of contracts from PCTs!

Options now remaining include:

- Approaching PBC clusters & PCTs for possible contracts / approval as a "choice" provider
- Developing the business plan for Futurebuilders loan
- Exploring further funding options from DH's Social Enterprise Unit

Rushcliffe Social Enterprise

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Dr Shortt and colleagues established Rushcliffe Social Enterprise, a not-for-profit community benefit company, limited by guarantee because they thought that existing community services were neither good value for money nor good quality. It aims to embed its business in community engagement and take account of patient voice. It also addresses the fact that the NHS now has powerful incentives to enhance quality and minimise the risk of future 'disenrolment' from practice lists under patient choice.

Dr Shortt and colleagues had already been looking to change services, feeling that current service delivery money was too focused on the acute sector, particularly A&E and elective care. They felt that precious little money filtered down to primary care to develop new services. The local health economy has vired resources out of secondary care to the new enterprise through collaborative practice-based commissioning, aiming to prevent supplier-induced demand.

Policy now permits any willing entrepreneurial provider to provide any primary care service up to list-based general practice. Dr Shortt speculates that Foundation Trusts will be able to pitch for this work on huge scale and with huge resources, with which GPs may find it hard to compete. He adds that the dynamic had now changed between his local PCT and practices – the former no longer so proprietorial towards the latter

The future of this agenda, according to Dr Shortt, will be about operating at scale. Entrepreneurs must aim to:

- Get coherence and synergies across the professions
- Develop the model of PCT community services
- Use the power and legitimacy of local public ownership and accountability

Ownership format

Rushcliffe Social Enterprise has 3 classes of stakeholders: 115,000 members, staff and the 18 participating practices. All registered patients are beneficiaries. It has tried to create an attractive vision and clear narrative for clinicians, developing incentives and sanctions for 18 practices working together. Participation and communication have been given a high priority throughout the 15-month inception.

The mix of the board is both clinical and lay, and it has a lay majority. The participating GPs passed up the right of veto over decisions potentially adverse to their businesses. Among the

reasons why they chose to incorporate legally was the desire to introduce binding and explicit performance measures.

To de-mutualise ownership would need the agreement of 50% of both the lay and professional board. Technically, they can legally make capital gains, but have put an asset lock in the constitution. (However, this is not an absolute lock: a simple majority can change the constitution.)

Developing this new form of ownership has a seen step-change of community involvement. They are developing outcome-focused services, and so need a new relationship with specialist care and to unbundle that from delivery in the old acute settings.

Money has been made available to the enterprise by the PCT under business continuity arrangements. The PCT also dedicated human resources and legal funding to the project. The practice-based commissioners involved also pooled their designated enhanced services (DES) money.

Appendix A – New ownership forms for entrepreneurial provision

Dr David Carson, Primary Care Foundation

The three main ownership options are:

- State ownership and control of provider - PCT; NHS trust
- Privately owned and controlled provider - GP partnership; private company (i.e. Netcare, UnitedHealth)
- Mutual or community-owned entity

'Not-for-profit' entrepreneurialism

If you are not running a business for profit, what are you doing it for? Operating profit is an essential part of entrepreneurial working. The NHS economic convention whereby 'cost equals price' is guaranteed to fail as more market-type mechanisms enter the NHS system.

The concept of shareholder value in a private company could be taken in three ways:

- export the value externally as profit;
- re-invest surpluses in the business;
- or maintain a public sector operating and financial model.

The last of these is clearly risky and doesn't work well, judging by the NHS's current financial problems.

Key questions before deciding on a corporate form for entrepreneurial provision

- do you want long-term stability with local accountability and little external influence?
- what speed of growth do you want – rapid or slow?
- do you want members or shareholders? If the latter, what extent of shareholding?
- do you want external investors? They can bring expertise and money, but in bringning these, they will also bring control
- is your aim to achieve capital growth? (to build the business and sell it) If so, price will be a multiplier of contract value and length
- do you have a social purpose, or are you just delivering health services?
- do you want staff to have ownership or limited ownership
- do you want asset locks to prevent exporting of capital value?

Capital will often be required, for premises, equipment, salaries and running costs. Options to access capital include:
personal investment by participants;
venture capitalists (who want a return on investment, and ultimately their money back);
gifts;
the DH / NHS;

and commercial borrowing (banks want a track record and evidence of revenue streams before lending).

Both co-operatives and companies limited by guarantee (CLGs) are able to borrow. Furthermore, capital is not merely financial – it can be expertise and time (intellectual capital).

Various available organisational forms:

Private sector

Partnership (the traditional general practice format)

- Difficult to make arrangements with other companies (a partnership is no real legal entity as such: just a group of people deciding to work together)
- Sub-contractor / lead contractor
- PBC / APMS contracts are potentially more risky if you get the costs wrong
- Personal risk if it goes wrong

Limited liability partnership (LLP)

- Reduces personal risk (provided you are acting legally!)
- Is it a good option for an organisation which will employ lots of people?
- Is the form best for your purpose and aims?

Community interest company (CIC)

- Private sector registered company
- Also on CIC register
- Asset lock - set up for specific social purpose
- More rules around disposal

Companies

- One option is PLC - publicly listed company with external investors
- Another option is a private company - no public listing
- Registered at Companies House
- Not a lot of difference in what the two can do, whether company limited by guarantee (CLG) or not
- First priority of a company is to make money and return on investment to shareholders (owners)
- Then comes service to customers
- Can be sold to other companies and individuals

Social enterprise

- The term is often used to cover both membership organisations; co-ops; and proper mutuals; as well as charities (which are often very good in one narrow area) and CICs.
- Why are social enterprises so attractive? Because they maintain the NHS ethos? Is the ethos public service? Or staff terms and conditions?
- Private sector organisations can do social enterprise

The proper title for a mutual / co-operative is:

Community benefit society

- a corporate legal model existing for the benefit of the community of members (to be defined)
- not registered at Companies House
- has members, not shareholders
- harder to demutualise than a community benefit society
- accountability depends on the constitution, purpose and membership
- must be registered with the Financial Services Authority.
- need to make profits
- argument that their accountability potential makes them more accountable when delivering public services – but not if they are only set up to serve one specific group
- can be set up as CLGs, but they are easy to turn into private companies and sell off
- if a co-op is set up with an asset lock, then if de-mutualised, rules state what happens to value (e.g. donated to local cats' home)
- Reward in revenue terms not capital (as no assets)

However, debating the merits of organisational form means nothing unless you win contracts.

Key factors for success

- A credible business plan
- A competent senior team
- At least £12 million annual turnover
- Systems and processes fit to run an organisation larger than a GP practice
- Recognition that what works on a 'corner shop' scale may not work on Tescos-type scale
- Recognition that loss-leading to get business is unwise in a service industry
- Recognition that commissioners who let contracts at less than costs of delivery are incompetent and dangerous
- Recognition that healthcare is a highly regulated industry, and compliance costs money

Appendix B - Entrepreneurs' event: key issues arising

NHS Alliance Providers' Network ran an event in January 2007 at the Kings Fund, with delegates who were engaged in entrepreneurial provision. The following is a summary of some key comments, observations and questions from the plenary discussion.

Fear

- Fear of less control when community services go 'out-of-house'
- Fear of competition in the new market
- Motivating people to look into new working – risks of not doing anything vs. risk of change
- Promoting the quality of a new service has to include selling the benefits of being in the club, and expulsion must be a risk – these drivers can behove organisations to join
- The fear message does not galvanise everybody
- "We have to do PBC because of threats of not doing it – we're telling PCT proactively what we are going to do".

Finance

- Deficit PCTs hold contracts – it is agreed policy that 70% of savings in commissioning groups should be re-invested unless there is local agreement otherwise
- Real entrepreneurs will partner with others or form consortia (perhaps in the manner of NHS LIFT)
- There is no money in commissioning, only in provision
- We have to invest in training professionals to run things.
- We need entrepreneurialism inside practices, as well as out of them
- What we set up has to be financially sustainable

GPs

- Getting GPs on board is a challenge
- GPs and nurses often fear management by non-GPs
- This area needs dynamic GP leaders and leadership

Patients

- Different populations of need might need different contracts.
- Patients currently tend not to move from a practice

PCTs

- PCTs have changed, from organisations who felt they owned practices to managers of contracts who have data and are asking practices what they are to do about their referral rates etc.
- PCTs' indifference, inertia or hostility is perceived to be a problem by several people

Quality

- Clinical governance (inspection) is increasingly starting to go into primary care organisations – and there will be more coming
- Governance and control (or comfort level of control) are vital issues for GPs

Working practices

- Change management skill sets are needed
- Direct control doesn't tend to work with highly-paid professionals
- It is hard to change working practices
- Out-of-hours (OOH) providers are successful because they're often small, and it all works because most of their staff are just very part-time
- Practice-based commissioning won't work without alternative providers
- There's a notion emerging that we're going back to trying to meet people's needs: a bit like the PMS pilots 7-8 yrs ago. There's also a concern that we are still focus on rearranging the biomedical model. We need to meet people's needs in a more holistic way, but also form needs to follow function.
- Using data to prove points, peer review and internal review are extremely powerful
- We're going to start with core business and add on gradually

Questions

- What exactly do we want to change with new entrepreneurial services?
- Should we look to grow with capital and sell the business, or grow the non-capital route and increase revenue?
- What is the role of PCTs in provider development?
- How engaged is the PCT in the management of relationships?
- Could we contract with self-employed therapists etc? And ex-NHS staff?
- In the area of therapy, could we form a company of sorts with SLAs with others for parts of provision? If we split off the staff working in the acute trust, then we'll be too small to deliver services.
- What do GPs want?
- How would DH like us to be set up?
- How about co-payment to provide complementary and alternative medicine (CAM) not covered by our PCT?
- Is it legitimate to do commercial commuter clinics as an NHS organisation?
- What is the latest GPC guidance on charging patients?
- How can we engage to best effect with the PCT?
- Big organisations can do training and do back-office functions effectively; but how can smaller ones do so?
- What does a director of provision do?
- How do we generate change within the practice?

How might we address these key issues?

Change within general practice

- We need to look at what we do, rather than where we do it
- Who will own general practice in the future?
- It's about embedding key values: longer appointments, continuity of care, holistic care.
- "The real enemy of general practice is not big corporations, it's the GP down the road who's not pulling his weight"
- Back office functions should be done properly, and at city-wide-type scale.

Co-payment and dual organisations

- Regarding dual organisations, there's a feeling that as long as you have a separate organisation (distinct from practice / partnership in size and name), then that organisation could provide services to patients for a fee - but there's some potential greyness
- Payment in kind – our physios are able to have 2 sessions a week in our practice for no charge if they see our patients for 1 session a week. This has reduced costs, and we can even present it to the PCT as an income stream!

Engagement with PCTs

- It's about open discussions – but you can force the issue if they will not listen. The PCT manager with the plan must be encouraged to disseminate it, so that we can at least be in the same book - if not on the same page.
- We need to quell their fear of GPs and primary care staff as 'bad guys', out to do PCT down.
- PCTs have a great fear of losing influence and power by losing commissioning and provision.

New employment options

- More therapists would be interested in bidding for services if contracts were big enough, reliable and long-lasting. Groups of entrepreneurs would form if contracts were for large volumes and long-lasting. We're currently training new therapists to consider self-employment options – telling them, 'look at where the service actually is today and where it's going.'

Appendix C - Survey

As part of the research for this report, a range of individuals identified as actively pursuing the development of entrepreneurial services in primary care were sent a short questionnaire to gather their views and progress on this area.

26 responses were received. While we do not pretend that such a small survey offers authoritative data, it gives a snapshot of the views and attitudes of people already engaged in this area. It also raised an interesting list of the major obstacles to developing entrepreneurial services – see below for the full list.

What do you see as the main reasons for developing more entrepreneurial services in primary care? (Rated in order of importance where 1 = highest)

1. Increasing capacity
2. Offering choice
3. Financial / profit
4. Improving efficiency
5. Quality of patient experience
6. Quality of clinical care

7. Other (please specify)

(N.B. 7. Other has been separated from main list as only ¼ of surveys chose to rate it)

Responses specified under 'Other'

- Enabling innovation in service design
- Control over service development
- Moving services into extended primary care
- Protecting general practice locally from outside private providers
- Independence from managers out-of-touch with work done
- Protecting our individual patient-focussed practice ethos / independence
- Ability to introduce innovative ways of working; breaking the mould
- Perceived threat from alternative providers

What do you regard as the major hindrances to for developing more entrepreneurial services in primary care?

- The difficulties of overcoming legal and business challenges
- Lack of financial resources within PCTs; lack of ability of PCTs to shift resources within existing budgets / contracts
- The time commitment and risks involved
- Reluctance of staff groups to move away from perceived security of NHS structures

- Lack of sign-up by PCTs to PBC; lack of full PCT staff engagement in PBC; PCT's lack of timely and needed information; lack of dedicated staff to assist in commissioning from different providers; conflict with PCT desires to re-establish the Community Trust; NHS antipathy to non-NHS / for-profit companies; primary care clinicians' change fatigue; chasing QOF points; few "volunteers" to take PBC / entrepreneurial services forward; lack of capacity in primary care to do the day job as well as all the additional work of NHS reform; primary care taking the view that most reforms are only around for 2-3 years before the next one
- Lack of direction from local PCT, including financial and activity information. Clear contracting routes with developed service specifications in advance of the need for provision, with at least 3 months.
- Lack of support or understanding from the PCT
- Lack of resources, guidance, and probably the bureaucracy of getting through the hurdles of the regulations etc through PCT.
- Lack of vision and looking to the past. Fear.
- Too much bureaucracy. Everything (including simple ideas) takes far too long to get off the ground. We are shelving good plans because we think that 10 years down the road it will be not fit for purpose … yet we don't want it to evolve!
- Financial start up and staff buy-in: "hearts and minds stuff" – particularly from NHS and local authority staff, who say to me constantly that they want "security" and that job security is what underpins their decision-making – and this is in the substance misuse sector, where individuals are supposedly values-driven and socially conscious
- My time; PCT time; slowness to turn services around; lack of really hard data
- Inertia; leadership; not understanding / appreciating NHS political change linked with PBC; fear of risks; lack of capacity (GPs, business-minded GP's and business support)
- Professional barriers at both primary and secondary level. The "no-can-do" culture of the NHS. Apparent lack of strategic vision and guidance from the DH.
- Clarity of direction from the centre, and the lack of resources at PCT level to enable us to move forward
- It's not a real market. Service users do not have a direct influence as they do not pay for the service. Also, premises: adequate premises are difficult to find, and it's impossible to fund new build with the uncertainty of short-term contracts
- Lack of clarity from PCTs about the service they need / want. Preoccupation with financial issues. Protectionism in regard to local acute trusts. Lack of engagement by local GPs.
- Ongoing NHS debt, adherence to evidence-based medicine for service development and requirement of proof for a proposed new service / way of working before money is released by the

Treasury. The prevailing biomedical mindset and powerful markets sustaining biomedical healthcare are likely to consolidate with APMS. New money diverted to the new GMS contract and QOF concept of quality. Payment by results and foundation hospitals putting service before patients and profits before service.

- Capacity to do the work; access to information about how to go about it; and support to make it happen (albeit virtual)
- Other GPs not wanting to take risk themselves, and therefore not wanting others to do it and get any advantage.
- The local PCT and the local acute trust
- PCTs constantly repeating the 'what' and the 'why' of PbC but with little to no understanding of or commitment to the 'how' – 'headless chickens' come to mind. Lack of appropriate financial / monitoring systems & structures for at PCT level to inform success. Lack of initial investment / resources – although this can be easily overcome
- Lack of engagement with either users or other professional / health provider groups. Red tape and political agenda. Inappropriate targets. Statutory strangulation. Clever people with high level of business acumen with interest in the delivery of these services (I think this type of person is more interested in profit, and these principles are counter to the present ethos of the NHS).

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List of acronyms

APMS	Alternative Personal Medical Services
DES	Designated enhanced services
DH	Department of Health
FT	foundation trust
PBR	payment by results
PCT	primary care trust
QOF	quality and outcomes framework
SHA	strategic health authority