The King's Fund

ORGANISATIONAL *Audit*

ORGANISATIONAL AUDIT FOR HEALTH AUTHORITIES & PRIMARY CARE COMMISSIONERS

PROJECT EVALUATION REPORT

AUGUST 1996

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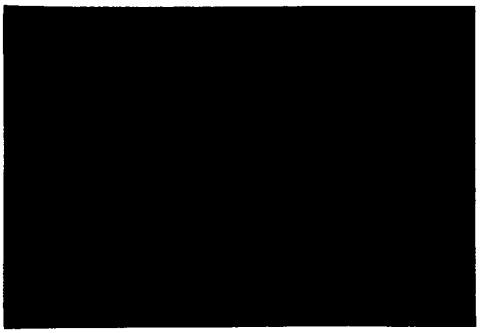
REPORT



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OA FOR HEALTH AUTHORITIES AND PRIMARY CARE COMMISSIONERS

CONTENTS

QUOTES

'It's not the standard of the standard that counts, but where the ensuing conversation leads'

'I was sent to be a surveyor when I thought I had more important things to do. However, in retrospect it has been a fascinating experience in which I have matured my thinking about organisations and how to handle them'

'I enjoyed this role (coordinator), and by creating a universal involvement within the HA got the best out of staff'

'One provider got a flat tyre en route and jogged the last 3 miles to the practice so as not to upset the timetable - determined or what!!'

'OA enables the organisation to stop and take stock against a set of criteria and standards of good practice the outcome will provide a clear blue print for the future development. Gives everyone an opportunity to show their achievements'

INTRODUCTION

At the beginning of 1995 King's Fund Organisational Audit set up a project to develop organisational audit for health service commissioning.

Six health authorities and five primary care organisations subsequently agreed to become pilots for the newly developed process. They were:

- Bennett's End Surgery
- Birmingham Multifund
- Coventry Health Authority
- Doncaster Health Authority
- Dorset Health Authority
- North Staffordshire Health Authority
- Northumberland Health (2 GP groups)
- Sheffield Health Authority
- South and West Devon Total Fund
- South and West Devon Health Authority

Standards and criteria for health authorities and primary care organisations were developed during 1995 and involved a wide range of organisations and individuals in addition to the pilot organisations followed by comprehensive consultation.

In preparation for subsequent surveys approximately 50 senior staff from health authorities and primary care organisations were trained as surveyors over 1½-2 days.

The well known OA process was used as the starting point and adapted to the commissioning environment. New developments included the extensive use of external interviews during the surveys, the selected use of questionnaires to external organisations and the piloting of topic based OA in three authorities.

Surveys took place between April and June 1996 and involved 3-4 surveyors over 2-3 days depending upon the size of the organisation. Evaluation of the project has been an ongoing process throughout the project itself. Detailed questionnaires were completed by pilot organisations, surveyors and King's Fund personnel the results of which were discussed in a workshop on 19 July 1996. Thirty-two people representing the pilot organisations, surveyors and the King's Fund discussed a number of the key issues that had emerged and made recommendations.

This report presents the results of the evaluation process, including the findings of the workshop and the wider views of participating organisations and individuals.

ACKNOWLEDGEMENTS

The King's Fund is indebted to all the organisations which have played such an important part in this project. A full list is enclosed at the end of this report. The enthusiasm, willingness to try out new ideas and helpful suggestions have all contributed to an extremely good trial and formed a sound basis for development of the subsequent programmes.

Within the King's Fund I would particularly wish to thank Velda, Judy, Caroline, Karen, Alys, Ruth, Jane and all the members of the Project Team for their support.

John Hubbard
Project Manager

1. EXECUTIVE SUMMARY

STANDARDS AND CRITERIA

Standards for health authorities were issued as a first edition in October 1995 and have proved to be an effective foundation for the survey process both in terms of implementation by clients and in ease of use by surveyors. These standards have now been revised and reissued in light of comments from the consultation phase and implementation by pilot organisations. Weightings have been added in consultation with pilot organisations.

It is clear that these standards will have to be continuously reviewed given the rapid pace of change in commissioning and in particular in the roles of health authorities and primary care commissioners. The second edition of these standards will therefore be needed during 1997.

Standards and criteria for primary care commissioning have been included in the revised primary care manual for the first time. These are fully applicable to practices including fundholders and will be appropriate in modified form for other primary care commissioners such as totalfunds and multifunds. Work is taking place to see how best to fit standards to these organisations and it is anticipated that this work will be completed by mid-autumn 1996.

IMPLEMENTATION

Timescale

It has become clear to all concerned that the minimum implementation period for commissioners is 9-12 months. This would be the period when the standards and criteria were available for local self assessment and use prior to an external survey. It was also clear that for commissioners there are good and bad times of year to undertake surveys and to carry out the intensive work needed beforehand.

Coordination

Experience showed how important the role of the coordinator is to a successful organisational audit programme. A clear picture has developed of the preferred skills required and how best to ensure that coordinators get the necessary support.

Local needs

It is important, particularly for primary care organisations which are so variable in size and structure, to ensure that implementation and the survey itself is appropriately organised to fit local circumstances.

THE SURVEY PROCESS

Length and team requirements for surveys

Experience has proved that the appropriate length for health authority surveys is 3 days using 4 surveyors with preliminary meetings between the survey team and the client taking place the evening before the first day.

For the majority of practices which are audited against the commissioning standards the length of survey will only slightly be increased to allow for the external interviews. For other organisations the length and number of surveyors will have to be decided on an individual basis.

Documentation

The provision of documentation to support the survey was felt to be about right. However improvements can be made to the way in which documentation is made available to surveyors so that information is presented clearly and quickly.

External interviews

External interviews represented approximately 50% of the overall survey. This was felt to be broadly the right balance and furthermore that they were a vital part of understanding commissioning.

External questionnaires

Questionnaires to external organisations were used by several pilot organisations successfully. In future they should be sent to a variety of external organisations, some of which will also be interviewed. They provide a broad range of response and reduce the dangers of subjectivity from having a small selection of external interviews. Administration of the questionnaire can be improved to make better use of the information they contain.

Topic based OA

Three health authorities tried out topic based OA which involved the selection of a health gain area and the assessment of it against 22 selected criteria from across the 8 health authority standards. Sexual health services and cardiac services were chosen. For a variety of reasons it was not that easy to undertake a full survey in relation to the topics. Nevertheless there is agreement that the idea should be pursued. Further work will be done to develop this process and it will be offered as an optional element within the future programmes.

Feedback to the client organisation

Several different styles of feedback were tried out during the project and a good body of experience developed on what is more or less effective. There was consensus that this was an important part of the whole survey and that it should be developmental. Feedback needed to be structured to allow discussion with senior staff and to give a clear and honest summary of findings to the wider organisation including wherever possible representatives of alliance partners.

Survey report

The comprehensive report of findings of surveyors is an important element particularly if the survey process is to be seen as part of an organisational development plan. The format during the pilot phase was generally liked and seemed to be an important reinforcement of the feedback.

Selection and training of surveyors

The training programmes for surveyors during the project was well received and formed a firm foundation for the surveys themselves. In future surveyors will be selected for the task as well as trained. A number of aspects will be emphasised including the value of team working.

BENEFITS

The project highlighted many benefits to participating organisations. These included:

- the opportunity to reexamine practice and to identify strengths and weaknesses
- it encouraged team working through the need to be reviewed together
- the independent assessment was welcomed
- it gave staff the opportunity to shine
- it encouraged external communication in particular the sharing of the commissioning perspective with other agencies
- finally, it gave a framework to organisational development with a focus on priorities for action.

There were disadvantages expressed the most common being the time that was needed and inevitably the opportunity cost. Nevertheless the majority felt that the effort was worthwhile and the benefit worth having.

Surveyors also gained considerably from taking part in organisational audit. Particular benefits included:

- the insight gained from a detailed review of another organisation
- the opportunity to question how surveyors themselves worked
- the value of working intensively with a team of peers
- appreciating other people's problems and successes

THE NEXT PHASE

Organisational audit for health authorities is being made available to all health authorities and boards with effect from autumn 1997. Timescales will vary but it is likely that participating health authorities will be surveyed in the period from May-September 1997.

The primary care programme is now offered with commissioning as an integral part. Further work is ongoing in relation to other primary care commissioners and individual programmes are likely to be available later in 1996.

2. COMMISSIONING STANDARDS AND CRITERIA

2.1 The predominant response to the Health Authority standards was positive. Repeated expressions included:

- *relevant and a useful framework*
- *easily understood and logical*
- *easily split to be coordinated by a lead surveyor*
- *created a benchmark*

2.2 Some felt that:

- *certain criteria needed more than just yes/no - to describe a measure of progress*
- *as surveyors their lack of knowledge of the standards hindered them*
- *the standards need to be weighted*
- *it is possible to meet the standards and still fail - see topic based OA*
- *standards did not reflect* ***how*** *a health authority performed eg how are priorities set?*

2.3 The primary care commissioning standards were felt to be clear, but more guidance would be helpful. Nevertheless at least one of the pilots found it difficult to be surveyed using the primary care standards beside the commissioning standards which led to overlap and some confusion.

Comment/Recommendation

2.4 A single integrated primary care manual has now been produced and will be the basis for all future surveys of practices. Multifunds and total funds are likely to use a selection of standards from the manual.

2.5 Health Authority standards have now been weighted and following consultation these will be issued to new clients.

2.6 OA has adopted yes/no assessment rather than a graded scale to reduce the degree of subjectivity which inevitably arises. The expectation is that surveyors will assess the degree of compliance during interviewing using open questions to find out how and why.

One health authority used the comments column to show, in all cases, **how** the criteria had been met. This will be very helpful to surveyors and is recommended.

2.7 It might be possible to meet certain standards on the surface yet not be performing effectively. However a thorough assessment of Health Authority standard 7 - organisational fitness and Primary Care standards 4, 5 and 7 will reveal gaps between functions and in implementation of policies and procedures.

Standards Development

2.8 The initial drafting of standards and criteria took place from April-December 1995.

- *multidisciplinary groups were good*
- *overall approach good*
- *some would have preferred a more structured framework instead of a blank sheet of paper*

- *it is possible that some comments and views have got lost in the drafting process*
- *now standards are in place it is vital that they remain challenging.*

Comment/Recommendation

2.9 Several pilot organisations and surveyors would be willing to periodically work with KFOA on standards development to ensure they reflect the changes in commissioning.

2.10 KFOA will need to consider how best to continuously review the standards in addition to the above.

3. IMPLEMENTATION OF STANDARDS

3.1 The implementation phase of the project was the period from receiving and distributing the standards and completing the initial self assessment to the survey. This period lasted six months for a number of the pilot sites but was significantly shorter for others owing to complications in setting up the project locally and also other factors such as moving offices, completing protracted and difficult contract negotiations, and in the case of fundholders concluding the arrangements at the end of the financial year.

For many organisations the implementation phase was not long enough.

The role of the coordinator

3.2 This was a critical role for the success of organisational audit and in most people's eyes worked very well.

3.3 In discussion on the role profile key attributes were:

- *central to the organisation*
- *ideally reports to the chief exec*
- *flexible workload*
- *knows lots of people*
- *a fixer/communicator*

3.4 It is important that coordinators are well supported internally and the KFOA survey manager and with guidance and milestones.

3.5 The coordinators had to undertake the task of collating the results of self assessment. This was time consuming. It is important that a paperless system is introduced as quickly as possible.

The Steering Group

3.6 Most pilots found the steering groups useful. Many chose named individuals to lead on particular standards. The size of the group varied and opinions divided on which was the most effective. A small group can work efficiently together but may have more difficulty in communicating within a larger organisation.

Comment/Recommendation

3.7 Some felt that steering groups needed more support from the King's Fund during implementation. It will be important in the programme that the survey manager attends this group on key occasions.

3.8 It is essential that the implementation phase is a minimum of six months and preferably 9-12 months. This action alone would have reduced a number of the problems that occurred during the pilot project.

3.9 Development of the coordinator role profile will assist their selection and training. Realism on the OA workload is important. One day per week over one year is realistic.

4. PREPARATION FOR THE SURVEY

Development of the Timetable

4.1 There was a considerable amount of hard work put in by coordinators to develop effective timetables and plans. Those that had more time in general were able to put together timetables which needed least amending before the survey. Most of the pilots managed to get a good spread of external and internal interviews. They found the sample timetables and presurvey briefing notes provided by KFOA particularly helpful.

4.2 One organisation felt disappointment at the lack of support from KFOA at the early stages.

Comment/Recommendation

4.3 It is important for KFOA and the client to be clear about the amount of KFOA support from the outset.

Early contact with the survey manager is essential.

Documentation

4.5 Documentation did not provoke much comment. The documentation checklist for pilots was useful and succinct. Most surveyors found it difficult in the time to review the documents which were supplied. Pilots found that they had little opportunity to present documents in the most useful way.

Comment/Recommendation

4.6 Gathering of documents needs to begin at an early stage. Surveyors need to get a full list of documents when they receive presurvey documents and to also have a list of others which could be accessed if required.

4.7 Documents need to be marked to indicate how they satisfy a particular criteria and grouped in a logical way for easy reference.

5. PRESURVEY MEETING

5.1 The meeting between surveyors and the survey manager the afternoon before the survey worked well for most people, comments were:

- *useful*
- *punctual*
- *well organised*
- *very constructive*

Comment/Recommendation

5.2 Two teams felt that too much time had been set aside and that one and a half hours would have been sufficient, but this view was not universal.

It is important that all surveyors arrive at the same time and that attention is paid to the venue to avoid outside disturbances.

Meeting with coordinator and chief executive and/or senior team members

5.3 The evening meeting between the survey team and the coordinator and one or two senior staff seems to have been productive. In the main the meetings were informal, a couple were over dinner and all seemed to set the scene well for the following days.

6. THE SURVEY TIMETABLE

6.1 One of the key questions for evaluation was the length of the survey and the number of surveyors used.

The predominant response for both primary care and health authority surveys was the length and the number of surveyors was about right. Additional comment included:

- *it was hard work*
- *well structured*
- *a hectic 3 days but good value for money*
- *the right length*
- *worked well in parts*
- *a success*

6.2 There were a variety of comments where things did not work quite so well. Some of the key ones were:

- *survey was too short to complete the interviews*
- *the trust was not well briefed and appeared defensive*
- *allocation of standards to lead surveyors not quite right*
- *some timetables were altered very late in the day and extra interviews requested*
- *June is a bad month*
- *there was not enough time to meet with colleagues and exchange information*

Comment/Recommendation

6.3 There should be more review time built into the timetable for surveyors to recheck and to read and exchange information and some space for one or two additional interviews.

6.4 At least one and a half hours is needed for a meeting on each evening.

6.5 It is strongly recommended that a meeting with the chief executive/practice lead should take place just before feedback.

7. EXTERNAL QUESTIONNAIRES

7.1 Where these were used they were well liked:

- *a useful introduction*
- *well written and clear*
- *well received*

Some people questioned how representative the questionnaires were and felt that it was important to get feedback from those who had not responded to find out why. In some cases the material on the questionnaires was not really used to full effect because of a lack of time.

7.2 Interviews did not always allow for the fact that questionnaires had been completed and issues were not picked up.

Comment/Recommendation

7.3 KFOA should issue a recommended list of the types of external organisations to be invited to participate. It is for the client to decide on the final list of organisations to involve.

7.4 Questionnaires should be sent out well in advance of the survey to avoid the pressure of a deadline and the results need to be collated by the survey manager and sent out to surveyors as part of the presurvey documentation.

7.5 Knowledge of who responded and who did not would enable surveyors to consider carrying out a telephone interview to find the reasons for a nil response.

7.6 Questionnaires should be professionally compiled and also be tailored to local circumstances.

7.7 They should be returned to KFOA.

8. THE VALUE OF INTERVIEWING

8.1 For the majority of surveyors it was their first experience of peer review and of the standards. Nevertheless they were able to use their experience and skills developed in training to very good effect. Many of those surveyed felt that the interviews drew out the issues and produced generally accurate conclusions.

8.2 There were strong views expressed that the process can identify good and poor performance beyond the basic level of compliance with criteria. Probing with 'how' and 'why' questions as well as extensive cross checking will identify good and poor practice especially in relation to health authority standard 7 organisational fitness and primary care standard 5.

Comment/Recommendation

8.3 Compliance with the standards and criteria must be the core question for all interviews supported by more open interviewing to assess implementation.

8.4 Suggestions about good practice from surveyors may be welcome but should not be overdone.

8.5 Cross checking between surveyors throughout the interview process will ensure a rigorous assessment and reduce the likelihood of inaccurate findings. Points 8.3-8.5 should be emphasised in surveyor selection and training.

9. EXTERNAL INTERVIEWS

9.1 External interviews accounted for approximately 50% of the survey and were considered to be an invaluable feature of the overall approach. Typical comments were:

- *interviewees were open and well briefed*
- *very useful*
- *worked well*
- *well organised*
- *a vital part of the audit*

9.2 In a number of cases people came to the health authority or the practice for the interview which clearly saved the surveyors time. Opinion varied on the maximum number to be involved in the external interview, 3-6 seemed possible but no more.

9.3 However some respondents said:

- *need to avoid lunchtime interviewing*
- *interviews were too short eg with social services*
- *perhaps because of time constraints some external organisations felt that they were not challenged enough*
- *travel in some cases was difficult (Euro 96!)*

Comment/Recommendation

9.4 KFOA should issue a guide to the range of external organisations which could be involved and recommend a spread of interviewees from different organisational levels.

It would then be for the client to produce the specific list which would be discussed with KFOA.

9.5 Check external interview travel times carefully. If long distances are involved plan to have more at the health authority or practice.

9.6 Develop guidelines for telephone interviews.

9.7 Surveyors need good briefing on the external interviewees and some training on interviewing focus groups.

10. FEEDBACK

10.1 Feedback was recognised to be one of the most difficult parts of the survey process. It was divided into 2 or 3 stages: One meeting with the executive team or equivalent and secondly to all or some of the staff. In some cases there was a one to one meeting with the chief executive or practice lead/manager before these two took place.

10.2 Overall there was satisfaction with the feedback with comments such as:

- *a good summary of findings*
- *the use of themes worked well*
- *the initial meeting with the chief executive gives a mandate for productive meetings to follow*
- *Use of overheads worked well*
- *We were delighted to see the Board joined in the staff feedback*
- *All staff who attended it enjoyed it*
- *The dry run worked well*

Comment/Recommendation

10.3 Ensure sufficient time is given to preparation and emphasize this skill in surveyor selection and training.

10.4 Arrange a meeting with the chief executive/practice lead before feedback.

10.5 Clients should think about who to invite to feedback early on. Encourage the involvement of alliance partners.

10.6 Encourage a developmental approach and allow discussion on the issues with the executive group.

10.7 Ensure the room is not too hot or overcrowded, keep staff feedback fairly short but avoid it becoming superficial. Allow questions.

10.8 Feedback on difficult issues needs time to prepare to get the messages across clearly but sensitively.

10.9 Vary the presentation to suit local circumstances. KFOA needs to issue guidance on the possible approaches.

11. THE SURVEY REPORT

11.1 Most pilots had received the report in at least its draft form. There was general support for the format and presentation of contents. The detail was about right.

Comment/Recommendation

11.2 If possible it would be clearer to include the text of the criteria as well as the reference number.

11.3 The report will need to show weightings and allow the grouping of recommendations of an equal weight together.

11.4 If the feedback is given in themes, consideration should be given to also writing the report in themes.

11.5 KFOA needs to ensure that external organisations are also given feedback by the client. This might be in the form of a summary of the report drafted by the client.

11.6 If a timescale is given for report production this must be adhered to by KFOA.

12 TOPIC BASED OA

12.1 This was undertaken by 3 out of 12 pilots and involved the choice of one or two health gain topics: sexual health services and cardiac services or both were chosen and these topics were assessed against a selection of the criteria from the standards numbering 22 in total. The idea was that there should be separate documentation supplied for the topic and preferably one or two additional interviews. Furthermore all surveyors would, when asking questions during general interviews, use the health topics to get further evidence and examples of how things worked.

12.2 There was a recognition of the value of this approach but in practice a number of difficulties occurred:

- *lack of time meant that separate documentation was not generally available and additional slots had not been inserted into the timetable.*
- *given that all the surveyors were new to the standards it was probably asking too much to add topic based OA to their agenda. What they were able to do was rather too superficial*
- *the process was seen as separate from the main survey.*

Comment/Recommendation

12.3 Work on topic based OA should begin at the launch of the programme to allow plenty of time to gather information and for the client organisation to make progress following self assessment.

12.4 An early start will enable organisations to be clear about who needs to be interviewed and what documents are required before and during the survey. Surveyor selection can ensure an appropriate lead surveyor is nominated for the topic.

12.5 Surveyors should be briefed in advance on the need to interview against the topic and what it is intended to achieve. This needs to be included in training.

12.6 The possible range of topics needs to be reviewed. Health of the Nation targets might be considered.

12.7 Topic based OA should remain a voluntary element for the time being.

13. SURVEY MANAGEMENT

13.1 There was generally a high level of satisfaction with hotel and other arrangements. Comments included: *excellent, good, brilliant, superbly organised, excellent hotel and organisation.*

Nevertheless some things were not quite right:

- *two hotels were felt to be unsatisfactory and did not give the surveyors the environment they needed*
- *all hotel meetings, including the evening ones, should be in a separate room away from distractions*
- *surveyors need a desk and space to spread out papers etc*
- *all directions to the organisation and hotel need to be clear and detailed*

14 THE SURVEY TEAM

14.1 There was a high level of satisfaction with the quality of the survey teams and the way they rapidly worked together.

14.2 Some surveyors felt inexperienced at times and may not have been as effective as possible in passing on information about standards for which they were not leading.

14.3 There was generally acceptance with the allocation of lead surveyors that had been made in advance in the case of health authority surveys and only one instance when the allocation was felt to be inappropriate. A few surveyors were less than happy in interviewing in areas for which they were not experienced but the majority made no adverse comment.

14.4 Teams did work differently. Some used the proformas for the interviews fully and ran out of copies. Other found the proforma used to pass notes between surveyors of great benefit.

Comment/Recommendation

14.5 A mix of backgrounds within the team was felt to be essential. Core team members for health authority surveys were:

- *chief executive*
- *public health consultant*
- *finance/contracting or finance/information*

Surveyors should be the equivalent of director or assistant director in seniority and experience in the majority of teams.

14.6 In selecting survey teams, KFOA should find out primary and secondary experience of surveyors to ensure as broad a range of knowledge as possible.

14.7 KFOA must secure the full commitment of surveyors to the whole survey period and to the necessary preparation.

15. OVERALL SUPPORT FROM KFOA

15.1 Pilots were asked for their thoughts on the degree of KFOA support prior to the survey. Only in a few cases was this not what they would have wished for. Some would have welcomed more specific guidance on the standards and others early and specific support in timetable development and in dealing with press interest during the run up to the survey. The combination of a primary care survey with new commissioning standards did complicate matters in two cases and with hindsight more input would have been helpful.

Comment/Recommendation

15.2 Clients will be allocated a survey manager from the outset and it is important to get agreement on exactly the degree of input that will be given at the various stages of the programme. Complex organisations will require to plan the key stages of the survey.

15.3 In the case of primary care commissioners the survey process will need to be carefully tailored to the particular organisation. A standard approach which might be appropriate for health authorities cannot necessarily be adopted.

16 SURVEYOR TRAINING AND SUPPORT

16.1 Surveyors were asked to indicate how far the training they received was appropriate to the job they had to do. There was a high level of satisfaction with the surveyor training that had taken place. Several respondents thought that no improvements could be made.

16.2 Surveyors would welcome feedback on their own performance.

16.3 Criteria for the ideal OA hotel would be useful.

Comment/Recommendation

16.4 A role profile for surveyors would help with recruitment, selection and training.

16.5 In training and selection the following should be given emphasis:

- *team working*
- *the specific requirements for report writing by surveyors*
- *interviewing groups*
- *using standards as a foundation to probing interviews*

16.6 KFOA should consider using surveyors in training and selection.

16.7 Further ways of supporting surveyors need to be considered. These might include:

- *refresher days*
- *briefing on new or revised standards*
- *regular newsletter*
- *surveyor advisory groups*

17. CONCLUSION

17.1 The project has successfully tested out organisational audit for commissioners of health services. In doing so many benefits were identified:

Benefits to clients

- *the opportunity to reexamine internal processes, strengths and weaknesses, against national standards*
- *it brought the team closer - greater corporacy*
- *independent peer assessment*
- *an opportunity to shine*
- *stressed external and internal communication*
- *clarified priorities*
- *gave an organisational development framework*

17.2 The project clearly showed how the process can be improved upon and many recommendations are listed in this report to KFOA to build into the programme to follow.

The principal disadvantage was the time and the opportunity and cost of involvement.

17.3 Further work is needed on the process for total funds and multifunds.

Benefits to surveyors

17.4 There were many positive statements made about the benefits that surveyors took away with them. These included:

- *insight into another organisation*
- *questioned the way I work*
- *helpful to go outside the (surveyor's) region*
- *cheered me up that others had similar problems*
- *in retrospect a fascinating experience*
- *valued the teamwork*

17.5 Finally it was encouraging that in spite of significant pressures on time pilot organisations and surveyors declared their willingness to support OA in development of the programme.

WITH THANKS

Pilot Sites

Bennett's End Surgery
Birmingham Multifund
Coventry Health Authority
Doncaster Health Authority
Dorset Health Authority
North Staffordshire Health Authority
Northumberland Health (2 GP groups)
Sheffield Health Authority
South and West Devon Total Fund
South and West Devon Health Authority

Reference Group

Ray Jones, *Director of Social Services*, **Wiltshire County Council**
Roselyn Wilkinson, *Information Officer*, **Association of Community Health Councils**
Dr Mike Armstrong, **Alvanley Surgery**, Stockport
Neil Goodwin, *Chief Executive*, **Manchester Health Authority**
Geoff Meads, **NHS Executive, South and West RHA**, Bristol
Brian McCloskey, *Director of Public Health*, **Worcester Health Authority**
Angela Coulter, *Health Services Director*, **Development Centre, The King's Fund**
Dr Chris Newman, **Public Health Laboratory Service**, Leeds
Derek Smith, *Chief Executive*, **King's Healthcare**
Virginia Beardshaw, *Director of Commissioning*, **Barnet Health Authority**
Ian Carruthers, *Chief Executive*, **Dorset Health Authority**
Dr Barry Robinson, **The Lyme Community Care Centre**, Lyme Regis, Dorset

Coordinators

Edward Colgan, *Director of Corporate Development*, **Dorset Health Commission**
Howard Crosthwaite, *Director of Corporate Affairs*, **Doncaster Health Authority**
Helen Dinsdale, *Training Coordinator*, **South and West Devon Health**
Ann Foreman, *KFOA Coordinator*, **Northumberland Health**
Sandra Gower, *Practice, Business & Development Manager*, **Bennetts End Surgery**
Andrea Jones, *Associate Director Primary Care*, **North Staffordshire Health Authority**
Max Jones, *Consortium Fund Manager*, **ABH Medical Consortium**
Brian Maynard-Potts, *Project Manager*, **South and West Devon Health**
Mike Sharon, *Chief Executive*, **Birmingham Multifund**
Mike Spooner, *Head of Corporate Affairs*, **Sheffield Health**
Gill Pascott, *Assistant Complaints Officer*, **Sheffield Health**
Sue Wilcox, *Head of Personnel*, **Coventry Health Authority**

Surveyors

Janet Aylward	*Primary Care Locality Manager*, **West Herts Community NHS Trust**
Dr Steve Bridgman	*Consultant in Public Health*, **North Staffordshire Health Authority**
Ian Carruthers	*Chief Executive*, **Dorset Health Authority**
Dr David Carson	*Head of Professional Development*, **East London & City Health Authority**
Peter Colclough	*Chief Executive*, **S&W Devon Health Authority**
Edward Colgan	*Director of Corporate Development*, **Dorset Health Authority**
Graham Coomber	*Director of Development and Primary Care*, **West Midlands NHS Executive**
Gareth Corser	*Healthcare Director*, **Birmingham Multifund**
Dr Declan Dwyer	*GP*, **North Road West Medical Centre**, Plymouth
Chris Fewtrell	*Chief Executive*, **North Derbyshire Health Authority**
Ann Foreman	*KFOA Coordinator*, **Northumberland Health**
Peter Forrester	*Director of Primary Care*, **Coventry Health Authority**
Pat Frost	*General Manager*, **Fife Health Board**
Louise Glover	*Practice Manager*, **Pembroke Surgery**, **S&W Devon**
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Cathy Hamlyn	*Chief Executive*, **Sheffield Health Authority**
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Dr Paul Heatley	*GP*, **Bennetts End Surgery**, Hemel Hempstead
Denise Holden	*Project Manager*, **Dorset Health Commission**
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Roger Hoyle	*Chief Executive*, **Liverpool Health Authority**
Andrea Jones	*Associate Director Primary Care*, **North Staffordshire Health Authority**
Dr David Kerry	*GP*, **Bennetts End Surgery**, Hemel Hempstead
Mike Lincoln	*Director of Finance & Contracting*, **S&W Devon Health Authority**
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Brian Maynard Potts	*Totalfund Project Manager*, **S&W Devon Health**
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David Meachan	*Director of Research and Information*, **Doncaster Health Authority**
Mark Millar	*Director of Contracting & Finance*, **Suffolk Health Authority**
Heather Mitchell	*Head of Corporate Effectiveness*, **Dorset Health Authority**
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John Newton	*Chief Executive*, **Doncaster Health Authority**
Helen Orchison	*Group Manager*, **Lintonville Medical Group**
Dr Hilary Page	*Director of Public Health*, **Doncaster Health Authority**
David Panter	*Chief Executive*, **Hillingdon Health Authority**
Hester Parsons	*Director of Primary Care*, **North Staffordshire Health Authority**
Richard Priestley	*Chief Executive*, **North Staffordshire Health Authority**
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Mike Ridley	*Director of Finance & Performance Management*, **Sheffield Health Authority**
Dr Barry Robinson	*General Manager & GP*, Lyme Community Care Unit, **S&W Devon**
Geoff Shepherd	*Associate Director*, **Kensington Chelsea & Westminster Health Authority**
Janet Soo-Chung	*Director of Commissioning*, **North Staffordshire Health Authority**
Jo Tatham	*Primary Care Development Directorate*, **Northumberland Health**
Paul Taylor	*Director of Finance*, **Coventry Health Authority**
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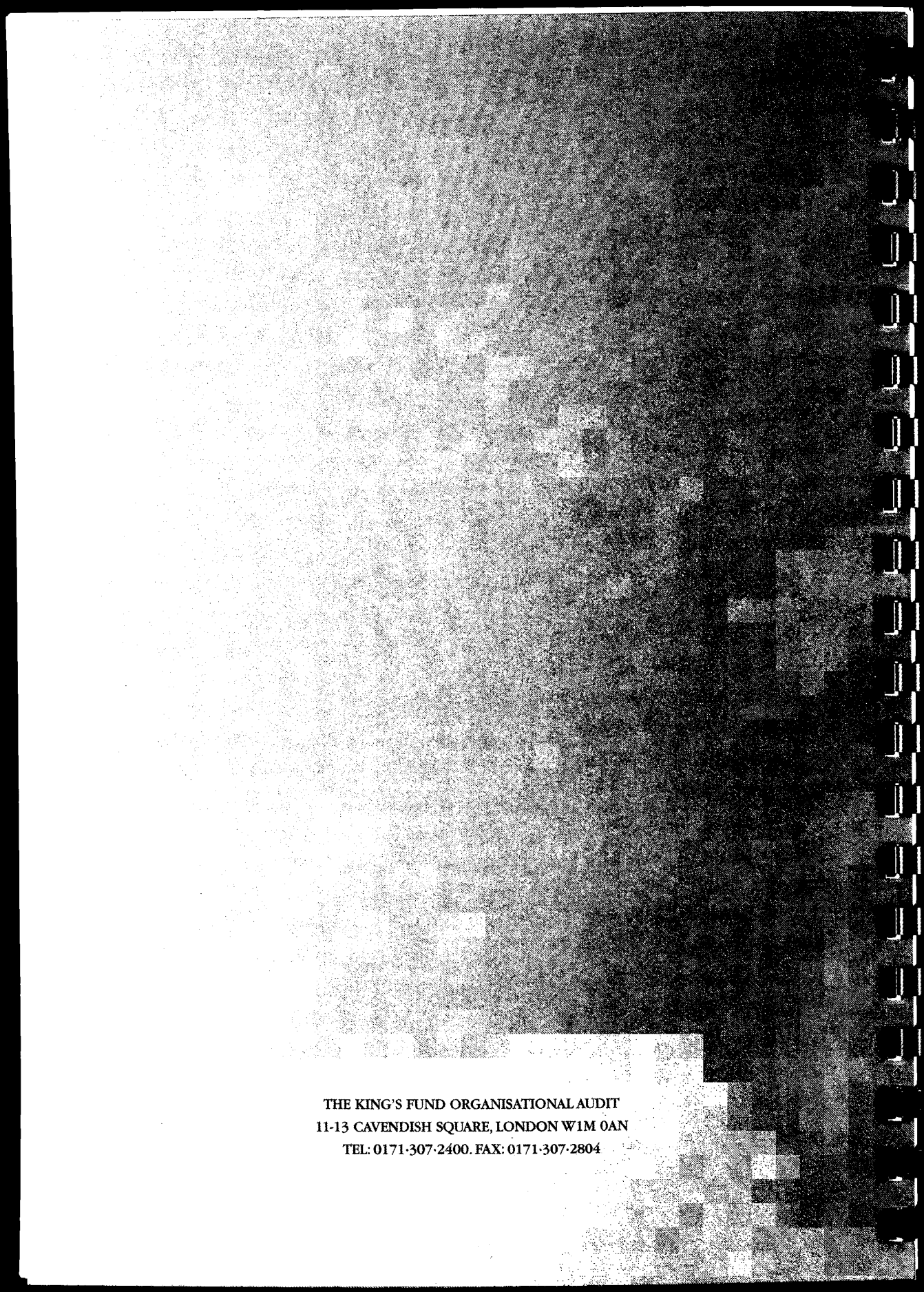
Dr Richard Thompson	*Senior Lecturer*, **Department of Public Health Medicine, Newcastle**
John Tuckett	*Chief Executive*, **Tees Health**
Iain Tulley	*Team Leader Localities*, **S&W Devon Health Authority**
Georgie Webb	*Head of Contracting*, **Dorset Health Authority**
Dr Keith Williams	*Director of Public Health*, **Coventry Health Authority**
Neil Wilson	*Director of Finance*, Quality & Contracting, **Norfolk Health Authority**
Alan Wittrick	*Director of Finance*, **Doncaster Health Authority**
Peter Wood	*Director of Quality Finance & Contracting*, **Norfolk Health**



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