

Clinical engagement in primary care-led commissioning: a review of the evidence

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Glossary

| | |
|-------------|---|
| ACHCEW | Association of Community Health Councils in England and Wales |
| CCGs | Clinical Commissioning Groups |
| CHCs | Community Health Councils |
| EBM | Evidence-based medicine |
| EPPI-Centre | Evidence for Policy and Practice Information and Co-ordinating Centre |
| FH | Fundholders |
| GMS | General Medical Services |
| GP | General Practitioner |
| GPFHs | GP Fundholders |
| HA | Health Authority |
| HSMC | Health Services Management Centre |
| LAs | Local Authorities |
| LMCs | Local Medical Committees |
| NHS | National Health Service |
| NPCRDC | National Primary Care Research and Development Centre |
| OBD | occupied bed days |
| PbC | Practice-based Commissioning |
| PbR | Payment by Results |
| PCGs | Primary Care Groups |
| PCG/Ts | Primary Care Groups and Trusts |
| PCTs | Primary Care Trusts |
| PEC | Professional Executive Committee |
| PPI | Public and patient involvement |
| TP | Total Purchasing |
| TP-NET | Total Purchasing National Evaluation Team |
| TTPs | Total Purchasing Pilots |

Contents Page

- 1 Background1
- 1.1 Introduction.....1
- 1.2 The development of primary care-led purchasing and commissioning in England2
- 1.3 Methods.....5
- 2. Nature of clinical engagement/involvement in commissioning models9
- 2.1 Introduction.....9
- 2.2 Motivations for joining and attitudes towards the scheme9
- 2.3 Clinical leadership and influence (within the organisation) 11
- 2.4 Budgetary control / contracts 14
- 2.5 Links with GP practices 15
- 2.6 Perceived influence of the commissioning organisation outside itself (by both the GPs and other agencies) 18
- 2.7 Summary of findings on clinical engagement 20
- 3. Impact of different clinical commissioning models 21
- 3.1 Introduction..... 21
- 3.2 Changing patterns of care 21
- 3.3 Contracting 25
- 3.4 Changing primary care practice 26
- 3.5 Attitudes towards performance management 27
- 3.6 Quality and experience 27
- 3.7 Relationships 30
- 3.8 Conclusion..... 32
- 4 Discussion 33
- 5 Conclusion..... 36
- References: 39
- Appendix 1: The role of GP commissioning consortia..... 47
- Appendix 2: Hand searched bibliographies 48
- Appendix 3: Full list of 218 References used in the review..... 49
- Appendix 4: Examples of data extraction sheets 58

1 Background

1.1 Introduction

1.1.1 This review presents evidence on the role of clinical engagement in primary care-led commissioning and how this has contributed to the delivery of health care services. The main aim was to examine the nature of clinical engagement / involvement in the various primary care-led commissioning models that were introduced into the National Health Service (NHS) since 1991. The review forms part of a suite of research being undertaken by the Policy Research Unit in Commissioning and the Healthcare System and presents evidence to inform and support the Department of Health's policy on commissioning. The focus of the review was agreed with the Department in April 2011 in response to proposals for developing General Practitioner (GP) consortia as defined in *Equity and Excellence: Liberating the NHS* (DH 2010).

1.1.2 The key objectives of this review are to examine the evidence from previous approaches to clinically-led primary care commissioning in the English NHS on:

- What kinds of roles clinicians played in commissioning
- What was the nature of clinical engagement in the commissioning process
- How much control and influence did clinicians have over commissioning decisions
- The impact of clinical engagement on:
 - the ability to effect patterns of care including: changes in referrals to secondary care, impact on emergency admissions, service development (eg outreach clinics or changes in hospital and community services), and contracting.
 - changing primary care practice including prescribing and performance management.
 - quality and experience including improvements in waiting times, patient satisfaction, quality of care, the use of evidence (EBM) and improved information.
 - financial issues such as costs versus savings and the awareness of costs.
 - improved relationships within commissioning groups and with other agencies.

1.1.3 The proposals in the White Paper outlined the commissioning role of proposed GP consortia (See Appendix 1) where it was argued that GP involvement would ensure that “... *the redesign of patient pathways and local services is always clinically-led and based on more effective dialogue and partnership with hospital specialists. It will bring together responsibility for clinical decisions and for the financial consequences of these decisions. This will reinforce the crucial role that GPs already play in committing NHS resources through their daily clinical decisions – not only in terms of referrals and prescribing, but also how well they manage long-term conditions, and the accessibility of their services. It will increase efficiency, by enabling GPs to strip out activities that do not have appreciable benefits for patients’ health or healthcare.*” (DH 2010: para. 4.4).

1.1.4 Drawing on this vision our definition of primary care-led commissioning includes all commissioning approaches where GPs and other primary care clinicians took a lead role in commissioning decisions. In the context of the purchaser-provider split in the UK, it is everything about the relationship between purchasers and providers (or potential providers). This includes approaches where clinicians were involved in health needs assessment, service specification, setting quality standards, negotiating contracts and activity and controlling resources. The White Paper makes a specific reference to the need to learn from previous experience acknowledging that

*“GP-led purchasing has history. Practice-based Commissioning was an attempt by the last Government to build on the successful parts of previous Conservative approaches, such as total purchasing pilots. There have been some examples of practice-based groups making progress, in spite of a flawed policy framework that confuses the respective responsibilities of GPs and PCTs, and fails to transfer real freedom and responsibility to GP practices. Our model is neither a recreation of GP fundholding nor a complete rejection of Practice-based Commissioning. Fundholding led to a two-tier NHS; and Practice-based Commissioning never became a real transfer of responsibility. **So we will learn from the past, and offer a clear way forward for GP consortia.**” (DH 2010 4.5).*

- 1.1.5 This review explores what happens, in different contexts, when GPs (or other clinicians) are involved in commissioning. The next sections briefly outline the development of primary care-led commissioning in England and the methods used for identifying and selecting relevant research to include within this review. Sections 2 and 3 detail the findings of the review. In Section 2 we examine evidence on clinical engagement and then in Section 3 we assess the impact of clinically-led commissioning. Drawing on the evidence identified Section 4 discusses the contribution of clinical engagement to achieving commissioning outcomes. Finally in the conclusion we identify key lessons and examine the implications of our findings for the future development of Clinical Commissioning Groups (CCGs).
- 1.1.6 The review focuses upon evidence from the UK NHS, as we are interested in the specific context of UK primary care involvement in commissioning. Whilst we recognise that there are international examples of primary care clinicians engaged in purchasing decisions, these occur in a very different context, and fall outside the scope of this review. We have also not looked at the general evidence relating to Commissioning in the UK, as our focus here is on clinically-led commissioning. Evidence relating to such broader issues has been reviewed by Newman, Bangpan et al (2012), Similarly, we have not looked at initiatives to improve commissioning practice such as World-class Commissioning, because these initiatives were managerially led, with very little involvement of primary care clinicians. Finally, we have not explored the literature that purports to advise managers on 'how to do' commissioning, as this is rarely based upon empirical evidence and does not focus upon the role of clinicians.

1.2 The development of primary care-led purchasing and commissioning in England

- 1.2.1 The introduction of the internal market in 1990 led to a number of significant changes to the UK NHS. The Government's proposals were set out in the White Paper *Working for Patients* (Department of Health 1990) and led to the separation of District Health Authorities as funders of health care and the development of hospitals, community health and mental health services as health care providers. It came at the same time that there was increasing policy interest in the role of primary care (Peckham and Exworthy 2003) and there was, therefore, a growing interest in exploring how the unique role of GPs practice - as managers and gatekeepers of patient care - could be harnessed within the new organisational arrangements for the NHS. Engaging GPs in service development and planning was seen as being of critical importance and from 1990 a number of approaches to engaging GPs and other primary care clinicians were developed starting with GP Fundholding and its multi-fund and non budget-holding variants in the early 1990s. Since then a number of organisational models have been experimented with including Total Purchasing (TP), GP Commissioning Groups, Primary Care Groups and Trusts (PCG/Ts), Practice-based Commissioning (PbC) and now CCGs (See Figure 1).
- 1.2.2 The schemes varied in their organisational structure, degree of autonomy, governance and accountability arrangements and the extent of clinical engagement. However, the experience of these previous commissioning models provides useful insights into the role of clinical engagement and how different degrees of engagement impacted on the way these organisations worked and what they achieved. Before examining the evidence the following sections provide a brief overview of the development of primary care-led commissioning models.

Figure 1: A history of GP commissioning



1.2.3 GP Fundholding

Fundholding was a voluntary scheme that was introduced in 1991 as part of the development of an internal market in the UK NHS (Department of Health 1989). It was initially seen as a minor innovation introduced as a way of improving local secondary care responsiveness, where GPs acted as advocates for patient care. It later became a centre piece of government policy reflecting the growing policy importance of primary care. The key aims of this past scheme reflect current (2012) policy:

“The scheme stems from an acknowledgement that by virtue of their clinical behaviour – making referrals and prescribing drugs – GPs influence important areas of NHS expenditure, and that their closeness to patients means that they are uniquely placed to act as purchasers on their patients' behalf. Fundholding aims to make GPs aware of the financial consequences of their clinical decisions and, by giving them an incentive to make and spend audited savings, to encourage them to consider the costs of different courses of action. The expectation is that this will lead to more economic and efficient use of hospital and community health services, and more rational prescribing. Giving GPs the power to contract with providers, and the freedom to choose between them, is intended to give providers – particularly hospitals and their consultants – an incentive to listen more carefully to what GPs have to say and to take steps to improve the quality of their services (Audit Commission 1996: pp5-6).

Fundholding enabled GP practices, subject to list size (of which the threshold was progressively reduced) and technical capability, to hold a budget which could be used to purchase a defined list of hospital and community services. These services included: inpatient, outpatient, direct access, diagnostic and community nursing services; the cost of pharmaceuticals and appliances prescribed by the practice; and payment for non-medical staff employed by the practice (Glennister 1994). In addition, practices received funds to improve their information systems and a management allowance. Following the entry of 300 practices in the first wave in 1991, the scheme grew at a prolific rate with 2,221 funds covering 41% of the population in England and Wales by 1995, although regional variations were substantial (Audit Commission 1995). During the lifetime of the scheme (1991 to 1997), new waves were approved on an annual basis and there were seven in total (Moon, Mohan et al 2002). Fundholders (FHs) operated either as single practices or in multi-fund groups.

1.2.4 **Alternatives to GP Fundholding 1991-97**

In response to fundholding, a plethora of alternative commissioning models emerged. These were generally developed as partnerships between non-fundholding GPs and their constituent health authorities (Glennister, Cohen et al. 1998). By 1997, around 20 variants of commissioning models involving primary care clinicians were reportedly operating (Smith, Barnes et al. 1998). These alternative models were generally based on locality structures grouping GP practices by geographical area.

1.2.5 **Total Purchasing**

TP was a scheme whereby FHs could volunteer to receive a delegated budget from their local Health Authority (HA) in order to purchase potentially all hospital and community health services for their patients. The idea was first developed locally by GPs who were keen to extend the range of services they were able to purchase as FHs. Following the establishment of four 'pioneer' Total Purchasing Pilots (TPPs) in 1994, a national scheme was launched (Mays 1996). Regional Health Authorities sought to identify groups of GPs interested in becoming pilots. Leese and colleagues found that, in practice, the impetus for the majority of projects in their study came from either the GPs themselves or from GP/HA collaborations (Leese and Mahon 1999). In 1995, the first wave of 53 pilots began (Mays 1996) with a lifespan of three years - one preparatory year and two years of live purchasing. A second wave of 34 pilots began live purchasing in 1997 (Malbon, Goodwin et al. 1998). Total Purchasing National Evaluation Team (TP-NET) conducted a before-and -after and comparative evaluation between October 1995 and September 1998 (Mays, 1996). All pilots were included in the evaluation, although some reports only focus on a subset of pilots.

The name 'total purchasing' is misleading in terms of the scope of the scheme. Whilst pilots did have the freedom to purchase all hospital and community care for their patients, none of them did (Mays 1996; Malbon, Goodwin et al. 1998). The term selective purchasing has been used and is a more accurate way to describe the nature of the pilots. The decision to purchase selectively does not appear to have been imposed upon the pilots by the HA; rather, GPs constrained themselves. TPPs selected areas they were keen to influence and these tended to be either areas of local concern or areas where GPs had a specific interest. A mechanism existed whereby funding could be automatically returned to the HA. This process of 'blocking back' was exercised by most TPPs, typically in service areas where GPs lack confidence (Malbon, Goodwin et al. 1998). Alternatively co-purchasing arrangements were an option. GPs' personal experience and awareness of specific local issues dictated purchasing priorities for both first and second wave TPPs. Projects strategically chose a few service areas to focus on where the need for change was clear, the workload would be manageable and the probability of success was high (ibid). This approach was practical, rather than 'total'.

1.2.6 **GP Commissioning**

In June 1997, following the abolition of GP Fundholding, the Labour Government announced plans to pilot new approaches to the commissioning of health services and 40 general practitioner (GP) commissioning pilots were launched in April 1998. While the pilots pre-dated the 'New NHS' White Paper (NHS Executive 1997) they provided an opportunity for groups of general practices to trial aspects of new models of primary care led commissioning. The groups all assumed responsibility for an actual cash-limited prescribing budget and were expected to work in partnership with nurses, social services, and the public (NHS Executive 1998). They also assumed a varied range of other commissioning responsibilities, such as actual or notional hospital and community health services budgets, and elements of general medical services budgets. In December 1997, the government then announced it would be establishing a national network of Primary Care Groups (PCGs) (Department of Health 1997) and the GP commissioning groups provided early lessons for the establishment and implementation of PCGs.

1.2.7 **Primary Care Groups and Trusts**

Primary Care Groups (PCGs) were established in 1999 following the abolition of fundholding and as the TPPs neared the end of their life. PCGs brought together all GPs in a locality along with community nurses, social services, the HA and lay representatives (Audit commission 2000). The Labour government at the time declared that local doctors and nurses would drive the organisations and GP practices were viewed as the building blocks. Four levels of PCGs, each allowing differing degrees of

autonomy were outlined by the 1997 White Paper. The level would depend on existing skill, expertise, and GP involvement in the existing commissioning models in a locality. At the bottom end (level one) a group of GPs and community nurses would act as an advisory group to the HA. The ultimate plan was for all organisations to develop into an independent trust comprised of GPs and nurses (level four) whereby they commission primary, secondary and community health services for the local population. These organisations were to be called Primary Care Trusts (PCTs) (Peckham and Exworthy 2003). However, in 2000 The Government announced that in England all commissioners should become PCTs which would have a clinical committee - the Professional Executive Committee (PEC) chaired by a GP and a Trust Board comprising executive directors (including the PEC Chair, other clinicians and managers) and lay non-executive directors and a lay chairperson (Department of Health 2000). By 2010 there were 152 PCTs and in many trusts the PEC had ceased to have the degree of importance envisaged in earlier guidance.

1.2.8 Practice-based Commissioning

In order to address the perceived lack of GP engagement in the PCT commissioning process, a scheme named 'Practice-based Commissioning' was introduced in 2005. Volunteering GP practices received an indicative budget with which to commission and provide services. The scope of this budget was not fully specified by the Department of Health, but official guidance suggested that, as a minimum, it should include: hospital activity covered by the 'payment by results' regime (ie hospital outpatient, inpatient and emergency care); community services; mental health; and prescribing. Although the scheme was voluntary, the successful enrolment of practices in the scheme became a key performance indicator for PCTs. In order to bring this about, PCTs were empowered to offer practices a direct incentive to join in the form of a payment called a 'Directed Enhanced Service' (DES). As a result, by late 2006 PCTs were able to claim almost 100% coverage of practices participating in a PbC. The initial guidance relating to the scheme implied that practices would undertake PbC alone, but in fact most practices joined together with others to form groups, often known as 'consortia' or 'localities' (Checkland, Coleman et al. 2008). A survey carried out in 2007 found that the range of size of PbC consortia was from population coverage of 10,000 to 480,000 persons, with a mean population size of 82,271 (Coleman, Harrison et al. 2007). PbC groups were hosted and supported by the local PCT, and, whilst nominal coverage was 100%, enthusiasm for the scheme varied between PCTs; as a result, engagement and enthusiasm varied across England (Audit Commission 2007).

1.3 Methods

- 1.3.1 This review builds on an National Institute of Health Research Service Delivery and Organisation programme -funded research project 'Effective approaches to public sector commissioning: A systematic review of the research evidence' undertaken by the Evidence for Policy and Practice Information and Co-ordinating Centre (EPPI-Centre) at the Institute of Education between October 2009 and August 2010. The aim of the EPPI-Centre research was to 'identify research evidence on commissioning or public service purchasing in the UK and other countries in order to investigate the factors which influence the impact of different approaches to public service purchasing and to identify lessons for health care commissioning and practice.'
- 1.3.2 Following an initial scoping exercise comprising of a literature review and a stakeholder survey, the Institute of Education research team conducted a systematic search of the literature (mid-January to mid-February 2010). This search was carried out using multiple sources (13 electronic databases, over 20 websites, Google and reference lists of reviews) in order to identify all possible empirical evidence (both published and unpublished) relevant to the scope of the review. Details of their search strategy and methodology can be found in their final report (Newman, Bangpan et al 2012). They identified 17,588 citations which, through text mining, was shortlisted to shortlist 6,497 potentially relevant studies. From this 8,320 potential relevant titles and abstracts were screened and 1,402 full texts were reviewed ultimately leaving 600 studies for inclusion in their systematic map (database). This provided the core database for starting this systematic review.

1.3.3 Of the studies in the database, 446 were concerned with health (with the others focussing on social care and education). The titles of the 'health' references were screened and all studies conducted somewhere other than the UK were discarded. The remaining 339 references were entered into an Endnote library. We then conducted a search to expand and update the database identified from the EPPI-Centre review.

1.3.4 An electronic literature search was conducted in 'social policy and practice', 'econlit', 'Medline', 'PsychINFO' and 'CINAHL' following the same search strategy used by the EPPI-Centre (limited to publications from 2010 onwards) in order to retrieve any studies published in the past year. This was carried out in March 2011. In addition we hand-searched the following journals from 1991 (post Purchaser-Provider split) to the present day:

The British Journal of General Practice
The British Medical Journal
Health Services Research and Policy.

In addition hand searches of the bibliographies of a number of key reviews on primary care commissioning (see Appendix 2).

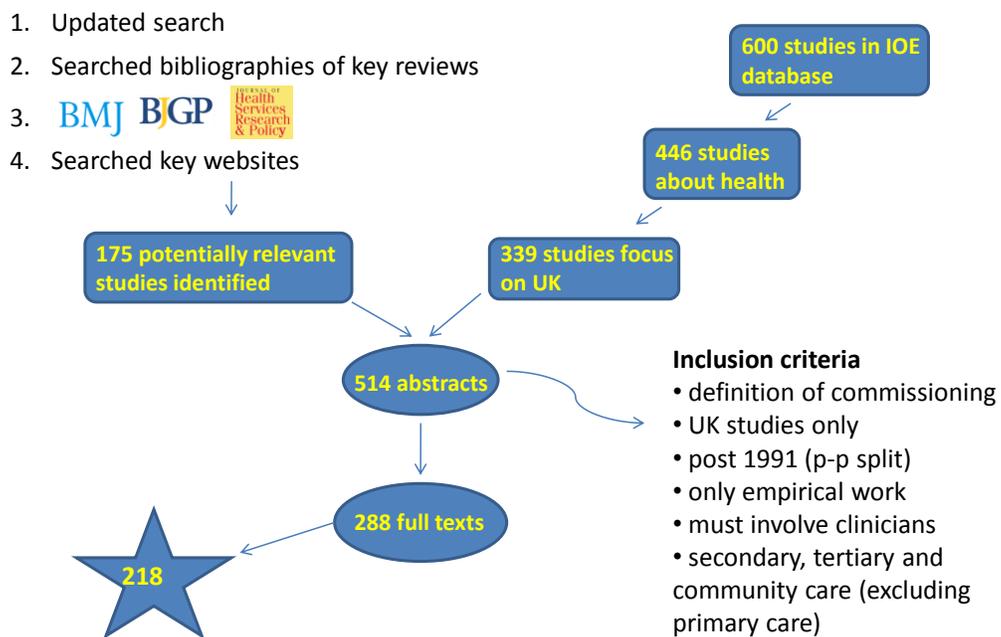
1.3.5 A number of primary care-led commissioning schemes had formal evaluations (See Table 1). The evaluations of TPPs and GP Commissioning Groups were specific programmes funded by the Department of Health Policy Research Programme. *Evaluations of PCGs and PbC* were undertaken by the Department of Health-funded National Primary Care Research and Development Centre (NPCRDC) at the University of Manchester. The main reports, topic specific reports and other published papers from these evaluations are included in this review.

Table 1 - Formal evaluation programmes of primary care-led commissioning schemes

| Scheme | Evaluation team | Time frame | Main evaluation report? |
|---|--|---|---|
| Total Purchasing Pilots (TPP) | TP-Net led by the King's Fund. | 1995 to 1998 | Yes (Wyke et al 1999; Mays et al 2001) and a number of topic specific reports |
| GP Commissioning | Health Services Management Centre, University of Birmingham | 1997 to 1999 (when focus changed to PCG/Ts) | Yes (Smith 2000) |
| Primary Care Groups (PCGs) / Primary Care Trusts (PCTs) | National Primary Care Research and Development Centre, University of Manchester Health Services Management Centre, University of Birmingham | 1999 - 2002 From January 1999 until 2000 12 case study PCG/Ts followed from original cohort of GP commissioning pilot groups | Yes (Tracker survey results x 3) plus associated papers Yes (Regen et al 2002) plus interim reports and papers |
| Practice-based Commissioning (PbC) | National Primary Care Research and Development Centre, University of Manchester | | Yes (Coleman et al 2009) plus papers. |

- 1.3.6 The websites of the institutions known to be involved in these national evaluations of previous commissioning models were also searched:
- The King's Fund National Evaluation of the TPP Projects
 - Health Services Management Centre (HSMC) (University of Birmingham) - National Evaluation of GP commissioning groups
 - NPCRDC - (University of Manchester) National evaluation of PbC and PCGs
- 1.3.7 From these searches, 175 references were identified which appeared from the title to be potentially relevant to the review (ie were about commissioning in health care) and did not appear in the original 339 references extracted from the EPPI-Centre database. These were added to the Endnote library. Where possible, abstracts were obtained for the 514 selected references. A team of 6 reviewers viewed the abstracts. Each abstract was independently reviewed by three reviewers (See Figure 2 for an overview of the review process). The decision to obtain the full-text was guided by a general view that commissioning was conceptualised relating to everything about the relationship between purchasers and providers (or potential providers) and met the following broad criteria:
- Secondary, tertiary and community care (including mental health and other specialised services), primary care service developments (eg outreach clinics, general practice services, prescribing) to be included and other primary care (medical, dentistry, ophthalmology and pharmacy) excluded
 - Must say something about clinician involvement
 - UK studies only
 - Must be post-1991 (purchaser-provider split)
 - Was an empirical study
- 1.3.8 Where enough information was available, a decision was made to either discard the study or to keep and obtain the full text. In some cases, there were discrepancies between reviewers. In these instances, where only one of the reviewers deemed a reference relevant, it was decided to obtain the full text. Where enough information was not available from the abstract (or if abstract was not easily available) studies were kept and the full text obtained. Full texts were obtained for the 288 references deemed to be potentially relevant to the study question. Of these 218 were deemed suitable to include in the review (see Appendix 3). Full text articles were obtained in printed and electronic file form either as a PDF or scanned from the printed article.
- 1.3.9 We designed a data extraction tool (see Appendix 2) and piloted its use with one researcher reading a small number of papers and then discussed and agreed principles for data extraction. Each full text paper was then read by one researcher with a secondary researcher checking the extracted data. One researcher (RM) reviewed all papers. Drawing on the data in the extraction forms we constructed a number of evidence matrices and identified themes drawing on our key research questions and key issues emerging from the data. In the sections that follow, the inferences drawn are based upon a comprehensive assessment of all relevant references. In order to make the review more readable, we have not put every single reference in the text as, for example, many statements are underpinned by as many as 10 or 15 papers. Listing all of these would have made the review difficult to read. The text therefore contains the key references under each heading, with all 218 papers listed in appendix 3.

Figure 2: Overview of selection process for review



2 Nature of clinical engagement/involvement in commissioning models

2.1 Introduction

- 2.1.1 In this section we examine the nature of clinical engagement in commissioning. The aim is to understand what kinds of engagement were undertaken by clinicians in the various models of primary care-led commissioning. Since the introduction of the purchaser provider split into the NHS two decades ago, there have been numerous attempts to involve GPs and other clinicians in commissioning. In order to understand the effect this clinical input has had, it is necessary to assess the nature of clinical engagement in the commissioning process and from our analysis of the literature, we have sought to determine how much control and influence clinicians had over commissioning decisions under the various schemes to date.
- 2.1.2 There is no clear definition of 'clinical engagement' in commissioning. Drawing on the policy goals for clinical engagement and discussions of primary care-led commissioning in the literature we identified several key elements that appear to define 'clinical engagement'. Firstly, what are the attitudes of clinicians towards the scheme and what are their motivations for joining? Secondly there is the question of leadership. For example, what kind of leadership positions do clinicians hold within a commissioning organisation, and further, how much influence do these clinicians have? Thirdly, what is the nature of linkage between the clinical leadership and the wider clinical partnership? Fourthly, what level of control do clinicians assume over a budget and the contracting process? Finally, it is necessary to assess the perceived influence of the commissioning organisation over other bodies with which it interacts, for example the HA or provider trusts. Taken together, these elements can enable us to draw an overall picture of the extent of clinical engagement within different initiatives. Further, we can explore how and why it varied between and within commissioning models.

2.2 Motivations for joining and attitudes towards the scheme

- 2.2.1 Each of the different models of primary care-led commissioning (except for PCGs and PCTs) were introduced in similar ways with calls for volunteers or 'pilots' and then gradually expanded. Practices and GPs were not, therefore, required to participate and those that did choose to join schemes did so at different stages. Motivations for joining the fundholding scheme could be broadly categorised into two groups - positive and negative. 'Positive' motivations were seen more commonly in the first wave and were primarily concerned with improving the quality of service for patients (Glennerster 1994). This group of GPs were keen to participate actively in the innovation and believed fundholding was a vehicle through which they could break the mould, affect change and ultimately improve patient services (Duckworth, Day et al. 1992 ; Coleshill, Goldie et al. 1998). Those with 'negative' motivations were concerned with preserving their perceived threatened autonomy, not missing out on any financial inducements, and getting on the bandwagon for fear of being left behind (Duckworth, Day et al. 1992; Glennerster 1994; Coleshill, Goldie et al. 1998; Surender and Fitzpatrick 1999).
- 2.2.2 Ennew and colleagues termed the first group of GPs, who sought to exploit the opportunities created by fundholding, 'true entrepreneurs', and the latter, who simply recognised fundholding as a trend for the future and were essentially pushed into the scheme, 'reluctant entrepreneurs'. 'Partial entrepreneurs' had mixed motives and featured somewhere in between (Ennew, Whynes et al. 1998). The more 'entrepreneurial' the senior GP's beliefs were, then the greater the likelihood that the GP's practice became a FH, and did so in an earlier wave (Whynes, Ennew et al. 1999). While most studies of fundholding focused on lead GPs, Surender and colleagues' study of six fundholding practices atypically included rank and file GPs in the interview sample. They found stark differences in the enthusiasm and motivation of GPs (leads vs rank and file) within the practices. Initially, many of the non-leads were either actively opposed or indifferent to the idea (Surender and Fitzpatrick 1999).

- 2.2.3 Those GP Fundholders (GPFHs) who applied to become Total Purchasers viewed the concept of TP as exciting, offering the opportunity to be innovative. GPs interviewed in the TPP evaluation reported that they thought TP would provide much greater freedom than standard fundholding (Leese and Mahon 1999). Yet the financial incentives to join the scheme were weak and GP participation appears to have been driven mainly by the interest of GPs in the specific local developments being pursued by TPPs (Wyke, Mays et al. 2003).
- 2.2.4 In contrast, the motivation for GPs to engage in the alternative commissioning models that emerged was generally driven by a shared hostility towards fundholding. This was partly due to a belief that GP Fundholding had created a two tier system. As a result a number of local non-FH GPs and their constituent health authorities came together across the country (Glennerster, Cohen et al. 1998). Some of these locality approaches were largely driven local health authorities, but others developed out of a genuine enthusiasm amongst non-fundholders to find an alternative. In general the evidence does not suggest that these GPs were driven by a strong desire to engage in commissioning processes; rather, it was their intention to mitigate what they saw as the harmful effects of fundholding and demonstrate the potential of other alternatives that drove their involvement.
- 2.2.5 While these earlier approaches were based on GPs voluntarily joining schemes, the development of PCGs marked a change in approach as membership of the local PCG was mandatory. Similarly, with the transition to PCTs practices were not consulted or engaged in the organisational change. One postal survey of all lead GPs and managers of TPPs regarding their views on PCGs revealed that some staff were experiencing 'change fatigue', having previously been involved in both fundholding and TP (Malbon and Mays 1998).
- 2.2.6 PCGs were only developed in England. However, in Scotland similar mandatory changes were being undertaken with the imposition of new structures for engaging primary care. During the reorganisation of primary care and development of Local Health Care Cooperatives GPs felt they were excluded from the decision-making process and not sufficiently involved in the consultation phase (Coleshill, Goldie et al. 1998). Having enjoyed the freedom under fundholding, they were unhappy about the return to the old style of central decision-making that was perceived as top-down control, constraining development and disheartened because all the hard work they had put into fundholding appeared to be in vain (ibid).
- 2.2.7 While engagement in PCGs was mandatory the introduction of PbC was again on a voluntary basis. Similarly to fundholding practices, they were heavily incentivised to take at least a nominal part in PbC (through a Direct Enhanced Service payment in the GMS contract). This payment was made when a practice formally signed up to join, and required practices to do little more than signal their intention to take part (Checkland, Coleman et al. 2008). In addition to this, PCTs were also required to offer further incentive schemes which rewarded active participation. Such schemes included, for example, payment for meeting prescribing targets, payments for staying within the indicative budget or payments for participating in meetings and events (Coleman, Harrison et al. 2007; Checkland, Coleman et al. 2008). Payments made under these schemes were direct payments that could be taken as income. Studies of PbC demonstrated that such schemes were effective in generating activity by practices (Coleman, Harrison et al. 2007; Peretz and Bright 2007; Checkland, Coleman et al. 2008). In addition, PbC carried with it the incentive that practices (or groups of practices) could have access to 70% of any savings made on their indicative budgets. This money could not be taken as practice income, but had to be invested in the development of new services. The extent to which such savings could be realised (and therefore the extent of the incentive offered) depended upon the scope of budgets that had been delegated (Checkland, Coleman et al. 2011).
- 2.2.8 In addition to these direct incentives to join PbC, studies suggested that some GPs were significantly motivated by the possibility of using PbC to effect change to services in their localities and enthused by the possibilities for collaboration that it provided (Coleman, Harrison et al. 2007; Checkland, Coleman et al. 2008; Curry, Goodwin et al. 2008; Coleman, Checkland et al. 2009; Wells 2010). However, there was also evidence that GPs were concerned as to the possible longevity of the scheme, with some GPs expressing the opinion that there was little point in actively engaging because it was likely that, like

previous schemes such as TPP, PbC would soon be abolished (Curry, Goodwin et al. 2008; Coleman, Checkland et al. 2009; Wood and Curry 2009).

- 2.2.9 Unlike some previous schemes aimed at generating clinical engagement in commissioning, PbC did not provide additional funding for management costs. Management support was provided by PCTs, and there was some evidence that where PCTs demonstrated a greater commitment to providing such support this could have a beneficial effect on practices' engagement with PbC (Audit Commission 2007; Coleman, Checkland et al. 2009). Finally, a number of studies suggested that the past history of GP commissioning in an area could have a significant impact upon how PbC was perceived and how GPs engaged with it. In particular, past experiences of Fundholding and PCGs were found to cast long shadows in terms of both positive and negative attitudes to commissioning, and more specifically in relation to how practices might be grouped for commissioning purposes (Peretz and Bright 2007; Coleman, Checkland et al. 2010).
- 2.2.10 In summary, each new scheme generated differing levels of engagement and this engagement was driven by differing motivations depending upon the focus of the scheme. For example, fundholding enabled 'entrepreneurial' GPs to generate investment in their practices, whilst engagement in alternative schemes tended to be driven by hostility to fundholding. Overall, most schemes were led by a relatively small number of enthusiasts, with 'rank and file' GPs exhibiting varying degrees of engagement from acquiescence to (in some cases) outright hostility. There was some evidence of 'change fatigue', with studies of PbC (Coleman, Checkland et al. 2009) showing that clinicians drew lessons from the abolition of previous schemes (eg TPP), regarding the new scheme as potentially temporary.

2.3 Clinical leadership and influence (within the organisation)

- 2.3.1 Central to all models of primary care-led commissioning is the concept of clinical leadership. In GP fundholding the hierarchical structure of general practice reportedly allowed the lead GP and business manager to take decisions on behalf of the practice. These actors assumed the majority of responsibility of running the scheme, including budgeting and contracting tasks and liaising with the consortium board, HA and local providers (Surender and Fitzpatrick 1999). A small descriptive study recounting the early implementation of fundholding in a single practice found that whilst a business manager could take on a significant proportion of administrative tasks such as organising the budget and negotiating contracts, GPs (especially the senior partner) had to play a major management role because they were seen as responsible for giving direction by the support staff (Bain 1992). Essentially, within the fundholding scheme, GPs were the undisputed leaders. Lead GPs were closely and directly involved in decision-making. Fundholding made it easy for GPs to 'do things' as they had greater autonomy over the areas they held budgetary responsibility for.
- 2.3.2 However, Cowton and Drake (1999a) found that the decision about who would take the lead came second to the decision to join the scheme. With many practices demonstrating a lack of positive support for fundholding, they found that a nomination for lead was not always forthcoming. Further, where the motivations for joining were positive, this did not ensure any one senior partner was enthusiastic to take the lead. Whilst many GPs accepted rather than took the lead the same study also revealed that doctors grew to appreciate a management role once having experienced it (Cowton and Drake 1999a). Once established in the scheme, enthusiasm amongst 'GP managers' increased. This increased enthusiasm was attributed to having more control and GPs feeling that they held autonomy and power (Cowton and Drake 1999b). On the other hand, there were clearly a group of activists or 'true entrepreneurs', especially in the first wave, eager to assume a lead role. For example, a survey of GPs in one regional HA area found that practices with the more entrepreneurial GP leaders were particularly active (Whynes, Ennew et al. 1999). The enthusiasm held by these GPs was possibly related to the opportunities the scheme gave for proactive action.
- 2.3.3 GPs also took leadership roles in non-fundholding commissioning models. In a national survey in 1996, health authorities (94/100 responded) were found to obtain medical advice for the commissioning process through one of three broad approaches (BMA 1997). 'Locality-based advice' or 'locality

commissioning' occurred where potentially all local GPs had the opportunity to meet regularly to discuss matters related to secondary care purchasing. Consensus opinion was then transmitted to the HA. 'Group based advice' was similar to the locality approach but the advice came from a group of representatives of the GP community. The third avenue for involving GPs was 'centrally based'. Local doctors were nominated or appointed directly to an identified decision-making body. Some health authorities appointed independent GP advisors. In all three models, it is apparent that clinicians had an advisory role rather than a leadership position.

- 2.3.4 Similar results were seen in a further postal questionnaire involving 28 health authorities; the majority of models identified GPs as acting in an advisory capacity. Only one scheme was described as 'GP-dominated' (Hudson Hart, Drummond et al. 1999). In some areas GPs themselves took the initiative to instigate collaboration with their HA (Black, Birchall et al. 1994). Such schemes were labelled as 'GP commissioning' and considered to be bottom-up in their approach but were different to the national GP commissioning pilots that were introduced by the Labour Government in 1997. In a self-reported study the Nottingham non-FHs found that 200 GPs (67% of all Nottingham GPs) supported the scheme. In this example the HA paid a sessional rate to a working group to advise on purchasing (ibid). The group attribute a number of successes to this arrangement but it is not possible to determine the extent of GP influence over the HA decision-making process from this report.
- 2.3.5 The BMA survey of health authorities attempted to assess the level of impact that medical advice had on the commissioning process. Nearly half the respondents (45%) reported that the advice was 'taken into consideration' by the HA, as opposed to actively acted upon (9%). Interestingly, Local Medical Committees were more optimistic about GP influence, with 69% believing the advice was considered (BMA 1997).
- 2.3.6 An evaluation of 13 locality commissioning groups in Avon found that participation in these groups was high (82% of practices were represented at meetings on average), although this was variable. Only 41% of non-lead GPs and 67% of lead GPs, however, felt their group had influenced the HA. This was consistent with the views of the HA link staff, of whom, 62% felt this was true. Further almost all GPs, both lead and non-leads, wanted more influence (Hine and Bachmann 1997). The main barriers identified to greater influence were lack of time and information; lack of cohesion between practices; and ambivalence towards locality commissioning in the HA. It was felt that a more structured scheme with better funding would yield more influence. 8/13 lead GPs felt the scheme was not sustainable and were frustrated by uninterested GPs, the slow pace of change, lack of leadership and work overload (ibid). Glennerster et al's (1998) study of six 'alternatives to fundholding' concluded that the effectiveness of these schemes, in terms of engaging GPs, depended on the extent to which HAs were prepared to act as the GPs agents. Where they were committed to this role, GPs remained with the scheme. Where they did not, GPs tended to move onto actual fundholding (ibid).
- 2.3.7 There was no organisational template for TP and as a result there was substantial variety between the pilots, in terms of both organisational structure and the nature of the interaction between GPs and their constituent HA (Mays 1996). Although every TPP was technically a sub-committee of the HA there was a continuum which ran from top-down HA-led projects to bottom-up, GP 'controlled' projects, with equal partnerships lying somewhere in the middle (ibid). At the end of the first 'live' purchasing year the TP-NET categorised the first wave pilots into five distinct types. This typology was based on the stage of development, project objectives, achievements and future ambitions and is as follows: *under-performing TPPs* - projects not intending to achieve service change; *developmental TPPs* - projects in a preparatory phase who had not yet achieved change in TP-related areas but intended to do so; *co-purchasing TPPs* - projects influencing service provision through partnership with the HA; *primary care developer TPPs* - projects focussing on developing primary care in TP-related areas, either through holding a budget and contracting independently or through co-purchasing; *commissioning TPPs* - projects that hold budgets, contracts independently and purchases directly in TP-related areas to achieve change in both primary and secondary care (Mays, Goodwin et al. 1998). This typology reiterates that in some pilots GPs enjoyed a higher degree of freedom and level of influence than in others.

- 2.3.8 Leese and Mahon (1999) identified three broad categories of relationships between HAs and TPPs. Good relationships, where the HA played a supportive role and allowed sufficient autonomy; initial conflict but improving relationships, where the need for collaboration was acknowledged but conflict could arise when the TPP wanted more autonomy (in line with fundholding) but as the budget holder, the HA felt responsible for their activities; the third relationship was one characterised by lack of trust of the HA and scepticism regarding their belief in the scheme (Leese and Mahon 1999) (Leese and Mahon 1999).
- 2.3.9 Interview data from TPP lead GPs and managers revealed that in the early stages of the scheme, the process was very much TPP-led, with lead GPs being the key players. Involvement of other GPs was varied. There was also significant HA involvement although this did not appear to affect development decisions (Dixon, Goodwin et al. 1998). In 1995, only 36% of health authorities (92% response rate) reported affording their TPP 'total' autonomy in decision-making. Most (55%) aimed to give as much freedom as possible, but with qualifications. This usually required ensuring alignment with HA strategy. A small number (9%) allowed the TPP little or no autonomy in decision-making (ibid).
- 2.3.10 In practice it appeared that the TP projects badged as 'commissioning TPPs' had more autonomy and hence influence over decision-making compared to the other projects, and hence had more meaningful clinical input in the commissioning process (albeit if the clinical input came predominantly from lead GPs). Even by their second year, however, most likely due to the nature of the scheme, all pilots still had a degree of dependence on the HA (Malbon, Goodwin et al. 1999). Despite this, 'commissioning' pilots were the highest achievers in terms of their own objectives and objectives relating to TPP service areas (Goodwin, Mays et al. 1998).
- 2.3.11 The introduction of PCGs marked the beginning of a shift in the role of GPs in commissioning organisation. Early findings of the national evaluation of PCG/Ts conducted by the Birmingham HSMC, suggested that decision-making within the PCG was centred within the chief executive/PEC chair (who was always a GP) pairing. The HA was also flagged as a key site for decision making. Further, the chair was felt to be the most influential member (Smith, Regen et al. 2000). This was also confirmed by (Regen, Smith et al. 1999; Wilkin, Gillam et al. 2000; Wilkin, Gillam et al. 2001). Therefore while it appeared that clinical leadership was evident it was limited predominantly to one single GP who did hold considerable power within the PCG.
- 2.3.12 The same study found that PCG boards were typically not working effectively. A specific tension between GP board members and other board members was noted. Many non-GP board members felt that the PCG agenda and board meetings were 'inappropriately dominated' by GPs (Smith, Regen et al. 2000). In some areas, the number of GPs on the board was deliberately kept to less than half in order to facilitate more inclusive working. GPs contribution to the PCG and their motives were also questioned by others (ibid). On the whole, the attitudes towards GPs within PCGs appeared to be negative with very much an 'us' and 'them' feel. In a study of clinical input into HA health improvement programmes the Audit Commission (2000) found that most shadow PCGs and clinicians had little involvement in this and in some cases only the shadow PCG chair was consulted.
- 2.3.13 Clinical engagement in commissioning in PCTs, prior to the introduction of PbC, appears to represent a historical low point, in terms of clinical engagement. An interview study, conducted in 2004, provides a detailed and informative description of how commissioning was undertaken by PCTs (Bate, Donaldson et al. 2007). The study found that the role of clinicians was marginal and they were used primarily as a 'sounding board' and at best, a source of factual information. In terms of the commissioning process, if anything, clinicians represented a 'problem' in that their behaviours and decisions acted to frustrate 'rational' commissioning. The study concluded that in the process of moving from PCGs to PCTs, GPs were effectively and deliberately side-lined (Bate, Donaldson et al. 2007). Results from a qualitative subsection of the national evaluation of PCG/Ts echo these findings (Locock, Regen et al. 2004). GPs reportedly felt that with the movement from PCG to PCT, the agenda became more managerially driven (with a general increase in the number of managers), making it more difficult for GPs to exert control over decision-making (ibid).

2.3.14 As with TP there was no central specification of PbC structures, and as a result there was considerable diversity, with past experiences having some impact on the structures set up (Coleman, Checkland et al. 2010). Most PbC consortia had some sort of 'Executive' group which undertook the work associated with the scheme and had delegated decision making powers. These groups were usually dominated by GPs, with some also having practice managers, nurses and occasionally lay members. In some areas the GPs were voted into position, whilst in others there were insufficient volunteers to require a vote to be held (Curry, Goodwin et al. 2008; Coleman, Checkland et al. 2009). Most consortia had some kind of managerial support provided by the PCT, and the extent to which GPs truly led the agenda depended to a large extent on the dynamics of the relationship between the assigned managers and the GPs. At best, the assigned managers were facilitative and supportive, acting as enablers to promote clinical leadership; however, in some areas the PCT maintained a strict control over what could be done by consortia and limited the extent to which clinical leaders could make decisions and act upon them. More widely, the extent to which GPs were able to act as leaders was heavily dependent upon the dynamics of the overall PCT-PbC relationship. Thus, for example, PbC groups had limited autonomy to make major decisions about services, and in many areas even small investment decisions had to be 'signed off' by PCT committees. Whilst in some areas this process was relatively simple and unproblematic, in others it could be tortuous and complicated, with significant delays whilst decisions were passed between PCT committees. Some PCTs took the approach of allowing PbC consortia autonomy over small amounts of expenditure, whilst requiring 'sign off' for more substantial investment (or disinvestment) decisions. A small number of PCTs took a much more radical approach, devolving significant proportions of the overall PCT budget to PbC consortia. In these areas, GPs felt that they were truly leading and setting the agenda. The role of managers has been shown to be crucial in engaging clinicians. A new type of manager was identified in the national evaluation of PbC. They were termed 'animateurs' and worked creatively to ensure that PbC groups behaved in certain ways. These players were seen to positively facilitate clinical commissioning (Checkland et al 2011). Studies of PbC in general found that there was very little involvement from other clinicians such as nurses (Coleman, Harrison et al. 2007; Curry, Goodwin et al. 2008; Coleman, Checkland et al. 2009).

2.4 Budgetary control / contracts

- 2.4.1 The degree of budgetary control varied considerably in the different forms of primary care-led commissioning. Only FHs had complete autonomy over the budget which was devolved to the fundholding practice or consortium. In all alternative and later schemes budgets were only nominal with health authorities remaining responsible for expenditure.
- 2.4.2 FHs had complete autonomy over a specified (and somewhat constrained) budget which was devolved to them by their HA. This increased financial and managerial control and accountability reportedly caused GPs to become more aware of the costs associated with their behaviour (Howie, Heaney et al. 1993; Coleshill, Goldie et al. 1998). Responsibility for negotiating contracts also rested with the FHs. Despite the extra work these responsibilities brought, GPs reportedly relished the job due to the associated increase in power (Glennerster 1994).
- 2.4.3 In schemes established as alternatives to fundholding only some practices received a small nominal budget. On the whole, however, budgetary control and negotiation of contracts rested mainly with the HA (Glennerster, Cohen et al. 1998; Hudson Hart, Drummond et al. 1999).
- 2.4.4 While TPPs evolved from fundholding and practices within the TPP were fundholding practices, the absence of legislation to give TPPs organisational autonomy meant that budgets were indicative. Whilst TPPs held a budget, budgetary responsibility ultimately remained with the local HA (Mays 1996). The national evaluation found that GPs were more willing to accept financial responsibility for their clinical decisions where they were actively engaged in the management of a budget (Place, Posnett et al. 1998). This responsibility was often devolved to a small minority. Holding a budget also signified that a pilot had the potential to contract. This was thought to be as important as actually contracting (Malbon, Goodwin et al. 1999). In the first 'live' year of purchasing, 62% of pilots contracted independently for at least some

services (Robinson, Raftery et al. 1998) and, surprisingly, this figure barely rose in the second 'live year' (Robinson, McLeod et al. 1998)).

- 2.4.5 PCGs were essentially a sub-committee of their constituent HA and as such budgetary responsibility ultimately rested with the HA. In a survey of PCGs in 2000 the Audit Commission found that of those PCGs that had held meetings with their main provider trusts to review services only 1/5 involved clinicians from primary and secondary care. A further 1/5 involved no clinicians from either side in these meetings (Audit commission 2000). As PCGs progressed to PCTs, they became statutory bodies in their own right and took on the management of the entire NHS purchasing budget. (Peckham and Exworthy 2003). By 2002 (Wilkin, Coleman et al. 2002) showed an increased devolution of budgetary responsibility from HAs to PCG/Ts and in turn PCG/Ts being encouraged to devolve notional budgets to their practices.
- 2.4.6 PbC budgets were indicative, and as such, the PCT, as statutory body, retained overall responsibility. PCTs varied in the extent to which they devolved responsibility for budgets to PbC consortia (Checkland, Coleman et al. 2011). A small number of PCTs devolved the entire PCT commissioning budget, but in general devolution was much more limited than this. A survey carried out in 2007 suggested that a quarter (24%) of PbC groups in the sample had a devolved budget covering the nationally suggested minimum of: secondary care services covered by payment by results; prescribing; community services; and mental health services. A further 26% of groups had a devolved budget covering secondary care services and prescribing, whilst 18% had a budget covering secondary care services only and 9% described a devolved budget covering a wider range of services than the suggested minimum (Coleman, Harrison et al. 2007).
- 2.4.7 In practice, however, such devolutions were often nominal, with PbC consortia having little actual control over the spending of the budget. On the other hand, although consortia were generally unable to make any significant spending decisions without PCT authorisation, detailed observation of meetings in one study revealed that many PbC consortia took their budgetary responsibilities seriously. For example, it was common in meetings for figures to be presented that itemised the spending across all elements of the budget by GP practice, with the presentation of 'league tables' and 'naming and shaming' of overspending practices. This type of scrutiny depended upon the provision of accurate expenditure figures, which could be a problem at times. Whilst prescribing costs were easily obtained and broken down to practice-level, scrutiny of hospital expenditure was hampered by the tardy provision of activity data by hospitals. PbC groups were also seen to expend some energy in ensuring that hospital Payment by Results (PbR) claims were accurate, with some PbC consortia claiming some success in challenging hospitals over their bills (Coleman, Checkland et al. 2009). At the end of each year, savings were calculated and PbC consortia were entitled to reinvest 70% of these in new services. However, these calculations were neither straightforward nor uncontested (Audit Commission 2007; Checkland, Coleman et al. 2011).
- 2.4.8 Under PbC, contracting responsibilities remained with the PCT but in some areas the PCT involved PbC clinicians in contract discussions. There was some evidence that GPs involved in this way were more likely to be confrontational in their dealings with Hospital Trusts than PCT managers (Coleman, Checkland et al. 2009).

2.5 Links with GP practices

- 2.5.1 Apart from single practice fundholding schemes all commissioning models involved networks of practices. The relationship between the lead GPs and other GPs and practices is an important one as it provides the basis for the legitimacy of GP-led commissioning. However, in their study of fundholding practices, Surrender and Fitzpatrick (1999) found that in practices where lead GPs assumed the bulk of responsibility this was satisfactory for most non-leads; although some struggled with the dilemma of not wanting to take on extra responsibility yet wishing to be more involved in project decisions. It appears that a single enthusiastic GP (along with management administrative support) was sufficient to lead the

scheme and assume responsibility for the majority of the work. It was, however, also important that rank and file GPs needed to believe that the 'activist' was legitimate (Surender and Fitzpatrick 1999).

- 2.5.2 The involvement of GP practices within HA advisory bodies varied. Whilst 'locality-based' models potentially gave all GPs a say, 'group based' advice was criticised because the fora did not necessarily represent the local GP community at large. The 'centrally based' approach, where the advice obtained rested upon a few chosen doctors, did not necessarily reflect local GP opinion and was perceived to be the least accountable (BMA 1997). We found were no studies that reported on mechanisms used to communicate with GPs not involved in the advisory group.
- 2.5.3 The TP-NET team closely examined GP linkages in 11 case study pilots. A central theme relating to why some pilots were able to achieve more change than others was found to be the result of 'key leaders and willing followers'. The most enabling scenario was one where strong dynamic leadership was teamed with other key TPP players willing to play a part whilst at the same time being willing to respect leadership (Goodwin, Abbott et al. 2000). Higher achievers were more likely to report having an enthusiastic lead GP and lower achievers more likely to report lack of enthusiasm amongst GPs (Malbon, Goodwin et al. 1999). Where there was heavy reliance on a limited number of key individuals, there was an understandable concern regarding the fragility of the pilot. Successful TPPs learnt, both structurally and culturally, to create an environment for inter-practice cooperation and leadership within the pilot (Goodwin, Abbott et al. 2000).
- 2.5.4 A detailed case study of one of the 'pioneer' TP projects (Walsh, Shapiro et al 1999), reported that it was very much a collaborative venture between GPs, the HA and hospital trusts. Akin to the TP-NET data, a lead GP from each practice sat on the board of the main decision-making body and these were the key players. They represented the needs of their 'non-lead' colleagues. This arrangement was, in the most part, deemed acceptable although there were some negative comments regarding the paucity of input from these doctors. Good communication links and 'faith' in the lead GP were found to be crucial for the wider partnership to lend support to the lead (Walsh, Shapiro et al. 1999).
- 2.5.5 Single practice TPPs reportedly went further to engage rank and file GPs and ensure they were aware of the financial consequences of their clinical decisions. In these pilots, all GPs rather than just the lead were more likely to receive monitoring information, be involved in decisions concerning expenditure, and agreeing protocols for making changes to referral policies if required due to budget constraints. These communication mechanisms appeared to increase GP buy-in to the project and as a result enabled budgets to be managed more effectively (Bevan, Bachmann et al. 1998).
- 2.5.6 The TPP evaluation team also examined transaction costs and found that in some sites GPs were happy to delegate most of the routine responsibility to the TPP management team and the lead GP. As projects became more established, this trend became more apparent (Place, Posnett et al. 1998). Whilst this lack of active GP engagement reduced the transaction costs of the pilots, it also reduced the extent to which GPs were influenced by their referral behaviour. In short, the extent to which GPs accepted the financial responsibility for their clinical decisions depended on how actively engaged they were in the management of the budget. Ensuring the engagement of rank and file GPs came, however, at a high monetary expense (ibid). Place et al's study of seven TPPs found that more than 50% of the incremental cost associated with TPPs (compared to purchasing as FHs) was committed to managing internal relations ie coordinating the views of independent GPs and involving them in the commissioning process.
- 2.5.7 In an evaluation of PCG/PCTs Regen (2002) examined the level and nature of GP involvement. In two surveys sent to grassroots GPs in 1999 and 2000, GPs reported that the main way they were involved with the PCG was through a GP representative (usually a board member) who was responsible for both representing the wider voice of GPs and informing constituents of developments at PCG level (Regen 2002). These surveys also collected data on grassroots participation in PCG/T activities. The vast majority 'rarely' or 'never' attended board meetings and almost two thirds 'rarely' or had never attended a subgroup meeting. Locality meetings were far better attended with more than half 'always' or 'sometimes' attending. Further, in nine of the twelve case study PCG/Ts over half the GPs reported that they 'always'

or 'sometimes' commented on discussion documents. This was felt to be critical in terms of 'lending credibility to PCG/T policy' (ibid).

- 2.5.8 Overall, Regen (2002) found low levels of direct and active participation by GPs in these organisations. GPs cited heavy workloads and time constraints as barriers to more involvement. Some respondents objected to the wider policy context. They disagreed with the idea of clinicians taking on managerial responsibilities and believed GPs should focus on clinical duties rather than rationing. Finally, GPs reported that they were marginalised in key decision-making processes (Regen 2002). In another study of GP perceptions of PCGs, the authors found GPs were generally unaware of published priorities, indicating a low level of engagement in the commissioning process (Dowswell, Harrison et al. 2002).
- 2.5.9 The Audit Commission (2000) surveyed PCG chief executives and found that the majority of them perceived practices to be supportive. However, some respondents did express concern regarding 'GP suspicion, lack of involvement or vision and the scale of cultural change required.' Tensions were reportedly present between 'reformers' and GPs unconvinced of the need for change. PCGs that had area sub-groups were more likely to cite GPs as being supportive. Other mechanisms listed to improve involvement included improving communication through information, news sheets and meetings; securing ownership; and practice-based planning or devolved decision-making (Audit commission 2000). Bravo-Vergel and Ferguson (2006) found that without GP buy-in, enforcing rationing policies was difficult. GPs were found to respond better when other GPs acted as educators and disseminators. They were seen to have more legitimacy than the PCT (Bravo Vergel and Ferguson, 2006).
- 2.5.10 The National Tracker Survey of PCG/Ts undertaken by the NPCRDC revealed that the majority of organisations had not won the support of their GPs (Wilkin and Coleman 2001). Two fifths (43%) of PCGs who were later evolving into PCTs (aiming to gain PCT status in 2002 or later) cited GP resistance or disinterest as an obstacle to becoming a successful PCT although a third of those moving early to Trust status (in 2001 or earlier) did so without active, local GP support. 'Early' trusts alluded to those gaining PCT status in 2001 or prior and 'late' trusts were aiming for 2002. This evidence suggested that GPs were not committed to the Trust agenda.
- 2.5.11 PbC was introduced as an approach directly led by GPs. While a Kings Fund/Nuffield Trust study suggested that the engagement of GP practices under PbC was limited (Curry, Goodwin et al. 2008) the findings of the evaluation undertaken by the NPCRDC (Coleman, Checkland et al 2009) provided a more nuanced picture, suggesting that, whilst it was true that only a minority of GPs were actively involved with PbC, this was not necessarily a bad thing. Their report concluded that what was required (and was present in many places) was a committed group of activists prepared to do the work of PbC, who were perceived by their constituent GPs as having legitimacy to act on their behalf. In addition, there needed to be a willingness amongst GP practices to undertake work specified by this executive group. Such legitimacy was helped by: formal sign up arrangements, with clear written inter-practice agreements; a sense amongst 'rank and file' GPs that they were being kept fully informed about PbC and its processes; systems that ensured that GPs were aware of and able to use any new services or pathways had been developed; a financial incentive scheme perceived to reward work appropriately; and perceptions that progress was being made. Factors that undermined the perceived legitimacy included: concern that national policy might substantially alter or abolish PbC at any time; and perceived excessively tight control by PCTs, with overly bureaucratic processes or a failure to support innovation (Coleman, Checkland et al. 2009). In addition, it was felt to be helpful if PbC consortia had been able to form themselves into groups that they had chosen themselves, rather than having been allocated by the PCT (Checkland, Coleman et al. 2008).
- 2.5.12 PbC consortia had put in place a variety of processes with which to communicate with their constituent practices. These included: plenary meetings to disseminate information, explain budgetary figures and answer queries; newsletters and round-robin emails containing information about progress and budgets; and visits to practices to discuss their individual issues and problems. In addition, some larger PbC consortia had local sub-groups (often called localities) at which representatives from all practices in a geographical area met together to discuss progress under PbC (Coleman, Checkland et al. 2009). One unexpected finding in this study of PbC was the appetite amongst those involved for the active

performance management of constituent practices. In some areas this went beyond performance management against devolved budgets, and included attention to such things as performance against the General Medical Services (GMS) contract Quality and Outcomes Framework. Methods of performance management adopted included the public dissemination and discussion of performance figures, and visits to practices to discuss individual performance (Coleman, Checkland et al. 2009).

2.6 Perceived influence of the commissioning organisation outside itself (by both the GPs and other agencies)

2.6.1 The issue of how much influence GPs or the commissioning organisations had is of particular relevance to determining the impact of primary care-led models of commissioning and the role of clinician engagement in them. It is important to recognise that GPs, managers and other organisations would have different perceptions about the degree of influence and its impact. Thus, this section is divided into two broad subsections. The first examines the perception of how clinicians viewed their own influence and the second on how *other* relevant agencies viewed their level of influence.

GPs' perceptions

2.6.2 Fundholding staff reported achieving the most immediate impact of their actions - for example seeing waiting times fall or setting up a new clinic (Bain 1992; Consumers Association 1995). Fundholding GPs thus perceived that they had increased control and influence over hospital services. In a small qualitative study, GPs claimed that they were able to improve service quality due to their ability to negotiate with hospitals (Lapsley, Llewellyn et al. 1997). This sense of having more power in the health economy than they had previously experienced, led to GPs feeling enthused and empowered (Ellwood 1997; Cowton and Drake 1999). This positive feedback loop appears to have been a driving factor motivating GPs to either remain or become involved in the scheme. This perception of influence worked both at the single practice-level but was enhanced when GPFHs worked together. Locock reported that GPFHs were able to exert more influence over providers when they worked together (Locock 1994). The perception of influence appears to be particularly relevant to whether GPs engage in commissioning processes. Surender and Fitzpatrick reported that GP leads claimed more benefits than non-leads (Surender and Fitzpatrick 1999).

2.6.3 A survey investigating the participation of GPs in a specific HA-GP commissioning collaboration (City and Hackney's GP forum) found that one quarter of responding GPs doubted the extent of their influence on the health service locally. The reasons GPs doubted their influence was based on their view that there had been a lack of visible results, a lack of power due to the forums advisory nature, and a disregard of the GP representation by government, HA and providers (Graffy and Williams 1994). Similarly many of the GPs in non-fundholding schemes in Glennerster et al's study, who had hoped to achieve change, were disappointed and reportedly became disillusioned by their lack of influence (Glennerster (a), Cohen et al. 1998). It seems acting directly (as a FH) was more satisfactory than having an agent at one remove responsible for purchasing on one's behalf (ibid).

2.6.4 Perceptions of success and influence were important in influencing the activities of TPPs. There is evidence that in the second year of 'live' purchasing, fewer TPPs prioritised the more 'complex' areas. For example, 50% fewer TPPs tackled emergency admissions in 1997/8 compared with 1996/7 (Malbon, Goodwin et al. 1999). The likely reason is that this proved to be a particularly difficult area to influence. Only a minority of TPPs successfully achieved the majority of objectives in influencing secondary care. TPPs reported this was due to their inability to negotiate new contracts with current providers (who sought to maintain their income) or switch to alternatives (Malbon, Goodwin et al. 1999; McLeod and Raftery 2000). In a telephone interview survey of first wave pilots, 82% of TPPs contracting independently reported problems in obtaining agreement on some or all of their contracts (Robinson, Raftery et al. 1998). Where successful, collaborative relationships, rather than exerting influence through contracting was frequently reported as an important enabling factor for achieving change to hospital services (Robison 1998; Wyke, Hewison et al. 1998). While influencing secondary care proved difficult TPPs found they were better able to influence change in primary and community services compared with

secondary care and thus focussed their attentions on developing these areas (ibid). Arguably, these areas could largely be controlled within the TPP, rather than having to influence outside organisations.

- 2.6.5 GPs perceived PCGs to have even less influence or impact and Wilkin et al (Wilkin, Coleman et al. 2002[~]463)[~] found that two fifths of commissioning leads believed they had very little leverage over NHS providers of hospital services. Interview data from 49 GP principals in two health districts in the North of England revealed that over a third of GPs felt the PCG had no impact and few were inspired by this arrangement (Dowswell, Harrison et al. 2002). Of a group of 16 GPs interviewed as part of the study by the HSMC, seven felt there was potential for, or actual improvement in quality of care locally. Seven felt PCG/T policies had resulted in little change to quality and a further two felt quality of care had declined (Locock, Regen et al. 2004). Postal survey and interview data revealed that many GPs perceived their PCG/T to be 'ineffective or impotent'. GPs were particularly disappointed with the lack of tangible change (Regen 2002). In a Scottish study examining the establishment of local GP co-operatives after the end of fundholding, ex GPFHs reported that they felt disillusioned that efforts from FHs seemed to have been in vain (Coleshill).
- 2.6.6 Published reports evaluating PbC suggest scepticism amongst GPs about the influence of PbC, with beliefs that the policy might be abandoned at any time being a significant factor in reducing enthusiasm (Curry, Goodwin et al. 2008; Wood and Curry 2009). This suggests that there has been a cumulative impact of the adoption and abandonment of clinical commissioning schemes since the 1990s on GP enthusiasm. Coleman et al (Coleman, Checkland et al. 2009) by contrast found many activist GPs claiming significant successes as a result of their involvement in PbC. Examples included: redesign of services or service pathways; development and provision of new services, both in GP practices and across the area as a whole; and the improvement of service quality in general practices, including, for example, the purchase of new equipment such as ECG machines. In general, in common with previous GP commissioning schemes, PbC consortia found it easier to develop and change services in primary care than they did to change services provided by hospitals, with little evidence of successful disinvestment in services (Curry, Goodwin et al. 2008; Coleman, Checkland et al. 2009).

By other agencies

- 2.6.7 Although initially dismissive of FHs, in time, hospital trusts came to realise that their survival depended on getting FHs' money (Glennister 1994). While fundholding only represented 14% of hospital and community services funding, providers did view GPFHs as being powerful. In one study, NHS trust staff described FHs as having a disproportionate level of influence in relation to their relative market share (Drummond 2001). However, their potential to affect wide-scale change in the health system was always bounded as District Health Authorities remained the major purchaser. Even in non-fundholding models GPs were viewed as influential. For example, 92% of NHS managers asked about the City and Hackney GP forum felt it was influencing the health service. The study's authors do, however, advise treating this data with caution, because they believe these stakeholders would be reluctant to admit they were not open to GP influence (Graffy and Williams 1994). This point is demonstrated in the findings of the study by Hudson et al (1999). They interviewed 31 GPs and 41 HA managers within 28 HAs. While all GPs interviewed identified positive benefits from their involvement in the commissioning process, in stark contrast, 63% of HA respondents identified no beneficial outcomes. This suggests that, in these areas, GPs influence was less than they perceived themselves (Hudson Hart, Drummond et al. 1999).
- 2.6.8 Being 'new players' in the health economy, TPPs initially struggled to be taken seriously by health authorities and hospitals (Robinson, Rafferty et al. 1998). Wyke and colleagues (2003) report on three main features which caused NHS trusts to not take TPPs as seriously as they might have. Firstly, 'pilot status' was viewed as 'an expression of uncertainty rather than a desire to learn through experimenting'. This enabled hospital trusts to resist contractual changes that would ultimately lead to a shift of resources from secondary to primary care. Secondly, TPPs did not receive the supportive backing they required from Conservative Ministers. When low quality, high cost hospitals were destabilised due to reallocation of resources by purchasers, ministerial support tended to favour hospital trusts in order to preserve popularity with the public. This, in turn, weakened TPPs' legitimacy and influence. Thirdly, within the TPP lifespan, it became clear that Labour, who had promised to end fundholding and other practice-based purchasing schemes, were likely to win the 1997 general election. This speculation, and reality when

Labour were eventually elected (and signalled the new direction of mandatory PCGs), made it even harder for TPPs to engage the attention of providers (Wyke, Mays et al. 2003).

- 2.6.9 We found no evidence about how other agencies perceived PCGs and PCTs or the role of clinicians within them on commissioning activities. There is also little evidence in published *research* reports about the way in which PbC was perceived by other organisations. However, a report by the House of Commons Health Select Committee (Health Select Committee 2010) obtained anecdotal evidence from a range of commentators, with a consensus emerging that PbC had not had a significant influence overall. This led to calls for it to be abandoned, or at least significantly altered in its operation (Curry, Goodwin et al. 2008; Wood and Curry 2009), with Simmons and English (Simmons, English et al. 2011) arguing that clinical networks would be more likely than PbC consortia to have the expertise required to significantly improve specialist services such as those for diabetes.

2.7 Summary of findings on clinical engagement

- 2.7.1 The evidence presented in this section identifies a number of key themes about the kinds of roles clinicians played in primary care-led commissioning, what the nature of clinical engagement in the commissioning process was and how much control and influence did clinicians have over commissioning decisions. The evidence examined for this review suggests that some GPs and, where evidence is available, other clinicians, have been keen to engage with commissioning issues. The evidence shows that there have been different degrees of clinical engagement both between schemes and also within schemes. One common theme that emerges from all the schemes is that a key determinant of clinical engagement is the extent to which GPs, in particular, feel that they have some autonomy and control to respond to what they perceive are key issues that affect their patient's experience of health care.
- 2.7.2 Those GPs who engaged in commissioning decision-making were generally driven by a desire to improve services for their patients because they believed that they were in the best position to make such decisions. GPs considered themselves better informed about patient needs as they had practice-level data and direct feedback from patients on health care services. They felt HAs and PCTs, for example, were less well informed.
- 2.7.3 However, it is clear that in whatever scheme that was followed not all GPs were active supporters of those GPs who engaged with the scheme. Maintaining wider clinical engagement was felt to be a priority by those leading schemes but the extent to which this was achieved varied considerably. Engagement was easier in smaller schemes but these tended to be limited in scope (eg GP fundfolding) while more comprehensive schemes found it more difficult to engage with a wider GP community. For commissioning schemes where only a minority of clinicians were involved or where decision-making was shared with another body (eg locality schemes, PCGs and PCTs) GPs felt less engaged and tended to feel without influence and eventually disengaged from schemes.

3. Impact of different clinical commissioning models

3.1 Introduction

3.1.1 In this section we examine the evidence on what impact clinician involvement had on outcomes. Early studies of fundholding and TPP focused on identifying impacts of the schemes. These can be examined in terms of the actual impacts and the motivations and mechanisms used to achieve these. We have categorised the different types of impact and these are grouped as follows:

- The ability to effect patterns of care including: changes in referrals to secondary care, impact on emergency admissions, service development (eg outreach clinics or changes in hospital and community services), contracting and priority setting.
- Changing primary care practice including prescribing and performance management.
- Quality and experience including improvements in waiting times, patient satisfaction, quality of care, the use of evidence (EBM) and improved information.
- Financial issues such as costs versus savings and the awareness of costs.
- Improved relationships.

3.2 Changing patterns of care

3.2.1 There is evidence to suggest that the strength of fundholding was the closeness of GPs to their patients. This translates into an intimate knowledge of demands and needs. GPs prioritised being an advocate for their patients above other concerns and priorities mostly reflected perceived local needs. Strong ownership of these issues reportedly helped GPs to plan strategies (Tobin and Packham 1999). In other schemes, priorities were also based on GPs views and gut instincts about local services (Dixon, Goodwin et al. 1998; Walsh, Shapiro et al. 1999). Purchasing goals were also found to be very much those of GPs and did not take the views of other health professionals into account (Malbon, Goodwin et al. 1999). The evidence also reports a significant tension between tackling national priorities and addressing local issues (Regen, Smith et al. 2001; Wilkin, Coleman et al. 2002).

Referrals to secondary care

3.2.2 Most of the evidence on referral rates for GPs holding budgets comes from research on fundholding. This evidence is, however, mixed. Early research comparing FHs and non-FHs concluded that there was no clear impact of the scheme on referrals with a later follow up study also concluding that fundholding had little impact on referrals (Coulter and Bradlow 1993). However, the following study revealed that whilst referral rates increased by 25.3% in non-fundholding practices and only 7.5% for fundholding practices, FHs had inflated their referral rates in the preparatory year (Surender, Bradlow et al. 1995). Similarly in their analysis of referrals and admissions by waves 3 through 6 in one HA Croxson and colleagues found that GPs responded to the direct financial incentives of the scheme by raising their referrals and admissions in the year prior to becoming FHs and then subsequently reduced them the following year (Croxson, Propper et al. 2001). This phenomenon of lower increases for FHs was also observed in other studies on orthopaedic referrals and referrals to a community old age psychiatry service (Fear and Cattel 1994). Another study in Scotland found that while there had been a general reduction in hospital activity this was accompanied by an increase in the use of direct access services such as physiotherapy (Howie, Heaney et al. 1995).

3.2.3 Perhaps the most comprehensive and robust analysis of the effect of budget holding referrals and admissions is a retrospective analysis conducted by Dusheiko et al. (2006). They examined chargeable elective admissions and found that ex-FHs' rates increased by between 3.5 and 5.1% following the abolition of the scheme. This effect was even stronger (an increase of 8%) for early wave FHs. The authors attribute three-fifths of the difference between chargeable elective admissions for FHs and non-

FHs (a log percentage difference³ of 7.3% in 1997/8) to the incentive effect of fundholding (Dusheiko, Gravelle et al. 2006). This reflected the findings of an earlier analysis on cataract surgery which found that fundholding status was the only characteristic of practices that was significantly associated with referral rates. Earlier FHs had lower admission rates than both later FHs and non-FHs to the extent that a patient of a first wave fundholding practice was one third less likely to be admitted (Gravelle, Dusheiko et al. 2002). Further research by the same group revealed that FHs referred to a wider range of providers than non-FHs but that these differences disappeared after the abolition of the scheme (Dusheiko, Goddard et al. 2008). Elective admissions became significantly more concentrated across hospitals between 1997/8 and 2002/3. Whilst admissions at the main hospital for HAs in 1997/8 constituted a 49.4% share, this figure rose to 69.4% for PCTs in 2002/3 (ibid).

- 3.2.4 Evidence on changing patterns of referrals to secondary care is less concrete for the other commissioning schemes. Results from the TPPs evaluation suggest that a couple of the pilots managed to decrease elective admissions by more than comparator groups (Raftery and McLeod 1999). There have also been some indications of success in managing demand in TPP and PbC (Mays, Goodwin et al. 1998; Coleman, Checkland et al. 2009) and reports of limited impact under PbC (Curry, Goodwin et al. 2008).
- 3.2.5 A longitudinal study which examined the response of a cohort of FHs to price signals during the first four years of the scheme found that FHs tended to use their power to instigate change in the services provided by existing suppliers rather than exploiting the huge savings that could be realised by changing referral patterns, (Ellwood 1997). This finding is supported by other studies that also found no evidence that FHs shopped around for cheaper prices (Propper and Wilson 1996; Spoor and Munro 2003). Research findings suggest that hospital location, service quality and waiting times were powerful influences on referral behaviour, often more important than price (Ellwood 1997; Strong and Lloyd 1997). FHs were also concerned with maintaining local services (Ellwood 1997; Tobin and Packham 1999) and Whyntes and Reed (1994) found that confidence in the consultant and the quality of feedback were key drivers in referral choice. (Whyntes and Reed 1994).
- 3.2.6 Several studies provide insights about why FHs changed their referral patterns. Mahon et al 1994 found that FHs were less likely to perceive that there was only one hospital available to them while Tobin and Packham (1999) found that all FHs in their study identified unmet need and remedied this by increasing supply. The mechanisms employed included shifting providers, negotiating with existing providers, changing the nature of referrals (eg orthopaedics to physiotherapy), setting up in-house clinics and sending those waiting the longest to private clinics (Tobin and Packham 1999). Some FHs focused on managing demand through peer review of clinical activity - sharing information and auditing activity against guidelines for best practice (Mays, Goodwin et al. 1998; Curry, Goodwin et al. 2008; Coleman, Checkland et al. 2009).

Emergency admissions

- 3.2.7 While fundholding studies provide most evidence on referral decisions the majority of evidence concerning tackling emergency admissions comes from the evaluation of TPPs. During fundholding, emergency admissions remained the responsibility of the HA and as such were outside of the remit of FHs. One study investigated whether FHs sought to game the system by increasing the proportion of patients admitted as an emergency but found no evidence of this (Toth, Harvey et al. 1997).
- 3.2.8 Where TPPs had specific objectives relating to altering patterns of acute hospital use (often this was their *raison d'être*), they experienced some success. Only 16 pilots pursued the objective of reducing acute hospital admissions and/or length of stay throughout two years of 'live' purchasing (McLeod and Raftery 2000). An analysis of hospital episode statistics revealed that 11/16 (9 multi- and 7 single practices) of these pilots reduced their occupied bed days (OBDs) significantly more than a comparator (all local practices) (ibid). In the first live year of purchasing (1996/7) 31 pilots sought to influence emergency

³ Using a log percentage difference - calculated from the natural logs derived from the raw data - provides a more accurate percentage difference than if percentage differences in raw data are used.

hospital admissions and these were most commonly 'commissioner' (the most autonomous) pilots (Raftery and McLeod 1999). Clearly many pilots abandoned this ambition in the second year suggesting that achieving success in this area was particularly difficult.

- 3.2.9 A PbC/PCT partnership reports on an anticipatory case management scheme which aimed to reduce emergency admissions by 5%. Close linkages that improved relationships between PbC clinical leads, PCT commissioners and managers in the local authority (LA) were thought to have led to fruitful work on preventative services (Peretz and Bright 2007).
- 3.2.10 Common mechanisms employed to reduce emergency admissions included increasing the number of GP beds at the local community hospital; using community nursing teams to prevent admissions; improving GP out of hours cover; and focussing on the elderly population. Those targeting length of stay commonly used community hospitals to receive early discharged patients and appointed a nurse or primary care liaison manager to facilitate early discharge (Raftery and McLeod 1999).
- 3.2.11 Whilst the minority of pilots that did make emergency activity a sustained priority did have success in reducing OBDs, most found it extremely difficult to move resources away from acute hospitals. TPPs faced resistance from trusts in contract negotiations and struggled to agree new contract currencies (eg based on admissions or bed days) which would allow them to relate changes in activity to funding (McLeod and Raftery 2000). This brings in to question the sustainability of such initiatives. In many cases, rather than making savings, the resource implications were positive because essentially TPPs were paying for two services concurrently. Most pilots received supplementary funding for their initiatives from their constituent HA (commonly 'winter pressures' money) (ibid).

Service development

- 3.2.12 Throughout the years, a number of service developments have been set up in the name of clinical commissioning. These have ranged from small, practice-based initiatives to larger schemes. FHs specifically focussed on increasing the services that they could provide in-house. The objective behind this was to improve the quality of the service offered by practices (Glennerster 1994). The type of new services set up included consultant 'outreach' clinics, paramedical and diagnostic clinics, increased minor surgery and facilities for investigations (Consumers Association 1995; Corney and Kerrison 1997; Redfern and Bowling 2000; Drummond, Iliffe et al. 2001). Dermatology, ophthalmology, general surgery, ENT, orthopaedics and urology were particularly popular specialities for consultant clinics with mental health and physiotherapy being the most popular paramedical areas (Bain 1992; Corney and Kerrison 1997). A small postal survey of 17 FHs practices in the South Thames area found that almost half of the medical specialist and paramedical clinic hours were provided by private practitioners (Kerrison and Corney 1998).
- 3.2.13 A marked increase in the number of mental health professionals attached to practices was observed in FH practices (Corney 1996) and the number of practice nurses employed by practices also increased, as did the scope of their activities. Community nursing, however, was not thought to benefit from the scheme and there was some concern that GPs do not fully understand the nursing role (Tinsley and Luck 1998).
- 3.2.14 The type of criticisms regarding current service provision was found to be strikingly similar between FHs and alternative schemes. The type of changes to service provision instigated in the alternative schemes tended, like FHs, to primarily revolve around improving existing primary and community services and also speeding up access to secondary care (for example, developing practice-based physiotherapy and developing referral criteria for community mental health services) (Hine and Bachmann 1997; Glennerster (a), Cohen et al. 1998; Hudson Hart, Drummond et al. 1999). FHs were, however, found to be more critical and as a result planned more change than other types of GP commissioners. GPs not involved in any type of commissioning scheme were far less critical than the other two groups (Glennerster (a), Cohen et al. 1998). It is not, therefore, surprising that more service developments were observed in FH practices compared to their non-FH counterparts (Corney and Kerrison 1997) and although the differences were sometimes small they have been found to be statistically significant (Redfern and Bowling 2000). Some GP commissioning groups did, however, claim that they did not have

comparable resources at their finger-tips in order to instigate service developments (Glennister (a), Cohen et al. 1998).

- 3.2.15 Under FH, whilst service development at the practice (micro) level was quite prolific, activity at the meso (HA) level and beyond appeared to have been limited (Drummond, Iliffe et al. 2001). These findings were echoed by a study investigating the shift towards primary care in 1998/9 (it included both FH and non-fundholding models) which concluded shifts in activity from secondary to primary were 'small, non-strategic, piecemeal and not underpinned by resource shifts' (Craig, McGregor et al. 2002). It is difficult to judge the success of the service developments in primary care because few were subjected to rigorous evaluation. Whilst some practices hailed success simply due to the addition of a new clinic (Bain 1992); more comprehensive work suggests that the limited benefit of outreach clinics on health status does not justify the substantial higher cost (Bowling and Bond 2001). Further, whilst on the surface, the attachment of mental health professionals to practices might seem positive; taking these staff away from their multidisciplinary teams may fragment services and actually be counterproductive (Corney 1996). In the locality-type models it was felt that schemes were unsustainable, mainly due to lack of GP time and sufficient resources from the HA (Hine and Bachmann 1997).
- 3.2.16 Primary care development appears to have been the area where TPPs achieved most change (Wyke, Mays et al. 2003). Having experienced difficulty negotiating changes to secondary care in the first live year through contracting, more pilots dropped such objectives and focussed their attentions on developing and extending primary and community care, believing progress in these areas would be more achievable (Mays, Goodwin et al. 1998; Malbon, Goodwin et al. 1999). Some pilots changed tactics and attempted to manage emergency services through intermediate care primary care projects (Wyke, Mays et al. 2003). Case study TPPs reported numerous service changes associated with bringing care closer to the TPP. This was achieved through both commissioning more local services and modifying existing services provided by primary health care teams. Service areas most commonly tackled were mental health and maternity services, community and continuing care, and early discharge. Changes initiated in these areas included creating a discharge liaison officer introducing nursing home beds and more integrated nursing; and commissioning community-based care. (Goodwin, Abbott et al. 2000; Wyke, Mays et al. 2003). Enabling mechanisms found to aid service change included financially incentivising GPs, encouraging non GP-leads to take an active and leading role in developments, hard-working and committed staff, thinking more strategically, pooling funds and general inter-agency cooperation (Lee, Donnan et al. 1999; Goodwin, Abbott et al. 2000).
- 3.2.17 Areas for development were often chosen based on GP interest or where an obvious local need existed (Mays 1996). On the whole, service development was not informed by population needs assessment or user engagement (Wyke, Abbott et al. 1999). Many of the changes made were not necessarily new but stemmed from existing ideas and were very much shaped by historical context. In the main, the pilots acted as a catalyst and provided the impetus for action (Wyke, Myles et al. 1999).
- 3.2.18 Evaluation of TPP service developments is near non-existent. Low achievement was reported in areas which were new to TP and not under the remit of FHs. TP-NET found achievement in complex areas such as mental health as low but in areas under the pilot's direct control, such as developing the primary care team, objectives were more commonly achieved (Goodwin, Mays et al. 1998; Wyke, Mays et al. 2003). The second live year of purchasing saw a move beyond narrow, local thinking to a more strategic approach which involved planning and equity concerns (Goodwin, Abbott et al. 2000).
- 3.2.19 In terms of service developments, like TPPs, it appears that PCG/Ts were also more concerned with establishing intermediate and community care services than focussing on practice-based initiatives (as FHs did). They too, found challenges in dealing with the acute sector and made significantly more progress with community care and the primary/secondary care interface (Regen, Smith et al. 2001). Health Improvement Programmes (HImPs) were a driver for some of the service development that occurred under PCGs. Specific examples include extension of the community mental health team (including longer opening hours) in Southampton, outreach family planning and sexual health service for young people in Devon, and accident prevention in Blackburn (Regen, Smith et al. 2001).

- 3.2.20 Areas in which GPs engaged were clinical governance and primary care development. Addressing variations in quality underpinned much of the primary care development work. Some practice-based services set up under FH were abolished in pursuit of equity in what was termed 'levelling down' by some. In other areas, practice-based services were expanded. Another common initiative within practices was new services to aid chronic disease management. At the PCG/T-level, groups developed specialist services within primary and community settings to serve as cheaper alternatives to secondary services. Examples include a PCG-wide diabetic and a gastro-intestinal service in Harrow and Southampton respectively. New community services were commissioned in order to reduce unnecessary hospital admissions and included community-based physiotherapy and mental health services. GP value was particularly noted in service developments due to their professional insight. It was also reported that GPs were more interested in local changes that would affect their everyday practice rather than implementing a national agenda (Regen, Smith et al. 2001). A study scrutinising decision-making within a PCG found that clinicians perceived simply the action of commissioning a new clinic an achievement in itself. There was little regard for further discussion about the nature of a service which did not concern them (McDonald 2002). Doing something was judged by participants to be more successful than doing nothing and in the absence of rigorous evaluations of service development we must be careful in labelling any developments as 'successful'. Interestingly, within PCGs, views of service adequacy and priorities for future development significantly differed between GPs and district nurses (Barclay et al 1999).
- 3.2.21 A significant number of new services were set up under PbC. These ranged from practice-level innovations to initiatives covering whole localities. Outreach services provided by hospital consultants were rare. As with some of the other schemes, such as TPPs, these initiatives had often been planned previously but it was PbC that provided the impetus for continuation, development and actual implementation (Curry, Goodwin et al. 2008; Coleman, Checkland et al. 2009). Larger scale redesign of whole care areas and specific clinical pathways was observed during this time and whilst these had PbC representation and engagement they were not, bar a few exceptions, led by PbC groups (Coleman, Checkland et al. 2009; Wells 2010). In line with previous clinical commissioning schemes, it was reported that only a minority of GPs were enthusiastic about broader commissioning with a population-based view and most were intent upon more changes in primary care settings (Coleman, Harrison et al. 2007; Curry, Goodwin et al. 2008). Coleman and colleagues suggest that rather than a lack of appetite for larger-scale change, PbC groups were constrained by their host PCT. There appeared to be a correlation between PCT attitudes towards PbC, the level of control they wished to maintain and the scale of innovations implemented. Those with tighter control confined groups to small-scale practice-based services (Coleman, Checkland et al. 2009). The Audit Commission found that practices were more interested in expanding their own provision of services rather than commissioning from others. They reiterated the importance of developing comprehensive business cases and appropriate management of conflicts of interests (Audit Commission 2007).

3.3 Contracting

- 3.3.1 Only a handful of studies have focussed on the contracting process for clinical commissioning schemes. Some of these looked at how FHs managed this aspect of commissioning and it was also an area which the TP national evaluation took an interest in.
- 3.3.2 Glennerster found that FHs developed more sophisticated contracts over time and that they were keen to measure performance against targets (Glennerster 1994). A similar pattern was observed in the TPPs, suggesting that there was a significant amount of 'learning by doing'. In the first live year less than half of the pilots studied made significant changes to the HA contract they inherited. The second live year, however, saw many more changes with a particular emphasis on quality, clinical guidelines and protocols. (Robinson, Raftery et al. 1998; Robison, McLeod et al. 1998). GPs reportedly used more quality specifications than health authorities (Glennerster 1994). GPs also used contracts successfully to improve the information they received from trusts, for example penalty clauses were written into contracts for late discharge information (Robison, McLeod et al. 1998; Drummond, Iliffe et al. 2001).

- 3.3.3 Locock and colleagues undertook a survey of purchasers in Oxford Regional HA. The resulting report provides a good insight into how FHs and districts sought to 'get the best from providers'. They found that districts used GPs in contract meetings (locality-style purchasing models) and found their expertise useful especially when hospital clinicians were involved. They also involved GPs in review meetings with clinical teams to verify hospital claims. Both districts and FHs used sanctions to ensure quality and waiting time targets were met. FHs were found to seek direct contact with clinical hospital staff but were careful not to inappropriately bypass management. GP FHs were found to be more comfortable using cost-per-case contracts in comparison to districts. They believed that the threat of losing work caused the providers to limit price rises. Further, FHs found that this type of contract encouraged providers to ensure that activity data were both accurate and timely. Validating invoices for individual patients was also believed to be easier than for block lists of patients. In terms of monitoring, FHs found their direct knowledge of patient care useful when discussing quality with trusts. Keeping anecdotal reports of poor care was reportedly useful in discussions with hospitals (Locock 1994).
- 3.3.4 There appears to be a slight tension between relational and contracting approaches to achieve change. Whilst collaborative relationships were widely believed to facilitate service development, views regarding the importance of contracting varied (Robison 1998; Wyke, Hewison et al. 1998). Whilst many TPPs intended to move to more refined forms of contracts (activity-related /length of stay sensitive) they often struggled to implement this change due to resistance from providers who were unwilling to accept such a high proportion of financial risk (Robison 1998). In Fishbacher's study of purchaser provider relationships, the majority of FHs did not want to move contracts and only did so as a last resort. Forming a partnership relationship was valued by GPs (Fischbacher and Francis 1998).

3.4 Changing primary care practice

Prescribing

- 3.4.1 A key area of attention for primary care-led commissioning schemes has been on GP prescribing costs. The fundholding scheme demonstrated that attaching monetary incentives to prescribing tended to reduce the rate of growth of prescribing costs (Burr, Walker et al. 1992; Bradlow and Coulter 1993; Maxwell, Heaney et al. 1993; Wilson, Buchan et al. 1995; Wilson and Walley 1995; Audit Commission 1996; Harris and Scrivener 1996; Baines, Brigham et al. 1997; Corney and Kerrison 1997; Rafferty, Wilson-Davis et al. 1997; Whynes, Baines et al. 1997; Wilson, Hatcher et al. 1997; Wilson, Hatcher et al. 1999). This held true for the first three years, after which rates of growth tended to parallel non-incentivised growth rates, with costs remaining at a lower overall level (Wilson and Walley 1995; Harris and Scrivener 1996; Whynes, Baines et al. 1997; Wilson, Hatcher et al. 1997). Only one study, involving 13 practices in the Oxford region, found little effect of fundholding on prescribing costs (Stewart-Brown, Surender et al. 1995). There was no evidence that FHs artificially inflated their prescribing costs in the year prior to entering the scheme (Healey and Reid 1994). This trend of containing prescribing costs was also seen in the GP commissioning pilots, PCGs and PbC Groups (McLeod, Baines et al. 2000; Smith, Regen et al. 2000; McLeod 2001; Ashworth, Armstrong et al. 2002; McLeod 2002; Walker and Mathers 2002; Coleman, Checkland et al. 2009).
- 3.4.2 The mechanisms employed to control prescribing costs by these schemes were varied and included:
- increasing generic prescribing or choosing the cheaper medicines within a therapeutic class thus lowering the cost per item (Bradlow and Coulter 1993; Glennerster 1994; National Audit Office 1994; Audit Commission 1996; Rafferty, Wilson-Davis et al. 1997; Wilson, Hatcher et al. 1999; Ashworth, Armstrong et al. 2002; McLeod 2002; Coleman, Checkland et al. 2009);
 - using incentive schemes (McLeod, Baines et al. 2000; Smith, Regen et al. 2000); closely monitoring repeat prescribing (Glennerster 1994);
 - developing a prescribing formulary (Audit Commission 1996; Dowell, Snadden et al. 1996; Tobin and Packham 1999; McLeod, Baines et al. 2000; McLeod 2002);
 - using prescribing advisors, particularly pharmacists to review prescribing behaviour at practice-level (McLeod, Baines et al. 2000; Smith, Regen et al. 2000; McLeod 2001; Ashworth, Armstrong et al. 2002);

- stopping the prescribing of medicines with dubious clinical benefit and those available over the counter (Audit Commission 1996; Dowell, Snadden et al. 1996);
- containing the rise in prescribing volume (Wilson, Hatcher et al. 1999);
- agreeing guidelines with hospitals regarding discharge arrangements (Audit Commission 1996);
- acting more cautiously with respect to introducing new and expensive preparations into their repertoire (Maxwell, Heaney et al. 1993);
- peer review and sharing prescribing data amongst practices which resulted in peer pressure to change habits (Mays, Goodwin et al. 1998; McLeod, Baines et al. 2000; Smith, Regen et al. 2000; McLeod 2002).

3.5 Attitudes towards performance management

- 3.5.1 As mentioned in section 3.3.3 above, peer review was used across the schemes in order to influence the behaviour of rank and file GPs within the purchasing organizations. For example, 83% of TPPs had protocols for sharing information on activity and financial performance between practices (Bevan, Bachmann et al. 1998). Peer review was not limited to changing prescribing habits but was also commonly used to control referrals. It was found to be an effective strategy. TPP evidence reveals that GPs in pilots with more than 20 practices were significantly less likely to consult before making a costly referral (Bevan, Bachmann et al. 1998). It can be inferred that GPs in larger organisations could easily blend into the background, unnoticed. The actions of those in smaller pilots were clearly more easily identifiable and this appears to be an important determinant of clinical behaviour.
- 3.5.2 Attitudes of GPs towards peer review seems to have evolved. Research of a GP commissioning pilot shows that despite mixed reactions initially, peer review became normalised and was accepted over time (Whynes, Baines et al. 1997). Similar findings were reported from a study of GPs involved in a prescribing initiative (Walker and Mathers 2004). By the time PCGs came into being, most GPs expected there to be a focus on performance management and there was some support for this approach (Smith, Regen et al. 2000; Dowling, Wilkin et al. 2002)). Research on PbC reported that a new willingness by GPs to engage in peer review was an unexpected, yet positive, consequence of the scheme. The mechanisms employed included visits to practices to discuss performance and publication of named performance data (Coleman, Checkland et al. 2009). These findings are echoed by further work in this area (Curry, Goodwin et al. 2008).

3.6 Quality and experience

Waiting times

- 3.6.1 During the FH era some evidence was published which suggested FHs negotiated shorter waits for non-urgent elective surgery and outpatient appointments (Kammerling and Kinnear 1996; Dowling 1997). A more recent, retrospective analysis showed that, in one HA, waits for patients having procedures covered by FHs fell by 8% (Propper, Croxson et al. 2002). Further work, which accounted for selection bias, also concluded that patients of FH practices had shorter waiting times for both chargeable and non-chargeable elective admissions (Dusheiko, Gravelle et al. 2004). Conflicting data from Redfern and Bowling found no objective evidence of FH patients being seen more quickly. This study did, however, only focus on local NHS hospitals so could not pick up referrals to private providers (Redfern and Bowling 2000).
- 3.6.2 In 1993, the Joint Consultants Committee documented examples for 32 hospitals where preferential treatment was available. For example, in Ashford, *'clinics have been arranged for fundholders' patients only to enable them to be seen more quickly'*; in Oxford *'consultants were asked to give priority to fundholders' patients for elective surgery'*; and in Essex *'the trust board has given an order of priority for patients treatment which puts patients of fundholders before long waiters and puts DHA patients' elective surgery at the bottom of the list (Joint Consultants Committee 1993)*. A subsequent survey conducted by the BMA revealed that patients of GPFHs were offered arrangements not available to patients of other

purchasers in 40% of responding hospitals. Around the same time, an Association of Community Health Councils in England Wales (ACHCEW) survey revealed that a fifth of Community Health Councils (CHCs) reported that GPFH patients got priority access to hospital services. Further work by this organisation exposed more cases where FH patients were fast-tracked (Association of Community Health Councils for England and Wales 1994).

- 3.6.3 However, Kammerling and Kinnear in their research on such fast tracking, suggested that GPFHs only referred sicker patients who were thus allocated higher priority and seen more quickly (Kammerling and Kinnear 1996). It is unlikely that this totally explains the shorter waits phenomenon. Improving the quality of the service offered to patients was a core objective for many FHs (Glennister 1994). One way in which they sought to achieve this was by improving waiting times for their patients. Dowling argues that FHs had more determination and incentives (keeping their patients happy) to reduce waits. He rejects the suggestion that the shorter waits were a result of overfunding, case-mix or better contracting. He concluded that the use of alternative (private) providers to secure shorter waits triggered NHS providers to offer shorter waits to attract FHs work and hence income (Dowling 2000). This is a plausible explanation and other work shows that whilst there was no evidence FHs shopped around for cheaper prices, quality and waiting times were drivers for referral behaviour change (Propper and Wilson 1996; Ellwood 1997) ie they were willing to refer to a different facility on account of short wait times.
- 3.6.4 Long NHS waiting list times were cited by GPs as a reason to use private services (Ellwood 1997; Tobin and Packham 1999). Propper et al have argued that it was FHs' ability to pay for care directly to a hospital coupled with their ability to choose providers that incentivised NHS providers to reduce their waits rather than their ability to choose different hospitals (Propper, Croxson et al. 2002). Setting up outreach clinics was another mechanism by which to reduce waiting times for patients to see a hospital consultant (Bowling and Bond 2001). Securing shorter waits does seem to have been an important factor for FHs.
- 3.6.5 Little other work was found on waiting times for the other clinical commissioning schemes. One of the non-fundholding TPP schemes in Nottingham claimed to have reduced waits at their local provider. Local GPs were given waiting times of all providers that Nottingham HA had contracts with and these were reportedly utilised by more than three quarters of practices in the scheme. Like FHs, these GPs were also concerned about maintaining their local provider and cases were only moved around at the margin (Black, Birchall et al. 1994). TPPs also acted to reduce waiting times for their patients. An example is the tendering for a local back pain clinic in order to avoid an 18 month waiting list for orthopaedic appointments. The pilot funded the service using a combination of development money and resources shifted out of the acute trust. This initiative succeeded in reducing wait times for acute back pain sufferers (Goodwin, Abbott et al. 2000).

Patient satisfaction

- 3.6.6 There is little evidence on how the different commissioning models affected patient satisfaction. Only a few studies from the fundholding era report on this and the evidence is conflicting. Surender and Fitzpatrick sent a patient satisfaction questionnaire to patients of both FHs and non-FHs. They found satisfaction levels high amongst both sets of patients although FH patients were slightly more satisfied with access to hospitals and waiting times. They also liked the in-house services offered by the practices (Surender, Fitzpatrick et al. 1998). A larger, national study found conflicting results, with FH patients being overall less satisfied than their counterparts attending non-fundholding practices. The authors tentatively suggest that the financial incentives associated with the scheme may have reduced patient satisfaction (Dusheiko, Gravelle et al. 2007). Three studies found no difference in patient satisfaction between commissioning and non-commissioning practices (Wyke et al 2001; Corney 1999; Redfern and Bowling 2000).

- 3.6.7 Howie and colleagues were very interested in how budget holding would affect the nature of consultations with patients. They found that there was no significant change in the way consultations were conducted or the experiences of individual patients before and after fundholding (Howie, Heaney et al. 1993; Howie, Heaney et al. 1994; Howie, Heaney et al. 1995).

Use of EBM

- 3.6.8 Studies of decision-making within commissioning groups have revealed the process to be non-linear and at odds with the rational health economic approach (McDonald 2002; Bate, Donaldson et al. 2007; Eddama and Coast 2009). The evidence suggests that all forms of primary care-led commissioning groups have been shown to use little evidence when making purchasing changes and fared poorly in comparison to HAs (Baxter, Stoddart et al. 2001). GPs believed that evidence had only a small role to play when commissioning services whereas public health doctors greatly valued quality evidence (ibid). In some cases, GPs worked with and were supported by public health staff from the HA; this helped to aid the use of evidence about effectiveness of treatments (Walsh, Shapiro et al. 1999). Often changes that were implemented were responses to perceived local issues, and as such, local knowledge rather than hard evidence was used to react to service demands and inform change (Mahon, Baxter et al. 1998; McDonald 2002). GPs were found to be motivated by achieving the objectives that they had set, not by considerations of cost-effectiveness (Wyke, Hewison et al. 1998). They have shown little understanding of economic evaluation, little interest in public health and are not comfortable with a strategic, population-wide approach (McDonald 2002). It is therefore not surprising that health needs assessment was not widely used (Mahon, Baxter et al. 1998; Walsh, Shapiro et al. 1999).
- 3.6.9 Poor and untimely cost and activity data was identified as an inhibiting factor in all the commissioning schemes, making it difficult to make changes to services. Such data is reportedly crucial in order to inform priority-setting, budget-setting and contract monitoring functions (Robinson, Raftery et al. 1998; Leese and Mahon 1999; Checkland, Coleman et al. 2008)). FHs cited good hospital feedback and information as a top priority when considering where to refer; some even used cost-per-case funding as an incentive to encourage receipt of quality and timely information (Locock 1994; Whyne and Reed 1994).
- 3.6.10 GP's experience and local knowledge has been found to be a key source of intelligence in informing purchasing decisions (Graffy and Williams 1994; Walsh, Shapiro et al. 1999). Whilst non-GP led purchasing organisations, such as HAs, focus on a public health approach, purchasing according to needs, GPs are more likely to focus on waiting times (and other outcomes important to patients) and anecdotal knowledge about quality (Glennerster (a), Cohen et al. 1998). GP's intimate knowledge of what happens to their patients appears to be one of their key strengths and was likely utilised most in the models where GPs had the most decision-making power, ie GPFH.
- 3.6.11 Purchasing organisations which relied on a parent body (PCT or HA) often found the information support they received from this body was inadequate. This data was often mistrusted and practice data was felt to be the most accurate and relevant (Mahon, Baxter et al. 1998; Robinson, Raftery et al. 1998; Smith, Regen et al. 2000; Curry, Goodwin et al. 2008). A further problem identified by research on PbC was that where data was available, many GPs lacked the confidence and capacity to analyse it properly (Curry, Goodwin et al. 2008; Wood and Curry 2009). Checkland and colleagues argue that many of the problems associated with PbC were socially constructed and information problems were often a failure to agree on the purpose it served, rather than an actual problem of information (Checkland, Coleman et al. 2009).

Financial considerations

- 3.6.12 In relation to district-wide purchasing bodies, the smaller, clinically-led commissioning groups appeared to inflate costs. Looking purely at cost, leaving quality of services aside, the evidence reveals that the overall costs of the FH scheme outweighed the efficiency savings made (Audit Commission 1996). FHs did, however, make substantial savings and at a national level they were around 3.5% of the budget underspent. Variation between funds was substantial (Audit Commission 1995). In comparison, the locality schemes managed to increase GP involvement in commissioning for a fraction of the cost of fundholding but the level of engagement and impact does not rival what was accomplished through FH

(Hine and Bachmann 1997; Glennerster, Cohen et al. 1998). Conversely, the transaction costs associated with TP were over and above those of fundholding (Place, Posnett et al. 1998). Across the schemes there is evidence that sufficient management resources were paramount and further, higher management costs were associated with greater success (Mays, Goodwin et al. 1998; Posnett, Goodwin et al. 1998; Smith, Shapiro et al. 1998; Coleman, Checkland et al. 2009).

- 3.6.13 The TPP evaluation revealed that the relationship between primary care-led purchasing organisation size and cost is not clear-cut. Whilst one might expect economies of scale as an organisation grows in size, a core component of the additional costs of TPPs fell on internal relationships; essentially engaging GPs (Posnett, Goodwin et al. 1998). Coordinating views of rank and file GPs and ensuring meaningful engagement in the commissioning process was found to be very costly (Place, Posnett et al. 1998). The larger an organisation becomes, the harder it is for GPs to be close to decision-making. On the one hand, we have seen that if GPs are to take financial responsibility for their clinical decisions, then it is imperative that they are engaged in managing a budget. On the other, securing this engagement does not come cheap requiring substantial clinical time and management resources. (Howie, Heaney et al. 1993; Coleshill, Goldie et al. 1998; Place, Posnett et al. 1998). For example Howie, Heaney et al (1998) found that clinicians spent nearly several hours of clinical time on fundholding when they would normally see patients and Place et al calculated that transaction costs for GPFH and in TPPs were between £7 and £8 per head of population.

Quality

- 3.6.14 Whilst GPFHs claimed benefits in terms of ability to improve quality (Lapsley, Llewellyn et al. 1997), there is a lack of empirical data linking commissioning to quality of clinical care and morbidity/mortality outcomes. Redfern and Bowling argue that GPFHs made no difference to the quality of outpatient care (Redfern and Bowling 2000); Howie examined the quality of primary care consultations (see 3.6.7 above); finally, Strong and Lloyd state that the things that made GPFHs switch providers were factors amenable to management action, for example letter writing and billing, rather than clinical care (Strong and Lloyd 1997). In summary, the evidence available does not allow us to make any claims about whether clinical involvement in commissioning has led to improved quality for patients nor is their evidence to demonstrate that GP commissioners prioritised or addressed issues of quality.

3.7 Relationships

Relationship with parent body

- 3.7.1 TPPs, PbC groups and the alternative schemes to FHs did not exist as separate legal entities; as such, they were required to work with a parent body, either a HA or a PCT. This relationship was a key factor for the progress of such schemes (Glennerster (a), Cohen et al. 1998; Leese and Mahon 1999; Audit Commission 2007; Peretz and Bright 2007; Coleman, Checkland et al. 2009). These commissioning groups required support and permission from their parent body to go ahead and facilitate change and were essentially operating under constrained conditions. Some groups were frustrated by this and felt that the PCT/HA deliberately blocked them from doing anything (Dixon, Goodwin et al. 1998; Glennerster (a), Cohen et al. 1998; Coleman, Checkland et al. 2009). In these instances, the parent body either did not completely trust the commissioning group (and they were the accountable body) or had little enthusiasm for the scheme in general. There were also reports of existing tensions between professional and managerial views and parent bodies feeling threatened by the new organisations (Shapiro, Smith et al. 1996; Dixon, Goodwin et al. 1998). In the early days of PCGs, HAs were reportedly reluctant to 'let go' (Smith, Regen et al. 2000). Conversely, where the parent body was enthusiastic (especially senior members) and afforded autonomy to the groups to make changes, the latter thrived. For example, the TPP evaluation reported that higher achievers were more likely to report their HA providing 'fair or good' good support compared to lower achievers (Mays, Goodwin et al. 1998).
- 3.7.2 'Good' relationships were characterised by mutual trust, independence of the commissioning group and greater sharing of information (Dixon, Goodwin et al. 1998). Project managers were found to be a useful liaison tool between the two groups (Leese and Mahon 1999). Historical relationships and existing tensions were found to be important. Where there was a history of partnership working between the

groups, schemes were further along (Audit Commission 2006; Audit Commission 2007). Where there was no tradition of working together, recognising this was the case and laying foundations for the future was key (Leese and Mahon 1999). High quality managerial support for clinically-led commissioning groups could also be enabling, both in terms of organisational development and in improving the attainment of objectives (Abbott, Harrison et al. 1999; Wyke, Mays et al. 1999). In all the schemes associated with parent bodies, relationships were said to improve and develop positively over time and this in itself was often listed as a successful outcome (Black, Birchall et al. 1994; Pickin and Popay 1994; Smith, Regen et al. 2000; Curry, Goodwin et al. 2008; Wood and Curry 2009).

Relationship with practices

- 3.7.3 Good relationships with and between practices has been cited as an enabling factor for GP-led commissioning (Mays, Goodwin et al. 1998). For example buy-in from rank and file GPs is thought to be essential in order to manage budgets effectively (Bevan, Bachmann et al. 1998). In order for larger groups to be successful it has been reported that all practices and non-lead GPs need to have some involvement (Goodwin, Mays et al. 1998). TPP work, however, showed that GPs were reluctant to work in large groups, especially when they were compelled to do so (Malbon (b) and Mays 1998). Under PbC, the formation of groups appeared to be highly dependent upon historical links between GPs (Curry, Goodwin et al. 2008) and formal sign up to schemes helped facilitate legitimacy (Coleman, Checkland et al. 2009[~]90)[~]. The section 'links with GP practices' above provides a comprehensive overview of engagement with rank and file GPs.

External Relationships

- 3.7.4 Providers: Improved relationships between GPs and hospital consultants has been hailed as one of the main successes of clinical commissioning (Llewellyn and Grant 1996; Ellwood 1997; Place, Posnett et al. 1998; Wells 2010). Working collaboratively with local NHS trusts and their clinicians was seen as an effective way to facilitate change (Locock 1994; Gask, Donnan et al. 1998; Robison 1998; Smith, Shapiro et al. 1998). GPs valued the opportunity to participate in decisions related to clinical care (Fischbacher and Francis 1998). Relational power was seen to swing towards the GPs during their time as purchasers. The idea of moving care out of hospital, however, made some hospital staff feel threatened and uneasy (Fischbacher and Francis 1998; Curry, Goodwin et al. 2008).
- 3.7.5 Social services: overall within the schemes, engagement with this groups was limited (Thistlewaite 1997; Secker, Davies et al. 2000; Audit Commission 2007). The two worlds of NHS and social services were said to be not understood by the other (Wyke, Myles et al. 1999). GPs also lacked trust of other disciplines (Goodwin, Abbott et al. 2000). TPP research revealed that collaboration between health and social services was improving with a move towards greater integration of care (Goodwin, Abbott et al. 2000). This kind of inter-agency collaboration was found to aid progress (Malbon, Goodwin et al. 1999). Social Services representatives were board members of PCGs but this formal link was removed with the development of PCTs. While in some PCGs the social services representatives were able to influence policy decisions generally such influence was low or non-existent (Wilkin, Gillam et al. 1999). Under PbC, engagement with LAs was made more challenging where PbC boundaries did not coincide with LA boundaries (Coleman, Checkland et al 2009).
- 3.7.6 Patient and public: there is little evidence to suggest that practices engaged patients and public in a meaningful way. Across the schemes GPs believed that by definition, they had an excellent understanding of patient needs and could act as reliable proxies for their patients; as a result they did not think of formal PPI as a priority (Dixon, Goodwin et al. 1998; Wyke, Myles et al. 1999; Coleman, Checkland et al. 2009). Where efforts to consult patients were made, it was often seen as a box ticking exercise (Dixon, Goodwin et al 1998). In PCGs, where approaches to involve patients and public had been initiated, this was more at the informing rather than participatory level. It has been suggested that PPI is relatively underdeveloped in primary care and GPs need to be educated about its value (Elbers and Regan 2001).

3.8 Conclusion

- 3.8.1 The evidence on the impact of primary care-led commissioning is particularly focused on a number of limited areas. There is good data on what changes commissioners made to services for patients and areas where impact could be easily measured – such as prescribing and waiting times. We found less evidence on the impact of primary care-led commissioning on quality or on the impact of commissioning more widely.
- 3.8.2 The evidence on impacts of clinically-led primary care commissioning clearly demonstrates that GPs focused on issues they felt were relevant for their patients and prioritised issues that mainly reflected perceived local needs (Dixon, Goodwin et al. 1998; Walsh, Shapiro et al. 1999). The evidence also suggests that there were significant tensions between tackling national priorities and addressing local issues.
- 3.8.3 Good relationships between primary care commissioners and ‘parent body’ commissioners and constituent practices were critical for success. Most previous schemes (except PCTs) involved delegated powers or advisory status with a larger commissioning body (the HA or PCT) holding ultimate responsibility for commissioning local services and maintaining financial stability. Where relationships were good and provided a supportive and permissive context primary care commissioners were more likely to succeed in achieving their objectives and be more innovative. However, this success was also dependent on maintaining the engagement and support of constituent practices which was seen as important in legitimising commissioning decisions.

4 Discussion

- 4.1** While we found 203 relevant papers discussing aspects of clinically-led commissioning, the evidence varies from scheme to scheme both in terms of quantity and focus. We found most papers discussed GP fundholding and its derivatives including TP. There was less relevant research on PCGs and PCTs, and only limited evidence on PbC. The pattern of evidence is likely to have been influenced partly by novelty – GP Fundholding was a new type of health care purchasing and the first model of primary care-led purchasing to be introduced in the UK. However, there was no centrally funded evaluation of GP fundholding unlike for TP, GP Commissioning and PbC. As such, different researchers focused on different aspects. However, for many early schemes the key focus was on outcomes of the schemes with a tendency to examine outcomes that were easy to measure – for example changes to GP prescribing and establishing new services. Few studies focused on how these were achieved and whether clinical engagement was important.
- 4.2** In this review we have sought to examine how GPs and, where possible, other primary care clinicians were involved in commissioning and what impact this had on the outcomes. Section 2 explored the attitudes of clinicians towards the different schemes and their motivations for joining. Central to understanding clinician impact is the GP's leadership role. A number of studies examined what kind of leadership positions clinicians held within commissioning organisations, and what influence and control they had over commissioning decisions, the budget and the contracting process. Fewer studies explored the nature of the relationship between the clinical leadership and the wider clinical body. There were also few studies that examined the perceived influence of the commissioning organisations over other bodies with which they interacted, for example the HA or provider trusts. Despite the limited amount of evidence in some of these areas it is clear that the degree and impact of clinical engagement varied both between and within different commissioning models.
- 4.3** It is perhaps useful to first set out what we did not find. During the early 2000s a narrative grew up that one of the reasons that commissioning was deemed to have 'failed' was that there had been insufficient clinical engagement and that managers alone were unable to do the job (House of Commons Health Committee 2010, Smith, Curry et al 2010). Subsequent commentary surrounding the 2010 White Paper and later policy documents has emphasised the supposed benefits of clinical involvement in commissioning. It was against this background that this review was conceived, as we were concerned to explore how many of the claimed benefits were actually rooted in empirical evidence. It will be clear to readers that the impacts of clinically-led commissioning that we have identified here are somewhat more modest than those claimed in policy rhetoric. In part this reflects what has been studied, and in part it reflects the difficulty in clearly demonstrating more subtle effects on, for example, influencing colleagues or changing minds. Furthermore, each manifestation of clinically-led commissioning that we have looked at was quickly superseded by the next initiative, making it difficult to fully assess which aspects of each scheme were having an effect. However, it remains the case that empirical evidence of significant impact of clinically-led commissioning remains somewhat limited. Readers of the review may feel that what is presented here does not reflect their personal experience. This is because this review focuses upon the empirical evidence relating to clinical involvement in commissioning, which may not necessarily chime with individual experiences.
- 4.4** There is evidence from all previous primary care-led commissioning schemes that some GPs were highly motivated to develop primary care-led commissioning. Key motivations were the potential for innovation and the development of services for their patients. The focus of such developments tended to be on local, community based services. Financial incentives were important in fundholding and PbC where savings could be reinvested in practice-based services and other service developments but this was more easily achieved in fundholding where practices had budgetary autonomy.
- 4.5** GPs who led schemes and who were fully engaged tended to be only a small proportion of the GP body and many other GPs in commissioning organisations were not as engaged or were often not supportive of commissioning developments. However, GP leaders were generally engaged in commissioning even when the primary care commissioners were not the main commissioning body (eg GP Commissioning, PbC). In broader-based commissioning organisations such as PCTs and HAs while GPs were involved

these were either a very select number (eg the PEC chair and committee) or were not seen as very influential (eg locality commissioning).

- 4.6** The evidence clearly demonstrates that GPs enjoyed more autonomy and were generally more engaged in GP fundholding than in later schemes. GPs had greater control over their delegated budget than in later schemes. Fundholding practices also tended to have strongest links between GP leaders and the wider body of GPs. This was partly a function of size as GP Fundholding schemes were often single practices or smaller networks of practices.
- 4.7** We found no evidence to show whether the inclusion of non-GP clinicians added value. Some schemes such as PCGs included nurses but there is no research evidence reporting on any impact of this although nurses involved in PCGs did express the desire to become more involved on commissioning activities (Wilkin, Gillam et al. 1999).
- 4.8** Overall the evidence on engagement suggests that while there were different degrees of engagement between schemes and different number of GPs and other clinicians engaged in commissioning there are some common themes. Essentially where GPs had more autonomy (over decisions about services, budgets etc) they were more likely to be innovative in terms of changes made. The ability to innovate was a key driving factor in motivating engagement in commissioning. Interestingly, the evidence suggests that where GPs who were originally non-enthusiasts of commissioning became involved in decision-making their commitment tended to grow. However, where autonomy was limited this limited the degree of influence or the extent of influence and this was likely to create less engagement by the wider body of GPs and clinicians.
- 4.9** In Section 3 we examined the evidence on the impact of clinically-led primary care commissioning. Again the extent and variability of the evidence and topics examined produces a mixed picture. Areas where there is most evidence relates to those which were easiest to measure such as changes in prescribing, waiting times, referrals and specific service changes. Determining whether such changes were successful is more complex. Whereas reductions in prescribing costs and reduced waiting times suggest success, some studies raise questions about service changes where there are similar concerns about equity and also duplication.
- 4.10** There is strong evidence to demonstrate that more GP engagement seems to lead to more success in achieving goals and stated objectives. This finding is supported by data from Fundholding, TP and PbC. These schemes demonstrate that governance systems that engage the wider body of GPs and other clinicians provide the commissioning organisation, and those leading it, with greater legitimacy. However, this increased engagement leads to increased organisational overheads and higher costs. This is particularly true for larger organisations with large numbers of constituent practices and GPs resulting in higher transaction costs.
- 4.11** There is some evidence to suggest that primary care-led commissioners were innovative as a direct consequence of clinical engagement. However, the evidence from most schemes highlights the importance of the degree of control invested in the commissioning organisation. There is little evidence of success in changing secondary care services (Drummond, Iliffe et al. 2001; Craig, McGregor et al. 2002). Generally primary care clinicians focused their activities and attention on areas they were most knowledgeable about such as primary and community care. GPFHs focused predominantly, and most successfully, on changing the prescribing practices of GPs to make savings. This was an area that TPPs also focused on. Studies of PbC did show that wider service changes were achieved and that clinicians were engaged in these. However, it is not possible to ascertain the impact of such engagement although there is some evidence that the development of PbC provided an impetus for pushing through planned changes (Curry, Goodwin et al. 2008; Coleman, Checkland et al. 2009).
- 4.12** For GPs there appears to be a strong incentive to make changes in services when provided with the power and autonomy to do so. However, these changes tend to be small, practice-based, focused on primary and community care services and there is little evidence to demonstrate the success of such schemes improved quality of care for patients or their cost-effectiveness. The evidence to date suggests

that very few GPs are interested in wider, large-scale, population-based commissioning. Evidence from TP and PbC suggests that change is more successful when GP leaders are supported by the membership.

- 4.13** There is little evidence from previous schemes to show whether clinically-led primary care commissioners were more patient focused. At most the evidence suggests that GPs were more likely to respond to the experiences of their patients or to try to change things that they saw as affecting their patients. We found no evidence that primary care commissioners prioritised or developed processes for public and patient engagement.
- 4.14** Overall clinical engagement in most schemes was driven by clinicians wanting to improve services for their patients. Clinicians, especially GPs, felt that they were in a better position to know what their patients needed. They responded to direct patient feedback on secondary and primary care services that patients were referred to, they felt that the information held in the practice was better than that held by HAs or PCTs and thus as commissioners they were better informed.

5 Conclusion

- 5.1** In reviewing the evidence it is clear that while findings suggest that some schemes were successful, the variability in both quantity and quality of the research means that drawing cumulative conclusions should be undertaken with caution. For example while GPFHs were not constrained in their autonomy over how they utilised their fundholding budget their scope of action was limited in terms of their impact on secondary care services and patterns of care more generally. Conversely schemes that had a wider scope, such as TP or GP Commissioning, were constrained by the actions and degree of control exercised by the main commissioning organisation such as health authorities, or, in the case of PbC, the PCT. Research on different schemes has tended to focus on different aspects, with older research tending to focus on what was achieved while more recent research has explored how the organisations ‘worked’ highlighting the shift from simply documenting impact to trying to understand how commissioning processes affected services for patients. This review highlights the important differences between schemes and therefore drawing lessons for current developments in clinically-led commissioning is not straightforward. Table 2 provides an overview of our review of the evidence and compares this with the current situation relating to CCGs.
- 5.2** Despite the need for caution in interpreting the evidence a number of key themes emerged from our analysis. In schemes, such as GP fundholding, TP and PbC, the evidence shows that where GPs achieved changes they were more likely to ‘do more’ and explore further innovations and changes to services. Conversely in schemes where GPs felt they had little influence – such as in PCTs and to a certain extent in PCGs - there was a tendency to disengage. This suggests that there are virtuous cycles where engagement is shown to lead to successful actions and ‘vicious cycles’ where clinicians withdraw from engagement if they feel they have no influence. In particular, perceived success is linked to a willingness to accept financial responsibility for clinical decisions related to engagement with managing the budget.
- 5.3** A key message from our analysis is that the environment and culture within which clinically-led commissioning organisations operate is important in determining whether they are successful. Primary care commissioners in areas where there was a more permissive environment, where the HA or PCT provided a supportive environment, were generally more able to achieve goals, more likely to develop commissioning and achieve their stated objectives. Primary care commissioning organisations were generally more ‘successful’ when they felt they were allowed to get on with it and had freedom and autonomy to act. It is also true that the HA and PCT also acted as a “safety net” as they were the main holder of local financial risk. Therefore primary care commissioners could focus on aspects of care without needing to address the whole range of health issues or be ultimately responsible for health service delivery in the local health economy. This is clearly very different from the context within which CCGs will operate as they have full devolved responsibility for the delivery of health care for their population and are financially accountable.
- 5.4** While there are some significant similarities between some previous primary care-led commissioning schemes and the current structure and functions of CCGs there are clearly significant differences relating to the role of clinicians in decision-making structures and processes, the degree of autonomy over commissioning decisions, the comprehensive and extent of what could be commissioned and relationships between different clinician groups and with external agencies. For example, CCGs will be similar to GPFHs as they will have full budgetary autonomy, CCGs will be commissioning a wider range of services. However, their autonomy may be less as they need to work with local authorities, Commissioning Support Services and the NHS Commissioning Board who also have commissioning responsibilities. Another key difference is that CCG membership is not voluntary – a distinct difference to the majority of preceding schemes. However, based on the findings of this review it useful to compare the different schemes and table 2 summarises the key characteristics of the various clinically-led primary care commissioning schemes comparing them with the current development of CCGs.

Table 2: Key characteristics of clinically-led primary care commissioning

| | GP Fundholding | Non-fundholding scheme (locality groups etc) | Total purchasing | GP Commissioning | Primary Care Groups | Primary Care Trusts | Practice-based-Commissioning | Clinical Commissioning Groups |
|---|-------------------------|---|-------------------------|-------------------------|----------------------------|----------------------------|-------------------------------------|---|
| Comprehensiveness of commissioning activity | Limited | Limited | Limited | Variable | Fully | Fully | Limited | Fully |
| Clinical leadership | High | Medium | High | High | High | Low | High | High |
| Clinical autonomy over commissioning decisions | High | Low | Medium | Medium | Medium | Low | Medium | Low-medium |
| Budgetary autonomy | Limited devolved budget | Shadow budget | Delegated budget | Shadow budget | Delegated budget | Full autonomy | Delegated budget | Devolved budget |
| Financial autonomy in commissioning | High | Low | Medium | Medium | Low | Low | Low | High |
| Strength of linkage/ relationship with member GPs | High | Medium | Variable | Variable | High | Low | Variable | Variable depending size and governance arrangements |
| Strength of relationship with health authority/main commissioner | Variable | Low | Variable | Variable | Medium | N/A | Variable | New relationship with NHS Commissioning Board |
| Strength of relationship with other organisations | Variable | Low | Variable | Low | Medium | High | Low | Formal links via HWB |

- 5.5** Strong clinical leadership does not ensure the engagement of rank and file GPs and as commissioning organisations become larger they tend to struggle to engage clinicians from all constituent practices/organisations. Yet maintaining broader engagement is indicative of successful clinical leadership and appears to support more successful commissioning activity. For larger organisations maintaining such engagement is an important activity but requires substantial resources leading to high transaction costs.
- 5.6** This review has focused specifically on exploring the impact of clinical engagement in primary care-led commissioning. While the evidence is variable in terms of quantity and quality we have identified a number of key lessons which are relevant for developing CCGs:
- If GPs are given sufficient space to innovate, small scale change is likely (focus on issues close to GPs);
 - Scope to achieve change in these areas diminished over time (already focussed on);
 - In terms of service development, over time clinical commissioning models have shown that GPs start to engage with a wider strategic focus but initially the focus will be very localised, at micro and meso-levels;
 - Primary and community care are likely to be an area pinpointed for development, especially providing intermediate alternatives in order to reduce use of secondary care services. It is imperative that these changes are accompanied by resource shifts out of hospital so not paying for double services. Also, evaluation of new developments would be useful to see if they are more successful than the status quo;
 - Prescriptive guidance re membership may squeeze out GP interest and influence;
 - Cannot be sure what the added value of clinical leadership (in the wider sense) will be;
 - Grassroots engagement is key to affecting behaviour of individual GPs but mergers between CCGs may lead to loss of grassroots engagement.
- 5.7** The review also clearly demonstrates that identifying the exact contribution that clinical leadership makes to commissioning is complex and it is not easily discernible exactly what added value clinical involvement brings. While it is possible to demonstrate some changes in commissioning and service provision as a result of clinical engagement there is insufficient evidence to demonstrate whether this had benefits for patients. Key areas of activity related to primary and community service change, changing prescribing practice (where significant financial gains were initially made) and reviewing GP referrals. There is scant evidence of any successful changes to secondary care. Whether there is further room for addressing GP prescribing practices to achieve savings is questionable.
- 5.8** The findings of this review of the evidence suggest that ensuring continuing constituent support will be crucial in ensuring that CCGs achieve their aims and objectives. They will also require substantial management support and investment in internal organisational arrangements to ensure that clinicians are supported and engaged in the CCG.
- 5.9** The evidence from previous approaches to clinically-led primary care commissioning does provide some key lessons for the organisation and functioning of CCGs. There are also important lessons regarding areas where CCGs are likely to experience significant problems and will need additional support. It is not possible to definitively identify what value the involvement of clinicians will add as this has not been uniform between schemes. However, the evidence suggests a general willingness among some GPs to engage in commissioning and that such engagement can bring about change.

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Appendix 1: The role of GP commissioning consortia

- We envisage putting GP commissioning on a statutory basis, with powers and duties set out in primary and secondary legislation.
- Consortia of GP practices, working with other health and care professionals, and in partnership with local communities and local authorities, will commission the great majority of NHS services for their patients. They will not be directly responsible for commissioning services that GPs themselves provide, but they will become increasingly influential in driving up the quality of general practice. They will not commission the other family health services of dentistry, community pharmacy and primary ophthalmic services. These will be the responsibility of the NHS Commissioning Board, as will national and regional specialised services, although consortia will have influence and involvement.
- The NHS Commissioning Board will calculate practice-level budgets and allocate these directly to consortia. The consortia will hold contracts with providers and may choose to adopt a lead commissioner model, for example in relation to large teaching hospitals.
- GP consortia will include an accountable officer, and the NHS Commissioning Board will be responsible for holding consortia to account for stewardship of NHS resources and for the outcomes they achieve as commissioners. In turn, each consortium will hold its constituent practices to account against these objectives.
- A fundamental principle of the new arrangements is that every GP practice will be a member of a consortium, as a corollary of holding a registered list of patients. Practices will have flexibility within the new legislative framework to form consortia in ways that they think will secure the best healthcare and health outcomes for their patients and locality. We envisage that the NHS Commissioning Board will be under a duty to establish a comprehensive system of GP consortia, and we envisage a reserve power for the NHS Commissioning Board to be able to assign practices to consortia if necessary.
- GP consortia will need to have a sufficient geographic focus to be able to take responsibility for agreeing and monitoring contracts for locality-based services (such as urgent care services), to have responsibility for commissioning services for people who are not registered with a GP practice, and to commission services jointly with local authorities. The consortia will also need to be of sufficient size to manage financial risk and allow for accurate allocations.
- GP consortia will be responsible for managing the combined commissioning budgets of their member GP practices, and using these resources to improve healthcare and health outcomes. The Government will discuss with the BMA and the profession how primary medical care contracts can best reflect new complementary responsibilities for individual GP practices, including being a member of a consortium and supporting the consortium in ensuring efficient and effective use of NHS resources.
- GP consortia will need to have sufficient freedoms to use resources in ways that achieve the best and most cost-efficient outcomes for patients. Monitor and the NHS Commissioning Board will ensure that commissioning decisions are fair and transparent, and will promote competition.
- GP consortia will have the freedom to decide what commissioning activities they undertake for themselves and for what activities (such as demographic analysis, contract negotiation, performance monitoring and aspects of financial management) they may choose to buy in support from external organisations, including local authorities, private and voluntary sector bodies.
- We envisage that consortia will receive a maximum management allowance to reflect the costs associated with commissioning, with a premium for achieving high quality outcomes and for financial performance.
- GP consortia will have a duty to promote equalities and to work in partnership with local authorities, for instance in relation to health and adult social care, early years services, public health, safeguarding, and the wellbeing of local populations.
- GP consortia will have a duty of public and patient involvement, and will need to engage patients and the public in their neighbourhoods in the commissioning process. Through its local infrastructure, HealthWatch will provide evidence about local communities and their needs and aspirations.

Appendix 2: Hand searched bibliographies

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Appendix 4: Examples of data extraction sheets

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| Paper | 16. Bain, J. (1992). "Budget holding in Calverton: one year on." <u>British Medical Journal</u> 304 (6832): 971-973. |
| What is the phenomenon being examined? | GPFh |
| At what point in time is it being examined? | 1992 |
| At what point in its life-span is it being examined? | A year after the introduction of GPFH |
| What is the nature of the clinical involvement? | GPs made decisions on where to send their patients and their capacity to negotiate a better deal for vulnerable patients |
| What are the data collection methods? | Not mentioned but sounds like interviews |
| How well described are the processes that are being examined? | Quite well described |
| What are the descriptive findings? | <p>Progress:</p> <ul style="list-style-type: none"> - Getting agreement on the budget was a torturous process. - The projected annual prescribing costs were higher than the prescribing budget so prescribing budget was increased. - The practice has not negotiated block contracts so has been working in cost per case basis which allows them greater flexibility (eg. can negotiate with the hospital if they are not satisfied) but leads to cumbersome administration as staff has to check every patient procedure. - Variation in prices for hospital procedures would determine where patients would be referred to. - Stress among staff was considerable so they organised a practice retreat for the partners and business manager. <p>Improving services:</p> <ul style="list-style-type: none"> - Started a monthly health centre based clinics in neurology & geriatric medicine and will introduce physiotherapy clinic - Success stories in specialties dermatology, ophthalmology & orthopaedics - patients travel much shorter distance and costs per case are notably lower than in one of Nottingham's main hospital. - GPs have the capacity to negotiate a better deal for vulnerable patients – 'hospitals now accountable to use as opposed to the reverse'. - New referrals to medical and surgical specialists have fallen than before fundholding. |

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| | <ul style="list-style-type: none"> - Nurses and admin staff has increased involvement in providing services. <p>Problem:</p> <ul style="list-style-type: none"> - The assumption that a business manager could take administrative load of medical staff was unrealistic so GPs cannot avoid a management role. - Senior partner has to be constantly available to help business manager/admin staff understand how hospital care has to be negotiated. - Confusion about coding – practice’s coding system for diagnoses and procedures didn’t match the health authority’s coding system. |
| Does the paper provide explanations for the findings? | No |
| What inferences do the authors make? | <ul style="list-style-type: none"> - 5 partners in the practice are not enthusiastic about the new GP contract and saw budget holding as having more control of services. - The objective of budget holding was to stimulate the practice to work within a specific allocations and make savings for future investment. |
| What inferences do you make? ** | Same as above |
| Critical evaluation of the paper ** | <ul style="list-style-type: none"> - Based on an experience from one practice (Calverton practice) around 3 villages outside Nottingham so can’t be applied widely. - The progress and problems are quite well described. - Interviews with GPs and practice team. <p>v. small but still warrant mention in Part 1 (RM)</p> |

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| Paper 24 | Bradlow 1993 BMJ 307:1186 |
| What is the phenomenon being examined? | GPFH prescribing |
| At what point in time is it being examined? | 1991/2 |
| At what point in its life-span is it being examined? | Early – wave 1 |
| What is the nature of the clinical involvement? | GPFH |
| What are the data collection methods? | Used routine PACT data to analyse changes in prescribing costs. Also asked practices how they were tackling prescribing. Only 15 practices |
| How well described are the processes that are being examined? | Straightforward - GPFH |
| What are the descriptive | GPFH had the lowest rate of increase in their prescribing |

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| findings? | costs. This applied to both dispensing and non-dispensing practices. Non-fundholders started off with the lowest costs, but by the end had the highest costs, suggesting that this isn't simply an effect of the 'best' practices taking up GPFH. Reports that GPFH reduced growth in costs by: <ul style="list-style-type: none"> • Increase in generic prescribing • Practice formularies • Advice from prescribing advisors |
| Does the paper provide explanations for the findings? | No |
| What inferences do the authors make? | Argues that 'clear' incentives involved in the scheme had an effect. Being a dispensing practice provides incentives not to prescribe generically – but it seemed that GPFH incentives over-rode this effect. |
| What inferences do you make? ** | As above |
| Critical evaluation of the paper ** | Straightforward statistical analysis of PACT data. Relatively small study, with no real additional context provided, so unable to tell what factors contributed to success. Part 1 |
| Paper | 44. Cowton, C. J. and J. E. Drake (1999). "Went fundholding, going commissioning? Some evidence-based reflections on the prospects for primary care groups." <u>Public Money & Management</u> 19 (2): 33-37. |
| What is the phenomenon being examined? | GP Fundholding practice management |
| At what point in time is it being examined? | 1998? |
| At what point in its life-span is it being examined? | Spread across the waves (1-6) of fundholders. |
| What is the nature of the clinical involvement? | Looks at GPs (primary care) views on management roles in fundholding practices. Why they undertook the role? |
| What are the data collection methods? | Qualitative data collected as part of a wider project into the management of GP fundholding practices. 12+ practices from 4 different HAs in N England (recruited by a variety of methods – leaflet response, recommendation ie opportunistic). Some factual info collected before interviews by a questionnaire (15-80 mins). Semi-structured interviews – 2 at each site. |
| How well described are the processes that are being examined? | Details provided on why the lead GP came to undertake this role. Each case study reported separately and then conclusions drawn overall. |
| What are the descriptive findings? | How individuals became lead partners in the context of their practice's decision to go to fundholding – set out as individual case studies. |

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| | <p>Decision to take the lead was secondary to the overall decision to go to Fundholding (ie often little ambition of lead partner to become a manager).</p> <p>Impression of reluctance is consistent with the many findings on clinical directors.</p> <p>With many practices demonstrating a lack of positive support for fundholding , it is not surprising that a nomination for lead was not always forthcoming.</p> <p>The presence of positive reasons for going to Fundholding doesn't imply any one senior partner will be enthusiastic to take the lead role.</p> <p>Doctors can grow to appreciate a management role – new finding.</p> |
| Does the paper provide explanations for the findings? | GPs as generalists or less glamorous areas of medicine , used to operating in partnership (as compared to secondary care) may be expected to take more readily to management. |
| What inferences do the authors make? | <p>Some doctors who were initially reluctant became more keen on undertaking a management role once they had experienced it.</p> <p>Widespread negative belief amongst clinicians (in literature) about the nature of management and managers so difficult for them to say anything other than they did not wish to be a manager.</p> <p>Findings still relevant even with the announcement of demise of Fundholding – doctors attitudes to management roles.</p> <p>Important as this research focuses on primary not secondary care (important given future role of GPs on PCGs).</p> |
| What inferences do you make? ** | |
| Critical evaluation of the paper ** | <p>Two interviews per site to avoid the views of one person only.</p> <p>Not examined the views of non-fundholders or partners not involved in management (as comparisons).</p> <p>Sample is not random.</p> <p>Part 1</p> |