Mapping Approaches to Commissioning

Extending the mosaic

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Marian Barnes
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King's Fund

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Executive Summary

This report summarises the main results of a survey of approaches to commissioning undertaken by the Health Services Management Centre (HSMC) at the University of Birmingham on behalf of the Department of Health. Information was gathered through a structured questionnaire administered by telephone interviews between August and October 1997. All health authorities in England were surveyed and a 100% response was achieved. Information from the questionnaire was supplemented with views obtained from national representative bodies and from regional offices of the NHS Executive. The survey sought to map different approaches to commissioning and to assess the impact of these approaches from the perspective of health authorities. Total purchasing and the main types of standard fundholding were excluded from the survey as information about these approaches was already available to the Department of Health.

Section 2 of the report shows that a wide variety of approaches to GP commissioning was in existence in the NHS in 1997. These approaches included not only the five principal categories used at the outset of the survey - multifunds, fundholding consortia, locality commissioning, commissioning by groups of practices and health authority wide groups - but also joint commissioning, commissioning focused on particular client groups or specialties, and a range of area based approaches. There were variations both between and within the eight English regions in the number and type of approaches that had been adopted (see maps 3-8). The most common number of approaches reported was three (33 % of respondents) and the most common type of approach reported was health authority wide groups involving GPs (69 % of respondents). There were also variations within districts in the approaches used. The map of commissioning can be likened to a mosaic which is continuously being refined as new tiles are added and existing ones extended.

The pattern that emerged suggested that different approaches had different strengths. In interpreting our findings, it is important to remember that fundholders as well as non-fundholders were often involved in locality commissioning, commissioning by groups of practices and health authority wide groups. Variations between multifunds and fundholding consortia on the one hand and the remaining approaches on the other should not therefore

be seen as evidence of better performance by fundholders or vice versa. Health authorities and GPs were developing approaches to commissioning which made it increasingly difficult to maintain a distinction between the original population centred (eg. locality commissioning) and patient focused models (eg. practice based commissioning), a development which suggested a perceived need within the NHS to find ways of combining the strengths of these models.

Our survey suggested that multifunds and fundholding consortia had had a greater impact than other approaches on prescribing, the provision of extended primary care services, referrals and inpatient waiting times (see Section 4). By contrast, locality commissioning, commissioning by groups of practices and health authority wide groups had had a greater impact than multifunds and fundholding consortia on services for chronically mentally ill people and continuing care policy and arrangements. All approaches had made a beneficial impact on service quality, and equally all had had a limited impact on emergency admissions.

Data on involvement of other staff and organisations in commissioning presented in Section 3 show that locality commissioning, commissioning by groups of practices and health authority wide approaches tended to be more inclusive whereas multifunds were more self contained. Beyond this, locality commissioning, commissioning by groups of practices and health authority wide groups were more likely to contribute to strategic commissioning, while multifunds and fundholding consortia were more likely to be involved in implementation tasks such as contract negotiation and monitoring.

All approaches contributed to health authorities' capacity to make services more responsive but locality commissioning, commissioning by groups of practices and health authority wide groups were more likely than the fundholding approaches to have had a beneficial impact on health authorities' capacity to assess needs and consult with the public. And while there was some evidence that locality commissioning groups holding a budget had a greater impact on services and commissioning processes than those that did not, the number of responses was too small to be able to generalise with confidence.

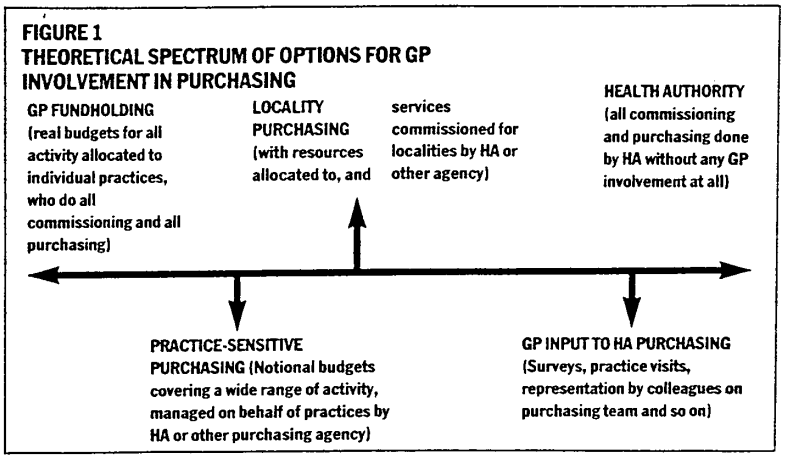
Section 5 summarises the main findings and seeks to illuminate the debate about the future of commissioning. It argues that the principle of GP commissioning was well established in 1997 but needed to be extended to those not currently involved, something which appears to have been addressed by the 1997 NHS White Paper's emphasis on the involvement of *all* GPs, along with input from community nurses, other primary care team staff, social services personnel and community health councils. Given that no single approach was found to have performed consistently well, it was concluded that a range of levers and approaches were likely to be needed to deliver the government's objectives for the NHS. Some of these levers were seen as possibly evolving from the powers available to fundholders, and others from the foundations laid by locality commissioning, commissioning by groups of practices and health authority wide groups. Future commissioning arrangements were also deemed to need to build in scope for different functions to be performed at different levels.

The subsequent proposals for primary care groups and trusts appear to incorporate this range of levers and approaches. Groups have the choice of four levels of commissioning, ranging from advisory bodies to free-standing trusts with a total health care budget. Whilst groups will hold budgets for prescribing and other services, they will also be required to commission for the health improvement of their local population. In placing primary care groups as the main commissioning bodies in the 'New NHS', the Government has implicitly supported the principle of primary care led commissioning. In parallel, it has also established arrangements which are intended to address the variations in performance and focus of existing groups as described in this report and elsewhere. In introducing new national and local frameworks, it might be expected that the mosaic of commissioning may become clearer in its definition in the coming years. The extent of variation of design and colour within that definition is yet to be revealed.

1 Introduction

The reforms introduced to the NHS in 1991 contained within their design two models of purchasing or commissioning. The first, based on health authorities, centred on the population and its health needs. The second, based on general practice, focused on patients and how services to patients could be improved by allocating a budget or fund to family doctors in individual practices. Population-centred and patient-focused purchasing, as these models have been termed (Ham, 1996)[1], evolved into a range of approaches, particularly as health authorities sought to involve general practitioners in decisions on the use of their budgets. Figure 1.1 illustrates a typology of approaches published in 1994 which reflects these developments.

Figure 1.1



Source: Ham C. and Willis A. 'Think Globally Act Locally' in ***Health Service Journal****, 13 January 1994* [2]

In parallel to the steps taken by health authorities to work more closely with general practitioners, fundholders in some places took the initiative to come together in networks that became known as multifunds, often as a way of enabling smaller practices to participate in the fundholding scheme. At the same time, other general practitioners collaborated in the establishment of fundholding consortia. The simultaneous move by health authorities to make their work sensitive to general practitioners and by some general practitioners to purchase services at a level higher

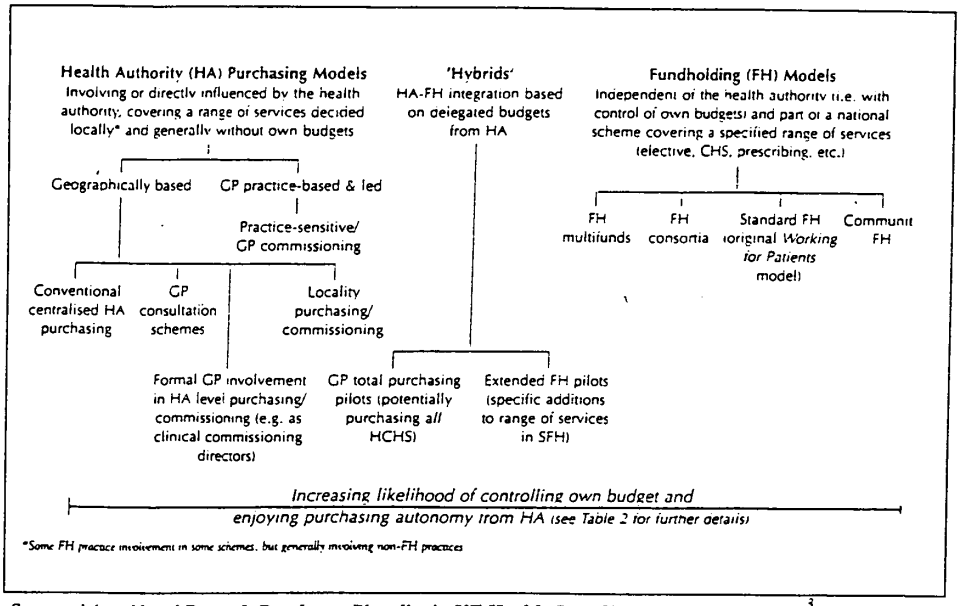
than the individual practice indicated that managers and doctors both recognised the need to combine aspects of population-centred and patient-focused purchasing. And while in the early phases of the 1991 reforms, the debate was often framed in terms of the superiority of one or other of the original models of commissioning, over time there was a keener appreciation that the more interesting and important question was how to bring together the most positive aspects of different approaches, recognising that there were strengths and weaknesses in each.

This debate was made more complex by the government's decision in autumn 1994 to develop a primary care led NHS (EL[94]79, Department of Health, 1994). One of the consequences of this initiative was the establishment as part of government policy of a variety of models of fundholding, including total purchasing projects in which general practitioners were able to commission all services for their patients. Another consequence was that health authorities renewed their efforts to involve general practitioners in purchasing, for example through the development of locality commissioning arrangements, practice sensitive purchasing initiatives and general practitioner commissioning groups. In a number of districts, representative general practitioners were appointed to sit around the top table with health authority managers as part of these efforts. The effect was to increase still further the variety of commissioning models, including hybrids which explicitly combined features of the two original approaches. This is illustrated in Figure 1.2 below. And unlike in 1991, the primary care led NHS policy initiative was accompanied by a commitment to evaluate the most significant of these hybrids, the total purchasing pilot projects.

As these comments indicate, purchasing and commissioning have evolved rapidly and in ways which were only partly anticipated by the architects of the NHS reforms. While the original impetus came from government, many of the most important innovations have resulted from managers and doctors using the flexibility built into the design of the reforms to establish arrangements appropriate to different circumstances. It was in this way that total purchasing emerged in areas like Bromsgrove and Berkshire in advance of government endorsement of this approach.

As a result, not only is there a high degree of purchaser plurality in health care (Mays and Dixon, 1996)[3], but also there are variations between districts in the coverage and mix of different approaches. This is illustrated by fundholding with map 8 (see below) showing the prevalence of standard fundholding in England. Not only this, but also the models of commissioning described in Figure 1.2 are rarely self contained, with general practitioners often involved in commissioning through more than one route, and health authorities developing a range of approaches in different parts of the areas they cover.

Figure 1.2 A typology of current purchasing organisations in the NHS



Source: Mays N and Dixon J, ***Purchaser Plurality in UK Health Care****, King's Fund, 1996, p15* [3]

To make this point is to illustrate the difficulty for researchers and policy makers alike of evaluating a rapidly changing picture and of painting this picture in a way which is accurate and does not contain too many blurs at the edges. Notwithstanding this difficulty, a large number of evaluative studies have been conducted, albeit of variable quality. As the literature review conducted by Le Grand and colleagues in parallel with our own research has shown (Le Grand et al, 1997)[4], many of these studies are of fundholding. The most systematic evaluation is the ongoing work by Mays and

colleagues on total purchasing. In comparison, there have been fewer studies of health authority commissioning and the models of commissioning, such as locality purchasing and general practitioner commissioning groups, that have evolved out of the population-centred approach.

There have been even fewer attempts to compare and contrast fundholding and non-fundholding models. Indeed, in view of increasing convergence between these models, and overlapping participation by general practitioners in different approaches, it would have been difficult in any case to control for confounding factors even if well designed comparisons had been set up. And to return to an earlier point, if the key policy question is less the superiority of any one model of commissioning than the strengths and weaknesses of different approaches, then an analysis of the evidence (such as it is) in relation to criteria such as equity and efficiency was perhaps the best way of informing the debate.

Having made this point, in 1997, there was one area in which our understanding of commissioning was particularly incomplete. This concerned the extent to which approaches other than standard fundholding and total purchasing had found favour in different parts of the NHS. Data on the coverage of these approaches were not collected centrally, nor had there been much work that has attempted to examine the impact of these approaches on patients and services. It was to fill this gap in our knowledge that the research reported here was commissioned.

The research had two broad aims: first, to map different models of commissioning; and second, to assess the impact of these models from the perspective of health authorities. As a starting point, five main types of commissioning (other than standard and community fundholding and total purchasing) were identified. These were multifunds, fundholding consortia, locality commissioning, commissioning based on groups of practices, and authority wide general practitioner groups. The definitions applied to these approaches by the research team are set out in Figure 1.3:

Figure 1.3

Glossary of terms

GP multifund
A grouping of GP fundholders who had formed a GP-led independent organisation for the administration and management of their fundholding activities. Multifunds were often companies limited by guarantee with GP shareholders. Fundholder funds remain independent but administration took place in a central agency or management organisation.

Fundholding consortium
A group of GP fundholders who came together to discuss issues such as purchasing priorities, contract specifications and other matters of policy. Each fundholding fund remained completely independent and management of fundholding took place at practice level. The consortium might or might not have negotiated contracts on a corporate basis.

Commissioning based on groups of practices
A group of GPs who formed a commissioning group based on a 'natural grouping' of GP practices. This may have been initiated by GPs or by the health authority. The GPs may have been fundholders, non-fundholders or total purchasers and increasingly, these groups included GPs from all these categories.

Locality commissioning (geographically based)
A group of GPs and others who had formed a commissioning group based on a defined geographical locality.' This may have been initiated by GPs, the health authority or another body such as the local authority. The GPs might have been fundholders, non-fundholders or total purchasers.

Authority-wide GP group
A commissioning group which covered the whole of the health authority area. All GPs were entitled to be a member or were represented in some way. The group may have been initiated by the health authority or by GPs.

The questionnaire used in the research asked about the coverage of these approaches, and also sought information about other approaches in existence in the authority. In relation to all approaches, information was gathered about the functions performed and the organisations and people involved.

The second aim of the research was pursued by asking questions about the perceived impact of the approaches that were reported to exist. Respondents were asked to assess impact on primary care and on trust based services using examples similar to those markers employed by the Audit Commission in its work on fundholding (Audit Commission, 1996)[5]. The questions asked during the survey sought to identify examples of detrimental as well as positive impact, and also posed a series of questions about the impact on health authorities themselves.

In all of these areas, it should be noted that it was **health authority perceptions** of impact that were sought. No information was gathered directly from general practitioners, although in preparation for the survey discussions were held with representative national bodies such as the National Association of Commissioning GPs, the Association of Independent Multifunds, the National Association of Fundholding Practices, and the General Medical Services Committee of the British Medical Association. In parallel, views were sought from primary care leads in regional offices of the NHS Executive.

It is worth mentioning what the research was **not** designed to do. As we have noted, the project excluded single practice fundholding and the 'official' total purchasing projects (those included in the national evaluation) as data on these forms of purchasing were already available to the Department of Health through other routes. Furthermore, the research only examined models of commissioning from the perspective of the health authority. Given the limitations of what can be achieved in a survey of this kind, it was decided, following discussion with those who commissioned the research, to omit analysis of the costs of different approaches to commissioning and related issues.

The survey questionnaire was prepared in close consultation with colleagues at the Department of Health and with input from colleagues in HSMC. A copy of the questionnaire is attached at **Appendix 2**. The questionnaire was piloted in three health authorities (two in Wales and one in England). The survey was conducted with all English health authorities between August and October 1997 and, following reminder letters, a 100% response was achieved. Interviews were conducted by a senior member of HSMC's academic staff by telephone with the health authority chief executive or a nominated lead officer. The survey questionnaire, guidance notes and glossary of terms were sent to respondents in advance of the interview. A copy of the guidance notes and glossary of terms are attached at **Appendix 3**. Respondents were given the opportunity to send additional or missing information to the research team following the interview, and many authorities took up this option.

The rest of this report presents the findings of the survey. It is organised as follows. **Section 2** presents findings related to the distribution of approaches across health authorities. **Section 3** describes the functions undertaken by the different commissioning approaches and describes who is involved in them. In **Section 4** health authorities' perceptions of the impact of the various approaches are reported. **Section 5** summarises the key findings. In **Appendix 1** we report on how regional offices viewed the mosaic of commissioning in their regions.

2 Distribution of approaches across health authorities

One of the main purposes of this study was to uncover and describe the range and type of approaches to commissioning throughout England. This section of the report presents a series of maps illustrating the way in which the various approaches are distributed across health authorities. Map 1 identifies health authorities which have defined sub-units within the authority for commissioning purposes. It demonstrates that it had become usual practice for some commissioning to be undertaken at sub-authority level.

Map 2 illustrates the number of different approaches being used by health authorities at the time of the interviews. These data are repeated in tabular form below. They show that the most common number of approaches was three (33% of respondents) with 84% of health authorities reporting between two and four approaches.

Table 2.1: No. of approaches per authority

No. of Approaches	Health Authorities	
	No.	%
1	8	8
2	28	28
3	33	33
4	23	23
5	7	7
6	1	1

Maps 3 - 7 illustrate the way in which the different models were distributed across the country. The maps show in which health authorities the different approaches were to be found, not the numbers of examples of each approach. Thus, the same shading includes authorities with one fundholding consortium and authorities with three or more; similarly an authority with one locality commissioning group looks the same as another with five or more. Bearing this in mind, the maps illustrate a wider distribution of fundholding consortia than of multifunds, and suggest a greater concentration of locality commissioning approaches in, for example, South and West region compared with Northern and Yorkshire.

Table 2.2 presents the distribution of types of approaches in tabular form, analysing the number and percentage of health authorities reporting each type of approach. As the table shows, the most common type of approach was health authority wide groups (69% of respondents) followed by locality commissioning (60%)

Table 2.2: Type of approach per authority

Type of Approach	Health Authorities	
	No.	%
GP multifund	34	34
Fundholding consortium	57	57
Locality commissioning	60	60
Commissioning based on groups of practices	36	36
Authority wide groups	69	69
Other	35	35

Map 8 is based on data provided by the Department of Health and details the percentage of the population in each health authority covered by GP fundholding. The survey itself did not collect information about individual fundholding or total purchasing projects and the map is attached for comparative purposes.

Map 9 is provided for reference. It highlights differences in total populations covered by health authorities.

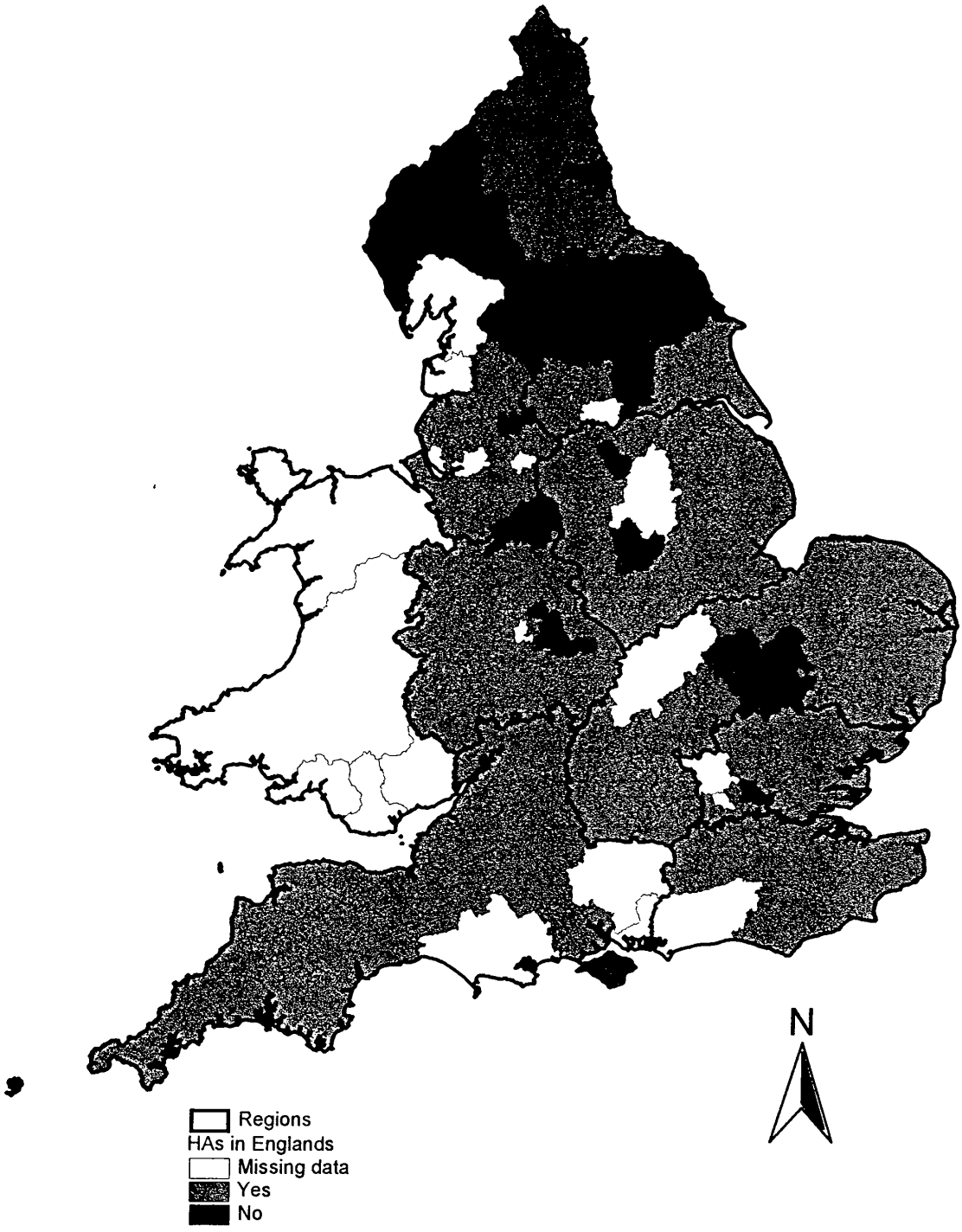
The frequency with which we recorded 'other' approaches to commissioning contributed to the diversity of the overall picture. While some approaches included within the 'other' category were one-offs, relevant to particular local circumstances (for example, the Isles of Scilly), others indicated additional approaches to commissioning which constituted an important part of the overall picture.

These include:

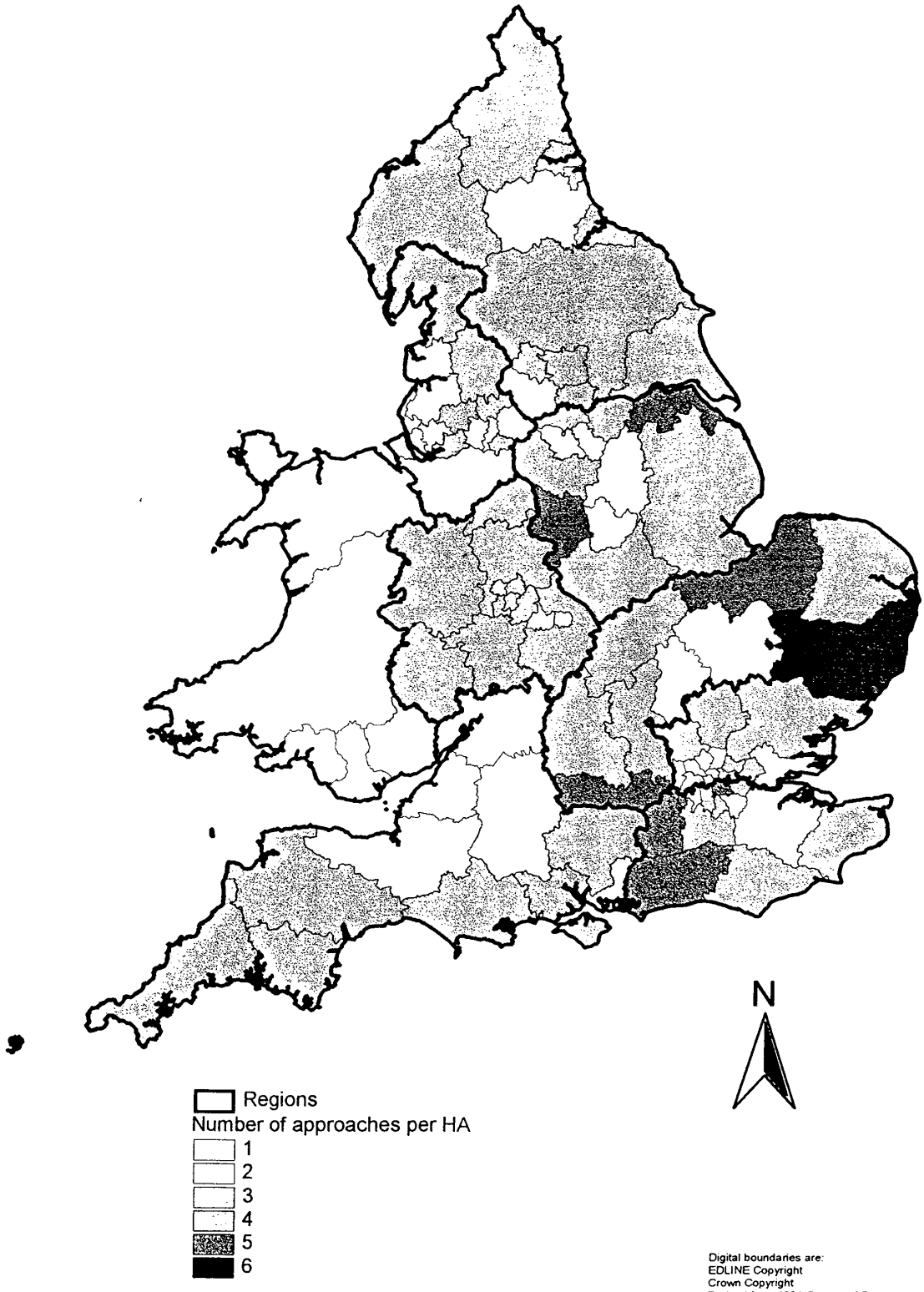
- joint commissioning with social services
- health alliances with local authorities
- client/specialty focused approaches
- health action zones/area/neighbourhood approaches

The emergence of these approaches, alongside the five main categories that provided the framework for the survey, indicated the way in which health authorities and GPs were continuing to develop commissioning arrangements at a local level. To this extent, the mosaic of primary care commissioning and provision described in the West Midlands region (Smith et al, 1997)[6] was not only replicated in other parts of the NHS but was more extensive in its pattern and detail than originally described.

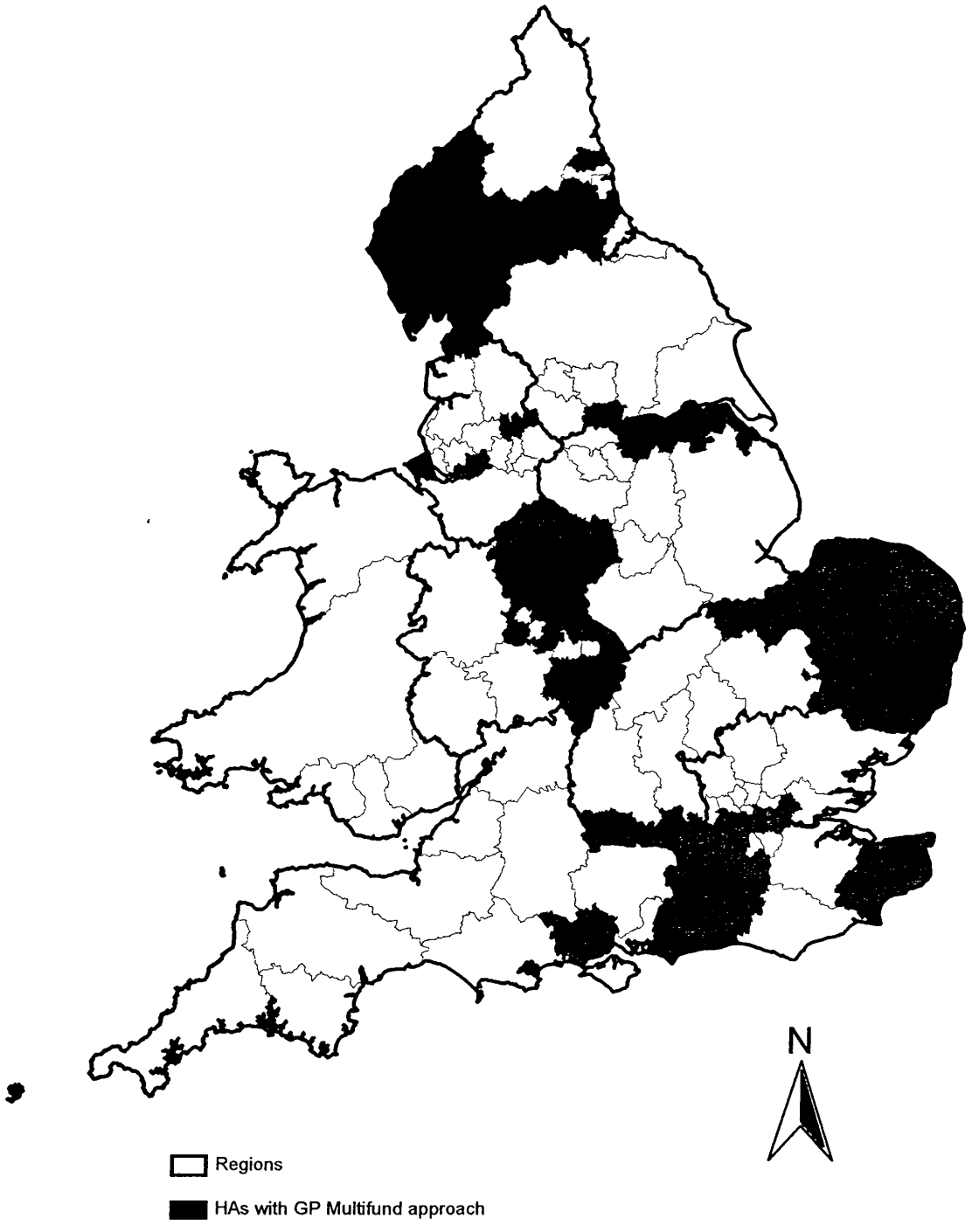
Map 1 Health Authorities Which Have Defined Sub-units For The Purposes Of Commissioning



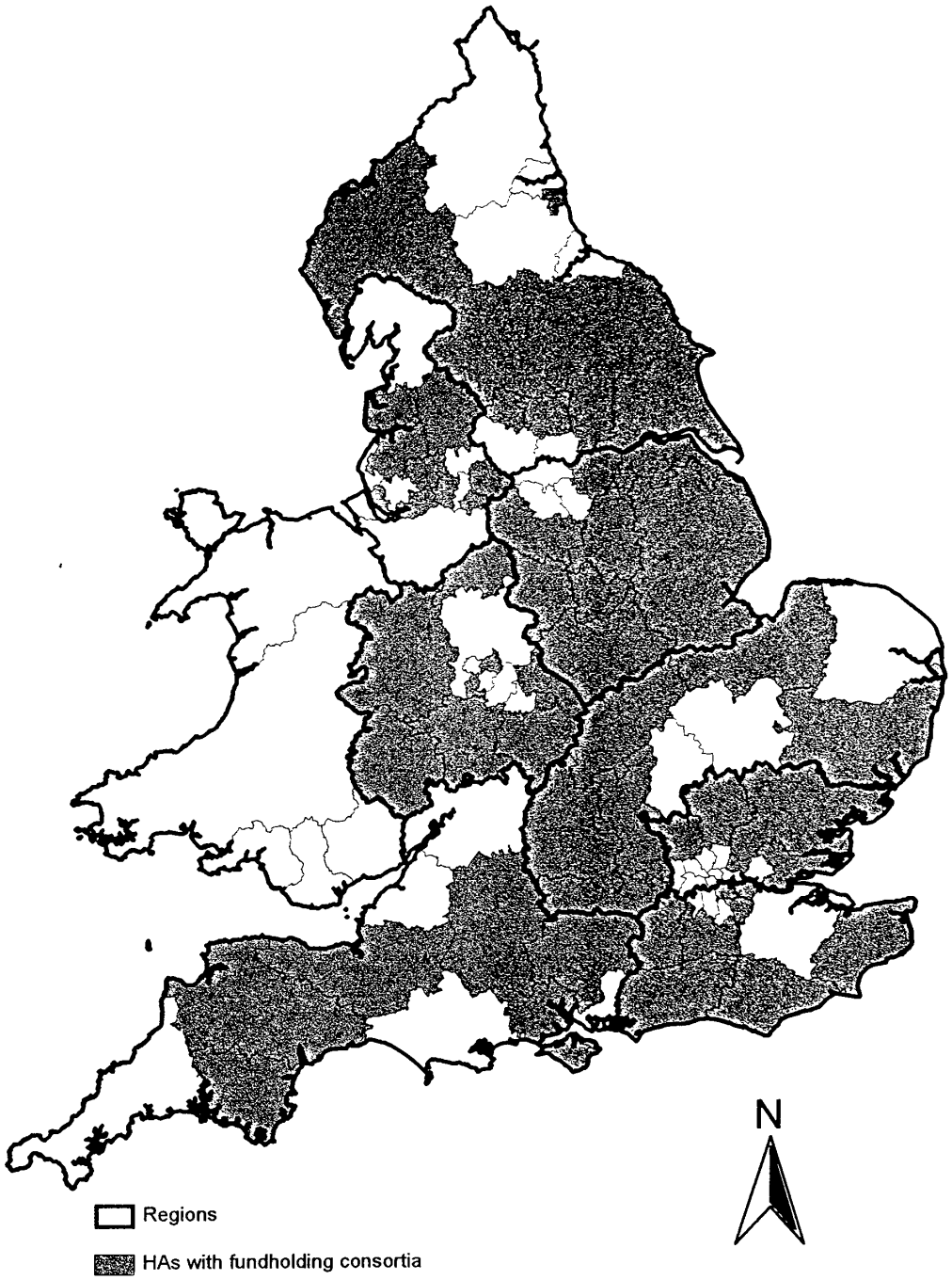
Map 2 Distribution Of Commissioning Approaches



Map 3 Distribution Of GP Multifunds

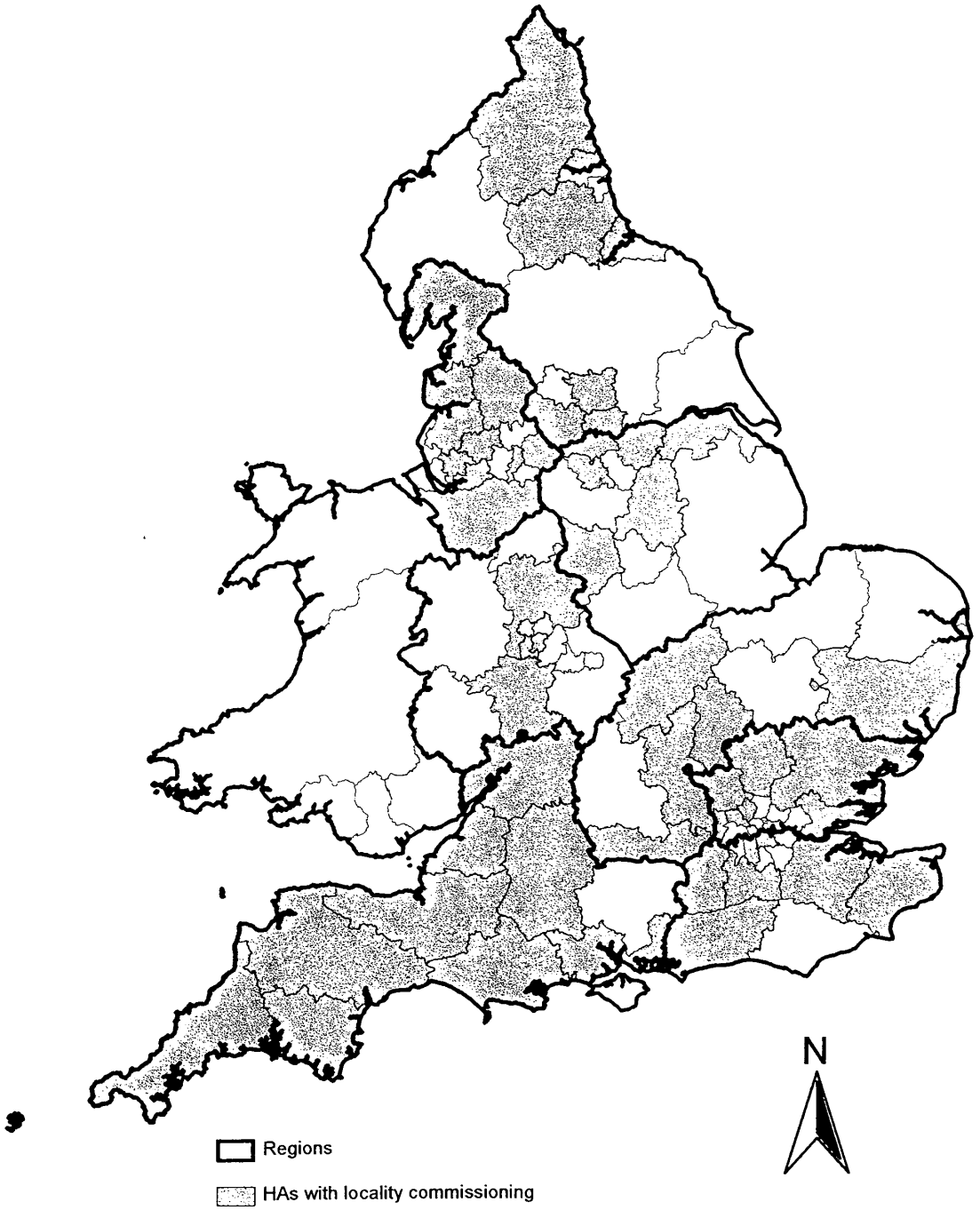


Map 4 Distribution Of Fundholding Consortia

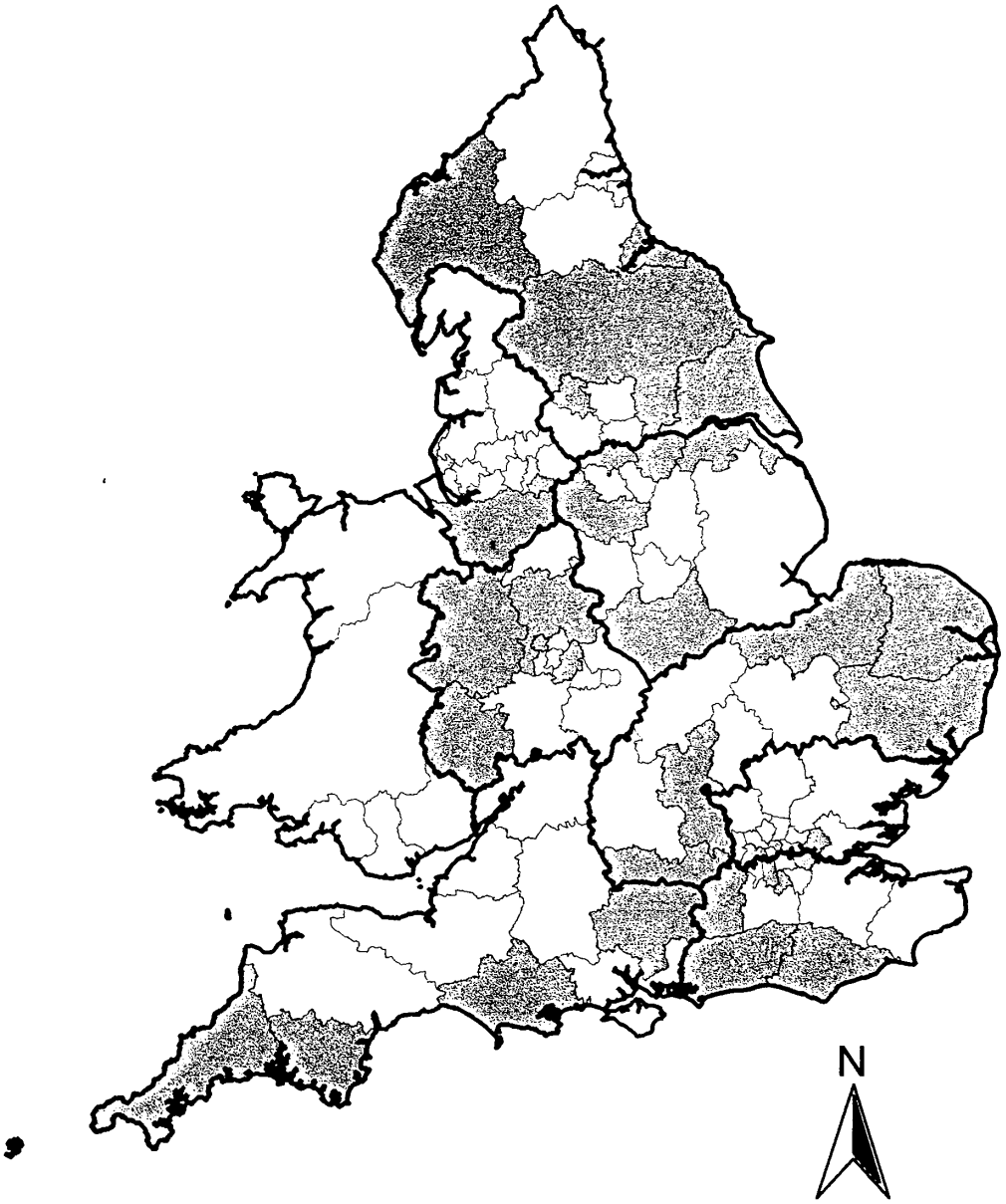


Map 4 Distribution Of Rural Areas

Map 5 Distribution Of Locality Commissioning



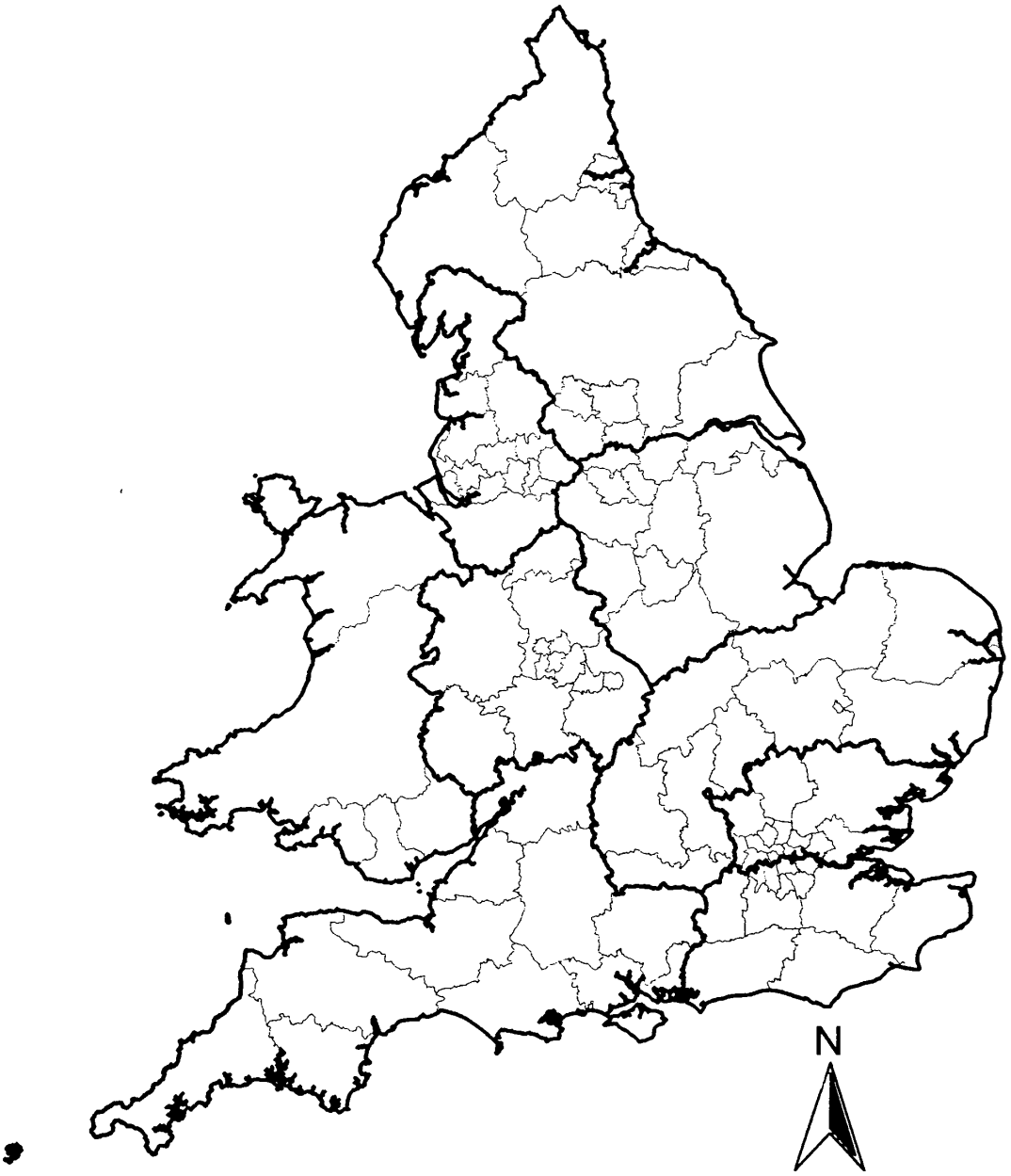
Map 6 Distribution of Commissioning based on Groups of Practices



Regions

HAs with commissioning based on groups of practices

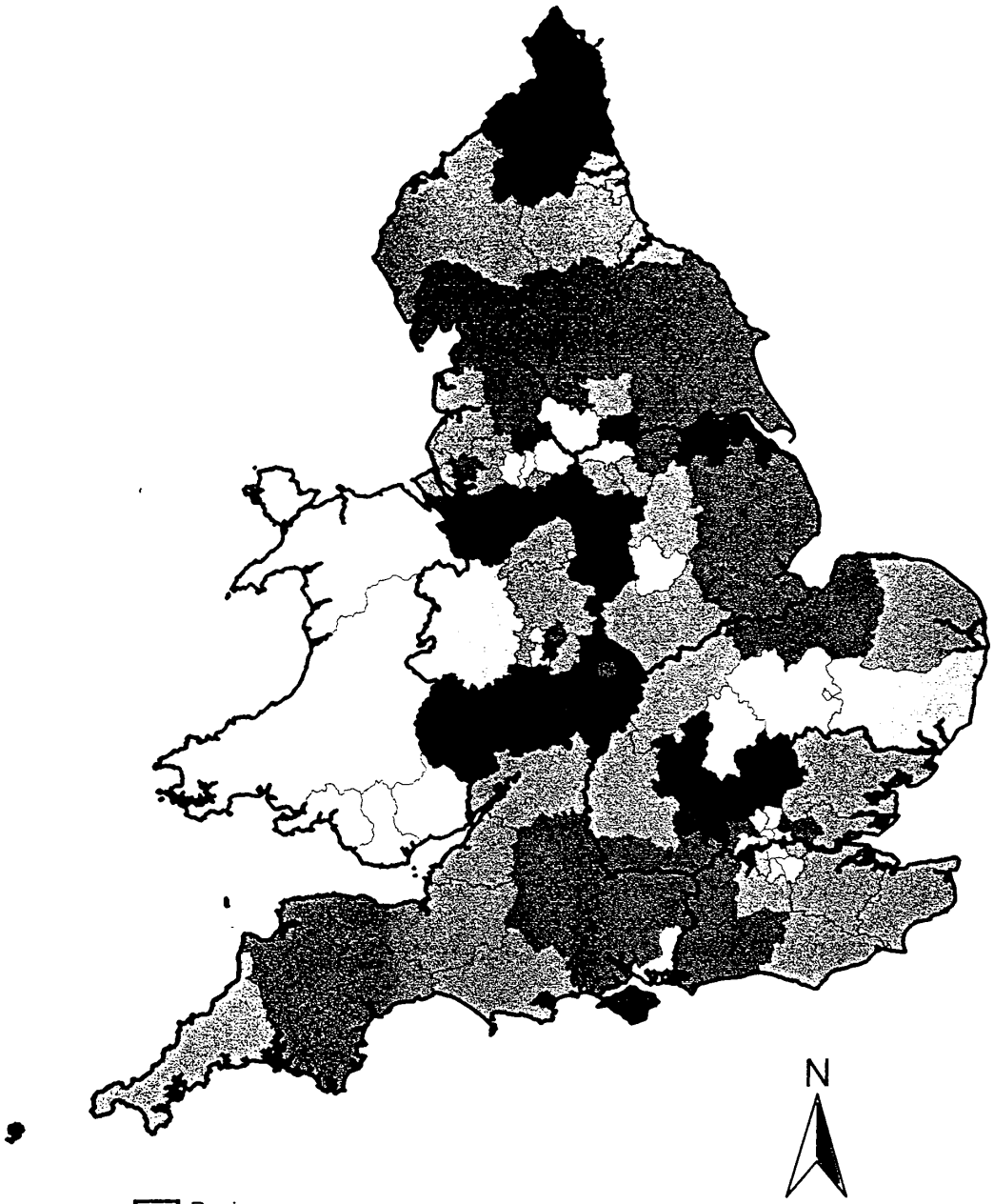
Map 7 Distribution of Authority Wide Commissioning Groups



Regions

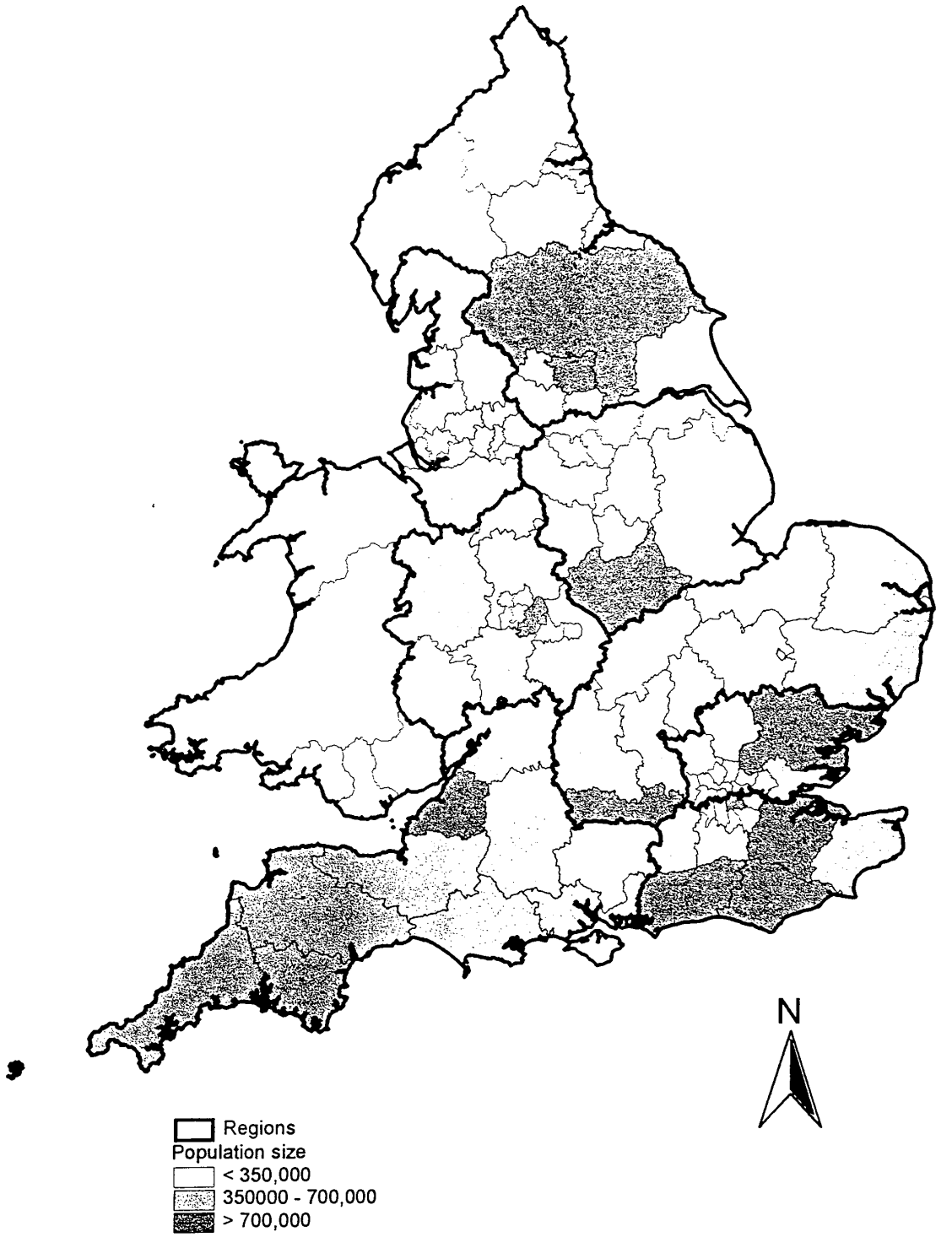
HAs with authority wide groups

Map 8 Percentage Coverage of GP Fundholding



Regions
% of population covered by GP Fundholders in each HA
13 - 34
35 - 48
49 - 60
61 - 73
74 - 100

Map 9 HA Populations



Map 9

3 The different commissioning approaches: functions and participants

In this section we report on three areas of questioning to health authority respondents: 1) questions about whether or not budgets were devolved to groups involved in commissioning; 2) the strategic, implementation and other tasks in which commissioning groups were engaged; and 3) questions about who else apart from GPs were participants or otherwise involved in the different approaches to commissioning. We present these results according to **function**, for example by illustrating what proportion of health authorities reported that each approach made an input to health needs assessment or the prioritisation of resources. In both this section and section 4 our aim has been to summarise the data and to present the results in tables with each table being followed by brief comments which seek to highlight key points of interest.

TABLE 3.3: APPROACHES MAKING AN INPUT INTO HEALTH NEEDS ASSESSMENT

Approach	No. and Percentages		
	Yes	No	Row Total
GP Multifund	19 61.3	12 38.7	31 10.8
Fundholding Consortium	30 53.6	26 46.4	56 19.6
Locality Commissioning	54 87.1	8 12.9	62 21.7
Commissioning by Practice Groups	27 77.1	8 22.9	35 12.2
Authority Wide Commissioning Groups	45 68.2	21 31.8	66 23.1
Other	26 72.2	10 27.8	36 12.6
TOTAL	**201** **70.3**	**85** **29.7**	**286** **100.0**

- Each commissioning approach was more often than not seen to make an input to health needs assessment.
- Locality commissioning groups were usually seen to make an input to health needs assessment - in less than 13% of cases were they considered not to make an input.
- Fundholding consortia were least likely to be seen to contribute in this way, but even so, over 50% of the health authorities reporting on such consortia thought they did make a contribution.

TABLE 3.4: APPROACHES MAKING AN INPUT INTO SERVICE PLANNING

Approach	No. and Percentages		
	Yes	No	Row Total
GP Multifund	27 87.1	4 12.9	31 10.9
Fundholding Consortium	47 83.9	9 16.1	56 19.6
Locality Commissioning	62 100.0	0 0	62 21.8
Commissioning by Practice Groups	32 94.1	2 5.9	34 11.9
Authority Wide Commissioning Groups	64 97.0	2 3.0	66 23.2
Other	30 83.3	6 16.7	36 12.6
TOTAL	**262** **91.9**	**23** **8.1**	**285** **100.0**

- Virtually all the commissioning approaches were seen to make an input to service planning.
- No health authorities with locality commissioning considered that such groups made no input to service planning.

TABLE 3.1: APPROACHES WITH A BUDGET

Approach[1]	No. and Percentages				
	Yes - actual	Yes - notional	No	Missing value	Row Total
Locality Commissioning	9 14.8	13 21.3	35 57.4	4 6.6	61 21.9
Commissioning by Practice Groups	2 5.7	8 22.9	25 71.4		35 12.5
Authority Wide Commissioning Group	8 12.3	4 6.2	53 81.5		65 23.3
Other	15 41.7	2 5.5	16 44.4	3 8.3	36 12.9
TOTAL	**34** **17.3**	**27** **13.7**	**129** **65.5**	**7** **3.6**	**197** **100.0**

[1] Our definition of GP multifunds means that all will have a budget over and above individual funds. It was not always clear whether fundholding consortia held a collective budget.

- Over half of health authorities reported that commissioning approaches other than multifunds and fundholding consortia did not hold a budget.
- Less than 15% of health authorities with locality commissioning groups said they currently hold a budget.
- Less than 6% of health authorities with GP commissioning groups said they currently hold a budget.
- Both locality and GP commissioning groups were more likely to operate within a notional budget.
- A substantial proportion of health authorities reporting on 'other' approaches said they had budgets. These included some 'unofficial' TPPs, but also other approaches (see categorisation).
- This was an area in which considerable change was expected - many respondents identified budget allocation as a focus for future developments, and the subsequent development of primary care groups adds further weight to this trend.

TABLE 3.2: FUNCTIONS OF DIFFERENT APPROACHES TO COMMISSIONING - STRATEGIC

Approach	No. / percentage inputting to: Health Needs Assessment		Service Planning		Resource Prioritisation		Consultation with Public	
	No.	%	No.	%	No.	%	No.	%
GP Multifund	19	61.3	27	87.1	24	77.4	9	29.0
Fundholding Consortium	30	53.6	47	83.9	44	78.6	16	28.6
Locality Commissioning	54	87.1	62	100.0	61	98.4	34	55.7
Commissioning by Practice Groups	27	77.1	32	94.1	30	85.7	19	54.3
Authority Wide Commissioning Groups	45	68.2	64	97.0	63	95.5	26	39.4
Other	26	72.2	30	83.3	28	77.8	20	55.5
TOTAL	**201**		**262**		**250**		**124**	

- Health authorities most frequently identified locality commissioning groups as making an input to each of the strategic elements of commissioning.
- However, with the exception of consultation with the public, each approach was more often than not viewed as making a strategic contribution.
- Apart from consultation with the public, the lowest levels of input in the 'strategy' context was that of multifunds and fundholding consortia to health needs assessment.

TABLE 3.5: APPROACHES MAKING AN INPUT TO PRIORITISATION OF RESOURCES

Approach	No. and Percentages		
	Yes	No	Row Total
GP Multifund	24 77.4	7 22.6	31 10.8
Fundholding Consortium	44 78.6	12 21.4	56 19.6
Locality Commissioning	61 98.4	1 1.6	62 21.7
Commissioning by Practice Groups	30 85.7	5 14.3	35 12.2
Authority Wide Commissioning Groups	63 95.5	3 4.5	66 23.1
Other	28 77.8	8 22.2	36 12.6
TOTAL	**250** **87.4**	**36** **12.6**	**286** **100.0**

- Well over three quarters of health authorities reporting each type of approach considered they made an input to the prioritisation of resources.
- Only one example of locality commissioning was not considered to make an input to resource prioritisation.

TABLE 3.6: APPROACHES MAKING AN INPUT TO CONSULTATION WITH THE PUBLIC

Approach	No. and Percentages		
	Yes	No	Row Total
GP Multifund	9 29.0	22 71.0	31 10.9
Fundholding Consortium	16 28.6	40 71.4	56 19.6
Locality Commissioning	34 55.7	27 44.3	61 21.4
Commissioning by Practice Groups	19 54.3	16 45.7	35 12.3
Authority Wide Commissioning Groups	26 39.4	40 60.6	66 23.2
Other	20 55.5	16 44.4	36 12.6
TOTAL	**124** **43.5**	**161** **56.5**	**285** **100.0**

- Consultation with the public was the function to which all approaches contribute least.
- Locality commissioning groups were most likely to make an input in this area, and over half of health authorities with locality commissioning groups and commissioning by practice groups reported that they contributed to consultation with the public.

TABLE 3.7: FUNCTIONS OF COMMISSIONING APPROACHES - IMPLEMENTATION

Approach	No. / percentage undertaking the tasks of: Specification of range and activity levels of services		Specification of contract quality standards		Negotiation/ monitoring of contracts	
	No.	%	No.	%	No.	%
GP Multifund	29	93.5	29	93.5	30	96.8
Fundholding Consortium	46	82.1	49	87.5	47	83.9
Locality Commissioning	45	72.6	48	77.4	39	62.9
Commissioning by Practice Groups	24	68.6	26	74.3	19	54.3
Authority Wide Commissioning Groups	40	61.5	39	60.0	37	56.1
Other	26	72.2	28	77.8	24	66.7
TOTAL	**210**		**219**		**196**	

- The pattern of involvement in the 'implementation' tasks broadly reversed the picture with regard to strategic involvement, which is not surprising, given the purposes for which fundholding approaches were established, i.e. the operational purchasing of a defined range of health care services.

- The multifunds and fundholding consortia were more often likely to be involved in undertaking these tasks than are locality commissioning groups, commissioning groups based on practices, and authority wide commissioning groups.

TABLE 3.8: APPROACHES INVOLVED IN SPECIFYING RANGE AND ACTIVITY LEVELS OF SERVICES TO BE COMMISSIONED

Approach	No. and Percentages		
	Yes	No	Row Total
GP Multifund	29 93.5	2 6.5	31 10.9
Fundholding Consortium	46 82.1	10 17.9	56 19.6
Locality Commissioning	45 72.6	17 27.4	62 21.8
Commissioning by Practice Groups	24 68.6	11 31.4	35 12.3
Authority Wide Commissioning Groups	40 61.5	25 38.5	65 22.8
Other	26 72.2	10 27.8	36 12.6
TOTAL	**210** **73.7**	**75** **26.3**	**285** **100.0**

- Virtually all health authorities with multifunds said they specified the range and activity levels of services to be commissioned.
- This is least likely to be a function of authority wide commissioning groups, but well over half of health authorities with such groups said they were involved at this level.

TABLE 3.9: APPROACHES INVOLVED IN SPECIFYING CONTRACT QUALITY STANDARDS

Approach	No. and Percentages		
	Yes	No	Row Total
GP Multifund	29 93.5	2 6.5	31 10.9
Fundholding Consortium	49 87.5	7 12.5	56 19.6
Locality Commissioning	48 77.4	14 22.6	62 21.8
Commissioning by Practice Groups	26 74.3	9 25.7	35 12.3
Authority Wide Commissioning Groups	39 60.0	26 40.0	65 22.8
Other	28 77.8	8 22.2	36 12.6
TOTAL	**219** **76.8**	**66** **23.2**	**285** **100.0**

- The picture here was very similar to that relating to the specification of service range and activity levels, although percentages were slightly higher in most instances.

TABLE 3.10: APPROACHES INVOLVED IN NEGOTIATING AND MONITORING CONTRACTS

Approach	No. and Percentages		
	Yes	No	Row Total
GP Multifund	30 96.8	1 3.2	31 10.8
Fundholding Consortium	47 83.9	9 16.1	56 19.6
Locality Commissioning	39 62.9	23 37.1	62 21.7
Commissioning by Practice Groups	19 54.3	16 45.7	35 12.2
Authority Wide Commissioning Groups	37 56.1	29 43.9	66 23.1
Other	24 66.7	12 33.3	36 12.6
TOTAL	**196** **68.5**	**90** **31.5**	**286** **100.0**

- The overall pattern of involvement was similar to the previous two functions, but the frequency of involvement by locality commissioning groups, groups of practices involved in commissioning and authority wide groups was lower.

- In some cases those responding to this question indicated that the approach was involved in either negotiation or monitoring, but not both.

TABLE 3.11: INVOLVEMENT OF OTHERS IN COMMISSIONING APPROACHES

Approach	No. / % reporting involvement of: Other Primary Care		Trusts		Local Authority		Patients		Public		CHC		Voluntary Organisations		Health Authority	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
GP Multifund	15	51.7	1	3.3	2	6.7	5	16.7	0	0	4	13.3	1	3.3	11	35.5
Fundholding Consortium	30	54.5	5	9.1	5	8.9	9	16.7	4	7.1	9	16.4	2	3.6	29	53.7
Locality Commissioning	32	52.5	22	36.7	27	43.5	11	18.3	12	19.7	26	41.9	15	24.6	59	96.7
Commissioning by Practice Groups	15	42.9	12	36.4	10	28.6	10	28.6	8	22.9	11	32.4	3	8.6	32	94.1
Authority Wide Commissioning Group	18	27.7	4	6.3	12	18.5	2	3.1	2	3.2	5	7.8	2	3.2	64	98.5
Other	16	50.0*	16	45.7	17	47.2	12	36.4	10	28.6	15	45.5	11	31.4	31	88.6
TOTAL	**126**		**60**		**73**		**49**		**36**		**70**		**34**		**227**	

* Percentage differ because of variations in numbers of missing values.

- Fundholding consortia were most likely to involve other primary care professionals in commissioning, closely followed by locality commissioning groups and GP multifunds.

- Direct involvement of trusts was most likely to take place in the context of 'other' approaches, locality commissioning or commissioning undertaken by groups of practices.

- Local authority involvement was most often seen in the context of 'other' approaches followed by locality commissioning. It was rare in the context of multifunds or fundholding consortia.

- Patients were more likely to be involved than the public generally and in both cases this occurred most frequently in the context of 'other' approaches and commissioning based on groups of practices.

- CHCs were most likely to be involved in the context of 'other' approaches and locality commissioning.

- Voluntary organisation involvement was rare overall, but was seen in nearly one quarter of health authorities in the context of locality commissioning initiatives and in nearly one third of 'other' approaches. This reflected the inclusion of joint commissioning approaches within the latter category.

- Locality commissioning, commissioning based on groups of practices, and health authority wide groups appeared to be integrated more often with the health authority through health authority officers participating in the boards or groups administering these approaches.

- Overall, GP multifunds might be considered to have been most self-sufficient (or 'exclusive') in terms of the involvement of groups other than GPs, and those involved in primary care.

- 'Other' approaches consistently involved a range of participants.

4 Does it make a difference? Health authority perceptions of impact

The results reported in this section are based on perceptions of health authority staff interviewed (who in some instances had consulted other colleagues), rather than on NHS statistical data. Since some commissioning approaches had not long been in operation, it was not always possible for respondents to make an assessment of impact. These two factors account for the high proportion of 'not known/unclear' responses in some instances. It should be noted that 'no impact' responses included instances in which action was being undertaken in other contexts which was intended to impact on the issue concerned. Thus a 'no impact' response did not necessarily mean that no impact was being made within the health authority.

Where impacts were variable within a health authority, for example when some locality commissioning groups were considered to have had a 'very beneficial' impact, and others to have had a 'beneficial' impact, the more positive response was recorded. Percentages are based on the number of health authorities reporting that they had each approach. In this section, the first part of this section presents findings in relation to each **area of impact**, whilst in the second part of the section we present findings for each **commissioning approach**.

4.1 Area of impact

The commentary below relates to tables 4.1 - 4.11.

- The approach most often considered to have had a positive impact on **prescribing practice** was the GP multifund - 79.4% of health authorities reported such approaches to have had a beneficial or very beneficial impact.

- Over half of all health authorities reported each approach to have had a positive impact on the provision of **extended primary care services**. The approach most often identified by health authorities as having beneficial or very beneficial impacts in this area was the GP multifund.

- Multifunds were also most often identified by health authorities as having had beneficial or very beneficial impacts on **referral practice**.

- Detrimental impacts on **in-patient waiting times** were reported on one occasion each in relation to GP multifunds, fundholding consortia, locality commissioning and one 'other' approach. The approach most often identified as having had a positive impact in this area was the fundholding consortium (64.9%).

- 85% of health authorities identified locality commissioning groups as having had beneficial or very beneficial impacts on **service quality**. The approach least often identified as having had a positive impact on service quality was the GP multifund (61.7% of respondents).

- Fewer health authorities considered these approaches to commissioning to have had a positive impact on the **management of emergency admissions** than other aspects of service provision. 'No impact' was recorded in 52.9% of health authorities with multifunds, and 64.9% of health authorities with fundholding consortia. Locality commissioning groups (38.4%) and health authority wide groups (37.7%) were most often reported to have had positive impacts in this area.

- Detrimental impacts on **services for chronically mentally ill people** were identified by three health authorities reporting on GP multifunds, two health authorities reporting on fundholding consortia, one health authority reporting on locality commissioning and one on an 'other' approach.

- Health authority wide groups were most likely to have had a beneficial or very beneficial impact on services for **chronically mentally ill people** (43.4%). 41.6% of locality commissioning groups were also identified as having had positive impacts in this area.

- These two approaches were also the approaches most often reported as having positive impacts on **continuing care policy** and arrangements.

- GP multifunds were least likely to be seen by health authorities as having had an impact on their **capacity to assess needs**. 78.3% of health authorities reported locality commissioning groups as having had a beneficial or very beneficial impact in this area.

- GP multifunds and fundholding consortia were rarely considered by health authorities to have had an impact on their capacity to **consult with the public**. In this area, locality commissioning (43.4%) and 'other' approaches (38.8%) were most often reported to have had beneficial or very beneficial impacts.

- There was a generally more positive response from health authorities about the impact of commissioning approaches on their capacity to **ensure more responsive services** were provided than on other functions. Beneficial or very beneficial impacts were reported by over 70% of health authorities responding on each approach.

TABLE 4.1: IMPACT ON PRESCRIBING

Impact	Approach											
	GP Multifund		Fundholding Consortium		Locality Commissioning		Commissioning based on Groups of Practices		Health Authority Wide Group		Other	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Not known/unclear	1	2.9	7	12.3	13	21.7	13	36.1	14	20.3	10	27.8
Very beneficial	7	20.6	10	17.5	5	8.3	1	2.8	3	4.3	4	11.1
Beneficial	20	58.8	25	43.9	12	20.0	4	11.1	16	23.2	6	16.7
No impact	3	8.8	13	22.8	29	48.3	17	47.2	35	50.7	14	38.9
Detrimental	1	2.9	1	1.8	-	-	-	-	-	-	-	-
Missing value	2	5.9	1	1.8	1	1.7	1	2.8	1	1.4	2	5.5

TABLE 4.2: IMPACT ON PROVISION OF EXTENDED PRIMARY CARE SERVICES

Impact	Approach											
	GP Multifund		Fundholding Consortium		Locality Commissioning		Commissioning based on Groups of Practices		Health Authority Wide Group		Other	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Not known/unclear	0	0	5	8.8	7	11.7	10	27.8	7	10.1	6	16.7
Very beneficial	4	11.8	5	8.8	8	13.3	2	5.6	3	4.3	5	13.9
Beneficial	20	58.8	33	57.9	27	45.0	18	50.0	37	53.6	16	44.4
No impact	8	23.5	13	22.8	17	28.3	5	13.9	21	30.4	9	25.0
Detrimental	-	-	-	-	-	-	-	-	-	-	-	-
Missing value	2	5.9	1	1.8	1	1.7	1	2.8	1	1.4	-	-

TABLE 4.3: IMPACT ON REFERRAL PRACTICE

Impact	Approach											
	GP Multifund		Fundholding Consortium		Locality Commissioning		Commissioning based on Groups of Practices		Health Authority Wide Group		Other	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Not known/unclear	4	11.8	13	22.8	11	18.3	9	25.0	13	18.8	9	25.0
Very beneficial	5	14.7	9	15.8	5	8.3	11	2.8	4	5.8	3	8.3
Beneficial	19	55.9	23	40.4	25	41.7	16	44.4	29	42.0	14	38.9
No impact	4	11.8	10	17.5	18	30.0	9	25.0	22	31.9	10	27.8
Detrimental	-	-	1	1.8	-	-	-	-	-	-	-	-
Missing value	2	5.9	1	1.8	1	1.7	1	2.8	1	1.4	-	-

TABLE 4.4: IMPACT ON IN-PATIENT WAITING TIMES

Impact	Approach											
	GP Multifund		Fundholding Consortium		Locality Commissioning		Commissioning based on Groups of Practices		Health Authority Wide Group		Other	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Not known/unclear	4	11.8	2	3.5	8	13.3	10	27.8	8	11.6	8	22.2
Very beneficial	6	17.6	13	22.8	4	6.7	-	-	4	5.8	5	13.9
Beneficial	15	44.1	24	42.1	20	33.3	11	30.6	29	42.0	9	25.0
No impact	6	17.6	16	28.1	25	41.7	14	38.9	24	34.8	13	36.1
Detrimental	1	2.9	1	1.8	1	1.7	-	-	3	4.3	1	2.8
Missing value	2	5.9	1	1.8	2	3.4	1	2.8	1	1.4	-	-

TABLE 4.5: IMPACT ON SERVICE QUALITY

Impact	Approach											
	GP Multifund		Fundholding Consortium		Locality Commissioning		Commissioning based on Groups of Practices		Health Authority Wide Group		Other	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Not known/unclear	6	17.6	8	14.0	4	6.7	8	22.2	7	10.1	7	19.4
Very beneficial	3	8.8	9	15.8	9	15.0	2	5.6	4	5.8	5	13.9
Beneficial	18	52.9	30	52.6	42	70.0	21	58.3	42	60..9	20	55.5
No impact	5	14.7	9	15.8	4	6.7	4	11.1	14	20.3	3	8.3
Detrimental	-	-	-	-	-	-	-	-	1	1.4	1	2.8
Missing value	2	5.9	1	1.8	1	1.7	1	2.8	1	1.4		

TABLE 4.6: IMPACT ON THE MANAGEMENT OF EMERGENCY ADMISSIONS

Impact	Approach											
	GP Multifund		Fundholding Consortium		Locality Commissioning		Commissioning based on Groups of Practices		Health Authority Wide Group		Other	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Not known/unclear	8	23.5	8	14.0	13	21.7	12	33.3	13	18.8	11	30.5
Very beneficial	1	2.9	1	1.8	4	6.7	-	-	4	5.8	2	5.5
Beneficial	4	11.8	9	15.8	19	31.7	7	19.4	22	31.9	8	22.2
No impact	18	52.9	37	64.9	23	38.3	16	44.4	29	42.0	13	36.1
Detrimental	1	2.9	1	1.8	-	-	-	-	-	-	2	5.5
Missing value	2	5.9	1	1.8	1	1.7	1	2.8	1	1.4	-	-

TABLE 4.7: IMPACT ON SERVICES FOR CHRONICALLY MENTALLY ILL PEOPLE

Impact	Approach											
	GP Multifund		Fundholding Consortium		Locality Commissioning		Commissioning based on Groups of Practices		Health Authority Wide Group		Other	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Not known/unclear	5	14.7	8	14.0	6	10.0	10	27.8	9	13.0	9	25.0
Very beneficial	1	2.9	2	3.5	5	8.3	3	8.3	7	10.1	-	-
Beneficial	4	11.8	6	10.5	20	33.3	9	25.0	23	33.3	3	8.3
No impact	19	55.9	38	66.7	27	45.0	13	36.1	29	42.0	23	63.9
Detrimental	3	8.8	2	3.5	1	1.7	-	-	-	-	1	2.8
Missing value	2	5.9	1	1.8	1	1.7	1	2.8	1	1.4	-	-

TABLE 4.8: IMPACT ON CONTINUING CARE POLICY AND ARRANGEMENTS

Impact	Approach											
	GP Multifund		Fundholding Consortium		Locality Commissioning		Commissioning based on Groups of Practices		Health Authority Wide Group		Other	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Not known/unclear	16	17.6	10	17.5	10	16.7	11	30.6	9	13.0	8	22.2
Very beneficial	-	-	1	1.8	2	3.3	1	2.8	4	5.8	6	16.7
Beneficial	3	8.8	8	14.0	19	31.7	5	13.9	26	37.7	6	16.7
No impact	22	64.7	37	64.9	28	46.7	18	50.0	29	42.0	16	44.4
Detrimental	1	2.9	-	-	-	-	-	-	-	-	-	-
Missing value	2	5.9	1	1.8	1	1.7	1	2.8	1	1.4	-	-

TABLE 4.9: IMPACT ON THE HEALTH AUTHORITY'S CAPACITY TO ASSESS NEEDS

Impact	Approach											
	GP Multifund		Fundholding Consortium		Locality Commissioning		Commissioning based on Groups of Practices		Health Authority Wide Group		Other	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Not known/unclear	6	17.6	6	10.5	4	6.7	6	16.7	7	10.1	3	8.3
Very beneficial	1	2.9	1	1.8	8	13.3	3	8.3	8	11.6	6	16.7
Beneficial	9	26.5	21	36.8	39	65.0	21	58.3	34	49.3	20	55.5
No impact	16	47.1	27	47.4	7	11.7	5	13.9	19	27.5	7	19.4
Detrimental	-	-	1	1.8	1	1.7	-	-	-	-	-	-
Missing value	2	5.9	1	1.8	1	1.7	1	2.8	1	1.4	-	-

TABLE 4.10: IMPACT ON THE HEALTH AUTHORITY'S CAPACITY TO CONSULT WITH THE PUBLIC

Impact	Approach											
	GP Multifund		Fundholding Consortium		Locality Commissioning		Commissioning based on Groups of Practices		Health Authority Wide Group		Other	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Not known/unclear	2	5.9	5	8.8	5	8.3	6	16.7	11	15.9	18	50.0
Very beneficial	-	-	2	3.5	10	16.7	2	5.6	3	4.3	7	19.4
Beneficial	4	11.8	6	10.5	16	26.7	11	30.6	15	21.7	7	19.4
No impact	24	70.6	42	73.7	28	46.7	16	44.4	39	56.5	4	11.1
Detrimental	2	5.9	1	1.8	-	-	-	-	-	-	-	-
Missing value	2	5.9	1	1.8	1	1.7	1	2.8	1	1.4	-	-

TABLE 4.11: IMPACT ON THE HEALTH AUTHORITY'S CAPACITY TO ENSURE MORE RESPONSIVE SERVICES ARE PROVIDED

Impact	Approach											
	GP Multifund		Fundholding Consortium		Locality Commissioning		Commissioning based on Groups of Practices		Health Authority Wide Group		Other	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Not known/unclear	-	-	2	3.5	5	8.3	6	16.7	8	11.6	5	13.9
Very beneficial	3	8.8	5	8.8	7	11.7	9	25.0	12	17.4	9	25.0
Beneficial	23	67.6	40	70.2	45	75.0	19	52.8	42	60.9	18	50.0
No impact	6	17.6	8	14.0	2	3.3	1	2.8	6	8.7	2	5.5
Detrimental	-	-	1	1.8	-	-	-	-	-	-	1	2.8
Missing value	2	5.9	1	1.8	1	1.7	1	2.8	1	1.4	2	5.5

4.2 Findings for each commissioning approach

In this section we report on the views expressed by health authorities about the impact the various approaches to commissioning had upon service areas. These service areas relate to primary care, trust based services and health authority based services. The following tables (4.13-4.17) examine the impact of each approach to commissioning in turn.

TABLE 4.13: IMPACT MADE BY GP MULTIFUNDS

Service Area	No. and Percentages				
	Very Beneficial	Beneficial	No Impact	Detrimental	Very Detrimental
Primary Care					
Impact on Prescribing	7	20	3	1	0
	21.9	62.5	9.4	3.1	0
Extended Primary Care Services	5	20	8	0	0
	12.5	62.5	25.0	0	0
Referral Practice	5	19	4	0	0
	15.6	59.4	12.5	0	0
Trust Based Services					
In Patient Waiting Times	6	15	6	1	0
	18.8	46.9	18.8	3.1	0
Service Quality	3	18	5	0	0
	9.4	56.3	15.6	0	0
Management of Emergency Admissions	1	4	18	1	0
	3.1	12.5	56.3	3.1	0
Chronically Mentally Ill Services	1	4	19	3	0
	3.1	12.5	59.4	9.4	0
Continuing Care	0	3	22	1	0
	0	9.4	68.8	3.1	0
HA Based Services					
Assess Needs	1	9	16	0	0
	3.1	28.1	50.0	0	0
Consult With Public	4	0	24	2	0
	12.5	0	75.0	6.3	0
Provision of More Responsive Services	3	23	6	0	0
	9.4	71.9	18.8	0	0

(Percentages do not add up to 100% because unknown/unclear responses and missing values have not been included)

- Over three quarters of health authorities reported that multifunds had made a beneficial or very beneficial impact on primary care service areas.

- More than half the health authorities reported that multifunds had made no impact on the management of emergency admissions, services for the chronically mentally ill and continuing care. Furthermore, 3-9% of these health authorities reported that multifunds had had a detrimental effect on these service areas.

- Whilst the majority of health authorities felt that multifunds did not contribute to the assessment of needs or consultation with the public, they did make a beneficial contribution to the provision of more responsive services.

TABLE 4.14: IMPACT MADE BY FUNDHOLDING CONSORTIA

Service Area	No. and Percentages				
	Very Beneficial	Beneficial	No Impact	Detrimental	Very Detrimental
Primary Care					
Impact on Prescribing	10	25	13	1	0
	17.9	44.6	23.2	1.8	0
Extended Primary Care Services	5	33	13	0	0
	8.9	58.9	23.2	0	0
Referral Practice	9	23	10	1	0
	16.1	41.1	17.9	1.8	0
Trust Based Services					
In Patient Waiting Times	13	24	16	1	0
	23.2	42.9	28.6	1.8	0
Service Quality	9	30	9	0	0
	16.1	53.6	16.1	0	0
Management of Emergency Admissions	1	9	37	1	0
	1.8	16.1	66.1	1.8	0
Chronically Mentally Ill Services	2	6	38	2	0
	3.6	10.7	67.9	3.6	0
Continuing Care	1	8	37	0	0
	1.8	14.3	66.1	0	0
HA Based Services					
Assess Needs	1	21	27	1	0
	1.8	37.5	48.2	1.8	0
Consult With Public	2	6	42	1	0
	3.6	10.7	75.0	1.8	0
Provision of More Responsive Services	5	40	8	1	0
	8.9	71.4	14.3	1.8	0

(Percentages do not add up to 100% because unknown/unclear responses and missing values have not been included)

- Over half the health authorities reported that fundholding consortia made a beneficial impact on service quality, extended primary care services, in-patient waiting times, referral and prescribing practices.
- Two thirds of health authorities reported that fundholding consortia (like GP multifunds) made no impact on the management of emergency admissions, services for the chronically mentally ill and continuing care.
- Health authorities reported that fundholding consortia rarely had a detrimental effect on service areas.
- Whilst the majority of health authorities felt that fundholding consortia (like multifunds) did not contribute to the assessment of needs or consultation with the public, they were seen as making a beneficial contribution to the provision of more responsive services.

TABLE 4.15: IMPACT MADE BY LOCALITY COMMISSIONING

Service Area	No. and Percentages				
	Very Beneficial	Beneficial	No Impact	Detrimental	Very Detrimental
Primary Care	5	12	29	0	0
Impact on Prescribing	8.5	20.3	49.2	0	0
Extended Primary Care Services	8	27	17	0	0
	13.6	45.8	28.8	0	0
Referral Practice	5	25	18	0	0
	8.5	42.4	30.5	0	0
Trust Based Services					
In Patient Waiting Times	4	20	25	1	0
	6.8	33.9	42.4	1.7	0
Service Quality	9	42	4	0	0
	15.3	71.2	6.8	0	0
Management of Emergency Admissions	4	19	23	0	0
	6.8	32.2	39.0	0	0
Chronically Mentally Ill Services	5	20	27	1	0
	8.5	33.9	45.8	1.7	0
Continuing Care	2	19	28	0	0
	3.4	32.2	47.5	0	0
HA Based Services					
Assess Needs	8	39	7	1	0
	13.6	66.1	11.9	1.7	0
Consult With Public	10	16	28	0	0
	16.9	27.1	47.5	0	0
Provision of More Responsive Services	7	45	2	0	0
	11.9	76.3	3.4	0	0

(Percentages do not add up to 100% because unknown/unclear responses and missing values have not been included)

- Over three quarters of health authorities reported that locality commissioning groups had made a beneficial or very beneficial impact on service quality, assessing needs and the provision of more responsive services. Over half the health authorities reported a similar impact on the provision of extended primary care services and referral practices.

- Just under half the health authorities felt that locality commissioning groups made no impact on prescribing patterns, continuing care, in-patient waiting times, and services for the chronically mentally ill.

- While 44% of the health authorities reported locality commissioning groups made a beneficial or a very beneficial impact in consulting with the public, 47.5% of health authorities felt they made no impact at all.

TABLE 4.16: IMPACT MADE BY PRACTICE BASED COMMISSIONING GROUPS

Service Area	No. and Percentages				
	Very Beneficial	Beneficial	No Impact	Detrimental	Very Detrimental
Primary Care					
Impact on Prescribing	1 2.9	4 11.4	17 48.6	0 0	0 0
Extended Primary Care Services	2 5.7	18 51.4	5 14.3	0 0	0 0
Referral Practice	1 2.9	16 45.7	9 25.7	0 0	0 0
Trust Based Services					
In Patient Waiting Times	0 0	11 31.4	14 40.0	0 0	0 0
Service Quality	2 5.7	21 60.0	4 11.4	0 0	0 0
Management of Emergency Admissions	0 0	7 20.0	16 45.7	0 0	0 0
Chronically Mentally Ill Services	3 8.6	10 25.7	13 37.1	0 0	0 0
Continuing Care	1 2.9	6 14.3	18 51.4	0 0	0 0
HA Based Services					
Assess Needs	3 8.6	21 60.0	5 14.3	0 0	0 0
Consult With Public	2 5.7	11 31.4	16 45.7	0 0	0 0
Provision of More Responsive Services	9 25.7	19 54.3	1 2.9	0 0	0 0

(Percentages do not add up to 100% because unknown/unclear responses and missing values have not been included)

- The majority of health authorities felt that practice based commissioning groups made a beneficial or very beneficial impact on the provision of more responsive services, assessing health needs, service quality and extended primary care services.

- Just under half the health authorities considered that practice based commissioning groups made no impact on prescribing practices (unlike fundholding consortia and multifunds), management of emergency admissions and inpatient waiting times.

- Just over half the health authorities felt that practice based commissioning groups made no impact on continuing care.

TABLE 4.17: IMPACT MADE BY AUTHORITY WIDE COMMISSIONING GROUPS

Service Area	No. and Percentages				
	Very Beneficial	Beneficial	No Impact	Detrimental	Very Detrimental
Primary Care					
Impact on Prescribing	3 4.4	16 23.5	35 51.5	0 0	0 0
Extended Primary Care Services	3 4.4	37 54.4	21 30.9	0 0	0 0
Referral Practice	4 5.9	29 42.6	22 32.4	0 0	0 0
Trust Based Services					
In Patient Waiting Times	4 5.9	29 42.6	24 35.3	3 4.4	0 0
Service Quality	4 5.9	42 61.8	14 20.6	1 1.5	0 0
Management of Emergency Admissions	4 5.9	22 32.4	29 42.6	0 0	0 0
Chronically Mentally Ill Services	7 10.3	23 33.8	29 42.6	0 0	0 0
Continuing Care	4 5.9	26 38.2	29 42.6	0 0	0 0
HA Based Services					
Assess Needs	8 11.8	34 50.0	19 27.9	0 0	0 0
Consult With Public	3 4.4	15 22.1	39 57.4	0 0	0 0
Provision of More Responsive Services	12 17.6	42 61.8	6 8.8	0 0	0 0

(Percentages do not add up to 100% because unknown/unclear responses and missing values have not been included)

- With the exception of service quality, between 31% and 50% of all health authorities felt authority wide commissioning groups had made no impact on primary care or trust based services.
- A majority of health authorities reported that whilst authority wide groups had made a beneficial or very beneficial impact on assessing needs and the provision of more responsive services but they had made no impact on consulting with the public.

4.3 Does having a budget make a difference?

While, by definition, GP multifunds and fundholding consortia have either budgets or can influence the way in which individual fundholders behave, other approaches may input to commissioning without having direct responsibility for budget. Thus we looked at locality commissioning and commissioning by groups of practices to consider whether they were operating with delegated budgets, and if so whether there was evidence of any difference in perceived impacts.

TABLE 4.18: LOCALITIES, PRACTICE GROUPS AND BUDGETS

BUDGET	Locality Commissioning	Commissioning by Practice Groups
Actual	9	2
Notional	13	8
None	35	25

In view of the very small number of examples of commissioning practice groups holding a budget, detailed analysis is not really feasible. The following table (table 4.19) sets out findings from this analysis in relation to locality commissioning, but once again results should be treated with caution because apparently large percentage differences may refer in practice to only 1 or 2 cases.

In most instances, having a budget is more likely to be associated with beneficial impacts. However, having a budget does not necessarily mean that health authorities perceive locality commissioning to have had an impact. It is important to remember our previous comment to the effect that some health authorities reported that action to address the impact areas surveyed was taking place in contexts other than those we were investigating.

TABLE 4.19: LOCALITY COMMISSIONING: HEALTH AUTHORITIES REPORTING IMPACT BY BUDGET (PERCENTAGE)

Impact Area	Not known/unclear			Beneficial/very beneficial			No impact			Detrimental		
	Actual budget	Notional budget	No budget	Actual budget	Notional budget	No budget	Actual budget	Notional budget	No budget	Actual budget	Notional budget	No budget
Prescribing	-	15.4	30.3	55.5	30.8	24.2	44.4	56.8	42.4	-	-	-
Provision of Extended Primary Care Services	-	-	18.2	88.9	69.3	42.5	11.1	30.8	36.4	-	-	-
Referral Practice	22.2	15.4	18.2	66.7	61.6	36.4	11.1	23.1	42.4	-	-	-
In-patient Waiting Times	-	15.4	15.2	55.5	46.2	27.2	44.4	38.5	48.5	-	-	3.0
Service Quality	11.1	-	6.1	88.9	92.3	81.8	-	7.7	9.1	-	-	-
Management of Emergency Admissions	11.1	15.4	27.3	66.6	46.2	30.3	22.2	38.5	39.4	-	-	-
Services for Chronically Mentally Ill People	11.1	7.7	9.1	33.3	46.2	45.4	55.6	46.2	39.4	-	-	3.0
Continuing Care Policy and Arrangements	-	23.1	18.2	44.4	30.8	33.3	55.6	46.2	45.5	-	-	-

4.4 Has the development of different commissioning approaches had any impact on health authority structures?

Finally, we asked whether health authority organisational structures had been altered consequent upon the development of different approaches to commissioning. The responses are summarised in table 4.20. From this summary, it appears that locality commissioning (80%), and practice based commissioning (61.3%), had had a greater impact than the other approaches. Furthermore, representatives from the locality commissioning groups were often members of authority wide commissioning groups, which again reinforced the closer inter-connection between health authorities and locality commissioning.

TABLE 4.20: NUMBER OF HEALTH AUTHORITIES WHOSE ORGANISATIONAL STRUCTURES HAVE BEEN ALTERED CONSEQUENT UPON THE DEVELOPMENT OF COMMISSIONING APPROACHES

Groups Involved	HAs reporting change in structure	
	No.	%
GP Multifund	34	18.2
Fundholding Consortium	57	25
Locality Commissioning	60	80
Commissioning by Practice Groups	36	61.3
Authority Wide Commissioning Groups	69	46.2
Other	Information not available	

(Percentages do not add up to 100% because unknown/unclear responses and missing values have not been included)

5 Summary of key findings

Our survey has demonstrated that a wide variety of approaches to GP commissioning were in existence in the NHS inherited by the Labour government in 1997. Excluding total purchasing and the main variants of fundholding, which were not included in the study, the research team identified multifunds, fundholding consortia, locality commissioning, commissioning based on groups of practices, and health authority wide commissioning groups. In addition, respondents to the survey reported a range of other approaches. These included joint commissioning, commissioning focused on a client group or specialty, and a variety of area based approaches. The number of types was difficult to quantify precisely but is considerably greater than the five principal categories used at the outset of the survey.

The maps of commissioning that emerged from the survey testified to the vitality of commissioning pluralism in the NHS of 1997. There were variations both within and between the eight English regions in the number and type of approaches that had been adopted. The most common arrangement was for there to be three approaches. As far as types of approaches are concerned, health authority wide groups were most frequently mentioned by respondents followed by locality commissioning. The mosaic of primary care led commissioning identified in an earlier study (Smith et al, 1997)[6] is therefore more extensive in its pattern and detail than originally described.

The variety that exists reflects the history of commissioning in different districts and inevitable variations in local circumstances. It demonstrates that health authorities and GPs had taken the original models of commissioning outlined in Working for Patients (Department of Health, 1989)[7] and adapted these models in ways they had felt to be appropriate. As a consequence, not only was there variation between health authorities in the number and mixture of approaches, but also there was variation within authorities. Particularly in the larger authorities, this could mean that several approaches co-existed, with some being more salient in some localities, and others more salient in others.

Commissioning has developed progressively since 1991 and it continues to evolve. Our survey took a snapshot in time of a rapidly moving picture. As such, it represents merely one in a series of stages of development. Respondents to the survey repeatedly gave examples of how local arrangements were in the process of further change and emphasised the importance of the then impending NHS White Paper. As an example, while at the time of the survey locality commissioning, commissioning by groups of practices and health authority wide groups typically operated without a budget, there were plans in many health authorities to establish either actual or notional budgets to consolidate existing approaches. In view of this, and the fact that some health authorities had been quicker off the mark than others in developing commissioning, it was possible that some of the variations in impact reported in this survey reflected different stages of development in approaches to commissioning.

Turning to the detail of the survey, the results demonstrate that all approaches contributed to the strategic elements of commissioning and implementation. However, there were differences of emphasis between approaches which affected their perceived impact in different areas. In overall terms, health authorities reported that locality commissioning, commissioning based on groups of practices and health authority wide groups were more likely to be involved in strategic functions such as health needs assessment, service planning, resource prioritisation and consultation with the public than multifunds or fundholding consortia. This pattern was reversed on implementation, with health authorities reporting that multifunds and fundholding consortia were more likely to be involved in functions such as contract negotiation and monitoring. Consultation with the public was the function to which all approaches made least contribution, although a majority of health authorities reported that locality commissioning, commissioning based on groups of practices, and 'other' approaches were involved with this.

A varied picture emerged when health authorities were asked about the involvement of others in different commissioning approaches. Health authorities themselves were more likely than not to be involved in all approaches apart from multifunds. This applied especially to health authority wide commissioning groups, locality commissioning and commissioning based on groups of practices. Other primary care

professionals were also reported more likely than not to be involved in all approaches, except for commissioning by groups of practices and health authority wide groups. Patient, public and voluntary organisation involvement was more limited than for health authorities and primary care staff in all approaches, but was most likely to occur in 'other' approaches, locality commissioning and commissioning by groups of practices. The data presented in this survey indicate that multifunds appeared to be least likely to include others in commissioning, while locality commissioning, commissioning by groups of practices and 'other' approaches were most likely to include others. The inclusiveness of 'other' approaches may have reflected the presence of joint commissioning in this category.

Responses to questions on the impact of different approaches revealed a particularly complex picture. Both multifunds and fundholding consortia were reported to have had a greater impact on prescribing, the provision of extended primary care services, referral practice, and inpatient waiting times than other approaches. By contrast, locality commissioning, commissioning based on groups of practices and health authority wide groups had had a greater impact on services for chronically mentally ill people and continuing care policy and arrangements than had multifunds and fundholding consortia. We noted however that the proportion of health authorities reporting beneficial impact in these areas was consistently lower than in relation to primary care, referrals and inpatient waiting times. All approaches were more likely than not to impact beneficially on service quality.

The impact of particular approaches did, however, vary within each of the main areas of investigation. For example, locality commissioning, commissioning by groups of practices and health authority wide groups had had a greater impact on the provision of extended primary care services, referrals to secondary care and service quality than on prescribing and waiting times. All approaches had had limited impact on emergency admissions, although around one third of health authorities reported health authority wide groups as having had a beneficial impact in this area, and one fifth of health authorities reported commissioning based on groups of practices and 'other' approaches as having had a beneficial impact. These approaches together with locality commissioning were also more likely than not to have had a beneficial impact on health

authorities' capacity to assess needs, in contrast to multifunds and fundholding consortia where it was reported that they were more likely than not to have had no impact. All approaches had had limited impact on health authorities' capacity to consult the public, although again locality commissioning, commissioning by groups of practices and health authority wide groups were more often reported to have had a beneficial impact in this area than multifunds or fundholding consortia. By contrast, all approaches had had a beneficial impact on health authorities' capacity to ensure that more responsive services were provided. This suggested that GP commissioning, whatever form it might have taken, had enhanced responsiveness within the NHS.

The Government has now set out its proposals for a way forward (Department of Health, 1997)[8] which enables there to be flexibility in different districts without this undermining the government's commitment to promote equity and reduce transaction costs. The proposed primary care groups (PCGs) are intended to rationalise current arrangements over time while avoiding the temptation to adopt a single solution for the NHS as a whole. Groups are offered a 'menu' of four levels of PCGs, each of which attracts a different degree of commissioning responsibility. All groups are to commission within the local health improvement programme, be accountable to the health authority, and operate within the new NHS 'duty of partnership' with other NHS and related organisations. In taking this approach, the government has recognised the need to combine a population centred and patient focused approach to commissioning. It has also accepted that the principle of GP commissioning (whatever form it may take) is now firmly embedded within the NHS.

Given the White paper proposals for the 'New NHS', ways have to be found of extending current approaches to GPs and others who have had little or no involvement and ensuring that the organisation of commissioning will help in delivering the government's objectives for the NHS. Our findings suggest that the more ambitious and wide ranging the government's policy agenda, then the more important it is to have available a range of levers to deliver improvements in performance. This is because no single approach performs consistently well in relation to all areas of service provision investigated in this survey. Recognising that the language is changing, some of these levers are evolving from the powers previously available to fundholders (such

as devolved budgets and the ability to vire resources within unified budgets), while others are building on the foundations established by locality commissioning, commissioning based on groups of practices and health authority wide groups (particularly their ability to engage significant others in commissioning, and to contribute to strategic commissioning). Linked to this, future commissioning arrangements via primary care groups and trusts need to build in scope for different functions to be performed at different 'levels' (such as the practice, the locality, the PCG, the supra-PCG and the health authority). As this happens, a delicate balance will have to be struck between allowing flexibility and variety on the one hand and ensuring consistency with national and local policies and standards on the other. This in turn has a bearing on the population to be served by PCGs in the light of research indicating that total purchasing pilots serving smaller populations appear to be more effective than those serving larger populations and (Mays et al, 1998)[9]. The establishment of 'groups within PCGs' may enable the circle to be squared, although at the risk of maintaining high levels of management costs and organisational complexity. As these observations indicate, there are inescapable trade-offs in the design of health policy. On the basis of our research over a number of years, the main challenges in making the arrangements are as follows:

- Extending involvement beyond a small number of enthusiastic GPs, seeking to engage doctors as a whole, along with other health professionals within primary care teams.
- Finding ways of involving patients and local people in the decision making processes of the groups and accounting to the local population for the work carried out and services delivered.
- Developing true partnership arrangements which enable the active engagement of agencies such as social services, local authorities, community health councils and NHS trusts in the work of PCGs.
- Supporting PCGs with an appropriate investment in management skills and reimbursing GPs for the time they give to management.
- Developing an equitable formula for the allocation of resources to PCGs and within PCGs and to ensure that budgets are based on need.

- Putting in place arrangements for managing risk to avoid budgets being blown off course by variations in demand and utilisation which are difficult to predict.
- Ensuring that commissioning within a health improvement programme leads to a greater consistency in the areas addressed by groups, and in particular that 'thorny' services such as mental health services, emergency admissions and continuing care receive appropriate attention.
- Developing mechanisms within PCGs for the development and management of primary care provision, drawing on the experience of multifunds, total purchasing projects and other approaches which addressed these issues within their commissioning activity.

The options for the future organisational arrangements may be more clearly defined than their fundholding and non-fundholding predecessors, but the map is likely to continue to vary in its topography, given the inevitable requirement for locally appropriate solutions. Indeed, the mosaic of primary care led commissioning is likely to prove to be clearer in its definition and pattern. The extent of variation of its colour and detail is however yet to be revealed.

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APPENDICES

1 Regional perspectives on commissioning

2 Survey questionnaire

3 Definitions

All interviewees referred to action by the regional office to support the development of new approaches to commissioning, but there was evidence of difference in the extent to which this was seen as supporting or leading. Most described a 'hands off' approach or one which was intended to be supportive to local initiatives through hosting workshops and seminars, or through enabling networks to be created rather than attempting to push any one commissioning approach. However, Anglia and Oxford was described by another region as having a template against which they judge approaches and the interview with the Anglia and Oxford primary care lead identified a number of specific issues of concern with which the regional office saw itself as being able to help. This included issues such as:

- What should be the structure for localities and how are localities resourced from the health authority?
- How do GPs develop a consensus in decision making?
- How do localities develop the wider health agenda and work with all agencies?
- How do localities achieve a strategic view at local level?
- How is public accountability achieved at local level?

The regional office has been involved (following requests from health authorities) in responding to these issues. For example, they have provided management training for GPs, and sought to influence national policy to ensure a more planned approach whilst maintaining local flexibility.

In response to the question about performance management across different models, one regional office talked about carrying out a risk assessment. There was some concern from the finance director about losing control and appropriate accountability. Another reported sharing intelligence and spreading good practice in this context, whilst another referred to the setting of minimum standards for both the provision and commissioning of primary care. This regional respondent did not consider it feasible to manage through 30 different commissioning groups and thus managed performance through the health authority rather than commissioning groups. However, another respondent discussed the difficulties experienced working with three geographical patches and referred to a considerable amount of 'firefighting' on issues such as finance and the Patient's Charter. Once again, there was little evidence of consistency in the way in which different regional offices were managing performance across authorities and commissioning groups.

Respondents identified the following features which they considered vital for an effective commissioning approach:

- clearly defined accountability: both upward to the health authority and downward to local people.

- setting objectives and evaluating performance in response to those objectives with objectives being shared between the health authority and GPs.

- a group of GPs who genuinely wish to influence commissioning and improve practice.

- a responsive and supportive health authority working with rather than in opposition to GPs.

- commissioning groups must be real entities capable of making decisions.

- commissioning groups must have a proper structure and formal mechanisms.

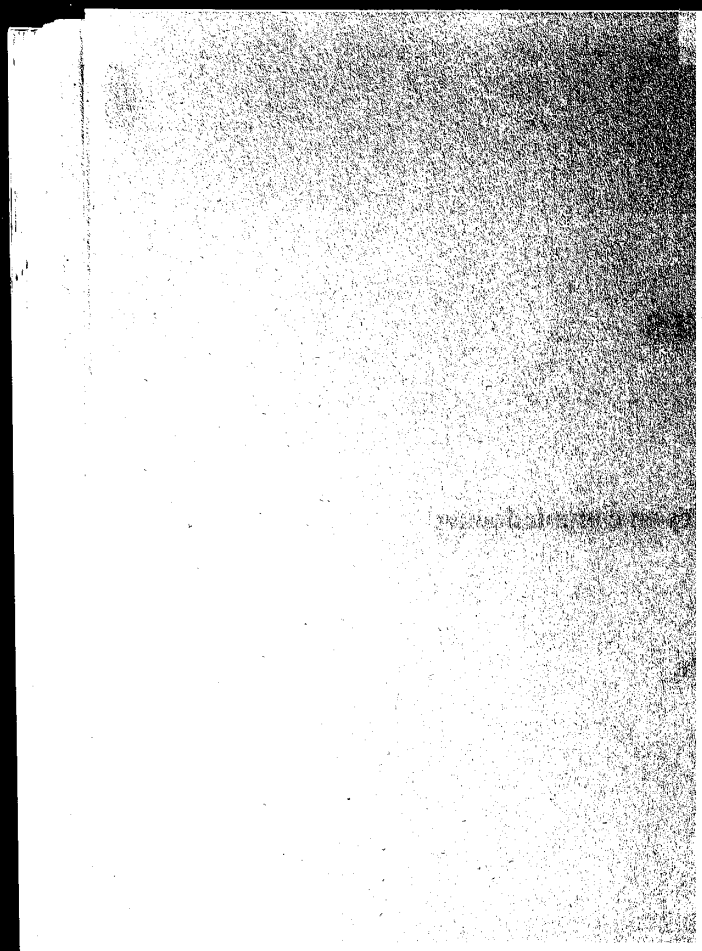
- commissioning groups must have real budgetary responsibilities, although the commissioning of specialist services should probably remain at health authority level.

- commissioning should include a public health responsibility.

- representativeness is crucial (although it was recognised that this could mean many things: the profession, the population, the locality).

- commissioning should not involve imposing ways of working on groups which are alien to them.

Such views were reflected in responses to the question of how regions would want to see commissioning look in three years time. Most respondents talked about addressing the problems and weakness evident in the current system rather than coming up with one blueprint for how things should look. There was a concern that commissioning should reflect what people want at a local level and there should not be a universal requirement for all GPs to be involved in something which



Appendix 1

REGIONAL PERSPECTIVES ON COMMISSIONING

Interviews were conducted with the regional primary care leads in order to obtain an overview of commissioning from a regional perspective. Interviewees were asked about: the range of approaches within their region and any particular example which stood out for them, the extent to which the regional office was involved in developing approaches to commissioning, and how they were relating to the different commissioning approaches. They were also asked which approaches they considered to be most effective and what they considered to be the vital features of commissioning approaches. Finally they were asked how they would like primary care led commissioning to look in 3 years time.

The regional perspective confirms the sense of diversity and difference which emerges from the survey. There is an awareness of substantial difference, not only in the models being applied, but also the degree of development both within and across models. Similarly, the level of power and influence of different groups involved in commissioning is seen to be varied with some described as little more than 'talking shops', whilst others are seen to have had a substantial role in bringing about change. North West and South West identified locality commissioning as the predominant approach within their regions, whilst Trent also suggested that many GPs and health authorities saw locality commissioning as the way forward.

The pattern of commissioning within regions is seen as being influenced by historical factors: particularly by the way in which and enthusiasm with which fundholding had been embraced. In some regions there are specific approaches which stand out: either health authorities which have taken a particular stance, or specific examples of approaches within health authorities. Thus one example was of a health authority which had devolved budgets to GPs and made them accountable for these, another was of a health authority which had developed a locality structure with locality representation on the health authority executive, and a third referred to the importance of work by health authorities in deprived areas where enormous strides had been made from a very low base. Once again though responses reinforced the picture of diversity: examples of approaches which in some way 'stood out' included TPPs, multifunds and locality commissioning.

they did not want to be engaged in. Only one spoke of a particular model which he felt should be the way forward. He hoped that commissioning would be based around natural communities. All primary care practitioners should be involved and so should the public. There should be public health involvement. Budgets based on capitation would be at the disposal of the localities, although specialist services should be commissioned at health authority level. Commissioning should include joint commissioning with social services. However, this did not imply that there was only one way of achieving this. A standard model could not be applied across diverse communities, and thus the key factor was seen as to work with and in different communities in ways that are appropriate to local circumstances.

Appendix 2 - Survey questionnaire

Health Services Management Centre

Mapping approaches to commissioning

Region: _____

Health authority: _____

Interviewee name: _____

Interviewee job title: _____

Contact numbers:

Tel: _____

Fax: _____

Date of interview: _____

Interviewer: _____

1f What is the range of population covered by a health authority defined commissioning unit? (ie. highest and lowest)

.....

1g) Are there any other units or groupings on which commissioning is based?

Yes ☐

No ☐

If yes what are they? .....

.....

.....

How many are there of these other units? .....

.....

.....

1h) Do any of these units coincide with other service organisation areas? (eg. social services)

Yes-health authority defined units ☐

Yes-other units ☐

No ☐

If yes, which are they? (please specify) .....

.....

.....

We have a number of questions (sections 3 and 4) we want to ask you about each of the approaches to commissioning in your health authority as defined in section 2. Please complete these sections for each separate approach and clearly indicate the name of the health authority and the approach on each sheet.

3) Functions of the approaches to commissioning

Name of health authority: .....

Name of approach: .....

3a) Does the approach have a budget, either notional or actual, linked to it?

Yes ☐ **actual**

Yes ☐ **notional**

No ☐ If no, go to question 3e)

If notional, are there any plans to move to actual? .....

.....

If yes, does the budget cover all HCHS?

Yes ☐

No ☐

If no, what services are excluded from the budget? (please specify)

.....

.....

3b) On what basis is the budget of the approach set?

Capitation ☐

Historic ☐

Mix ☐

Other ☐ Please specify .....

.....

.....

3c) Does the budget include non-NHS services?

Yes ☐

No ☐

If yes, what are these services? .....

.....

3d) Who should we contact if we want more information on how the budget(s) were set?

Name: .....

Position: .....

Telephone N°: .....

3e) From the health authority's perspective does this approach make an input to the following tasks?

Strategy formulation

Health needs assessment	**Yes**	☐	**No**	☐
Service planning	**Yes**	☐	**No**	☐
Prioritisation of resources	**Yes**	☐	**No**	☐
Consultation with the public	**Yes**	☐	**No**	☐

3f) Does this approach perform the following tasks?

Implementation

Specification of range and activity levels of services to be commissioned	**Yes**	☐	**No**	☐
Specification of contract quality standards	**Yes**	☐	**No**	☐
Negotiation and monitoring of contracts	**Yes**	☐	**No**	☐

3g) Does this approach to commissioning perform any other functions?

Yes ☐

No ☐

If yes, please indicate: .....

.....

.....

.....

.....

For each commissioning approach, please answer the questions in section 4, using a separate sheet for each approach.

4) Involvement in commissioning approach

Name of health authority: .....

Name of approach: .....

4a) Are primary care service deliverers, other than GPs involved in the approach?

Yes ☐

No ☐

If yes, who? .....

.....

.....

4b) Are people working within local trusts participants in the group/board which administers this approach?

Yes ☐

No ☐

If yes, is this trust :-

acute ☐

community ☐

acute/community combined ☐

other(please specify) .....

4c) Are local authorities involved in this approach?

Yes ☐

No ☐

If yes, who? (please specify).....

.....

4d) Are patients of the relevant practice(s) involved in the approach?

Yes ☐

No ☐

If yes, how are they involved? .....

.....

.....

4e) Are people living in the local area involved in the approach?

Yes ☐

No ☐

If yes, how are they involved? .....

.....

.....

4f) Is the local community health council involved in the approach?

Yes ☐

No ☐

If yes, how are they involved? .....

.....

.....

4g) Are voluntary organisations involved in the approach?

Yes ☐

No ☐

If yes, how are they involved?.....

.....

.....

4h) Does the health authority have officers who participate in the group/board which administers this approach?

Yes ☐

No ☐

If yes, who?.....

.....

.....

4i) If the approach is locality commissioning, are all GP practices within the locality(ies) covered by the locality commissioning group(s)?

Yes ☐

No ☐

If no, how are services commissioned for patients of these 'uncovered' practices.

Please answer sections 5 and 6 in relation to all approaches (ie. One sheet for the total number of approaches in your authority).

5) Impact of the approaches to commissioning

5a) From your health authority perspective, do you have evidence of impact on patient services of these approaches to commissioning? For each of the following service areas, please make an assessment of the impact made by the commissioning approaches.

Use the following scale when noting impact:

0 Not known/unclear
1 Very beneficial
2 Beneficial
3 No impact
4 Detrimental
5 Very detrimental

Service area	GP multifund	FH consortium	Locality comm[ing]	Comm[ing] based on practices	HA wide GP group	Other
Primary care **Impact on prescribing**						
Provision of extended primary care services						
Referral practice						
Trust based services **In patient waiting times**						
Service quality						
Management of emergency admissions						
Availability of services for chronically mentally ill people						
Continuing care policy and arrangements						

5b) From the health authority point of view, can you make an assessment of the impact of each approach on the authority in terms of the following:

Use the following scale when noting impact:

0 Not known/unclear
1 Very beneficial
2 Beneficial
3 No impact
4 Detrimental
5 Very detrimental

Authority activity	GP multifund	FH consortium	Locality comm[ing]	Comm[ing] based on practices	HA wide GP group	Other
Capacity to assess needs						
Capacity to consult with the public						
Capacity to ensure more responsive services are provided						

5c) Have the approaches had an impact in the way the health authority is structured?

GP Multifund **Yes** ☐ **No** ☐

FH consortium **Yes** ☐ **No** ☐

Locality commissioning **Yes** ☐ **No** ☐

Commissioning based on practices **Yes** ☐ **No** ☐

HA wide GP group **Yes** ☐ **No** ☐

Other **Yes** ☐ **No** ☐

If 'yes', to any of the above please describe : .....

.....

.....

6)

6a) What would you say are the most positive aspects of the commissioning approaches within your authority?

.....

.....

.....

.....

.....

.....

6b) What would you say are the most negative aspects of the commissioning approaches?

.....

.....

.....

.....

.....

7) The Future

Recognising that further developments in government thinking on commissioning are expected, do you, nonetheless, have plans locally for developing approaches to commissioning in the future?

.....

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.....

8) Follow up

Would you be prepared to be a case study for more detailed exploration of the issues covered in this questionnaire?

.....

.....

.....

.....

.....

Thank you very much for your co-operation with this project.

Judith Smith / Marian Barnes / Chris Ham
20 August 1997

HSMC

Appendix 3 - Definitions

Health Services Management Centre

Mapping approaches to commissioning
Survey questionnaire to health authorities

Notes for guidance

1. The interview will take place by telephone at the time booked with HSMC. The interview should take approximately 45 minutes and it will be led by a senior member of HSMC's academic staff.

2. We are sending you the survey questionnaire in advance of the interview, to give you an opportunity to gather the necessary information and to be briefed about the issues to be covered. This should also help to keep the length of the interview to 45 minutes or less.

3. Definitions of the generic approaches to commissioning set out in section 2 of the questionnaire are given in the glossary below - this is intended to assist understanding of the terms and to ensure consistency across health authorities.

4. We are also gathering information from national representative bodies (e.g. NACGP, NAFP) and from the primary care leads in regional offices.

5. We will be developing a selection of case studies in more depth, looking at areas which cannot be explored within the confines of a telephone interview. At the end of your telephone interview, you will be asked if you are prepared to agree to your authority forming an exemplar case study for the project's final report.

6. All questions about the project should be addressed to Marian Barnes or Judith Smith at HSMC. Questions about interview appointments should be addressed to Denise Wilson or Amanda Howe on 0121 414 6215.

Glossary of terms

GP multifund
A grouping of GP fundholders who have formed a GP-led independent organisation for the administration and management of their fundholding activities. Multifunds are often companies limited by guarantee with GP shareholders. Fundholder funds remain independent but administration takes place in a central agency or management organisation.

Fundholding consortium
A group of GP fundholders who come together to discuss issues such as purchasing priorities, contract specifications and other matters of policy. Each fundholding fund remains completely independent and management of fundholding takes place at practice level. The consortium may or may not negotiate contracts on a corporate basis.

Commissioning based on groups of practices
A group of GPs who have formed a commissioning group based on a 'natural grouping' of GP practices. This may have been initiated by GPs or by the health authority. The GPs may be fundholders, non-fundholders or total purchasers and increasingly, these groups include GPs from all these categories.

Locality commissioning (geographically based)
A group of GPs and others who have formed a commissioning group based on a defined geographical locality. This may have been initiated by GPs, the health authority or another body such as the local authority. The GPs may be fundholders, non-fundholders or total purchasers.

Authority-wide GP group
A commissioning group which covers the whole of the health authority area. All GPs are entitled to be a member or are represented in some way. The group may be initiated by the health authority or by GPs. The group may include fundholders, non-fundholders and total purchasers.

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