

# PRACTICE-BASED COMMISSIONING

Reinvigorate, replace or abandon?

Natasha Curry, Nick Goodwin, Chris Naylor, Ruth Robertson

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# Summary

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Practice-based commissioning (PBC) is one of the cornerstones of recent government health policy reform, but there is a widespread view that it has not yet lived up to expectations or delivered its intended benefits. This report examines the progress of PBC in four sample sites, and asks what the future might hold for this policy.

PBC was designed to put commissioning powers in the hands of those at the frontline of primary care service delivery (general practitioners [GPs], nurses and other primary care professionals), based on the belief that these people are best placed to make decisions about their patients' needs. As such, GP practices have been given 'virtual' budgets with which to 'buy' health services for their population, with primary care trusts (PCTs) continuing to hold the 'real' money. This approach is similar to that taken by the Conservative government in the 1990s with policies such as GP fundholding, with the key difference being that under the latter real budgets were devolved to GPs.

When it was introduced in 2005, the aims of PBC were ill defined. A clearer set of objectives has emerged in more recent documentation, though they remain very wide-ranging and non-specific:

- to encourage clinical engagement in service redesign and development
- to bring about better, more convenient, services for patients
- to enable better use of resources.

Drawing on in-depth interviews conducted with a range of key stakeholders in four PCT sites between spring 2007 and spring 2008, this report assesses what progress has been made in meeting these three objectives, and identifies the barriers that are limiting success. It then reflects on the future and considers what approaches are available to policy-makers, based on the evidence emerging from the case studies and with reference to previous research.

## Has practice-based commissioning delivered?

Progress to date has been slow in all sites: very few PBC-led initiatives have been established and there seems to have been little impact in terms of better services for patients or more efficient use of resources. Where initiatives have been developed, they have tended to be small scale, local pilots focusing on providing hospital services in community settings. Few practice-based commissioners have taken an interest in wider commissioning activities. Whether this represents a failure of the policy depends on whether it is seen as a mechanism for achieving widespread change, or as a more modest lever for enabling small-scale innovation.

PBC has been partially successful in encouraging GPs to become more engaged in commissioning and budgetary decision-making, but this has generally been limited to a small group of enthusiastic GPs in each PCT. The majority of GPs were supportive of the principles of the policy, but this has not translated into active engagement, with most GPs reporting that they were happy to observe passively and let others lead on their behalf.



The most substantial positive impact of PBC so far has been around improved relationships and communication. PBC has generally fostered more collaborative working relationships among GPs, and has opened up channels of communication between GPs and PCTs and, in some cases, between GPs and hospital staff. There were, however, exceptions to this – cases in which PBC had caused already poor relationships to deteriorate further.

The research detected a slight waning in enthusiasm between 2007 and 2008, with some GPs being deterred by the lack of tangible progress in terms of improved services for patients. Unless the barriers that have limited progress so far can be removed, there is a danger that what modest progress has been made will be lost.

## Barriers to progress

Despite having been in place for more than three years, PBC has made limited progress in terms of meeting its key objectives. There are several reasons for the slow progress, some of which might be relatively easily overcome, whereas others represent more fundamental issues. The key barriers highlighted by this research are as follows.

- **Roles and responsibilities** Although the lack of prescriptive national guidance around PBC offers flexibility to localities, it has also led to disagreement between GPs and PCTs over their roles and responsibilities in commissioning. There have been divergent visions for PBC at the local level, with GPs and PCTs struggling for control of the PBC agenda.
- **Capacity and capability** GPs have a limited amount of time to engage in PBC, and in many cases also lack the requisite skills in, for example, data analysis. The level of support that PCTs need to provide is therefore substantial, but they have been unable to deliver it. This has partly been an issue of capacity and capability in PCTs, with vacancies being carried in key positions and difficulties in recruiting experienced commissioners, but it has also been a question of the level of priority PCTs have afforded PBC.
- **Data** A lack of reliable, timely data in all study sites has meant that GPs have little information with which to develop commissioning ideas. PCTs have been unwilling to approve business cases developed without reliable data. PCTs have also struggled to agree to payments for parts of services delivered outside hospital due to the intricacies of unbundling the secondary care tariff. Lack of timely activity data has also made it difficult for GPs to manage budgets within a financial year.
- **Relationships** Our analysis highlighted the importance of functional relationships between stakeholders in PBC, underpinned by good communication, reliable information and trust. In the one site where relationships were historically poor, PBC has caused relationships to deteriorate further, communication has become confrontational, and progress has stalled.
- **Governance and accountability** Complexities around the management of financial and clinical risk have slowed the progress of PBC. As the financially accountable body, PCTs are concerned that there are few levers available to them for holding GPs to account. Clinical risks are also inherent when moving services out of hospitals, and, as non-medical professionals, staff in PCTs tend to be risk-averse when considering for approval business cases with a seemingly high level of risk.
- **Conflicts of interest** There are two areas of conflict of interest with PBC. The first arises from the opportunity for GPs to be both providers and commissioners of their own service, thus subverting patient choice. The second occurs at the PCT level, where some stakeholders are concerned that PCTs may favour the services they themselves

provide instead of tendering competitively for services commissioned under PBC. Methods of coping with these conflicts are emerging but have not yet been tested.

- **Wider context** Contextual factors have had a profound effect on the implementation of PBC. For example, poor quality relations between GPs and the government during the study period had a knock-on effect on engagement with PBC. A perceived deterioration in the level of priority given to PBC by the Department of Health has encouraged some GPs and PCT staff to invest less time and energy in the policy.

## The future of practice-based commissioning

In its current form, PBC is clearly not operating effectively. Progress has been slow and is stalling completely in some areas. However, to abandon the idea of PBC entirely would most likely be regarded as a significant breach of trust among GPs who have engaged and would risk undermining any future engagement with commissioning. The government has recognised the need to reinvigorate and redefine PBC, but the details of this have not yet been set out. What has emerged from our research is that simply re-energising the current set of arrangements is unlikely to result in success. Even if mechanistic obstacles can be overcome, certain fundamental issues around conflicts of interest and governance suggest that, without significant redesign, the policy will stagnate.

We would urge policy-makers to develop a ‘matrix’ model for PBC that recognises the multilayered nature of commissioning and the fact that certain types of commissioning are best performed at different levels. In this model, responsibility for strategic, population-wide commissioning would remain at the PCT level, but would be informed by a panel of GPs and other primary and secondary care clinicians who would be provided with incentives to play an advisory role. This would seek to build on the positive relationships that have emerged in many cases as a result of PBC.

At the same time, real budgets for specific service areas would be devolved to GPs and PBC clusters (which would become statutory organisations), providing them with more freedom and stronger incentives to innovate in terms of the care provided for patients. The strategic vision would still be developed at PCT level, but GPs and PBC clusters would be granted autonomy to design services within that overall vision. Unlike the previous system of GP fundholding, this model would involve a continuum of earned autonomy, in which high performers would be rewarded with increased independence. In addition, budgets would be devolved only for tightly defined areas, so that GPs and PBC clusters could commission only certain types of service directly, thus reducing clinical and financial risks while increasing accountability.

It is our suggestion that these two approaches are not mutually exclusive but are, in fact, complementary models that have the potential to overcome a number of barriers to progress while building on the positive impacts of PBC.

## Conclusion

If the modest gains made under PBC are to be built on, there is an urgent need to harness what remains of the limited enthusiasm among GPs. Above all, it is essential that the aims and scope of PBC are clearly defined, with an explanation of how the policy is to be integrated with the Department of Health’s overall commissioning framework. We propose that the government adopts a matrix model that builds on the relationship successes of PBC and solves some of the issues around accountability and risk. Moreover, creating such a framework would seek to give clearly defined roles and responsibilities to both PCTs and practice-based commissioners. This would overcome the power play between PCTs and GPs that has paralysed progress so far.

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# 1 Introduction

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Practice-based commissioning (PBC), under which general practitioners (GPs) are given their own 'notional' budgets with which to 'buy' health services for their patients, is one of the cornerstones of the current health service reforms in England. However, questions have been raised about its effectiveness and the extent to which it has been successfully implemented since its introduction in 2005. Indeed, the *NHS Next Stage Review: Our vision for primary and community care* acknowledged that 'there is a widespread view that, with some exceptions, it has not yet lived up to its potential', and set out the government's intention to 'redefine and reinvigorate' PBC (Department of Health 2008c).

This report examines how the PBC policy has been implemented locally, and its impact to date. It examines whether PBC is indeed a policy in need of reinvigoration, and, if so, what changes might be required at a local and national level to achieve this. More fundamentally, this report asks whether it is even advisable to reinvigorate PBC, as opposed to abandoning it altogether or replacing it with an alternative policy.

The report is based on a two-year investigation focused on four case study sites across England. It draws on a series of in-depth interviews with a variety of stakeholders with experience of implementing and working with PBC in these sites. These local perspectives are complemented by the testimony of PBC experts at the national level.

The report starts by giving some further details and background on the PBC policy, setting it within the context of other current health service reforms (*see* Section 2). The research methods are then explained, alongside a description of the site selection criteria (Section 3). Sections 4 and 5 give an in-depth account of the progress and impact of PBC to date, and the factors influencing this progress. Section 6 draws this evidence together to summarise what the most important factors have been in determining the progress of PBC. Section 7 discusses the future of PBC, evaluating different policy options in the light of the report's findings. The report ends with a short conclusion (Section 8).

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## 2 Policy background

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### What is practice-based commissioning?

Practice-based commissioning (PBC) is intended to engage general practitioners (GPs) and other primary health care professionals in the commissioning of health services. The Department of Health argues that, by providing frontline clinicians with resources and support to make commissioning decisions, PBC ‘will lead to high quality services for patients in local and convenient settings [because] GPs, nurses and other primary care professionals are in the prime position to translate patient needs into redesigned services that best deliver what local people want’ (Department of Health 2008f).

Policy guidance outlining the aims and objectives of PBC developed incrementally following its ‘announcement’ in the *NHS Improvement Plan* published in June 2004 (Department of Health 2004c). Early guidance was highly permissive in nature and stressed how PBC was a voluntary scheme aimed at stimulating local service innovations in primary care settings through the involvement of GPs in commissioning and the provision of care (Department of Health 2004a, 2004b, 2005b). Over time, PBC emerged as a key policy lever in shifting care out of hospitals and for managing demand (Curry and Thorlby 2007). Currently, PBC is intended to achieve the following.

- **Better clinical engagement** PBC gives practices and primary care professionals the freedom to develop innovative, high-quality services for their patients through understanding how resources are used and identifying areas that will benefit from redesign.
- **Better services for patients** PBC enables primary care professionals, working across boundaries with secondary care clinicians and others, to redesign services that better meet the needs of their patients. Patients benefit from a greater variety of local and more convenient services, and from reduced waiting times when they do need to go to hospital.
- **Better use of resources** By giving practices the ability to develop new services for patients within a framework of accountability and support, PBC will improve access, extend patient choice, and help to restore financial balance (Department of Health 2008a).

Practice-based commissioning was launched in April 2005 and gave GP practices the opportunity to use an ‘indicative’ commissioning budget allocated from their primary care trust (PCT) to commission and provide services. Since the budget is indicative rather than fully devolved, PCTs remain legally responsible for the money and its administration, and are responsible for any overspends. Involvement in PBC by GP practices is voluntary, but since the outset PCTs have been responsible for ensuring ‘universal coverage’. Initially, this required PCTs, by December 2006, to provide GPs with:

- clinical and financial activity data
- an indicative budget covering an agreed scope of services

- the offer of an incentive payment for participation
- agreed governance and accountability arrangements with practices (Department of Health 2006c).

To date, where they have been allocated, PBC budgets have been primarily based on a negotiated settlement with the PCT based on historic referral patterns and hospital activity. Since 2007, however, the government has pursued the development of a national formula in order to calculate each practice's 'fair shares' budget, based on detailed information about the age of the patients registered with the practice, along with data on average illness and deprivation levels in the local area. This exercise has revealed that some GP practices are substantially over, and some under, what they should be spending. In order to prevent any rapid changes in budgets and associated instability, the guidance dictates that movement towards 'fair shares' should be capped at 1 per cent per annum (Department of Health 2007b).

Practice-based commissioning budgets remain separate from the funds GP practices receive under their existing contracts for their core work (General Medical Services [GMS] and Personal Medical Services [PMS]). These arrangements will remain unchanged irrespective of whether they hold their own commissioning budgets (Department of Health 2006c). Once a GP practice has an indicative budget agreed with its PCT, it is then able to submit business cases to the PCT, proposing changes to commissioning or the establishment of new services.

Department of Health guidance suggests that GPs should organise themselves into PBC groups or networks 'to improve efficiency, recognise economies of scale and to work together in areas of service redesign' (Department of Health 2005b), but does not make such participation compulsory. Different areas have adopted various terms to refer to these groups, including 'clusters', 'consortiums', 'localities' and 'neighbourhoods'. Throughout this report the term 'clusters' has been used.

To engage GPs in the scheme, PBC provides a range of financial incentives. First was a centrally funded incentive scheme known as a direct enhanced service (DES) payment, which paid GPs directly for their involvement in PBC. This payment was announced in 2005 and was available until the end of the financial year 2007/8 (NHS Employers 2005). The DES payment was split into two segments, each worth £0.95 per patient. The first payment was payable when a GP practice initially signed up to PBC (in exchange for a brief plan setting out its aims and objectives for PBC). At the end of the financial year, 'if plans [were] achieved', GPs received another £0.95 per patient (Department of Health 2006d). Some PCTs now offer a similarly structured local financial incentive called a locally enhanced service (LES) payment in order to attract GPs to fulfil or invest in a particular commissioning activity.

GPs engaging in PBC are also entitled to retain a proportion of the indicative budget that is 'saved' at the end of the financial year (net of any administration costs). The latest guidance to this key incentive recommends that practices are able to keep up to 70 per cent of savings, with the remainder available for the PCTs to use for other purposes (Department of Health 2006c). Guidance determines what types of new investments can be made with these savings, such as capital development projects, investment in administrative capacity and commissioning skills, and new service developments. Crucially, the guidance states that PCTs are not able to top-slice savings to solve PCT deficits, although they may do so to develop a 'contingency fund' to cover risks. Significantly, management costs should be paid for out of 'efficiency gains', with the PCT providing the core administrative support.

One of the attractions of PBC is that it potentially empowers GPs not only to make commissioning decisions but also to develop their own services. In this scenario, if GPs are able to provide services that 'are the same as' those provided in acute trusts, they can attract the full cost for each episode of care under the Payment by Results system (Department of Health 2006d). However, the scope of what a practice-based commissioner wishes to commission, and the size of budget it wishes to hold, is flexible and locally determined in negotiation with the PCT. Crucially, the policy recommends that the commissioning priorities of practice-based commissioners must follow, or be complementary to, their PCT's local development plan.

The mechanics of the PBC policy are, therefore, permissive in nature, enabling practice-based commissioners with differing ambitions and priorities to co-exist. Interestingly, the policy itself provides nothing additional to the powers that PCTs already had to innovate. Indeed, innovative schemes that provided incentives to GPs to manage budgets were already in operation in some parts of England. For example, North Bradford PCT pioneered an incentive scheme similar to PBC in 2002 (Winterbottom 2008), in which the PCT offered the potential to retain 50 per cent of any savings made on an indicative budget linked to agreed investments in a practice, and provided direct cash payments for hitting prescribing and hospital service 'quality markers' (a form of LES payment).

As a result of their success in managing budgets, influencing hospital referrals and investing in community-based alternatives, schemes such as that pioneered in North Bradford PCT had a strong influence on the emergence of the PBC policy.

## The policy context

The PBC policy needs to be understood in the context of a number of key government objectives. Perhaps the most important of these was the 2006 White Paper *Our Health, Our Care, Our Say*, in which PBC was described as 'pivotal' to shifting care out of hospital settings and 'closer to home' where, it is argued, it is both more convenient and cost-effective (Department of Health 2006b). In particular, PBC was envisaged as playing an important role in finding innovative 'pathways' by which patients could access a range of diagnostic tests, minor procedures, consultations and follow-up appointments in locations other than hospitals.

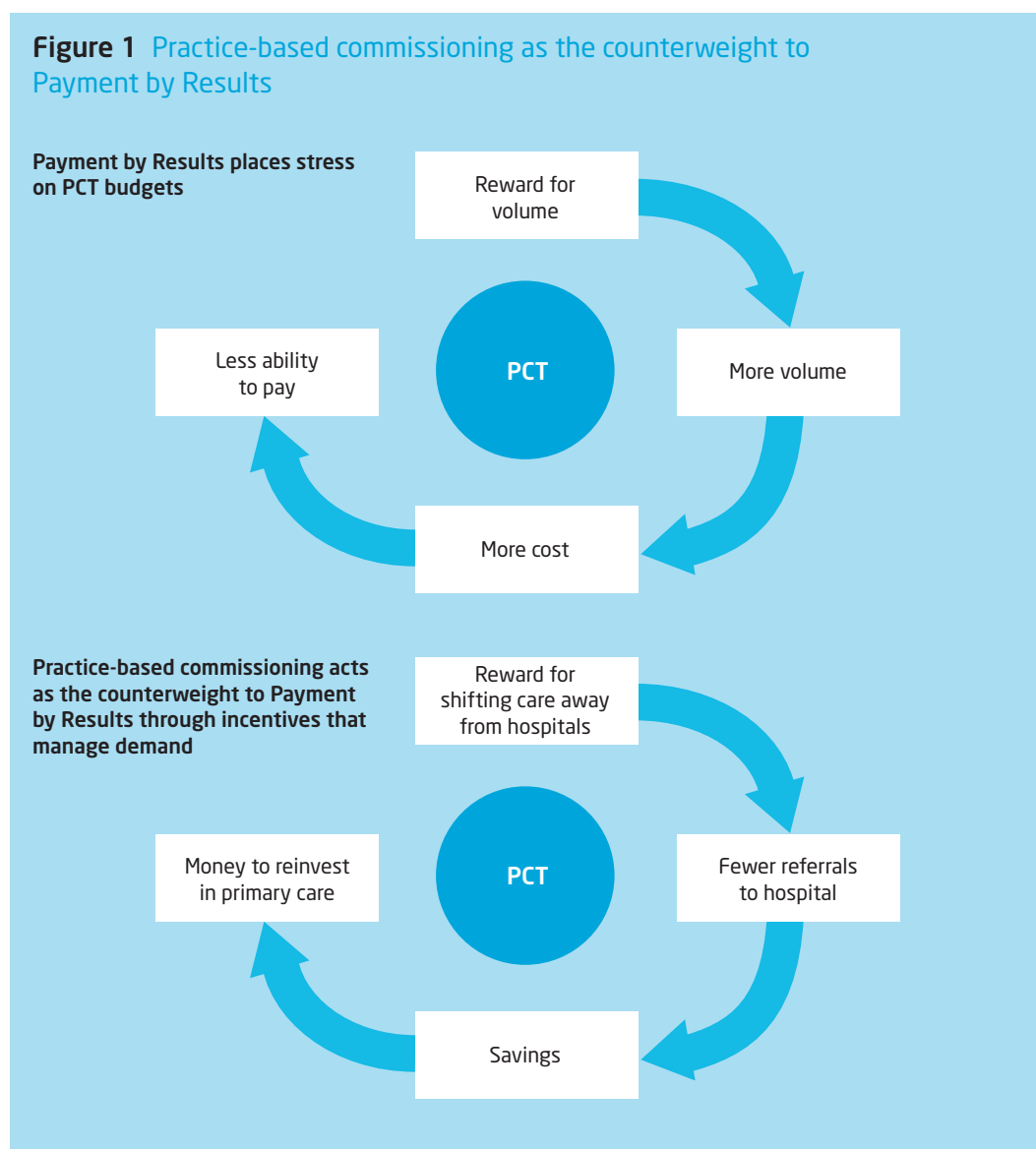
More recent guidance refers to PBC being a tool to help PCTs deliver the 18-week 'referral to treatment' waiting time target (Department of Health 2006d), by, for example, service 'redesign' allowing access to quicker, non-hospital-based diagnostic services.

PBC has also been suggested as a means of securing longer-term savings by promoting the delivery of better preventive care, by shifting the focus from treating illness to managing health. *Our Health, Our Care, Our Say*, for example, states that PBC will provide primary care teams with the 'freedom and incentive' to look after their populations more effectively (Department of Health 2006b).

In addition, PBC has been described as a key enabler for supporting the policy of patient choice (Department of Health 2004a, 2004b) by allowing GPs to identify a variety of different providers for their patients and, in the longer term, to add to the choices on offer by directly providing or commissioning new services themselves.

By 2006, the Department of Health had made clear that an explicit policy objective of PBC was to act as a counterweight to the potential for supplier-induced demand from hospitals as a result of a tariff-based 'Payment by Results' mechanism that rewards providers on the basis of the volume of activity performed (Department of Health 2006a). The incentives to make budgetary savings that are inherent in PBC mean it can

**Figure 1** Practice-based commissioning as the counterweight to Payment by Results



meet the explicit aim of controlling the overall rate of GP referrals to the hospital sector (see Figure 1 above).

PBC was thus regarded as part of a wider commissioning strategy for managing the demand for hospital care – something that had become particularly urgent as a result of widespread financial deficits across the NHS in England in 2005/6.

In 2006, the Department of Health issued guidance to PCTs that gave examples of the sort of initiatives that PBC ‘redesign’ could deliver, emphasising the possibility of fewer emergency admissions as a result of the provision of new primary care services or more community care. However, it emphasised that such schemes ‘must be cash-releasing’ (Department of Health 2006a).

Most recently, the government has placed renewed emphasis on strengthening the commissioning function in the NHS through its ‘world class commissioning’ initiative (Department of Health 2008g). This programme aims to address the tendency of health care commissioners to purchase care based on historic spend and activity (particularly in acute care settings) by shifting attention towards meeting local needs. The emphasis is thus placed on strategic objectives, in particular the delivery of improved health

outcomes. PCTs have been provided with a set of core commissioning competencies linked to an assurance framework, and they will be held to account by strategic health authorities (SHAs) for progress towards achieving them.

The Department of Health argues that PBC ‘sits at the heart’ of world class commissioning, but its role is primarily described as one of ‘supporting’ PCTs – such as in assessing local needs, deciding on local priorities, designing care, and providing feedback on provider performance – rather than of taking the commissioning lead directly. This suggests that the aspirations for PBC have been somewhat downgraded in policy terms from a headline act to a supporting role. Two things remain unclear: the extent to which PCTs will be held accountable for the active development of PBC as they begin to address the requirements of world class commissioning, and how this fits with the aspiration in the *Next Stage Review* to ‘reinvent’ PBC.

## The history and evidence base for practice-based commissioning

The PBC policy represents the re-emergence of the ideas behind practice-led commissioning introduced as GP fundholding as part of the NHS internal market by the Conservative government in the 1990s. Fundholding also offered financial incentives to GPs to manage budgets in the face of rising levels of prescribing costs and ‘unnecessary’ referrals; also promoted choice to patients; and also encouraged the primary care sector to develop new and more accessible services, thus giving hospitals an incentive to improve quality and efficiency (Smith and Goodwin 2006).

Primary care-led commissioning evolved rapidly during that decade. By 1997, more than 20 different types of primary care-led commissioning organisations were operating in England alone, with some health authorities having as many as eight models within their boundaries (Smith *et al* 1998). GP practices, for example, had taken the initiative to come together in ‘multifunds’ or ‘consortiums’ to create organisations that could pool resources, share financial risks, and develop a stronger corporate strategy in their local health economy. To benefit from clinical engagement in service redesign, health authorities also developed a more local focus and/or created GP commissioning groups to advise on local commissioning plans.

Total purchasing pilots (TPPs) were an extended form of fundholding offering fundholders the potential ability to commission all services for their patients, but working in partnership with health authorities, which held budgetary authority over the deployment of commissioning resources as TPPs were allocated indicative budgets for non-elective care. It is TPPs that are perhaps most akin to PBC.

These practice-led commissioning innovations came to a halt following the election of the Labour government in 1997. While in opposition, Labour had argued that GP fundholding gave an unfair advantage to those practices that took part, and that it had led to unacceptably high transaction costs and to a visibly two-tier service for patients. By 2004, however, there had been a change of heart, and in reinventing practice-led commissioning in the guise of PBC, the government argued that there was ‘good reason to be confident in these expectations because of the evidence supporting practice-based commissioning’ (Department of Health 2004a, paragraph 4), citing a discussion paper from The King’s Fund as evidence for its potential (Lewis 2004).

The lessons from the evidence do not, however, support this view unequivocally. For example, the only systematic review of GP fundholding noted that no overall consensus was reached at the time about whether it had been a positive or negative experience



(Goodwin 1998). Indeed, a key issue was how difficult it had been to empower general practices to take an active and innovative part within it.

Nonetheless, retrospective analysis of fundholding practices showed that they achieved quicker admissions for their patients than did non-fundholding practices, and so helped to reduce waiting times by about 8 per cent comparatively (Dowling 2000; Propper *et al* 2002). Moreover, a study by Dusheiko *et al* (2003) found that fundholders reduced referral rates to secondary care by 3.3 per cent in comparison with non-fundholders, a finding that suggested that budget-conscious GPs were either being more judicious in their referral behaviour, or were referring to a range of primary care-based alternatives.

On the other hand, research by Croxson *et al* (2001) suggests that much of the differential seems to have been the result of fundholders ‘playing’ the system by increasing referral patterns in the year before they became fundholders in order to gain a larger budget (since their initial budgets were determined by historical patterns of referral that year). Consensus has never been reached on the ability of GPs to use budgets effectively or on the real impact of fundholding on the cost and quality of care.

Perhaps the most apposite lessons can be drawn from the example of TPPs, on which a great deal of data was gathered in a three-year national evaluation study across 57 pilot sites (Mays *et al* 2001). These researchers noted how considerable variation existed between TPPs, both in terms of the scope of projects and relative progress, and they pointed out that the policy was implemented ‘without a central blueprint, with minimal guidance, partly because of strong conviction from the centre that GPs had great potential to improve the efficiency of services through their purchasing and that they should be allowed as much flexibility in implementation as suited local circumstances’ (cited by Mays and Mulligan 1998, p 85). The research found that this ‘hands-off’ approach by policy-makers presented considerable difficulties in making an assessment about the success or otherwise of TPPs given the lack of a national set of objectives for the scheme.

The conclusions from the TTP experience can be summarised as follows:

- achievements tended to be small-scale, local and incremental – the larger the size and scope of the pilot, the more time was needed to establish management systems before progress could be made against objectives
- pilots increased the costs of running the local health system
- emergency admissions were reduced by an average of 13 per cent compared with the overall admission trend in their host health authorities, but only by those TPPs aiming to do so
- emergency use of hospital services was, in some cases, reduced by providing alternative forms of care (Mays *et al* 2001).

TPPs achieved relatively modest successes, but these looked more substantial given the constrained policy context of the time. TPPs were time-limited pilot projects that relied on health authority goodwill to have control over their own budgets, and were relatively small-scale schemes with limited bargaining power and management capacity in relation to providers. In addition, during the lifetime of the pilots, national policy shifted away from fundholding and its derivatives towards the primary care group model of the new Labour government (Mays *et al* 2001).

Despite these limitations, current policy-makers are clearly convinced that PBC brings the potential to work with PCTs to shift the balance of influence in the NHS from the hospital towards other parts of the wider health system. Indeed, in terms of stimulating

primary care service innovation and, to a lesser extent, managing hospital admissions, this is a logical conclusion from the evidence.

Reviews of this period, however, concluded that things could have worked more 'optimally' had the scope of these commissioning initiatives been better defined. For example, it was argued that a more consistent framework of objectives for commissioning by primary care-led bodies should be created so as to ensure greater equity within commissioning, and to overcome the potential to stifle the community-based innovation of GPs who were keen to run and own 'their' organisations (Smith and Goodwin 2006). In other words, evidence exists of a potential for conflict in practice-led commissioning between the needs-based priorities of local communities with priorities that are based on the observations and preferences of individual GPs. The fact that the financial rewards for, and penalties of, participation were not sufficiently explicit or enforceable was also seen as a key deficiency (Le Grand *et al* 1998).

The lessons from history, then, generally support the potential for a policy aimed at harnessing the 'power of the frontline' (Lewis 2004), though in reality this has proven somewhat difficult to do outside a relatively small cadre of entrepreneurial pioneers (Goodwin 1998).

In addition to the historical research evidence, an increasing body of research has examined the facilitators for and barriers to effective commissioning in general, in order to determine whether and how practice-led commissioning fits into the wider picture (Smith and Goodwin 2002, 2006; Smith *et al* 2004; NERA 2005; Wade *et al* 2006). The primary conclusion is that practice-led commissioning does indeed have the potential to add value, as long as a number of issues are addressed. These include:

- overcoming or avoiding the contextual barriers to implementation, such as the national impact of NHS reorganisations or the local impact of financial deficits
- establishing an appropriate size and scope for the services to be commissioned by practices – the evidence suggests that primary care-led commissioning should be part of a continuum of commissioning but may be better suited to primary care services and community-based chronic disease management innovations
- securing clinical involvement in commissioning to provide insight into service redesign, to influence commissioning negotiations with providers, and to convince other clinicians to support change
- developing adequate capacity for commissioning, along with sufficient resources available to secure people with the skills to undertake and support commissioning
- establishing effective long-term relationships between key stakeholders
- giving practice-led commissioners the freedom to contract independently, as well as developing appropriate incentive schemes to influence their behaviour.

Table 1 opposite compares the characteristics of PBC with the historical approaches to practice-led commissioning reviewed above. As non-statutory GP-led organisations working with 'indicative' rather than 'real' budgets, practice-based commissioners are not directly comparable with any of their historical counterparts, but are most closely related to the TTP and GP commissioning groups that emerged as variants to GP fundholding in the 1990s. In most cases, practice-based commissioners have not developed any direct budgetary and contracting responsibilities, and work in a 'partnership' with host PCTs. However, some practice-based commissioners have established themselves as a local liability partnership (LLP) or as social enterprises in order to operate as statutory organisations with a more defined and autonomous commissioning role.

**Table 1** Comparison of key features of primary care-led purchasing and commissioning organisations (adapted from Smith and Goodwin 2002)

	Fundholding	Total purchasing pilot	GP commissioning	Primary care groups	Primary care trusts	Practice-based commissioning
<b>Date</b>	1991–7	1994–7	1996–8	1997–2000	1999 to present	2005 to present
<b>Size:</b>						
<b>average</b>	10,000	30,000	90,000	100,000	170,000	63,000
<b>range</b>	3,000–50,000	8,000–80,000	38,000–564,000	50,000–250,000	85,000–370,000	1,000–300,000
<b>Location<sup>1</sup></b>	Favours rural and suburban locations	Favours rural and suburban locations	Favours urban locations	National coverage	National coverage	National coverage
<b>Budget:</b>						
<b>type</b>	Real	Indicative	Indicative	Indicative (levels 1 and 2) Real (level 3)	Real	Indicative
<b>responsibility<sup>2</sup></b>	Elective care only	'Selective' of HCHS <sup>3</sup>	Some devolved budgets	Potentially all HCHS	All HCHS	'Selective' of HCHS
<b>Provider responsibility</b>	No	No	No	Primary care services	Primary and community care services	Potentially
<b>Structured clinical governance<sup>4</sup></b>	No	No	Sometimes developed	Yes	Yes	Sometimes developed
<b>Health promotion role</b>	No	No	Often	Yes	Yes	No
<b>Led by</b>	GPs	GPs and nurses	GPs	Primary care team	Management: PCT board and PEC <sup>5</sup>	GPs
<b>Formal status</b>	Independent	Sub-committee of health authority	Sub-committee of health authority	Sub-committee of health authority	Statutory organisation	'Voluntary-compulsory'
<b>How selected</b>	Voluntary, self-selected	Voluntary, self-selected	Voluntary, self-selected	Compulsory	Compulsory	Self-selected
<b>Budget characteristics</b>	<ul style="list-style-type: none"> <li>■ Negotiated (historic)</li> <li>■ Delegated</li> </ul>	<ul style="list-style-type: none"> <li>■ Negotiated</li> <li>■ Indicative to delegated</li> <li>■ Historic to capitated</li> <li>■ Ring-fenced</li> </ul>	<ul style="list-style-type: none"> <li>■ Cash-limited prescribing</li> <li>■ Indicative to delegated</li> <li>■ HCHS budgets</li> </ul>	<ul style="list-style-type: none"> <li>■ Move to capitated</li> <li>■ Towards delegated</li> <li>■ Integrated</li> </ul>	<ul style="list-style-type: none"> <li>■ Capitated</li> <li>■ Delegated</li> <li>■ Integrated</li> </ul>	<ul style="list-style-type: none"> <li>■ Negotiated</li> <li>■ Indicative to delegated</li> <li>■ Historic to 'fair shares'</li> </ul>

Key:

<sup>1</sup>Main locations where practice-led commissioning schemes featured<sup>2</sup>Real budget responsibility allowed direct control over contracting with providers, whereas indicative budgets meant that a health authority/PCT established contracts on behalf of the practice-led commissioner<sup>3</sup>HCHS, hospital and community health services<sup>4</sup>A structured clinical governance function would require all GP practices within the organisation to share and peer-review referral and prescribing activities<sup>5</sup>PEC, professional executive committee

## What is already known about practice-based commissioning

The policy of PBC was not subject to a trial or pilot phase, and a formal evaluation of the initiative has only recently been commissioned by the Department of Health. The evidence on how PBC has influenced the care provided in local health economies during its first three years therefore remains limited, and it is impossible to compare its performance with other methods.

The Department of Health has been collecting data regularly in order to measure the progress of implementation. Initially, this has been done against two main indicators:

- whether PCTs had achieved ‘universal coverage’
- the uptake of DES payments.

Universal coverage means that every PCT has put in place the information and processes required for PBC to operate (*see pp 2–3*) (Department of Health 2006e), and this has been monitored by SHAs. The government’s early guidance set a target for PBC to have achieved universal coverage in England by 2008, but this target was subsequently brought forward to the end of 2006 (Department of Health 2005a). According to the government, this target was achieved, and in 2007 the Department of Health published data that indicated that all PCTs in England had put in place the required arrangements for PBC to operate (Department of Health 2007a).

The Department of Health also collects data about the uptake of incentive payments. The figures indicate that 96 per cent of practices had taken up the first phase of incentive payments by the target date (Department of Health 2007a).

The Department of Health publishes data on PBC in quarterly GP practice surveys. The August 2008 edition – the fourth and most recent – suggested progress had been mixed (Department of Health 2008d).

On the one hand:

- the survey revealed a small increase in support for PBC, rising from 57 per cent in August 2007 to 63 per cent in August 2008
- the number of practices reporting that one or more new services had been ‘commissioned’ during the year as a result of PBC rose by 13 per cent to 46 per cent
- the number of practices that were providing a service commissioned through PBC rose by 11 per cent to 32 per cent.

On the other:

- only 18 per cent of practices in the survey agreed that PBC had improved patient care, with 29 per cent disagreeing
- half of practices rated managerial support for PBC as fairly or very poor, a picture largely unchanged over the period
- the number that reported that they were receiving an indicative budget or agreeing a commissioning plan with their PCT was down 7 per cent (to 59 per cent) and 5 per cent (to 52 per cent) respectively since the previous ‘wave’ of surveys, although this may simply reflect the stage in the commissioning cycle at the time the survey was undertaken. It should be noted that the Department of Health’s data is not open to comparative analysis over time as the data was collected from random samples of GPs in each ‘wave’.

The Department of Health has also published examples of the sort of changes that can be made to services under PBC (Department of Health 2008e) in implementation ‘progress reports’ for each SHA, detailing the activities that have been attributed to PBC and, where possible, the impact they have had. Although many examples of service redesign are cited in these reports, relatively few effects have been quantified – many simply state objectives or cite very high-level estimates for the impact achieved. Broad examples of the types of initiatives emerging in this body of evidence include the following.

- **Reducing avoidable emergency admissions through better management of people with chronic conditions** One example cited in the list of approved business cases in the East of England SHA is of a community diabetic service in Suffolk, with an estimated shift in activity from secondary care of 30 per cent, with potential savings of just under £4,000.
- **Referral management centres run by PBC groups in order to control the number of elective referrals** Many PCTs have been establishing referral management or assessment centres, often run by local PBC clusters, where each referral is scrutinised and, where deemed inappropriate, returned to the referring GP.
- **Setting up alternative sources of expertise** This builds on an existing initiative known as GPs with Special Interests, where GPs gain extra training and can take on some of the work that hospital consultants have done in the past. Examples provided by the Department of Health include GPs setting up dermatology clinics or GPs performing minor surgery in their surgeries.
- **Purchasing new diagnostic equipment to manage people in the community** For example, conditions such as congestive heart failure can be diagnosed using in-house echocardiography equipment. An example of a business case in Peterborough proposes setting up direct access echocardiography in the community, with the potential to remove 73 per cent of that activity from secondary care, but with no potential savings identified.
- **Reducing follow-ups** An approach being taken by a number of practice-based commissioners is to reduce follow-up outpatient appointments at hospitals (which are all charged for under Payment by Results), and instead for this care to be undertaken by the GP, thus reducing the inconvenience to patients and the cost to the PCT. Bedfordshire PCT has submitted a business case to reduce follow-ups for dermatology and trauma and orthopaedics by 10 per cent, with potential savings of £38,000 (Department of Health 2008e).

Other data about the progress of PBC has primarily come from surveys or case studies of the more ‘go-ahead’ schemes. For example, in the first year of operation of PBC, the Audit Commission examined the PCTs that were furthest ahead with it, but found limited observable progress (Audit Commission 2006). Specific issues included the need for:

- PCTs and practices to establish and agree a clear strategy with defined governance and financial management arrangements
- obtaining and providing accurate and timely information
- better management support to encourage GPs to develop their commissioning role.

The Audit Commission’s more in-depth follow-up study of PBC in 16 PCTs reiterated that only modest progress had been achieved despite £98 million of incentive payments having been made to GP practices (Audit Commission 2007). The report identified key barriers to progress being the need for greater engagement of GPs and the fact that some PCTs were not willing to relinquish control of budgets. Also, GP practices were more

interested in the opportunity to provide new services than they were in commissioning them or engaging in service redesign.

A report from the PBC network of the NHS Alliance cited numerous examples of innovations and concluded that patient care could be improved and cost-efficiencies made as a result of PBC (NHS Alliance 2006). However, the NHS Alliance recognised that in many areas across the country, PBC had faced significant implementation problems, including budget setting, data quality, and lack of management support and local ability to agree aims and objectives. The report argued that these had the potential to make the PBC policy 'fall apart' if not resolved quickly.

The King's Fund undertook a survey of 600 members of PBC and practice management networks run by the NHS Alliance, which elicited 257 responses (Lewis *et al* 2007). This, admittedly self-selecting, sample suggested PCTs had not had the time or the capacity to support PBC effectively, with many still recovering from organisational turmoil as a result of the restructuring of PCTs in 2006.

Such findings were echoed in a national survey of PCTs undertaken by the National Primary Care Research and Development Centre (NPCRDC) in the same year (Coleman *et al* 2007). It describes PBC at this time as being in a 'fluid state' of organisational development, with many issues still unresolved, including the setting of PBC budgets and incentive arrangements. Where GPs were participating in commissioning debates, these tended to reflect the demand management needs of PCTs seeking to control a high volume of elective admissions. Overall, however, the survey reported 'great difficulty' in encouraging 'active' clinical engagement.

The most recent evidence for the impact and progress of PBC is set out in the interim report on an NPCRDC study of five PBC clusters – pre-defined 'early adopters' – in three PCTs (Checkland *et al* 2008). This in-depth case study shows that cluster-based arrangements are emerging as the most common form of PBC, though the formality of these and their degree of development varies, as does the degree of understanding of their role as commissioners.

This finding is backed up by the most recent GP practice survey, which reported that 83 per cent of practices are part of a PBC cluster (Department of Health 2008d). The NPCRDC team reports that these clusters' main interest in PBC has been in the provision of services rather than in commissioning or redesigning care, leading to PCT concerns about potential conflicts of interest in the clusters' role as care providers and commissioners.

The NPCRDC interim report also identifies a number of recurrent themes in the evidence, including:

- a lack of willingness, capacity or ability among PCTs to support PBC
- inadequate management resources
- poor understanding and lack of clarity about the roles and responsibilities of GPs
- a lack of good data to use to set budgets
- general uncertainty about the ability to make and use savings.

On the positive side, and in line with findings of the Audit Commission report (2007), the NPCRDC report showed that the sharing of performance data had begun to change GPs' behaviour, making them more aware of their own performance and that of their peers. In addition, more GPs were aware of the cost implications of their referral behaviour, and were willing to change as a result (Checkland *et al* 2008).

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## Conclusion

The limited data available suggests that there has been relatively slow progress in meeting the government's stated aims for PBC. Although there is some evidence from a relatively small number of entrepreneurial and innovative practices across England that PBC has the potential to improve services in some form, it is clear that these benefits have not been widely replicated.

However, the research points to the need for further investigation into the progress and impact of PBC, particularly into the reasons behind the apparent barriers to progress. There has been a tendency in both the historical and current evidence to suggest that many of these barriers are mainly transitory. Contextual barriers – such as the impact of PCT reorganisations or a poor financial climate – can pass with time; but developmental barriers – such as management support, commissioning skills, governance arrangements, and data production and manipulation – can improve only with investment and training.

The research and commentary implies that PBC as a policy has the potential to work well once all the elements have been put in place to allow it to do so. This may well be the case, but in this report we aim to test this assumption by posing the question: should PBC be 'reinvigorated', as suggested in the recent review by Lord Darzi (Department of Health 2008b), or should it instead be replaced with a more effective alternative, or even abandoned altogether?

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# 3 Methods

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## Study design

This study was a qualitative project based on semi-structured interviews in four case studies. Originally intended to be a largely qualitative study supplemented by some quantitative data analysis (where possible), it became clear during the course of the work that the rate of progress of practice-based commissioning (PBC) rendered data analysis inappropriate because any changes in referral patterns are likely to be so small as to make it impossible to draw any conclusions (*see* Section 4).

The project was not designed to provide a representative snapshot of the state of PBC as such surveys are being undertaken by the Department of Health and the National Primary Care Research and Development Centre (NPCRDC) in Manchester. Rather, it was intended to provide an in-depth look at the implementation and impact of PBC, exploring the relationship between the ‘context’, the ‘mechanisms’ of change related to PBC incentives, and the ‘outcomes’ (that is, the effects) that they generate (Pawson and Tilley 1997). By taking four case studies, the research has tried to identify barriers to and facilitators for PBC, with the intention of providing relevant learning for other sites and the wider development of commissioning policy.

The study comprised four main phases:

- site selection
- scoping
- two phases of data collection
- analysis and synthesis.

## Site selection

Four primary care trusts (PCTs) were selected as case study sites to facilitate in-depth investigation and to provide a good overview of PBC implementation. The intention was to choose sites that were relatively advanced in PBC implementation so as to maximise the learning for policy-makers and other sites. An initial long-list of potential sites was created using the following criteria:

- the PCT had not been reconfigured in the October 2006 round of structural reforms (because it was assumed that reconfiguration was highly likely to have disrupted important PBC/PCT relationships with the potential to delay implementation while new relationships were developed)
- the incentive payment uptake was 70 per cent or higher by October 2006 (because it was assumed that incentive payments made in recognition of PBC activity would suggest that there would have been at least six months’ development prior to site visits).



In addition, in order to identify the facilitators for and inhibitors to PBC, it was important that a range of contextual factors were included. As such, the selection process ensured that the sample included:

- a mix of financial situations: two PCTs in financial deficit and two in balance/surplus in month 6 of 2006/7 (because it was assumed that the financial climate of the PCT is likely to have an impact on the uptake of PBC and the engagement of general practitioners [GPs]);
- a mix of rural and urban PCTs, with at least one in a largely rural area (because it was assumed that the availability of alternative providers [particularly hospital services], practice density and population characteristics are likely to affect the way PBC develops).

Once a shortlist had been prepared, a pragmatic approach was taken. PCTs that fitted the required criteria were approached until four case study sites with the appropriate mix of characteristics had agreed to participate. A brief outline of each of the sites selected is shown in Table 2 overleaf.

## Scoping

Once four PCTs had been identified and ethics and research governance approval had been obtained, a short scoping phase was undertaken. This took the form of short interviews with the local collaborator (usually a PBC lead) in each site, and the gathering of local data and documentation relating to the development of PBC. The aims of the scoping exercise were to:

- obtain an overview of how PBC was developing in the PCT, what approaches were being taken, and who the key players were
- get a sense of the environment in which PBC was developing, for example, the financial climate, relationships between commissioners and providers, and any pertinent issues in the health economy
- identify a list of relevant interviewees for the main research phase of the project, bearing in mind that structures and processes vary among PCTs
- gather relevant background data in the form of PBC and PCT reports and plans to establish any PBC priorities
- identify any sources of robust referral and usage data that could be used in the supplementary quantitative analysis.

## Data collection

The bulk of data collection took place via two rounds of semi-structured interviews, held between six and eight months apart. Some data collection also took place in the form of document gathering as and when appropriate sources were identified.

Interviews were undertaken with a range of PCT staff, acute trust staff and GPs/practice managers. PCT interviewees were identified using purposive sampling. In the first instance, the research team approached the chief executive, the director of commissioning, a non-executive director, the director of public health, the chair of the professional executive committee (PEC), a representative of the Patients Forum, and, where they existed, commissioning manager and/or locality manager.

The structure of the PCTs varied, so additional/alternative individuals were interviewed as appropriate. Participants were interviewed twice, except where someone had left a

Table 2 Outline of the four study sites

	PCT size/type	Financial situation	Sociodemographic characteristics	Secondary care provision
<b>Site A</b>	<ul style="list-style-type: none"> <li>Small</li> <li>Suburban</li> </ul>	<ul style="list-style-type: none"> <li>Deficit</li> <li>In turnaround</li> </ul>	<ul style="list-style-type: none"> <li>Relatively wealthy suburban area with pockets of deprivation</li> <li>Population growing at a faster rate than that in the surrounding areas, particularly in the 25–44 and over-85 age groups</li> </ul>	<ul style="list-style-type: none"> <li>Host commissioner for a large acute trust that is pursuing foundation trust status</li> <li>Regularly refers to at least two other nearby trusts</li> </ul>
<b>Site B</b>	<ul style="list-style-type: none"> <li>Fairly small</li> <li>Mixed urban/rural</li> </ul>	<ul style="list-style-type: none"> <li>Deficit</li> <li>Improving during 2007/8</li> </ul>	<ul style="list-style-type: none"> <li>Broad mix of very affluent and extremely deprived areas</li> <li>Popular retirement location – population disproportionately old but influx of young families in recent years</li> <li>Population swelled in summer by holidaymakers not registered with local GPs, as a consequence of which attendance at A&amp;E<sup>1</sup> is high</li> </ul>	<ul style="list-style-type: none"> <li>Host commissioner to a small district general hospital</li> <li>Half the population tends to use the local district general hospital, half to be referred to trusts outside the PCT area</li> </ul>
<b>Site C</b>	<ul style="list-style-type: none"> <li>Medium-sized</li> <li>Mixed urban/rural</li> </ul>	<ul style="list-style-type: none"> <li>Financial balance</li> </ul>	<ul style="list-style-type: none"> <li>Spearhead<sup>2</sup> PCT with high levels of deprivation</li> <li>Higher than average incidence of heart disease, hypertension, COPD<sup>3</sup> and infant mortality</li> </ul>	<ul style="list-style-type: none"> <li>Host commissioner for a foundation trust located in the middle of the PCT area</li> <li>Although the majority of patients attend the local hospital, there are alternatives nearby</li> </ul>
<b>Site D</b>	<ul style="list-style-type: none"> <li>Medium-sized</li> <li>Inner city</li> </ul>	<ul style="list-style-type: none"> <li>Financial balance</li> <li>Predicting a surplus for 2007/8</li> <li>Was in deficit for three years, during which a lot of staff were lost</li> </ul>	<ul style="list-style-type: none"> <li>Area includes extremes of both affluence and deprivation</li> <li>Relatively large, young, mobile, working population, which brings issues such as a high incidence of STIs<sup>4</sup></li> <li>The older population is relatively small but very needy</li> <li>High proportion of people from black and minority ethnic groups</li> <li>Increasing number of refugees</li> </ul>	<ul style="list-style-type: none"> <li>Host commissioner for a large acute trust that is developing its tertiary care provision</li> <li>Because the PCT is spread over a wide area, it also buys services from several other trusts in adjoining areas</li> </ul>

<sup>1</sup>A&E, accident and emergency department<sup>2</sup>Spearhead PCTs are defined by the Department of Health as a group of 88 PCTs identified through their high need status to benefit from targeted resources<sup>3</sup>Chronic obstructive pulmonary disease<sup>4</sup>STIs, sexually transmitted infections

post, in which case the new post-holder was interviewed in phase two. In a small number of cases, the vacancy had not been filled, as a result of which there were slightly fewer interviews in phase two. Table 3 below gives a breakdown of the interviewees by site and type.

A range of GPs and practice managers were approached in each PCT. Attempts were made to include very engaged GPs in leadership positions (as identified by PCT staff) as well as a random sample of GPs not in leadership positions, with the intention of gaining a variety of opinions. Of course, this approach is open to problems of definition and self-selection, but attempts were made to approach GPs who were considered to be disengaged by PCT staff and cluster leads, as well as those who volunteered to be interviewed.

Hospital interviewees were identified last. Where other interviewees had mentioned particular specialties or members of trust staff who were known to be involved in PBC, the research team approached those individuals as it was necessary to talk to people who had some experience, or opinion, of the policy.

It was decided to undertake two rounds of interviews in order to enable the research team to detect any changes or progress in the development of PBC, the attitudes towards the policy, or in relationships between the key individuals. Each semi-structured interview lasted up to one hour. Interview schedules were developed during the scoping phase of the work, and adapted for the second round of interviews to focus on specific issues. Interviews sought to explore the following topic areas:

- uptake of PBC across practices and motivation for getting involved
- development of local governance and accountability arrangements to support and control PBC
- relationships and communication between the main parties involved in PBC
- identification of PBC priorities and the key impacts/achievements of PBC to date against local and national objectives (including any data sources that may be available)
- interpretation of PBC policy and how it is likely to develop in the future.

## Analysis and synthesis

Interviews were recorded and transcribed in full. Transcripts were loaded into NVivo qualitative analysis software.

Key themes that emerged from the interviews were identified and organised into a coding framework (see Appendix A). Transcripts were coded according to the themes, and the use of NVivo allowed the application of a structured and systematic analytical framework. The Framework approach to thematic analysis of qualitative interview data developed by the National Centre for Social Research (NatCen) was used (Ritchie *et al* 2003).

**Table 3** Breakdown of interviewees by site and type

	Phase one				Phase two			
	GP/practice manager	PCT	Hospital	Total	GP/practice manager	PCT	Hospital	Total
<b>Site A</b>	7	7	3	17	6	5	3	14
<b>Site B</b>	7	7	3	17	7	7	3	17
<b>Site C</b>	4	9	3	16	4	9	3	16
<b>Site D</b>	6	10	2	18	5	11	3	19
<b>Total</b>	<b>24</b>	<b>33</b>	<b>11</b>	<b>68</b>	<b>22</b>	<b>32</b>	<b>12</b>	<b>66</b>

Framework is a highly practical form of qualitative data analysis designed for use in applied, policy-relevant social research to tight timescales. It involves the following stages.

- **Familiarisation:** immersion in the raw data so as to gain an overview of the material gathered.
- **Identifying a thematic framework:** drawing on a priori issues and questions derived from the objectives of the study, issues raised by participants and views that recur in the data. This produces a detailed index of the data that labels it into manageable chunks for subsequent retrieval and exploration.
- **Indexing:** applying the thematic framework to the body of data by annotating the transcripts with codes from the index.
- **Charting:** rearranging the data according to themes, thus building up a picture of the data as a whole.
- **Mapping and interpretation:** using the charts to aggregate patterns of data and, in doing so, define concepts, map the range and nature of phenomena, create typologies and find associations between themes. In other words, the findings are synthesised with a view to providing explanations for them.

During the interviews, any sources of data about service use that illuminated the statements made were identified and the feasibility of access to them explored. Unfortunately, because of the low levels of progress in developing PBC initiatives, and the lack of timely quality data, it was not possible to obtain any quantitative data that could illuminate qualitative findings.

In order to provide external validity to the findings from the research, and to debate whether the observed progress and impact of PBC from our sites could be generalised to a national picture, a seminar was convened to which were invited various experts in the field, including policy-makers, people involved in PBC, representatives from PCTs and academics. The debate was recorded. The seminar proved to be helpful in highlighting barriers common to all, and in clarifying the options for the future of practice-based commissioning as a policy (*see* Appendix B for a summary of the seminar).

# 4 Progress and impact

As set out in Section 2, the initial aims for practice-based commissioning (PBC) were somewhat ill defined. However, over time, three main objectives have emerged in government publications:

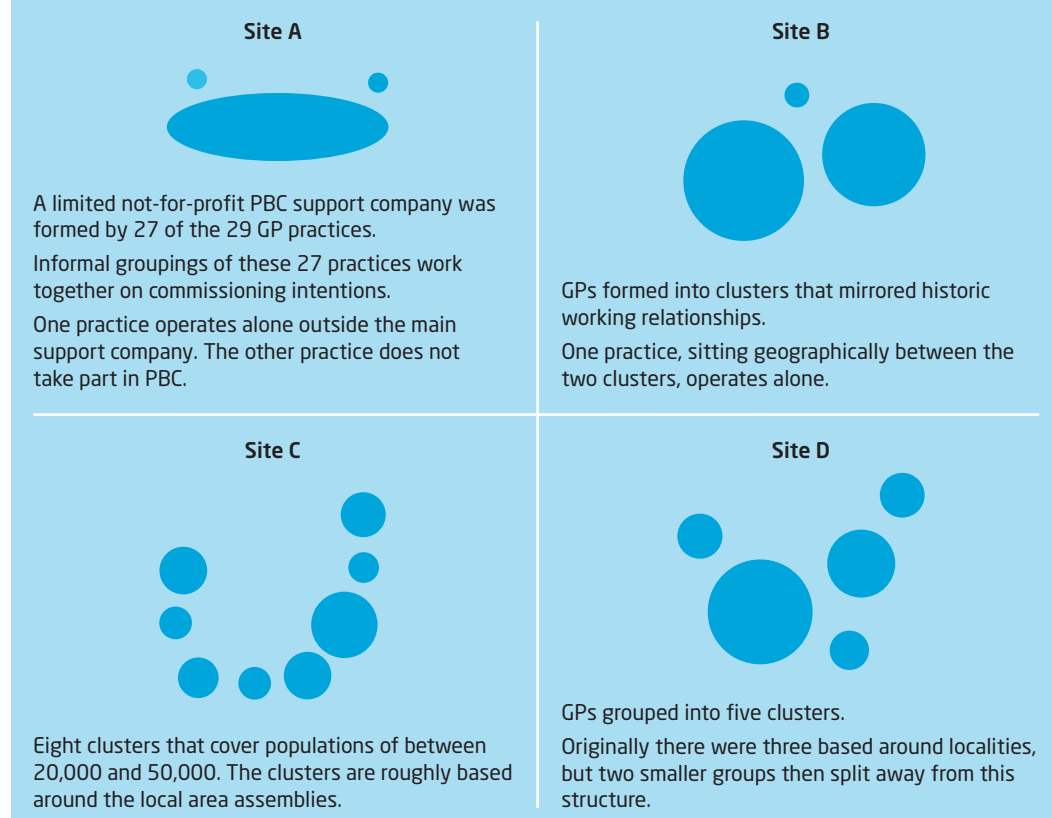
- better clinical engagement
- better services for patients
- better use of resources (Department of Health 2008a).

This section examines what progress has been made towards achieving these aims in the four case study sites (*see also* Appendix C for a tabulated, site-by-site summary of progress).

## Overview of developments

As a consequence of the deliberate absence of prescriptive central guidance, PBC has evolved in different ways in the four sites studied. For example, there is huge variation in how cluster formations developed in each location (*see* Figure 2 below). Site A has

**Figure 2** How practice-based commissioning cluster structures developed in the four study sites



established a single not-for-profit limited company to help support general practitioners (GPs) in implementing PBC. This organisation is not a cluster in the sense of generating business case and commissioning ideas, but it is the main grouping of GPs operating in the primary care trust (PCT). GPs in this site have also formed less formal groups for the purposes of submitting commissioning plans to the PCT. In contrast, sites B, C and D have three, eight and five clusters, respectively, each with formal governance arrangements. No particular formation emerged from our research as being demonstrably more effective than the others.

The approaches taken to establishing governance processes and identifying clinical priorities also varied. During phase one, interviewees in sites B, C and D said that they intended to establish operational governance arrangements and to define roles and responsibilities before moving on to deciding on clinical priorities. In contrast, GPs in site A seemed to have started deciding on clinical priorities before governance procedures had been established. As a result, in phase two, GPs in site A reported a considerable amount of confusion over roles, responsibilities and lines of accountability (*see* Section 5, pp 27–30 and 37–43).

Despite this variation in the approaches taken to it, the degree to which PBC has met its core objectives has been similarly limited across all sites. There has been some progress in terms of increased clinical engagement, but the extent to which there has been any tangible impact in terms of improved service quality or resource use is debatable. Each of these objectives is considered below.

## Better clinical engagement?

A key objective of PBC is to increase clinical engagement in service redesign and development. The extent to which clinicians have engaged with PBC is a useful proxy for this. The level of engagement with PBC varied greatly among the sites studied. Very few GPs were openly opposed to the principles of PBC, but most were not actively engaging with the policy.

‘Active engagement’ is an unspecific term, but in the context of this research, a GP who was actively engaged was one who attended meetings, contributed to priority setting, led on business case development and had an awareness of referral levels. In all four sites, a handful of very enthusiastic and engaged GPs was driving PBC, while the majority of GPs reported that they supported the basic principles but were happy to let others lead on their behalf. Although this meant that active engagement was relatively low in terms of the numbers involved, most interviewees did not think that it was necessary to have 100 per cent sign-up in order for the policy to gain and sustain momentum, as long as a ‘critical mass’ was active. Interviewees were not specific about what proportion of GPs constitutes a ‘critical mass’. Interestingly, no interviewees – whether GPs, PCT staff or hospital staff – mentioned the involvement or engagement of any other primary care professional group: clearly, PBC is currently perceived to be a policy that concerns GPs alone.

It is possible to categorise GPs into four levels of engagement. Most GPs fall into either the second or third groups.

- **Very engaged leaders:** there is a small number in each site trying to develop PBC.
- **Engaged in theory but taking little action:** GPs in this group sign up to the principles of PBC and attend meetings, but are happy to let others lead for them.
- **Little engagement:** like those in the last group, these GPs do not object to the principles of PBC but they do only the minimum required to obtain their initial

direct enhanced service (DES) payments (see Section 2). However, after that, they show no interest in attending meetings, developing business cases or getting involved in decision-making. Some of the more engaged GPs and PCT staff described this group as being ‘dragged along’.

- **Dissenters:** very few GPs fall into this group. These GPs object to the principles of PBC and refuse to engage at any level.

When asked about their reasons for engaging in PBC, the motivation cited most commonly by GPs was the opportunity to provide new and better services for patients. A few entrepreneurial GPs cited the opportunity to make financial gains. This was not, however, seen as a major motivation by most GPs, and the financial incentives in PBC appeared to be relatively weak, especially compared with those contained in the Quality and Outcomes Framework, which delivers larger monetary benefits to GPs and was consequently seen as more important.

*...they see the opportunity to make a little bit of a margin on some of it, but I don't think any of them have any anticipation of getting rich quick.*

(GP, site A)

Interestingly, when asked what motivated them to engage with PBC, more often than not GPs replied that it was a ‘fear of being left out’ rather than an active interest in the more positive opportunities mentioned above. A number of GPs admitted to having low interest in PBC and a limited understanding of how it operates but felt that it was always better to be on the inside of something than on the outside. Even the more engaged GPs pointed to defensive reasons for becoming involved. This is discussed further in Section 5.

Interviewees disagreed about whether their engagement in PBC changed between phase one and two. Some interviewees, especially PCT staff, felt that GP engagement in PBC had been increasing, but most GPs reported that they were less enthusiastic in phase two than in phase one, mainly because of a lack of progress in terms of the establishment of new services (see below). Scepticism about whether the policy could deliver tangible improvements appeared to be both a cause and effect of slow progress. A vicious circle seemed to be emerging, in which GPs were holding back until PBC had proved itself, but without GP involvement this being unlikely to happen.

*An awful lot of the GP practices, I feel, are very disgruntled because they're not seeing any benefit of practice-based commissioning.*

(GP, site A)

*All the other clusters, they're sharing exactly the same views, almost to the point of militancy, you know? They're just fed up with the lack of progress.*

(GP, site D)

In two sites, the appointment of new PCT staff had strengthened leadership and signalled a shift in managerial attitudes to PBC. In site D, PCT-run workshops about PBC and commissioning in general had resulted in a noticeable increase in engagement. These deliberate attempts by those two PCTs to push PBC up the agenda played an important role in the level of GP engagement. In contrast, in site A, PCT interest in PBC was perceived by GPs to be low and, although engagement had started out relatively high, it has declined steadily. GPs said they were not convinced that the PCT was committed to PBC, with one GP saying that the PCT was just ‘paying lip service’ to the policy and was ‘ticking the boxes but their heart's not in it’ (GP, site A).

The minority of GPs that have actively engaged in PBC have, in some cases, become more involved in commissioning and strategic decision-making, and in doing so have forged new relationships and communication channels with the PCT. These relational

developments emerged from our research as the most significant positive impact of PBC to date.

*PBC makes you co-dependent on each other in a way that we didn't have to be before, so the relationships are much, much better than they were.*

(PCT staff, site B)

*For the first time [the PCT] feels as if it's working with GPs in partnership and others in partnership, rather than actually having a somewhat aloof and rather arrogant approach to it.*

(PCT staff, site C)

*GPs are sitting round the table, trying to share the problems with the PCT...that wouldn't have happened two years ago.*

(GP, site B)

## Better services for patients?

In terms of establishing new services or designing new patient pathways, progress in all four sites has been slow. By phase two of the research, very few initiatives had been implemented and were operational. Where projects had been established, they tended to be small, local initiatives.

Although the number of new services established through PBC is still small, the research found that practice-based commissioners were involved in discussions about numerous clinical areas and pathways that had not yet moved on to the formal business case development stage. In terms of the clinical areas that were being focused on, some common themes emerged:

- all sites were discussing diabetic services, open access diagnostics, urgent care and anti-coagulation
- dermatology and ophthalmology were being discussed in three of the four sites
- models being developed for anti-coagulation and dermatology involved shifting the less complex activity out of secondary care and into primary care, the principal aims being to maximise convenience for patients, and to reduce the number of referrals and costs.

It is not yet clear how many of these discussions and plans will result in the implementation of any actual services.

In many cases, it is difficult to assess the precise contribution of PBC towards the improvement of services for patients because of the difficulty in attributing any developments specifically to PBC. Interviewees expressed a lack of clarity about what initiatives and ideas had truly come out of PBC and what would have happened anyway. In some cases, interviewees claimed that service developments already under way had been 're-badged' as resulting from PBC, such as a diabetic service and a musculoskeletal service in site B. Other interviewees claimed that PBC had been a catalyst for initiatives that had already been discussed at length but not put into practice.

In all the study sites, practice-based commissioners initially focused on the potential for relatively small-scale re-provision of services in primary care settings rather than on more ambitious commissioning agendas (such as redesigning care pathways, managing demand or tackling public health needs). As one member of PCT staff in site C commented, 'most business cases are for modest, local proposals, rather than [for] sweeping pathway reforms'.



There were a few examples of GPs showing an interest in broader commissioning, but these were very much in the minority. The most notable example of commissioning was in site B, where a large-scale review of urgent care was being undertaken. However, it appeared that this was being led by the PCT and had been discussed long before PBC was introduced as a policy.

There was disagreement around whether the focus on re-provision means that PBC is failing to meet its objectives. Some argued that these small-scale changes bring improvements for patients by, for example, making services more convenient to access, and that this is exactly what PBC should be doing. Others argued that the focus on re-provision means that PBC is failing to tackle the biggest issues, and delivering benefits to only a limited number of patients. One PCT staff member in site C described this as ‘a great disappointment’:

*It would be better if GPs got more involved in bigger projects, addressing broader issues, and commissioning services from others rather than themselves.*

(PCT staff, site C)

*PBCs should be getting involved in broader commissioning, but the PCT is encouraging a narrow focus on re-provision.*

(GP, site A)

The boxes below and overleaf give examples of services established under PBC. The first is an example of a successful service that started as a local initiative but might be rolled out across the PCT, thus becoming available to a much greater number of patients. The service described in the second box was less successful, and is given as an example of one of several services that were established under PBC in our study sites only to be abandoned for a variety of reasons.

#### Example of a pilot that was successful and might be rolled out across the PCT

<b>What?</b>	The appointment of a community geriatrician.
<b>Why?</b>	High numbers of emergency admissions of older people in the PCT population (especially from nursing homes).
<b>By whom?</b>	One cluster.
<b>How does it work?</b>	A retired geriatrician employed by the PCT goes out to practices, residential homes, nursing homes, PCT clinics, etc, effectively doing a mini-ward round every week rather than waiting for emergencies to develop. It operates in one cluster at present, pending evaluation.
<b>Aim?</b>	To provide outpatient appointments and preventive care outside hospital in order to reduce emergency admissions.
<b>How long has it been running?</b>	Since January 2007
<b>Impact?</b>	Formal evaluation is not yet complete. Anecdotal evidence suggests that it has saved money, seen reduced follow-ups in hospital, reduced referrals to hospital and reduced emergency admissions.

### Example of a project that was set up but later abandoned

<b>What?</b>	The appointment of an out-of-hours paediatric triager in the accident and emergency department (A&E).
<b>Why?</b>	There was a perception among GPs that paediatric attendances at A&E were high. The intention was to divert inappropriate attendance in order to reduce costs.
<b>By whom?</b>	Unclear: some say it was a PCT-driven initiative, others say it emerged from the PBC support company.
<b>How?</b>	The PCT approached three practices to run a pilot (there was no formal tendering process).
<b>How did it work?</b>	A GP was located in A&E during out-of-hours periods to operate a triage service for paediatric patients, diverting inappropriate attendance to the three participating practices.
<b>How long did it run?</b>	Three months
<b>What impact did it have?</b>	The answer to this varies according to whom you ask, and there was no data to back up responses. Some say it had no impact, one GP said it diverted 79 per cent of all cases, another said it diverted 88 per cent of all cases.
<b>Why was it abandoned?</b>	Some GPs in the area were concerned that there had been no tendering process and feared that the three practices involved were making money from it. The practices to which patients were diverted were not close to the hospital so it was not always convenient for patients.

There were few examples in the study sites of GPs undertaking systematic data analysis in order to identify needs and clinical priorities. Instead, initiatives appeared to be pursued as a result of an individual GP having a particular interest or experience. A PBC lead in one site commented that some of the biggest priorities among GPs had 'come out of a gut feeling' that certain areas needed work rather than priorities being based on quantitative evidence:

*...GPs do things they are interested in, not what the data points to.*

(GP, site A)

According to interviewees, this was partly due to the lack of high quality data (*see* Section 5, pp 33–35), but in one case, even though data were available, the overriding factor was that a GP knew someone who could provide the service:

*Well, it is usually a bit of a whim, I think. The [initiative] started initially because one of the GPs had a friend who could do it.*

(PCT staff, site C)

These findings suggest that GPs tend to look at what they *can* do easily, rather than at what is most *needed* in order to deliver better services for their populations. This concern was voiced by several PCT staff.

## Better use of resources?

PBC was intended to improve the use of resources by providing an incentive for GPs to reduce referrals to secondary care, either through demand management or by shifting services into community settings with lower overheads. Our research found that PBC was indeed being used as a vehicle for improving the use of resources, but that these efforts were largely driven by PCTs rather than GPs.

In sites A and C, where both PCTs were in deficit, the use of resources had become the main focus for PBC, with many GPs arguing that it had moved away from bottom-up, clinically led innovation to become instead a tool for the PCT to use for engaging GPs in top-down financial management (*see* Section 5, pp 27–30).

The extent to which PBC was successful in improving the use of resources has not yet been demonstrated conclusively, even in the two sites where this had become its main focus. Few quantifiable impacts were cited, and where they were, conflicting claims were made by different interviewees. Because of this lack of reliable, quantified data, it is unclear whether PBC represents a cost-effective form of commissioning.

Across all sites, the impact of PBC on referrals to secondary care appears to have been limited. Interviewees in secondary care said there had been few noticeable changes in admissions, referrals or case-mix, or that changes that had been seen were smaller than had been anticipated:

*...in terms of our referrals, it's not had as much of an impact as we expected [it] to have.*

(Hospital staff, site A)

*[There has been] very little impact to date. PBC is nibbling at the edges.*

(Hospital staff, site B)

*It's made no difference whatsoever to the number of referrals that we see.*

(Hospital staff, site C)

In site A, a referral management centre was established, in which all GP referrals to secondary care are peer reviewed, with the aim of reducing inappropriate referrals. However, the role of PBC in the establishment of this centre is disputed: some interviewees pointed to it as an example of PBC improving the use of resources, while others said that it would have been established irrespective of PBC.

All sites identified urgent care as a priority in terms of improving the use of resources, and various solutions to the problem of high attendance at A&E were developed. For example, site A focused on diverting to local GPs paediatric visits that would normally have gone to A&E, whereas site B focused on a PCT-wide reshaping of all urgent care. This illustrates a potential strength of PBC – the flexibility it offers to take an issue of national concern and adopt, adapt and develop local solutions to it.

Site C piloted an ophthalmology service in which a hospital doctor attended a local optician's to assess patients who had been recommended for referral, with the idea being that unnecessary referrals could be screened out before reaching the hospital. Evaluation of the pilot is still ongoing, but interviewees reported that the impact on referrals has not been as great as expected, and felt it was unlikely to be shown to be cost-effective.

Although hard evidence of PBC having led to actual changes in referral patterns and/or admission volumes is scarce, there is evidence that the act of giving GPs a virtual budget has raised awareness of their own referral behaviour. This was remarked on in all four sites. In sites C and D, GPs were required to complete a referral log as part of a locally enhanced service (LES) payment agreement. In sites B and D, GPs started to interrogate each other's referrals at practice meetings, and several GPs remarked that this peer review has made them more aware of their patterns of referral. In site A, although there was no formal review process, there was a feeling that GPs had become more aware of their referral behaviour.

Although there was little evidence to suggest that the raised awareness of referral behaviour had manifested itself in reduced referrals or different referral patterns, some believed that this could be the next step.

*...in the next couple of years you'll see some real data-driven efficiencies coming into general practice... The trick will be making it non-threatening and just changing people's behaviour without singling them out as 'bad people'.*

(GP, site C)

## Summary

Our research found that PBC has made limited progress in terms of meeting its key objectives. The most positive impact to date has been the effect on the relationship between different stakeholders, for example, between leading GPs and PCTs. The box below summarises the progress so far.

### Summary of progress of PBC in its first three years

- PBC has had few tangible impacts in terms of better services or improved use of resources. There are very few examples of initiatives that can be unambiguously attributed to PBC.
- Where there are such examples, these tend to be small-scale local pilots. Most GPs have focused on the provision opportunities that PBC presents rather than the commissioning opportunities.
- There is little evidence that clinical priorities are emerging out of systematic data analysis. In reality, ideas are emerging where GPs have an interest or some experience.
- The greatest positive impact so far has been improved relationships and communication among GPs and between GPs and PCTs, though in some cases the impact on relationships has not been positive.

The question that arises from the research is why, despite being in existence for three years, PBC has failed to deliver more profound changes to the health system, and it is to this question that this report now turns.

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# 5 Factors influencing progress

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As discussed in the previous section, progress towards achieving the aims of practice-based commissioning (PBC) has been slow, and the impact to date difficult to identify. This raises the following questions:

- Why has progress been slow?
- If certain barriers were not present, would PBC gain momentum and start to have an impact?

This section considers the reasons for the slow progress as well as the factors that seem to act as facilitators. Various themes emerged during the analysis phase of the project, and these have been used to organise the research results:

- lack of clarity over roles and responsibilities
- limited capacity and capability
- data limitations
- relationships between stakeholders
- complexities around governance and accountability
- conflicts of interest
- wider contexts.

A summary of these factors, broken down by case study site, can be found in Appendix C.

## Roles and responsibilities

One of the key findings of this research is that the process of defining the roles and responsibilities of the different stakeholders involved in PBC has been problematic. For example, in each of the four case study areas, much of the past two years has been spent on the process of establishing governance and accountability arrangements (*see pp 37–43*) and/or setting out a local *modus operandi* for the working relationship between primary care trusts (PCTs) and practice-based commissioners, as well as between practices working within PBC clusters (*see pp 35–37*).

The evidence suggests it has taken quite some time for those involved to come to terms with the scope and remit of the different players, such as in issues of budgetary control, administrative support, commissioning and business case development.

In part, the evidence leads to the conclusion that the character of the PBC policy itself – its lack of central guidance on how the roles and responsibilities of PCTs and general practitioners (GPs) should be determined – has affected the rate at which progress has been made locally.

It could be argued that the PBC policy was intentionally created without pre-determined rules on roles and responsibilities so that PCTs and GP practices could enjoy flexibility in

determining their own arrangements to suit local circumstances. Our research suggests, however, that this permissiveness has led to differences of opinion, tension and conflict, disagreements and confusion over the division of roles and responsibilities. Experiences in the four case study sites are characterised by a jockeying for position in the balance of power between PCTs and GPs.

## The balance of power

One of the main intentions of the PBC policy was to shift resources to frontline clinicians to enable them to make commissioning decisions and service innovations. At the same time, however, the policy made it clear that PBC needed to support the priorities of each PCT, as set out in its local development plan. Thus the policy seems to require PBC to attempt to combine ‘bottom-up’ innovation and clinical experience with ‘top-down’ priorities. In each of the case study sites, there was evidence that this had led to a power play between GPs and PCTs over control of the PBC agenda.

The PCTs in the case study sites had each developed different mechanisms to try to get GPs and PBC clusters to focus on PCT priorities. In site D, for example, GPs agreed five or six priority service areas with the PCT, following which it would provide full support for business case development only for plans in those areas. In site B, the PCT requested business cases from practice-based commissioners that were ‘corporate with a degree of flexibility’, implying that PCT priorities (especially reducing the deficit) were the more important. GPs in site B consequently felt that PBC was a top-down, financially driven process.

*Clinical considerations need to drive PBC more than at present. These need to be put in the context of financial constraints, rather than financial constraints entirely dictating what is going to happen.*

(Hospital staff, site B)

*Practice-based commissioning is a misnomer. As far as I can understand, [it] has been based largely on mechanisms to try and reduce the PCT's debt... It's top-down financially driven.*

(GP, site B)

In site C, the PCT explicitly regarded PBC as a way of engaging GPs in its PCT-led commissioning plans, rather than as a direct devolution of power, and it provided locally enhanced service (LES) payments (*see pp 37–43*) to secure buy-in. Consequently, PBC in site C has moved towards a model in which GPs can submit only plans that serve PCT or national priorities. Given the extent to which the PCT has attempted to sell this process to the GP community, acceptance of the model was more established than in site B, though many GPs were unhappy with the arrangement.

*PBC is not primary care-led in [site C]. It is used by the PCT as a way of saving money and addressing their priorities. The PCT is not interested in plans which do not fit their priorities... GPs have just ended up doing the things the PCT want them to do as specified by the LES.*

(GP, site C)

Only in site A has the PCT not openly insisted that GPs stick to its priorities, though GPs have reported less support for business cases not fulfilling these. Both the PCT and GPs in site A identified a thinly veiled agenda for managing financial deficits.

It is clear from the four case study sites that the balance of power in PBC lies firmly with PCTs. GPs who had expected a greater degree of autonomy to purchase and provide services in a manner similar to GP fundholding have been disappointed, and this has

led to some disengagement from PBC. Nonetheless, GP engagement with PBC in sites B and D appears to have fared better because the PCT has been open and honest about what sort of plans are likely to get more support. Site A fared badly in this respect because the rationing of PCT support to non-priority PBC initiatives was more implicit, thus angering GPs.

## Evolving and conflicting visions

The evidence from our case study sites suggests that many of the problems in resolving roles and responsibilities between PBC stakeholders were related to different interpretations and conflicting visions for its purpose and future. Interviewees in our research viewed the objectives of the PBC policy in several ways, reflecting the various policy intentions for PBC set out in Section 2 of this report.

One commonly held view was that the multiple objectives within the design of the policy, together with a lack of guidance on the roles and responsibilities of the key players in the process, had led to confusion and conflict between stakeholders. It was argued that the combination of goals was not necessarily a good mix since it had encouraged stakeholders to think about how they, or their organisation, might use the scheme to achieve their own priorities, rather than how they might work in partnership to achieve collective outcomes.

Three of the four PCTs in our sample – sites A, B and D – primarily saw PBC as a mechanism for demand management. In part, this reflected the financial health of these PCTs during the time of the research, and the obvious priority attached to managing hospital activity. Site C, however, was more interested in using PBC as a mechanism for innovation and improvement in quality and public health – an approach manifest in its development of a separate investment fund for this purpose.

In the second phase of our investigation, there was evidence that site D had begun to change its vision for PBC, transforming it from being a key tool in demand management to being the more modest focus for developing innovative services ‘at the margins’ – and thus giving GPs greater freedom to commission and provide new primary care-based services – as well as renewing the focus on service redesign. A new director of commissioning with a different vision for PBC was credited with this change of direction, underlining the fact that it was the PCT that held the power to determine it.

## Establishing roles

The division of roles and responsibilities between PCTs and practice-based commissioners has taken time to evolve, but there is evidence from sites B, C and D that greater clarity has emerged over time. Nonetheless, opinion was divided about how those responsibilities were shared out. For example, PCT respondents (and some GPs) in site D felt that the role of the GP was to provide expertise in developing commissioning intentions and plans rather than purchasing care directly, leading to questions about whether the complexity of devolved budgets was entirely necessary.

At the other end of the spectrum, some GPs called for greater freedom to contract independently of the PCT, and were somewhat disappointed by the lack of self-determination available to do so. All sites had one or two GPs arguing this point of view, though there was no overall consensus from GPs, as others recognised the legitimacy of working in partnership with PCTs.

In site A, roles and responsibilities have remained a source of confusion as an additional layer of organisational bureaucracy – the PBC support company – has acted as an

intermediary between the PCT and GP practices. The PBC support company has been unable to secure a mandate from all GPs to work collectively, partly as a result of a lack of role demarcation:

*[There are] disagreements over role division – [the PBC support company] wanted the PCT to employ a large team of [information technology] people to support [practice-based commissioners] in working with data, but the PCT replied ‘at some point you have to be mature enough to understand your role as a practice-based commissioner and take that seriously’... the role and responsibility of [the PBC support company] is not always clear to other GPs.*

(PCT, site A)

PCT respondents in sites A, B and D reported little change in their overall commissioning role as a result of PBC, as they still retained the core functions of contracting and performance management while retaining budgetary responsibilities.

The box below summarises our findings in the area of roles and responsibilities.

### Summary

- A lack of central guidance for how PBC roles and responsibilities should be determined has led to variation in approaches.
- Defining the roles and responsibilities of the different stakeholders involved in PBC has been problematic. Confusion and disagreement has led to a power play between PCTs and GPs.
- Agreeing the roles and responsibilities of the different stakeholders has been the most time-consuming element of PBC.
- Time and investment spent in bringing PCTs and practice-based commissioners together – such as in workshops and other face-to-face meetings – facilitated collective understanding.
- Where roles and responsibilities were well articulated, collective understanding was supported and progress was facilitated.
- Hospital trusts have remained passive observers of the PBC process, without an active role, though they continue to dominate dialogue with PCTs over commissioning intentions and plans.

## Capacity and capability

The research identified significant shortcomings in the capacity and capability of GPs and PCTs to implement PBC. The exact nature of these barriers varied according to local contexts, but all sites experienced difficulties in terms of skills, time and human resources among GPs and PCT staff.

### Capacity and capability of GPs

In order to be effective practice-based commissioners, GPs require good data analysis skills, business acumen and a good knowledge of commissioning. However, several GPs suggested that these were not skills that they possessed, having gone into general practice in order to be clinicians rather than business people, and having clinical rather than business expertise:



*...if I'd wanted to be a businessman, I'd have been a businessman, wouldn't I? You know, I'm a crap businessman! I'm happy about being a crap businessman – I'd hate being a good businessman, that's not my job.*

(GP, site B)

The research also uncovered some confusion among GPs over terminology and which services were included in Payment by Results. In addition, there was confusion among both GPs and PCT staff over what exactly constituted commissioning.

Given the general confusion over terminology and jurisdiction, coupled with GPs' perception that they lack the requisite analytical and business skills, it is perhaps unsurprising that most of those interviewed had seized on and were pursuing the opportunity to provide new services – an area in which they have both interest and expertise.

As well as these issues of capability, the research also uncovered significant problems with capacity in general practice. Engaging in PBC by attending cluster meetings, interrogating data and writing business cases requires a substantial time commitment on top of a GP's regular clinical workload. With the exception of the lead GPs in site A, who are paid a salary for their PBC work, others who engaged in PBC generally did so in their spare time. According to several of the GPs interviewed, there is little funding available to compensate them for their time. They have therefore found it particularly galling, after investing significant amounts of time in developing and submitting a business case, to see it seemingly disappear into a lengthy approvals process.

### Capacity and capability of PCTs

The difficulties with PBC that GPs have experienced inevitably put PCTs under great pressure to provide the high level of support GPs need to operate it. However, in all four case study sites, the capacity and capability of the PCT to meet those demands emerged as a key barrier to progress.

*[PCT] commissioning [is] already desperately overstretched in terms of capacity and capability.*

(Hospital staff, site D)

*I think, at times, there's a bit of a myth in 'PBC-land' that [the] PCT is sitting on all these people, on capacity, doing lots of commissioning. Whereas, actually, if you split my team out across five clusters, they'll probably each get about two people or something. We're not talking about huge capacity to support commissioning.*

(PCT staff, site D)

GPs felt that the support provided by PCTs was inadequate, and some PCT staff agreed with this. Even in site C, which had the strongest PCT support of all the sites studied, it was still regarded as insufficient by many GPs. The PCT there employed a designated PBC manager to support PBC clusters by facilitating meetings and helping write business cases, and although some GPs rated this as good (one GP said, 'the PCT bends over backwards to help'), others described it as 'negligible' or 'inadequate'.

The relatively high level of support offered by the PCT in site C is in contrast to the lack of it in site A, where PCT staff admitted offering GPs little help with regard to PBC. The PBC support company there was intended to provide the assistance normally offered by a PCT (for example, assistance with writing business cases and analysing data), but many GPs in the area reported that this was not the case.

In the other two sites, PCT support for PBC was reported to be weak but improving. One practice manager in site B, for example, felt that support improved markedly between

the two phases of the study. At the time of the first interview, this practice manager commented on a feeling that neither GPs nor the PCT knew what they were doing and that GPs had no one to approach for support. By the second interview, however, the feeling was that they could pick up the phone and ask the PCT for help and that that help would be forthcoming. In site D, GPs acknowledged that the level of support had improved greatly, but felt that it was still insufficient for PBC to deliver substantial improvements:

*[PCT support] is enough to maintain the status quo. I don't think it'll be enough to bring serious change...*

(GP, site D)

Central to the issue of PCT capacity is the question of how highly PBC features in the list of competing priorities. In site A, PCT interviewees admitted that PBC was a lower priority than achieving financial turnaround or hitting the 18-week waiting target. Far from seeing PBC as a tool in its armoury for fighting the deficit, the PCT appears to have seen it as yet another obligation requiring time and resources. Similarly, PCT staff in site D felt that the PCT had been 'ambivalent' towards PBC while the PCT was in deficit, and that although PBC had since become a higher priority, it continued to be 'trumped' by other tasks being pushed more vigorously by central government and the strategic health authority:

*...everything else just gets pushed to the side because you've got the operating plan to meet; you've got the commissioning strategy to meet. [The strategic health authority] wants things back... And you've just got to drop everything.*

(PCT staff, site D)

People with commissioning experience seem to be in short supply and existing resources are thinly spread. Three of the four case study sites have been carrying vacancies in their commissioning departments and, although recruitment is under way, getting people in post has been a slow process. A member of staff at the PCT in site B said, 'PBC [human] resources have doubled since your last visit, but the PBC team is still swamped', suggesting that the PCT had been unable to keep up with demand for support. Site B had particular problems with high staff turnover and long-term sickness, and PCT staff in site D also referred to resources being severely stretched.

In addition to problems of capacity, interviewees reported that there are also issues of capability. Where PCTs themselves lack commissioning skills, their ability to support practice-based commissioners is likely to be limited. Some of the PCT staff interviewed said that business case approval was stalling because staff were nervous about approving projects in which they had no clinical or commissioning experience. In site B, the PCT has since attempted to secure clinical input into the business case approval process but, because of the conflict of interest inherent in clinical input coming from local GPs, the PCT has had to recruit GPs from outside the PCT (*see pp 43–45*).

## Cluster size

PCTs have found it particularly difficult to support PBC where GPs have organised themselves into many small groupings. For example, in site B one practice had opted out of the local cluster structure and submitted PBC business cases on an individual practice basis. However, none of these ideas has been implemented as the PCT decided that, given finite capacity to develop and support business cases, priority should be given to larger schemes that would potentially benefit a greater number of patients.

Because of support issues, cluster size has had an impact on the types of initiatives pursued. It is easier for larger clusters, and more resource-efficient for PCTs, to

implement major changes in service provision and so realise large-scale impacts from PBC. This can be seen in the redesign of urgent care being considered by one large cluster in site B, and the referral management service implemented across site A by its large PBC support organisation.

Where GPs have formed smaller clusters, the scope of PBC has been reduced. This was acknowledged by several interviewees in site C, where eight small clusters operate. Although the level of PCT support there was arguably the highest available at any of the sites studied, it was felt that the main resource – the PBC manager – was spread too thinly.

*What eight clusters means is that we're more likely to continue having small localised proposals and developments and change rather than more radical [PCT]-wide change through PBC. [It] doesn't mean to say that we can't affect [PCT]-wide changes through other means... But I think it's unlikely to be generated through PBC if we have eight clusters.*

(PCT staff, site C)

The box below summarises our findings in the area of capacity and capability.

### Summary

- GPs lack the time to invest in PBC.
- Many GPs also lack the data analysis and business case development skills necessary.
- A shortage of PCT staff who have the time and requisite skills to support the implementation of PBC is adversely affecting progress.
- The capacity of PCTs to support PBC is affected by the cluster structure, with larger clusters generally being more resource-efficient in terms of the support required.
- The capacity of PCTs to support PBC is also a function of the priority given to it compared with other tasks.

### Data limitations

The majority of interviewees cited the lack of good quality data as one of the most important issues currently inhibiting the progress of PBC. The problem is twofold – it is not simply an issue of availability, although clearly that is important, but also one of ability to use the data that is available.

All the case study sites have experienced data problems. To some extent, these issues have been associated with national problems of timeliness, with GPs complaining that activity and referral data is three to five months out of date by the time it reaches them.

*We're here in February, and we're working on September's figures. We should be on December's figures.*

(GP, site C)

PCTs could supply GPs with uncleaned data, but most said that this would simply result in GPs receiving inaccurate and misleading data. Site B has been having particularly bad information problems. It was reported that the introduction of a new data system at the main acute provider resulted in the loss of a significant amount of data. As a result, there was a number of gaps in the historic data available to GPs, and there continued to be concerns about the accuracy of more up-to-date information.

In site D, GPs found the inadequate information particularly frustrating: because of the lack of up-to-date monthly information, a few GPs had put together business cases based on information they held in their practice records. The PCT rejected these business cases saying they were in an unacceptable format.

With a lack of data on which to build business cases, implementation of PBC has stalled. However, some PCT staff remained sceptical about whether GPs would actually use the data even if it were available to them. For instance, in site C, where all GPs had access to electronic referral data (albeit out of date) and had been offered training in using the system, the PCT reported that use of the system had remained low. According to one PCT staff member, GPs wanted to use information sources in order to challenge hospital coding in the hope of making savings. When they were told that by the time they got the data, it would be too late for GPs to make challenges, they lost interest and have not used the system since.

Our research uncovered further data issues. Even where data was available and practice-based commissioners had an inclination to use it, few GPs appeared to have the requisite data analysis skills to interrogate and analyse it properly. PCTs reported providing some training in computer systems (for example, in sites A, B and C), but most GPs reported having struggled with the process and having 'given up'.

With no concrete figures on which to develop business cases or prove impacts, PCTs have been cautious about approving business cases. Moreover, many GPs reported a high degree of distrust in the accuracy of the data provided to them – especially when hospital activity and budgetary expenditure data provided by the PCT was seemingly at variance with the activity estimated by a practice's own data systems.

A particularly important barrier to PBC has been how the lack of reliable data has led to problems and disagreements with both budget setting and budget expenditure, meaning that it was often difficult for GPs to make and retain 'surpluses' with any degree of certainty.

A final information-related barrier to PBC progress, reported in all case study sites, has been problems with the 'unbundling' of the Payment by Results tariff. The problem is twofold. First, GPs perceive local providers to be unwilling to 'unbundle' the tariff – to disentangle it into its component parts.

Second, the research found disagreement about whether services provided outside hospitals should be paid at a rate lower than the standard national tariff. PCTs argued that a tariff set on average hospital costs would lead to an overpayment of GPs for work shifted into the community under PBC, unless the price were adjusted to represent the less complex case-mix of patients seen in the community. This argument was resisted by hospitals, which claimed that giving GPs the opportunity to undercut them would result in core activity being taken away and so threaten wider service provision as hospitals might not be able to cover overheads.

There were two examples where PCTs agreed to GP proposals to provide a service outside hospital, only for a lengthy debate to ensue about setting the price, leading to a delay in establishing the services. The lack of standard national tariffs for such component services outside hospital, or for non-PBR services, is posing significant challenges to PCTs which, at present, do not appear to be confident enough (or equipped with adequate data) to be able to set rates locally.

The box below summarises our findings with regard to the limitations of the available data.

### Summary

- Data is a key problem in all sites. There is a lack of timely, reliable data and that is having a knock-on effect on business case approvals.
- There is a lack of appropriate skills at GP level in terms of data analysis.
- Unbundling the tariff is proving to be an issue in all sites and is slowing down the development of services outside hospital.

## Relationships

Section 4 touched on this issue and flagged improved relationships as one of the few impacts that PBC could claim to date. In addition, what has emerged from interviews with various stakeholders in the case study sites is that PBC cannot operate effectively without functional relationships underpinned by efficient communication mechanisms and trust.

The effect of PBC on the relationship between different parts of the NHS in each case study site varied according to the quality of those relationships at the outset. In sites where relationships were historically poor, PBC appeared to have exacerbated the distrust. For example, tensions between stakeholder groups in site A were magnified by PBC. In sites where there was a strong history of collaborative working, positive working relationships were established around PBC, and there was a sense of co-operation rather than confrontation.

The quality and effectiveness of relationships varies not only *between* but also *within* the case study sites. Different interviewees also offered different perspectives on the matter. With the exception of some relationships in site A, there seems to have been a general trend towards improving relationships between the two phases of interviews, which, some claim, has led to better progress in terms of PBC. In order to understand the relationships that are required to underpin effective PBC, it is necessary to consider the various layers of relationships as well as the context within which they have developed.

GP-to-GP relationships have been affected by the formation of PBC clusters, which have mostly emerged according to historical patterns. GPs in sites B, C and D have largely fallen into clusters that reflect former primary care groups (PCGs) or other local structures. Where attempts have been made to create ‘artificial’ groups based on newly formed boundaries, there has been considerable unrest. One cluster in site D split into two smaller clusters fairly early on in the process; the cluster structure at the time of this research reflected former PCG arrangements. In site A, the PCT attempted to persuade all GPs to work through the single PBC support organisation, but this led to tensions and a considerable degree of distrust between some of the GPs involved:

*I think the problem with [the site PBC support company] is that because the people are who they are, there is a certain amount of this trust factor which is in the area, and when the people are pushing something forward, one can't help thinking 'what's behind this?'*

(GP, site A)

In site A, relationships among GPs were found to be very variable, with a great deal of distrust and animosity within the GP community. It appears that the lack of trust stemmed largely from ambiguity over roles and responsibilities, and a lack of

transparency in the governance processes, with the result that some GPs were concerned that the leaders of the PBC support company could be benefiting personally, and that proper procedures for tendering and contracting were not being followed. These strained relationships should be considered in the context of an adverse financial situation that, according to GPs, exacerbated tensions that were already there.

However, financial difficulties have had the opposite effect in site B, where several GPs commented that this had made them pull together behind the common cause of resolving the deficit.

The second key relationship that is essential to PBC is the dynamic between GPs and PCTs. It could be argued that this relationship is the lynchpin of PBC because, fundamentally, PCTs bear the risk of GP behaviour. For this dynamic to work, good leadership, transparent governance and adequate support underpinned by efficient and high quality data transferral processes appear to be essential.

GP/PCT relationships varied among both sites and individuals. In sites B, C and D, GPs were mostly of the opinion that relationships had improved between the two phases. In site B, for example, the PCT had recruited several new staff members, and GPs and PCT staff all reported that this new team had succeeded in generating a feeling of trust between the parties that had not existed before:

*...there is much more of a sense that we are all going to have to work together to make this work for everybody.*

(GP, site B)

In contrast, relationships between GPs and the PCT in site A seemed to have deteriorated. One key factor appeared to be a lack of clarity over PBC processes. Some GPs said they were frustrated that proposals had been rejected by the PCT despite the fact that the PCT had been involved in their development from an early stage. Another major issue was that GPs perceived the PCT's support and communication as being directed solely at the small group of GPs leading the PBC support company, leaving other GPs feeling that the PCT had not been engaging sufficiently with them. The PCT recognised that a shortage of resources had not allowed it to provide the support that GPs might need.

Some GPs interpreted this lack of support from the PCT as evidence of its being actively obstructive. Part of the problem seemed to arise from a lack of clarity about the roles and responsibilities of the PCT compared with those of the PBC support company. Some PCT staff members said they thought relationships had improved over the past two years, partly because of PBC, whereas two GPs said that trust had been lost and that, as a result, the opportunity for PBC to succeed had passed:

*I think there was a window of opportunity for practice-based commissioning and there was a lot of enthusiasm and a lot of people felt it was a way forward and it was good and we want to provide better care for our patients but it's gone.*

(GP, site A)

Although perhaps not as difficult as in site A, GP/PCT relationships have had their problems in the other sites, too. Issues around support, clarity of roles and clear lines of governance and accountability, as discussed in other sections of this report, have contributed to these tensions and difficulties.

The third relationship that is key to the successful functioning of PBC is that between secondary care providers and PCTs/GPs. In general, acute hospital staff in all sites reported seeing little or no impact as a result of PBC to date, but there are distinct differences among the relationships of key individuals and organisations. With the exception of a small number of GPs who have forged positive relationships with hospital

consultants in site A, the relationship between the PBC support company and the hospital had deteriorated. Interviewees at the hospital said that they found the approach of GPs in site A to be combative at times, rather than collaborative.

In other sites, interviewees reported that the main effect of PBC on relationships between GPs and hospital clinicians was simply to formalise collaboration that had historically happened in a more ad hoc way. Hospital staff in these sites said they were open to having discussions with GPs about moving activity out of hospital, and supportive of practice-based commissioners reducing the volume of inappropriate referrals. However, they said they felt threatened when initiatives could potentially destabilise departments, such as where PBC plans appeared to be replicating a hospital service in the community, rather than simply meeting a need.

This was a particular issue in site B, where some concerns were raised by hospital staff about their particular specialties being financially destabilised. There were also concerns about managing clinical risk in services that had been shifted into the community (see pp 37–43). If not responded to appropriately, such concerns have the potential to jeopardise good relationships.

In two sites, PCT staff reported that PBC had resulted in a slight shift of power in the relationship between them and the hospital. They felt that PBC had given them more ‘clout’ when negotiating contracts because the hospital staff listened more closely when they realised GPs were behind the decisions, although GPs were still not directly involved in the conversations. Hospital staff said there was some confusion over how future negotiations would take place, and whether they would be expected to forge relationships with individual GP clusters.

The box below summarises our findings with regard to relationships.

### Summary

- Functional relationships at all levels are needed for PBC to develop.
- In areas where relationships are problematic, PBC has exacerbated these problems and progress has stalled.
- In order to foster good relationships and trust, it appears that good quality data, ample support and transparent governance processes are key.
- PBC has not led to direct clinical involvement in contract negotiations, although it may have had some indirect effect on the relationship between PCTs and acute trusts.

## Governance and accountability

As set out in Section 2, the Department of Health requires PCTs to create a governance and accountability framework that ensures practice-based commissioners make effective use of taxpayers’ money with minimum bureaucracy while ensuring that clinicians have the opportunity to innovate (Department of Health 2006d). A solid governance framework is required to ensure practice-based commissioners manage care within their allocated budgets, and that the care they commission is of a good clinical quality.

In all sites, all categories of interviewee – whether GPs or staff from the PCTs or hospitals – commented on the issues surrounding governance and accountability and the impact

they are having on the progress of PBC. The overall conclusion is that the complexities involved in the setting up of governance and accountability arrangements have delayed the implementation of PBC considerably.

## Managing financial risk

As the bodies that are financially accountable for the use of NHS funds, PCTs retain responsibility for ensuring that:

- PBC decisions are appropriate to population need
- PBC decisions provide care of the highest clinical quality at minimum cost
- GPs' referral levels remain within budget.

The role of PCTs in ensuring financial accountability is made more complex by the fact that they are required to balance their budget every year, whereas PBC guidance dictates that GPs must balance their budgets only every three years. The maintenance of financial stability is clearly more difficult with each party working to different financial accounting deadlines.

PCTs in our study sites have encountered problems in managing the financial risks associated with PBC at several levels. Only a limited amount of data is available for measuring GPs' performance, and where reliable data is available, PCTs have few sanctions with which to manage GPs against their performance. PCTs have established diverse structures and processes for managing financial risks, with varying degrees of success. These are discussed below.

## Measuring GP performance

One way for a PCT to measure the performance of GPs is through their referral behaviour, although a lack of good quality data inhibits the PCT's ability to do this effectively. In each of our case study sites, performance against budget could not be monitored throughout the year because of the delay in receiving Payment by Results data (*see pp 33–35*). Despite being unable to undertake real-time monitoring, PCTs in our sites used the data that was available to benchmark GP performance to a variable extent. However, across all sites, GPs had a greater role in performance managing their peers than did PCT staff, and PCTs identified peer pressure from other GPs as the main tool for managing GP referral behaviour.

In site C, the locally agreed incentive scheme requires GPs to log their referrals at source and use this data to compare their performance with that of practice colleagues. Clusters were anticipated to have a role in performance management in all sites, but this was not clearly defined and had not yet been tested at the time of our research. GPs seemed happy to peer review their colleagues' performance data, but less happy to play a more formal performance management role. GPs preferred peer review to being managed by PCT staff without a clinical background.

In site A, it was hoped that the limited company set up by GPs to support PBC would help with performance management by supporting practices in responding to PCT demands, but at the time of the research this role was not well developed.

It is not yet clear what impact peer review of referral activity and general peer pressure is having on PBC performance. Fostering a solid understanding of referral data among GPs is clearly a powerful tool in managing their performance, but it is a tool over which the PCT has no control and therefore is not, on its own, an adequate performance management mechanism from the PCT's point of view.



## Sanctions

PCTs have few sanctions available to ensure GPs remain within budget, even when the data required to measure performance and identify outliers does exist. In all of our case study sites, the PCT identified removal of the indicative budget and ultimately removal of the GP contract as the main sanctions available to them when performance managing GPs, but they did not feel these were particularly effective. It is unclear how removal of an indicative budget would affect a practice that is not engaging with PBC, as it would not suffer a real financial loss from it. It is also unclear how the arrangement would work in practice. Although removal of the GP contract is a more definite sanction, PCT interviewees acknowledged that they would use this only in very extreme cases.

## Local enhanced service (LES) agreements

With little timely and reliable data and few sanctions available to PCTs, they have turned to other tools to influence GPs' behaviour and manage their performance, particularly LES payments.

In three of our case study sites (B, C and D), LES payments were the main tool employed by the PCT to influence the referral and commissioning behaviour of its GPs. Although the specifics of the LES agreements differed in each site, they all followed the same basic structure, with the payment being split into two components, the first for exhibiting commitment to PBC (such as through submission of an annual commissioning plan or attending cluster board meetings), and the second for undertaking specific tasks.

In site C, GPs were awarded the second component for demonstrating use of their data analysis system, keeping logs of their referrals and contributing to PCT-wide service reviews. In site B, a trust in deficit, the LES payment required the meeting of specific targets in priority areas such as emergency surgery for those aged over 75 years.

Site D was considering a new component for the 2008/9 LES agreement: the awarding of £0.30 per patient to practices that remained within budget. This clearly demonstrates the difficulties that traditional methods of monitoring performance against plan pose to the PCT in trying to ensure that GPs remain within budget. It also shows the weakness of the incentive embedded in PBC to encourage GPs to keep within budget in order to generate savings that can be reinvested in patient care.

The impact of the LES payment on GP behaviour depended on what GPs were able to use the money for. In site A, 80 per cent of the LES payment is used to fund the PBC support organisation, making it a weak incentive for practices not engaged with that organisation.

## Budget setting

PCTs have found a number of ways to use budget-setting processes as a means of managing financial risk. In two of our case study PCTs (C and D), prescribing and secondary care budgets were ring-fenced. This was done to ensure that any improvements in prescribing levels generated through prescription incentive schemes would not be lost: that is, if a practice reported savings on its prescribing budget, these would not be cancelled out by any deficit generated by its secondary care activity, which is more difficult to predict and control. There was debate in both these sites about whether to retain this arrangement, as PBC aims to encourage practices to consider the needs of their population as a whole when managing activity and deciding how to make savings.

Our sites were moving towards budgets based on 'fair shares' (see Section 2), and some were concerned that this change might create a further disincentive to manage activity within budget for practices that were currently over their fair shares allocation.

In sites C and D, the PCTs retained a percentage of the overall budget before practice level budgets were calculated as an extra contingency to manage risk and cover overspends by practice-based commissioners. In site D, the contingency was used to pay for the extra activity required to meet the 18-week target. Although this ensured that the PCT remained within budget for the year, it eliminated the incentive to save on budgets as GPs were expected to overspend to meet the target and then be bailed out by the PCT.

*We kept back anyway a £5 million contingency for the 18-week hump. So therefore, what will happen is, the PBC will appear to overspend, the PCT contingency will pay off the overspend, but we're still going to underspend by £2 million, because the PCT financial rota didn't want to put that in their budget but should have done, because then it would appear as savings. So there isn't really transparency and fairness.*

(GP, site D)

In site B, GPs were said to be 'shadowing' their indicative budgets as the financial situation made them unwilling to take on budgets for which they were accountable. In the financial year 2008/9, GPs were expected to be held accountable for their indicative budgets.

### **Allocation of savings**

Savings provide another incentive for GPs to manage their finances well. GPs receive a percentage of any savings made on budgets, but they are not penalised for overspending. To ensure they have enough money to absorb any overspends while giving GPs their surpluses, a percentage of any surplus made is kept by the PCT. The percentage of savings given to GPs varied between sites. Sites A and C followed Department of Health guidelines by giving GPs 70 per cent of the savings made and keeping 30 per cent for themselves (though in site C this is the case only for secondary care budget savings, the split for prescribing budget savings being 50:50). However, guidance levels are not mandatory, and in site D a 50:50 split between the PCT and GPs was negotiated. In site B, practices have agreed not to receive any of their savings in order to allow the PCT to pull itself out of deficit.

Some GPs had managed to make savings in 2006/7 but had not yet spent them in March 2008. This was because guidance around what GPs can and cannot spend savings on is ill defined, which allows PCTs to determine rules at a local level. Savings have to be spent within the same year, so if GPs had not spent the money by the beginning of April 2008, they would have lost it. Some GPs said this was a significant disincentive to their making savings in future years.

### **Business case approval**

The PCT has an obligation to oversee the commissioning decisions of GPs, ensuring that they set up services that are appropriate to their populations' needs within budget. To ensure PBC initiatives are clinically safe and financially viable, PCTs have designed various governance processes for the approval of PBC business cases. The Department of Health recommends that business cases should be considered and approved or rejected within eight weeks of submission. However, GPs in all our sites complained that the delay between submission and response would often be considerably longer than this. In some cases, GPs were still waiting to receive approval more than six months after submission.

In site B, GPs said that a number of business cases had entered the approvals process but none had come out the other end. Some had been rejected outright, while others had entered the process but the GPs had heard nothing since. This was a familiar story in the other sites, too. Only site C was able to produce a complete list of business cases and their progress through the system.

GPs often felt that the business case approval processes were overly bureaucratic and required an unacceptable investment of their time and energy. Some interpreted this in terms of the PCT being deliberately obstructive towards PBC:

*...let's make sure [governance is] so tight and so bureaucratic that it probably won't be able to work.*

(GP, site A)

*The business plans, it's a bureaucratic nightmare! We have to fill in one set of forms then another set of forms. And then it goes to this committee – or sub-committee – of the board – it doesn't even go through the [professional executive committee] – where the doctors are there, allegedly. And they decide whether it's a good case or not. And then it has to come back and then we have to do a full business plan.*

(GP, site C)

In response to this view, PCTs said that the governance issues, particularly conflicts of interest (see pp 43–45), inherent in PBC were complex and that it was taking time to get them right.

In sites B and D, new approvals processes have been developed in which GPs present their commissioning ideas to the PCT at a very early stage in the idea's development. Promising ideas are then worked up into fuller business cases with help from the PCT. This process is intended to pick up major problems with business case ideas at an early stage and ensure time and money are not spent developing ideas that would later be shown to be unviable.

Clearly there is a trade-off between a process that is robust enough to ensure clinical quality and financial accountability, and the fast implementation of business cases avoiding bureaucracy. It is not yet clear if PCTs have got this balance right.

## Managing clinical risk

Having considered the financial risks of PBC and the weakness of the tools available to PCTs to manage them, we now turn to the important clinical risks associated with moving care out of hospitals.

PBC creates incentives to move services into the community if they can be provided more efficiently there. These services can be provided by hospital clinicians in a GP practice or polyclinic, by GPs or other primary care professionals who have received additional training, or by a private provider. For these schemes to be successful, good clinical governance is essential to ensure that quality is not compromised when the location, and sometimes the organisation providing a service, is changed.

In one site, clinical governance is identified as a major factor that is slowing down the PBC process. The PCT wants to ensure that PBC schemes are safe but, according to interviewees, there are gaps in the PCT's clinical knowledge that mean that gaining this assurance takes time.

*We need more clinical experience from people who aren't connected to the project to say whether they think it's safe or not, because I feel you can't have someone who is non-clinical like me deciding on whether a project is going to be safe or not.*

(PCT staff, site B)

Concerns about clinical risk were particularly acute in cases where hospital clinicians had not been involved in designing new services. For example, in site C, hospital staff were comfortable with an ophthalmology triage service in which they had been involved at the design stage, but they had concerns about a community-based ear care service that

had not involved their input. Their main concern was that assessments performed by less skilled community-based staff might lead to serious conditions not being detected until a later stage:

*We do see late presentation of patients with ear problems. They [community based ear care centre] don't have an audiologist providing that service who's highly trained; they have a nurse who's done a course. I don't want to belittle her qualification but it's different... I think the clinicians would say there's inappropriate assessment.*

(Hospital staff, site C)

Similarly, in site B, a GP-led emergency centre was planned, but a hospital clinician raised concerns about whether GPs had enough training to judge when cases needed to be referred on to the hospital emergency department for treatment.

## Patient and public involvement

According to the national guidance, practice-based commissioners are required to involve patients and the public in their commissioning decisions. Our research suggests that this has proved to be difficult, with interviewees describing two main challenges in establishing effective patient and public involvement (PPI) in PBC.

First, PBC can be difficult for patients to understand, and investment in education was necessary for patients to be sufficiently informed to be able contribute to the process in any meaningful way. Second, it was difficult to find an effective way to engage patients in PBC.

In three of our case study sites, these challenges were evidenced by a lack of patient involvement in PBC. Groups of patients were consulted about specific proposals to redesign services of particular relevance to them, but there was no patient involvement in the prior processes of generating ideas or setting priorities for commissioning. A number of interviewees said that they relied on GPs to represent their patients' views. All sites acknowledged that there was little awareness of PBC among members of the public and that persuading them to engage with it was difficult.

In site D, however, strong public engagement structures were in place. GPs were required to demonstrate PPI on their business case submissions (also in other PCTs), and such a requirement was also part of the locally agreed incentive scheme. The PCT and local GPs had developed a web-based PPI toolkit that provided resources and advice for GPs. One of the PBC clusters at this site had also set up a patient reference group, which meets every two months and feeds into the cluster meetings. There had also been an increase in the number of patient groups in practices, and interviewees reported that patients' representatives were well informed, asking challenging questions about how PBC was being managed within the PCT. However, even in this site a PCT staff member raised the concern that this might be a 'tick box' exercise.

It is not yet clear whether extensive public engagement structures of the type set up in site D will have an impact on the way PBC develops in the site.

### Summary

- The complexities around managing financial and clinical risks are slowing down the approval and implementation of business cases. GPs feel that PCTs are being overly risk averse, while PCTs stress that effective processes must be in place.
- Although financially accountable, PCTs have few levers or sanctions available to them to hold GPs to account for their referral behaviour.
- Only one site appears to be really committed to PPI, and it has gone to great efforts to ensure GPs undertake PPI activity before submitting business cases.
- Some GPs interpret bureaucratic complexities in terms of PCT hostility to PBC.

## Conflicts of interest

Conflicts of interest in PBC policy are experienced both by GPs and the PCTs.

### Conflict at GP level

Conflicts of interest arise from GPs having the opportunity through PBC to be both the commissioners and providers of a service. There is a risk that this could result in GPs' commissioning plans focusing on areas in which they can provide services and that, once business cases are drawn up for these areas, the GPs will commission themselves in preference to other providers. Not all the PCTs in our study sites have developed robust governance processes to deal with such conflicts adequately, and where they have they have not yet been tested. This throws up important issues around patient choice and competition. If patient choice between providers is subverted, then not only do patients not have free choice, but also acute providers will not respond to choice as a driver of quality improvement.

*I think my main concern about the... triage in particular is about patients being offered choice. Because, clearly, anybody who goes through a triage facility is not being offered choice.*

(Hospital staff, site C)

In site B, many of the GPs were part of a private provider company. Some raised concerns that GPs involved in writing a PBC service specification as commissioners were also potential providers of that service, although the PCT felt that it was dealing with this by using the GPs for their knowledge initially, and then excluding them from the later stages of the procurement process.

In site A, some of the GPs involved in PBC also sat on the professional executive committee (PEC), which considers the clinical aspects of business cases submitted under PBC. Although they did not consider financial data on the business cases, it could be argued that they were privy to inside knowledge about commissioning plans that other potential providers would not have had access to.

In all sites, the hospitals were concerned about these conflicts. Some felt it might stop them from being able to expand into primary care and vertically integrate their services. In some cases, they felt they had not had a fair opportunity to bid for services.

*A group of GPs... have decided to set their own limited company up to tender a bid to the PCT to take the workload on. And, interestingly, one of the GPs that is on that*

*public limited company also sits on the committee that is making the decision as to where the funding will be allocated in terms of which tendered bid will be looked on most preferentially by the PCT.*

(Hospital staff, site B)

Three of the case study sites seemed to rely on honesty and transparency to avoid potential conflicts. GPs were encouraged and expected to declare any conflict of interest as it arose in cluster meetings and not take part in discussions where participation was inappropriate. One PCT said that PCT directors had to make 'objective decisions' to avoid conflicts.

In site B, the PCT tried to embed structures that would stop a conflict from occurring. Practice-based commissioners were required to declare themselves to be either a commissioner or a provider. Only commissioners could sit on PBC boards. However, the decision about whether to be a commissioner or a provider is made by individual GPs, so a potential provider could work in the same practice as a GP on the PBC board. This PCT was also having difficulty finding GPs to sit on the business case approval panel who did not have any potential conflicts of interest, and had resorted to recruiting GPs from outside of the PCT:

*It does make it difficult at times because trying to find people to sit on the evaluation panel for tenders can be quite difficult. We've had to go outside of the PCT area to get that.*

(PCT staff, site B)

Despite these structures, PCTs are still reliant on honesty for any conflicts of interest to be avoided. Although some GPs and PCT staff thought this conflict was a fundamental flaw in PBC policy that could not be overcome, others felt common sense and robust governance structures could adequately deal with the problem. The structures and processes that had been put in place were yet to be tested at the time of the research.

## Conflict at PCT level

Conflicts of interest also arise in the PCT if it is a provider as well as a commissioner. Although nationally PCTs are starting to move their provider services to arm's length bodies, in our PCT sites this move was not complete. In some sites, interviewees suggested that provider services held an advantage in terms of inside knowledge when bidding to provide PBC schemes.

In site C, the PCT's provider services were the first port of call for most PBC pilot schemes. They argued that the schemes were not of high value and so not of interest to the private sector. Although they may be subject to a wider bidding process if rolled out after pilot stage, it is clear that, as providers of the pilot, the PCT provider services would hold an advantage in this process.

*Most of our services, we tend to get from our provider services. Because, if it's a pilot, you see, it's easier to use your own staff because, if you tender for something, it takes probably 12 months to go to a market test. And then, if you're tendering for a six-month pilot, it's not a very attractive option for the independent sector. So we tend to place it with our provider service so they can pilot it. And then we'd tender if it was a success potentially.*

(PCT staff, site C)

In site A, an accident and emergency department (A&E) triage service was set up to assess patients at the front door of A&E before they entered (and incurred any cost), so that, where appropriate, patients could be redirected to the local GP practices that

were operating out-of-hours services. Three GP practices were used for the scheme, and were reimbursed for the extra treatment they gave these patients. It was unclear how these practices were selected and, after complaints from other practices about lack of transparency, the scheme was aborted.

In site C, the hospital complained that a contract for direct diagnostics had not been properly tendered by the PCT and was awarded to a company with which the PCT had an existing relationship. The hospital was frustrated that it had not been given a chance to bid for the service in a competitive tendering process, an issue that raises questions about the application of competition rules.

### Summary

- Conflicts of interest arise out of GPs and PCTs having the potential to be both providers and commissioners. Processes to manage the conflicts of interest that can consequently arise have been developed in some sites but not fully tested.
- There is concern that the ability of GPs to refer to their own services subverts patient choice, which, in turn, means that hospital trusts will not respond to choice as a driver of quality.
- Concerns were raised in some sites over a lack of transparency in tendering for services.
- In some cases these concerns have had an adverse impact on relationships between PBC stakeholders.

### Wider contexts

Our research revealed that wider contextual factors have had a profound effect on the implementation of PBC. Although some acted to motivate GPs to engage (albeit defensively), others acted to discourage GPs from becoming involved, and presented obstacles to PCTs in their attempts to support PBC.

During the three years in which PBC has been operational, relations between GPs and the government have been strained by a number of policy developments, particularly in 2008 by the heated debate over GP extended hours and changes to the GP contract. Many of the GPs interviewed suggested that PBC had been a victim of these disputes, with GPs becoming less likely to engage in a 'partnership' with PCTs that were perceived to be conduits for government policy.

*I'm disillusioned because the profession is being dismantled in front of our very eyes... [GPs] are just punch-drunk.*

(GP, site D)

In addition, other reforms or policy ideas under discussion at the time were proving to be distractions for PCTs and GPs. In many areas, PBC had ground to a halt during our second wave of interviews as stakeholders waited for the conclusions of the NHS Next Stage Review. This was expected to have profound implications for the future of primary care – particularly around the contentious issue of polyclinics – and several interviewees considered it unwise to embark on any service developments before the release of the final report.

The effect of these political tensions may not have been entirely negative. Several GPs, including some of those leading PBC in their areas, described their motivation to engage

in PBC in terms of a defensive reaction to this contextual environment. They perceived general practice as being under threat from private sector companies and policies such as polyclinics, under which smaller practices could be merged, and saw PBC as a useful tool for defending themselves against these changes. By using PBC to group together and become more involved in wider decision-making, they felt they could strengthen the position and power of general practice within the health system.

*PBC is important in the fact that, if we don't do it, this practice will fold because it's a smaller practice and I know the government have got an agenda about smaller practices and trying to get them into big polyclinics...if we don't progress with PBC, we don't try and show that we are as efficient as any larger practice – that we can manage our budget pretty well – then we're going to fold. And all the patients – the 4,000 patients – that we hold here will have to go into a big polyclinic.*

(GP, site A)

*[A GP colleague] has been very engaged simply because she's lived through the effects of privatisation... So I think her motivation is to make sure that we maintain quality and sort of fight off the competition.*

(GP, site B)

Another contextual factor that has had an effect on the implementation of PBC was the common perception that the policy was not a national priority. Interviewees suggested that the signals coming from central government with regard to PBC were not as strong as the pressure to meet other goals, such as achieving the 18-week target, tackling hospital-acquired infections, and achieving financial health. PCT staff felt that there was little emphasis on PBC in the world class commissioning competency framework, and that this raised questions about whether PBC was to play a significant role in the Department of Health's strategy to improve the quality of commissioning.

Given this perceived lack of prioritisation at a national level at the time of this research, there was a feeling among some that the government might 'pull the plug' on PBC and that there was therefore little point in investing time and resources in it.

*I wouldn't want to become too totally committed to it in case they suddenly pull the plug.*

(GP, site D)

Many GPs were waiting to see clearer signals that PBC would continue to exist before becoming more involved. Several suggested that the coming year would be crucial for PBC, that if there was not a clear signal from central government that the policy is a high priority, GP engagement would be likely to fall below the 'critical mass' necessary for its survival. Whether the final report of the NHS Next Stage Review has provided this clear signal is addressed in Section 7, in particular the section on 'Current policy directions'.

Another important contextual issue that has played a role in impeding PBC is the difficulty in defining core GP work. As discussed at the beginning of this section, the lack of prescriptive national guidance has led to confusion about certain elements of the policy. The definition of what constitutes core GP work, as reimbursed under the GP contract, and what should be paid for in addition under PBC, is an example of this lack of clarity. This was cited as a particular problem in site C, where a number of interviewees named it as one of the main barriers to PBC progress.



### Summary

- Wider contextual factors are inhibiting the progress of PBC.
- A lack of prioritisation of PBC at a national level has led GPs to disengage from it because of a concern that the policy might change or disappear.
- Poor relations between GPs and the government at the time of the research were clearly having an adverse impact on GP engagement and enthusiasm for the policy.
- Competing priorities at a PCT level discourage GPs.
- The complexity of defining what constitutes 'core' GP work and what is 'extra' and therefore eligible for extra PBC funding is a further hamper to the progress of PBC.

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# 6 Discussion: understanding progress and impact

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The evidence from the four case study sites in our research suggests that, in the three years since practice-based commissioning (PBC) was introduced, overall progress has been slow. PBC has had a low or very modest impact on commissioning activity and service redesign in our study areas, despite those sites having been chosen specifically because the primary care trusts (PCTs) there were expected to be further ahead with PBC development than most (*see* Section 3).

It is not suggested that progress in the four case study sites is necessarily representative of PBC nationally, but it does appear to reflect the picture emerging from the four PBC surveys undertaken by the Department of Health (2008d), as well as the views that emerged from the seminar of experts held as part of this study (*see* Appendix B).

This section discusses why progress with PBC has been so slow. It draws on the barriers identified in Section 5, and relates these to evidence from earlier attempts to develop practice-led commissioning, and to the views expressed in the expert seminar. It divides the barriers encountered into those relating to the national context, those relating to the local context, and mechanistic barriers within the policy itself. It concludes by reflecting on those barriers that have been the most significant in limiting progress.

## The national context

The national context, particularly the wider political environment, had an important effect on progress in all four sites. Key observations that emerged from our research included the following.

- **Conflicting visions** The lack of a clear vision for the policy and its many competing objectives contributed to local conflict and tensions. For example, there were disagreements about whether its focus was on engaging clinicians in commissioning, managing budgetary deficits and/or stimulating local access to services.
- **PBC is not perceived as a national or PCT priority** Although the rhetoric placed the policy of PBC as central to commissioning reform, respondents – general practitioners (GPs) and staff from the PCTs and NHS trusts alike – often reported that PBC was regarded as being less important than other PCT priorities, such as the 18-week target, control of hospital-acquired infections, and the financial health of the PCT. Some GP respondents felt that PCTs were not adequately held to account in their role as supporters of PBC.
- **PBC is not perceived as a priority for GPs** The ability and willingness of GPs to make PBC a priority was limited since it sat alongside other commitments such as fulfilling the terms of the new GP contract, including the targets in the quality and outcomes framework.
- **PBC does not fit with world class commissioning** PCTs reported that their future commissioning responsibilities would be led by the competency framework for world class commissioning, and many pointed out that there was nothing in that framework

covering the role of, or justification for, PBC. This led them to question whether, in reality, PBC was a national priority.

- **PBC will be replaced sooner rather than later** The perceived lack of national support for PBC led some respondents to predict that PBC would go the way of previous practice-led purchasing innovations.
- **GP–government relations** During the period of this research, relationships between the British Medical Association (BMA) and the Department of Health were poor, with heated debates over polyclinics, GP opening hours and other changes to the GP contract, as well as claims by the BMA that general practice was under the threat of ‘privatisation’. This may have affected the ability of PCTs to draw GPs into a ‘partnership’, with some family doctors feeling that their goodwill had been compromised.

National factors have been shown to be critical in studies of earlier attempts at practice-led commissioning. For example, the impact of NHS reorganisations was reported as a key barrier to progress (*see* Section 2). In our investigation, the national context appears to have created a *negative* environment within which GPs and PCTs were attempting to take PBC forward. Although distrust and negativity towards PBC was by no means universal, when things did go wrong (for example, delays in the approval of business cases), the adverse political context might have encouraged a more negative interpretation of events (for example, by attributing malign intent to the other parties involved).

However, there is evidence that PBC has made considerable progress in some parts of the country, particularly as reported by proactive practice-based commissioners who attended the expert seminar (*see* Appendix B). Therefore, in terms of explaining the progress of PBC, the national context could be considered ‘sub-optimal’ rather than insurmountable. Indeed, it is possible that GPs and PCTs have used the national context as an excuse for the lack of local progress.

## The local context

A number of local contextual issues emerged from our research as key factors in the relative speed of development of PBC.

- **Financial deficits** Our study showed that PBC was provided with less support and made less progress when significant financial deficits were present. However, in site B, where addressing the financial deficit was agreed as an explicit local objective for PBC, this appeared to give PBC more focus and encouraged practice-based commissioners and the PCT to work together to solve this shared problem.
- **Capacity and capability** All sites reported significant shortcomings in the availability of staff, skills, time and facilities in PCTs and GP practices to support PBC implementation. The lack of adequate leadership and management support was a negative context faced by all sites.
- **Relationships** The progress of PBC has been influenced by the relationships between key stakeholders. Our research suggests that good functional relationships are a prerequisite for effective PBC, given its focus on a working partnership between PCTs and GPs. Where historical relationships between parties were poor, there was a greater level of distrust, leading to disagreements and conflict. In sites where governance systems had been more carefully constructed and there was also a history of collaborative working, there tended to be a greater sense of co-operation, greater enthusiasm, and more opportunity for progress to be made.

Variations in the nature of local contexts affected the relative speed of progress across the four case sites. The presence or absence of financial deficits was perhaps the most important of these factors, though our evidence suggests that deficits are not an insurmountable barrier as long as there is an open and honest dialogue about using PBC as a mechanism to manage demand. Historical relationships, often at a personal level, were also significant in how the dynamics of PBC developed. There was evidence, however, to show that relationships could be improved by clarifying roles and responsibilities or by the provision of data and budgets.

Capacity and capability were perhaps the most difficult problems to address and can be seen as a persistently negative contextual factor going back to historical studies of practice-led commissioning. Nevertheless, our research shows that investment by GPs in PBC business managers and/or greater support and attention from PCT commissioners was possible and could improve the capacity and skills-base. This was a particularly strong conclusion from the expert seminar, at which the presentations from the two proactive practice-based commissioners commonly reported comparatively sophisticated organisation and governance arrangements, a substantial investment in leadership and managerial support, and attention to key details such as the production of accurate and timely data. This was facilitated by the fact that these proactive practice-based commissioners had developed large corporate entities in which direct enhanced service (DES) payments were channelled into developing effective managerial support structures.

It should be noted that, although the availability of commissioning skills appears to some extent to be a national problem, the limitations in capacity and capability reported by our interviewees also arise out of the level of priority relative to other commitments in their daily working life afforded to PBC by GPs and PCT commissioners.

## The mechanisms and architecture of practice-based commissioning

The third kind of barrier emerging from our research relates to the mechanisms and architecture of PBC itself. A key task of this research was to tease out how key mechanisms (and combinations of mechanisms) have acted to enable the PBC policy to achieve its objectives, or have prevented it from doing so. In particular, the research assessed whether PBC mechanisms provided an enabling structure of tools and incentives with which GPs and PCTs could work together to meet local objectives or stimulate service innovations.

Respondents from across the sites discussed a wide range of problems associated with the mechanics of PBC, such as the lack of reliable data, the inability to set or agree PBC budgets, the complexities of the process of developing and approving business cases, and the difficulty in unbundling tariff prices for secondary care services. These problems were often highly time-consuming to overcome, and had contributed to a lack of progress; indeed in some cases they had fuelled the deterioration of key relationships.

Mechanistic barriers have meant that more energy has been spent in developing the organisational infrastructure to allow PBC to operate, than in the actual operation of PBC. A review of the historical evidence might conclude that it is possible to argue that investment in the many organisational processes involved can lead to progress in the longer term, and such an observation is somewhat supported here since some of our sites reported the number of business case submissions and other commissioning activities to have accelerated, albeit slowly, once governance structures and processes were in place.

The architecture of the PBC policy itself has also posed problems. Our research has shown how the permissiveness of its guidance and its multiple goals have led to a power play between PCTs and practice-based commissioners as different agendas were pursued simultaneously. Barriers related to the detailing of roles and responsibilities between

stakeholders and the determining of governance and accountability structures have all required a significant amount of time to resolve. Persistent issues related to differing priorities, conflicts of interest, and differences of opinion about whether GPs should be working in partnership with PCTs or given direct budgetary freedom have remained underlying barriers to progress. It could therefore be argued that PBC as a policy has some unresolved architectural flaws that will not be resolved by time alone.

## Understanding progress

Is the limited progress made by PBC best explained by contextual or mechanistic barriers, or a combination of both? In theory, it could be that PBC is an ‘appropriate’ policy but that its impact has been ‘stifled’ by non-receptive contexts for change. Alternatively, it could be that the mechanisms and architecture of the policy itself are flawed, leading to ‘underachievement’ despite supportive contexts (*see* Figure 3 below). In practice, our research suggests that progress with PBC has been slow as a result of a combination of *both* contextual barriers *and* mechanistic failures (low/no achievement in Figure 3). The question that is harder to answer is whether PBC can emerge as a successful policy from this position.

**Figure 3** Achieving progress in practice-based commissioning: the interplay between context and mechanism (adapted from Goodwin *et al* 2000, p 61)

<b>CONTEXT</b>	<i>Receptive</i>	Underachievement	Optimal achievement
	<i>Non-receptive</i>	Low/no achievement	Stifled achievement
		<i>Inappropriate</i>	<i>Appropriate</i>
		<b>MECHANISM</b>	

One of the startling features of our analysis is just how closely the current barriers identified mirror the historical evidence (*see* Section 2). Indeed, although the currency of the debate has changed, what is revealed is that PBC appears to be a rerun of history. As a mechanism for shifting care out of hospitals and leading to service redesign, PBC has not fundamentally altered the power in commissioning relationships, which are still dominated by large providers. Given the historical turnover of commissioning policies, such providers may opt to ‘wait and see’ rather than respond to the agenda, in the belief that PBC will soon ‘exit stage left’ as the next set of reforms appears in the wings.

This raises the question of whether we can expect anything different to result as PBC evolves. Like previous voluntary GP-led commissioning schemes, there is the possibility that PBC will be characterised as a part-time amateur sport pursued by innovative GPs, with PCTs giving it a low priority because their ‘day job’ lies elsewhere.

The questions raised by this report are fundamental ones. Is PBC likely to become a policy cul-de-sac or can it play a useful role as a key pathway to system reform? Can it be reinvigorated, and if so, how? If it cannot, how might it be replaced? Should it simply be abandoned? It is to these questions that this report now turns.

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# 7 The future of practice-based commissioning

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Our research shows that practice-based commissioning (PBC) is not achieving the aims set by the Department of Health. It is being held back by a range of barriers, some intrinsic to the policy itself, others related to the national and local contexts within which it is being implemented. If PBC in its current form is to emerge as a successful reform mechanism, the following would need to be achieved as a minimum.

- A clearer vision for the future role and remit of PBC. This would replace the current set of competing visions with a new consensus, making it clear whether PBC is a tool for small-scale local innovation or for broader service redesign.
- PBC would need to be a higher priority at every level and would need to be fully integrated into the world class commissioning framework in order to demonstrate its strategic importance and contribution.
- The roles and responsibilities of primary care trusts (PCTs) and practice-based commissioners would need to be more clearly differentiated and articulated.
- Clear arrangements for governance, accountability and performance management would need to be agreed. These would need to provide ways of resolving the current conflicts of interest within PBC.
- PBC would need to be properly resourced and supported. The capacity and skills in PCTs and among general practitioners (GPs) remain limited. Education, professional development and commissioning support would need immediate investment. PCTs would have to be made accountable for the quality of the support they provided to practice-based commissioners.
- Current failures in the mechanics of PBC would need to be resolved. Issues relating to PCT support of practices, the generation of timely and reliable data, and the setting of indicative budgets would have to be resolved quickly.
- The right ‘payment mix’ would need to be found to provide effective incentives for participation.

Removing these barriers would be a huge challenge – indeed, it is questionable whether it can be achieved without more fundamental change.

The principal problem indicated by our research is that it will be difficult to reinvigorate PBC so long as it remains a ‘hybrid’ model that seeks to involve GPs in a voluntary commissioning ‘partnership’ with PCTs while also devolving some of PCTs’ budgetary control to GPs. These partnerships have been strained by the inevitable differences in perspective between population-based commissioners and providers (that is, PCTs) on the one hand, and practice-based commissioners and providers on the other. PCTs have been unwilling to let go of responsibilities to voluntary, non-statutory PBC groups that they regard as unaccountable users of public funds with a tendency to think locally and entrepreneurially rather than strategically or for the good of the wider community. In addition, the fact that devolved budgets are indicative, with ultimate

financial responsibility resting with the PCT, has meant that there is a limited financial incentive for GPs to engage with PBC, and has increased the desire of the PCTs to retain responsibility for the majority of commissioning decisions.

As the hybrid model is unlikely to succeed, there are two possible changes that could be made to the system of budgetary accountability. First, real budgets could be devolved to GPs or other groups of health care professionals in order to strengthen budgetary accountability and the financial incentives associated with it. Second, an engagement model could be pursued, in which accountability for budgets remains with the PCT, while GPs and other clinicians play an advisory role, providing clinical input into PCT commissioning decisions as well as being directly involved in contract negotiations and performance management. Our argument, developed in the rest of this section, is that these are not mutually exclusive options. Rather, both are needed, each being appropriate to different service types.

## Devolving real budgets

A strong message from history is that practice-led commissioners have been more engaged and made more progress in terms of services commissioned and provided when they have been given the freedom to contract independently – albeit more for the micro-purchasing of primary/elective care that is ‘re-provided’ than for redesigning activities aimed at addressing wider public health concerns (Smith and Goodwin 2006).

This suggests that devolving real budgets and giving increased autonomy to practice-based commissioners might be part of the way forward for some commissioned services. Budgets could also be devolved to integrated care organisations (ICOs), which aim to provide integrated primary, community and social care services and to align incentives through amalgamating the commissioner and provider roles. This would have the advantage of broadening the leadership of PBC to embrace the collective views and knowledge of local health and social care professionals, and would avoid the potential parochialism associated with a purely GP-based perspective.

However, if practice-based commissioners or ICOs are to be granted real budgets, our evidence suggests that there would need to be some important caveats.

- It is clear that practice-based commissioners have been primarily interested in the re-provision of services that are based in primary and community care settings and, on the whole, have not sought to address the more strategic commissioning activities related to whole patient pathways. The scope of what can be purchased by budget-holding practice-based commissioners would need to be well defined within the overall strategic vision, with its ‘core business’ centred on elective care and the development of primary and community-based alternatives to non-elective care. It would be more appropriate for this strategic priority setting to take place at a PCT level, albeit with clinical engagement (*see below*).
- The conflict of interest question would need to be tackled head on, and robust governance arrangements put in place to ensure that patient choice and the quality of GP referrals are not compromised and that clinical risk is managed appropriately.
- Robust evaluation would be required to assess the value-for-money of devolved budgets as this policy is likely to increase the transaction costs linked to administration and contracting and therefore needs to demonstrate its quality and effectiveness in terms of better patient care. It might be that transaction costs are a function of scale, and that large commissioning groups could be as efficient as PCTs. The lessons of GP fundholding would need to be carefully considered so as to avoid the pitfalls of high

transaction costs and lack of transparency with regard to how any savings generated were spent.

- Investment in data collection and analysis to inform decision-making is essential, as is the power to undertake robust assessments of the quality of care so that contracts can be effectively performance-managed.
- A clear method of allocating budgets would need to be developed to ensure that budgets for defined services are understood and felt to be fair by practice-based commissioners.
- Clarity would also be required around where responsibility lies for all the different stages involved in commissioning, including needs assessment and contracting.
- PBC groups and ICOs would need to be clinically led. GPs and other professionals need to feel ownership of their organisation and be provided with incentives to work collectively towards its goals.

Our research, along with the historical evidence, suggests that giving PBC groups or ICOs real budgets – and thereby real statutory responsibility – could solve some of the key failures in the current scheme related to the lack of freedom to innovate, the low level of engagement by GPs, and the lack of accountability. However, many of the mechanistic barriers related to data, budget setting, roles, responsibilities and governance would remain to be resolved. Most importantly, even if PBC were to operate at its best, it is not appropriate for the entire health care budget to be devolved to this level.

The option for devolved budgets also raises significant issues about how strategic commissioning activities at a PCT level can be effectively combined with PBC priorities, which might be different. Although local innovation and autonomy is to be welcomed, important issues such as the growing number of elderly people with long-term care needs clearly require strategic planning and investment. If PBC is to sit within the requirements of world class commissioning, for example, this implies a requirement for practice-based commissioners to be engaged with both the strategic and the local agendas. Moreover, since current government policies are seeking to create a diversity of primary- and community-based organisations that compete with each other, devolving budgets to practice-based commissioners might potentially undermine contestability and patient choice.

To meet these agendas, an alternative model for devolved budgets would be for PCTs to tender with practice-based commissioners, ICOs or other organisational variants to deliver a specific service or range of services while simultaneously enabling these organisations to hold and deploy commissioning budgets in a risk-sharing arrangement.

The organisation winning the tender would have the freedom to provide services directly and/or to contract with other agencies to fulfil the terms of the contract provided. Thus, the tender itself would enable the PCT to address strategic service redesign issues while also enabling the delivery agency to deploy budgets and redesign care in innovative ways. Holding budgetary responsibility would be key to the arrangement, as bearing some or all of the financial risk would encourage the delivery agency to manage resources effectively. Organisations making savings would potentially benefit from being able to redeploy resources locally, and would be able to create their own set of incentives for the professionals working within them – using a ‘shareholder’ arrangement, for example.

An early variant of such an approach was established in April 2007, when 54 GP practices formed Stockport Managed Care to manage resources and commission care on behalf of Stockport PCT.



## Clinical engagement in primary care trust commissioning

If, as argued, PCTs need to retain responsibility for certain strategic commissioning activities, it is essential for them to be guided by meaningful and effective clinical involvement. Clinicians need to play a role in setting commissioning priorities, in developing new care pathways or service models, and perhaps also in performance management. The relationships developed through PBC between GPs and PCT commissioning teams would need to be built on. Importantly, structures designed to involve clinicians in PCT commissioning need to be widened to include not only GPs but also hospital clinicians and other health care professionals (Liddell and Timmins 2008).

There is strong evidence to suggest that effective commissioning requires a collaborative effort between commissioners and providers, especially through clinical engagement during contractual negotiations. This can have a real influence on service redesign as it provides insights that technocratic commissioners often lack (Smith and Goodwin 2006). It is also important that strategic health authorities (SHAs) use performance management to ensure that PCTs are able to demonstrate that there is active and effective clinical input into their commissioning activity.

Our research does not lead to the conclusion that devolved budgets should be abandoned in favour of a model based exclusively on clinical input into PCT-level commissioning. Abandoning devolved responsibility would rightly be regarded as a significant breach of trust among those GPs who have invested a great deal of time and resources into building relationships and developing organisational structures for PBC to work. GPs have been persuaded several times in the past to engage with the wider NHS; to abandon the policy now would risk undermining any future engagement with commissioning.

Moreover, despite the lack of overall progress uncovered by our research, there was some evidence to suggest that PBC has encouraged changes in GP attitudes and behaviour, with GPs becoming more willing to examine their referral and prescribing practices through peer review. PBC also remains one of the few demand-management vehicles available to counter the potential for supplier-induced demand that is inherent in the Payment by Results system. This would be lost if clinicians reverted to being involved in commissioning in a purely advisory capacity only.

## Current policy directions

The *NHS Next Stage Review: Our vision for primary and community care* (Department of Health 2008c) acknowledged that ‘there is a widespread view that, with some exceptions, [PBC] has not yet lived up to its potential’, and set out the intention to ‘redefine and reinvigorate’ PBC. The key elements of the strategy laid out in that document were:

- granting high-performing PBC groups ‘earned autonomy’, with ‘increased freedoms in managing resources and designing services’
- ensuring that ‘PCTs are held to account for the quality of their support, including the management support given to PBC groups and the quality and timeliness of data’ through the world class commissioning assurance system
- providing incentives to involve a broader range of professionals in PBC
- distinguishing more clearly between GPs’ role in working collaboratively with others to commission better care and their role in providing enhanced services
- piloting ICOs.

Although few details on these proposals have been released as yet, there is much to commend the strategy. The reaffirmation of the government's commitment to PBC is something our research suggests was urgently needed, and the recognition of the need to engage other clinicians alongside GPs is welcome. The strategy also recognises the need identified in our research to experiment with ways of granting PBC groups more freedom from PCTs, although it is not yet clear whether the concept of earned autonomy will include the devolution of real budgets. Earned autonomy implies that PBC clusters might evolve from their voluntary status to be replaced with stand-alone and statutory primary care organisations with direct accountability and freedom in budgetary deployment.

However, the strategy must also recognise that commissioning is a complex, multilayered process that requires a multilayered mechanism. It is our contention that autonomous PBC groups should not be allowed to become responsible for the entire health care budget (in effect replacing PCTs), but rather need to sit alongside PCTs in a matrix of commissioning approaches.

## Using a matrix approach to commissioning

Our overarching conclusion is that the future of PBC and commissioning more generally lies in a matrix approach, recognising the need for different types of services to be commissioned at different levels. This conclusion echoes the wider evidence base (Smith *et al* 2004).

There are at least three levels at which commissioning could take place within the PCT unit:

- general practices (including other primary care professionals as well as GPs)
- PBC clusters
- the PCT.

At the GP level, it might be appropriate to devolve real budgets for specific, well defined areas of care, such as that for patients with long-term conditions. This would facilitate and encourage small-scale innovations such as the re-provision of care outside hospitals and self-management support, and strengthen the financial incentive to keep patients out of hospital, something that is weak in PBC at present. The piloting of personal health budgets from 2009 is also likely to be primarily co-ordinated at the GP level.

At the next level, a PBC cluster could be given devolved budgets for a defined range of primary and community care services of relevance to the communities and patients they would be accountable to. In order for this to happen, PBC clusters would need to develop statutory organisational identities, such as by becoming a social enterprise or private company. Larger practice-based commissioners covering more than 100,000 patients may have greater scope to undertake commissioning across a larger population and have a more lasting impact, such as by shifting care out of hospitals. By limiting the scope of the commissioning powers of GPs or a PBC cluster, many of the financial and clinical risk issues that emerged from our report as obstacles to progress would be addressed.

At the other end of the scale, PCTs would be responsible for more strategic commissioning. This would not only relate to public health, tackling health inequalities and facilitating acute-sector reconfiguration, but would necessarily involve issues that extend across whole patient pathways, such as long-term conditions, urgent care and the future of primary and community care services. Consequently, strategic commissioning at a PCT level would require collaboration with a range of health care professionals from

both primary and secondary care, with local authority partners, and with budget-holders at PBC and GP level. Clinical engagement panels would be established for this function and PCTs would hold the budgets. This form of clinical involvement in commissioning should be seen as complementary to, but distinct from, the work of practice-based commissioners with devolved budgets. The approach taken by the PBC policy so far – to attempt to combine both clinical engagement and budgetary devolution within a single process – has led to confusion and conflict among stakeholders and has not proven to be effective.

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## 8 Conclusion

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It is clear from recent policy statements that the government recognises the need to reinvigorate and redefine practice-based commissioning (PBC), and this need is emphasised by our research findings. Moreover, our research would suggest there is an urgent need to harness what remains of the limited enthusiasm of general practitioners (GPs) – particularly given the recent political environment, in which the relationship between GPs and the Department of Health deteriorated significantly.

First and foremost, it is essential that a clear vision for the aims and scope of PBC is set out, with a robust explanation of how the policy is to be integrated with the Department of Health's overall commissioning framework and other key policies, especially patient choice. Alongside this is the need for a message to be sent out – from central government right down to individual practices – expressing a strong commitment to PBC as a policy priority and a determination to ensure it will be allowed to succeed.

It is evident that the power play between PCTs and GPs is paralysing progress, and that the only way to overcome this is to recognise that different levels of commissioning can co-exist in the same locality. Some commissioning activities should be the responsibility of autonomous PBC groups, while others should be reserved for the PCT: defining which responsibilities lie at each level is a key challenge and should be determined nationally.

We welcome the government's statement of commitment to PBC as we feel that to abandon the policy of devolved responsibility altogether would be seen as a significant breach of trust and lead to further disengagement among primary care professionals. The decision to pilot integrated care organisations and earned autonomy for PBC clusters is also welcomed but there is a need for an overarching framework to be developed to provide much needed clarity about the long-term goals of the policy and the level at which responsibility for different commissioning decisions should be held.

Three years have passed since the inception of PBC, during which only very modest progress has been achieved. Energy and resources have been invested in the policy and it is important, not only from a resource point of view, but also from an engagement point of view, that it is not left to wither on the vine. The task now must therefore be to define the aims of the policy and develop clear workable structures; only by doing this will it be possible for the current modest gains to be retained and built on.

## Appendix A

# Coding framework

High level code	Second level code	Description
1	PCT context	<ul style="list-style-type: none"> <li>General information about the PCT (eg, financial situation, presence of foundation trust/independent sector treatment centre, particular factual points that help put the site in context)</li> </ul>
2	PBC policy	<ul style="list-style-type: none"> <li>What do interviewees believe PBC is intended to achieve?</li> <li>Use for general opinions about PBC (eg, do they think it is generally a good/bad idea), but not specifics about problems</li> <li>Include comparisons with fundholding</li> </ul>
	Intention	
	Opinion	
3	PBC arrangements	<ul style="list-style-type: none"> <li>Structures in place for PBC (eg, are GPs in clusters? have GPs formed a single body? how do the arrangements work [eg, a board that meets monthly]?)</li> <li>Processes/policies in place to make PBC work</li> <li>Note: this code might need sub-codes</li> </ul>
4	Level of engagement and communication	<ul style="list-style-type: none"> <li>The current situation with regard to GP engagement</li> <li>Strategies the PCT/GPs have employed to engage people</li> <li>Channels of communication (eg, Kingston is holding a workshop for GPs, PCT and the hospital to identify a strategic vision)</li> <li>Include communications with public, hospital and all other stakeholders</li> </ul>
5	PCT support	<ul style="list-style-type: none"> <li>Include any support currently offered by the PCT (in terms of data, information, staffing, policies and procedures) and suggestions for what is needed</li> </ul>
6	Roles of the PCT and PBC	<ul style="list-style-type: none"> <li>What is the role of the PCT in the new arrangements?</li> <li>Performance management?</li> <li>Are there tensions between GPs and the PCT with regard to commissioning?</li> <li>What is the role of practice-based commissioners in commissioning?</li> <li>Are there differences in the way stakeholders describe their roles in the system?</li> <li>Include differences between the priorities of PBC and those of the PCT</li> </ul>
7	Current barriers and facilitators	<ul style="list-style-type: none"> <li>Include everything that is helping and hindering PBC, such as deficits, lack of communication, presence of conflicts of interest, balance of power between bodies in the PCT – things that have an impact on whether it is working</li> <li>Note: may need to break this down into sub-codes when we have a better grasp of what they are, but from the first transcript it does not seem possible to separate barriers from facilitators</li> </ul>
8	Future barriers and facilitators	<ul style="list-style-type: none"> <li>What is needed to make PBC work?</li> <li>What is likely to prevent it from working properly?</li> <li>These points often come up when interviewees are asked how PBC will be working in six months'/five years' time</li> </ul>
9	Commissioning activity and initiatives	Now
		Future
		<ul style="list-style-type: none"> <li>What initiatives are in place or being discussed?</li> <li>Note the clinical area and what processes and service-specific procedures are in place</li> <li>Note the stage of development</li> <li>How do interviewees see commissioning in future (eg, what services will be provided and by whom?)</li> </ul>
10	Behaviour and relationships	<ul style="list-style-type: none"> <li>How does/will PBC affect the behaviour of clinicians and the balance of power between organisations?</li> </ul>

High level code	Second level code	Description
11	Impact	<ul style="list-style-type: none"> <li>■ What impact does/will PBC have on the volume of referrals and patient pathways?</li> <li>■ What impact will PBC have on other local and national goals?</li> <li>■ Also include financial impacts</li> <li>■ Are the changes due to PBC?</li> <li>■ Will there be unintentional or unexpected consequences?</li> </ul>
12	Accountability	<ul style="list-style-type: none"> <li>■ How are practice-based commissioners being held to account by PCTs?</li> <li>■ What forms of accountability directly to patients are being developed?</li> <li>■ What are the views of practice-based commissioners, PCTs and others on the extent and adequacy of accountability?</li> </ul>
13	Catch-all	<ul style="list-style-type: none"> <li>■ Free code where anything not captured in codes 1–12 can be put pending subsequent coding</li> </ul>
14	Quotes	<ul style="list-style-type: none"> <li>■ Particularly pertinent quotes that could potentially be used in reports</li> </ul>

PCT, primary care trust

FT, foundation trust

ISTC, independent sector treatment centre

PBC, practice-based commissioning

GPs, general practitioners

# Summary of expert seminar

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## The future of practice-based commissioning: reinvigorate, replace or abandon? Expert seminar, 25 September 2008

A group of 18 policy-makers, academics, practice-based commissioners and primary care trust (PCT) staff were invited to The King's Fund to discuss the findings of the report *The Future of Practice-Based Commissioning: Reinvigorate, replace or abandon?* This expert seminar explored whether the picture of practice-based commissioning (PBC) painted by The King's Fund's research in four case study PCTs in England reflected the experience of others working nationally.

Participants broadly agreed with the findings of the report. The picture of limited progress resonated with the experience of others. Even in areas of good progress, participants commented that enthusiasm for the policy was waning. There were, however, some examples of innovative practice in which PBC clusters were actively redesigning pathways, commissioning new services, pulling care out of hospital and generating savings. In some areas, the mindset of GPs had shifted; they had begun to consider the needs of the local population as a whole, rather than those of individual patients alone, and were scrutinising the activity data of their peers.

Representatives from two of these 'innovator clusters' made a presentation to the seminar. Although we could not draw conclusions on the characteristics that make a cluster successful, it is worth noting that both innovator clusters were large, covering the entire population of their PCT. This allowed them to provide a far greater level of managerial support to practices than that received by GPs in The King's Fund case study sites. Both innovators were funded by GP direct enhanced service (DES) payments, and one was formally set up as a social enterprise.

Although participants generally agreed that a formal organisational structure was associated with progress with PBC, causality was unclear. Do the innovators seek formal status, or does formal status encourage innovation and progress? One of the clusters operated in a PCT in severe financial deficit, implying success was still possible even when monetary constraints existed.

Many of the barriers identified in The King's Fund's research were familiar to participants, including those in innovator PBC clusters. Problems with data availability, budgets, unbundling the tariff, the slowness of PCT approval processes and a lack of PCT capacity to support practice-based commissioners had been universally experienced. One participant commented: 'Essentially, what the health service is trying to do at the moment in England is a sort of Herculean task with tiny, tiny resources. Your average PCT is not equipped to do the job.'

None of the seminar participants was aware of health care professionals other than GPs and practice managers being involved in the management of PBC. The group discussed the importance of clinical engagement from across the health service. This should include

GPs, other primary health care professionals, and secondary care clinicians. The nature of PBC meant there were currently few incentives for secondary care clinicians to engage. Integrated care organisations might provide those incentives in the future. Participants reported examples of hospitals forbidding their clinicians from talking to practice-based commissioners.

A number of participants reflected on the similarity between PBC and previous initiatives such as total purchasing pilots, primary care groups and GP fundholding. All agreed it was important to retain the institutional learning from those initiatives. There were also calls for a strong commitment to PBC from the government, and some felt its presence in the world class commissioning framework should be strengthened.



# Summary of findings

	Site A	Site B	Site C	Site D
<b>Financial position</b>	Deficit	Deficit (SHA has written off part of the debt but there is still a significant savings target this year)	Surplus	Surplus
<b>Geography</b>	Urban	Rural/urban mix	Rural/urban mix	Urban
<b>Cluster structure (see also Figure 2)</b>	<ul style="list-style-type: none"> <li>■ PBC support company formed by 27 of the 29 GP practices</li> <li>■ Within that company, GPs created informal groups to write commissioning intention documents</li> <li>■ One practice operates alone outside the main support company</li> <li>■ The other practice does not take part in PBC</li> </ul>	<ul style="list-style-type: none"> <li>■ GPs formed into two clusters that mirror historic working relationships</li> <li>■ One practice, which sits geographically between the two clusters, operates alone</li> </ul>	<ul style="list-style-type: none"> <li>■ Eight clusters covering populations of between 20,000 and 50,000</li> <li>■ The clusters are roughly based around the local area assemblies</li> <li>■ No plans to formalise clusters into limited companies</li> </ul>	<ul style="list-style-type: none"> <li>■ GPs grouped into five clusters</li> <li>■ Originally there were three based around localities, but two smaller groups have split away from this structure</li> </ul>
<b>GP engagement</b>	<ul style="list-style-type: none"> <li>■ Highly variable – a few highly enthusiastic leaders, but many GPs are disillusioned</li> </ul>	<ul style="list-style-type: none"> <li>■ Variable – seems to be increasing in one cluster, but decreasing in the other cluster, which had initially been the more enthusiastic</li> </ul>	<ul style="list-style-type: none"> <li>■ Variable – most are engaged to some extent, but there is not a lot of real ambition</li> <li>■ Three or four practices are highly enthusiastic, the others are 'box ticking'</li> <li>■ Some signs that engagement might be starting to improve</li> </ul>	<ul style="list-style-type: none"> <li>■ Variable – some becoming more engaged in response to recent efforts made by the PCT, others frustrated by lack of progress, and disengaging</li> </ul>
<b>General support</b>	<ul style="list-style-type: none"> <li>■ PCT provided little support to GPs</li> <li>■ There have been vacancies in the PCT's PBC team</li> <li>■ GPs formed a limited company to support PBC, but as yet the support provided has been limited</li> </ul>	<ul style="list-style-type: none"> <li>■ PCT attends cluster meetings and provides some support with business case development</li> <li>■ However, there have been many vacancies in the PCT's PBC team, and a lack of capacity at the PCT was seen as a major barrier to the progress of PBC</li> </ul>	<ul style="list-style-type: none"> <li>■ Fairly developed support for practice-based commissioners</li> <li>■ Public health needs assessments have been provided to practices and clusters each year</li> <li>■ The PCT's PBC manager has supported operation of the clusters</li> <li>■ As there are eight clusters, the manager's support has been thinly spread</li> </ul>	<ul style="list-style-type: none"> <li>■ Vacancies in the PCT's PBC team</li> <li>■ GPs complain of lack of support</li> <li>■ Each cluster employs a management lead using their PBC incentive payments</li> <li>■ The PCT organised a number of workshops for GPs</li> </ul>

	Site A	Site B	Site C	Site D
<b>Data</b>	<ul style="list-style-type: none"> <li>■ The Solis system was implemented to allow GPs to analyse data</li> <li>■ Data in the system is up to five months out of date</li> <li>■ Few GPs are using the data system</li> </ul>	<ul style="list-style-type: none"> <li>■ Major problems with data from one of their provider trusts; now solved but some historical referral data is still missing</li> <li>■ The PCT provided GPs with benchmarking reports using the data available</li> <li>■ Dr Foster system in place, but GPs not trained in using it</li> <li>■ Few GPs using the data system</li> </ul>	<ul style="list-style-type: none"> <li>■ MIDAS analysis system implemented and training provided by the PCT for GPs</li> <li>■ Data in the systems is three to five months out of date</li> <li>■ Few GPs using the system</li> </ul>	<ul style="list-style-type: none"> <li>■ Problems with Secondary Uses Service mean it has been difficult to give accurate and timely data to GPs</li> <li>■ Lack of data on costs cited by GPs as barrier to business case development</li> <li>■ Some GPs are collecting their own referral data to challenge the data from the PCT</li> </ul>
<b>Locally enhanced service payment (LES) for 2007/8</b>	<ul style="list-style-type: none"> <li>■ £0.95 per patient paid to all to support participation in PBC</li> <li>■ £0.95 per patient for practices that delivered a balanced budget and met the objectives of their 2007/8 commissioning plan</li> <li>■ Practices are encouraged to contribute 80 per cent of their LES to the running costs of their PBC support company</li> </ul>	<ul style="list-style-type: none"> <li>■ £0.95 per patient to support operation of cluster boards</li> <li>■ £0.95 per patient for performance against targets in six PCT priority areas such as emergency surgery for patients aged over 75 years</li> <li>■ Data problems have made it difficult to judge performance against these targets</li> <li>■ The LES was the main tool for influencing GP commissioning and referral behaviour in the PCT</li> </ul>	<ul style="list-style-type: none"> <li>■ £0.95 per patient for submitting a commissioning plan, to pay for PBC management costs</li> <li>■ £0.95 per patient for practices using the data analysis system, inputting into service reviews and keeping referral logs</li> <li>■ The LES was the main tool for influencing GP commissioning and referral behaviour in the PCT</li> </ul>	<ul style="list-style-type: none"> <li>■ £0.20 per patient for attending cluster meetings and demonstrating patient and public involvement</li> <li>■ £0.75 per patient for undertaking two data collection exercises and two clinical audits</li> <li>■ The LES was the main tool for influencing GP commissioning and referral behaviour in the PCT</li> </ul>
<b>Budget setting</b>	<ul style="list-style-type: none"> <li>■ Budgets set using fair shares capitation</li> </ul>	<ul style="list-style-type: none"> <li>■ Data problems have made it difficult to calculate budgets this year, and practice-based commissioners are 'shadowing' their indicative budgets</li> </ul>	<ul style="list-style-type: none"> <li>■ Prescribing and secondary care budgets are ring-fenced</li> <li>■ Allocations are gradually moving towards fair shares in accordance with Department of Health guidance</li> <li>■ The PCT takes a percentage of the overall budget as a contingency before practice-level budgets are calculated</li> </ul>	<ul style="list-style-type: none"> <li>■ Prescribing and secondary care budgets are ring-fenced</li> <li>■ Secondary care allocations are based on historic activity or weighted capitation where no historic data is available</li> <li>■ The PCT takes a percentage of the overall budget as a contingency before practice-level budgets are calculated</li> </ul>
<b>Savings allocation</b>	<ul style="list-style-type: none"> <li>■ GPs should receive 70 per cent of the savings they generate on budgets in line with Department of Health guidance, although it was not clear whether this was happening in practice</li> </ul>	<ul style="list-style-type: none"> <li>■ GPs have agreed not to receive any of their savings on budgets to help the PCT move out of deficit</li> </ul>	<ul style="list-style-type: none"> <li>■ GPs receive 70 per cent of any savings they generate on their secondary care budget</li> <li>■ GPs receive 50 per cent of savings on their prescribing budget</li> </ul>	<ul style="list-style-type: none"> <li>■ GPs receive 50 per cent of any savings they generate on budgets</li> </ul>

	Site A	Site B	Site C	Site D
<b>Business case approval</b>	<ul style="list-style-type: none"> <li>The PEC comments on clinical aspects of business cases that have been approved by a sub-committee of the PCT chaired by a non-executive director</li> <li>This committee did not seem to have considered any business cases at the time of the interviews</li> <li>The process for business case approval was not clear to all GPs</li> <li>There was no requirement for business cases to fit with PCT priorities, but less support for those that do not</li> </ul>	<ul style="list-style-type: none"> <li>The PCT has established a comprehensive business case approval process involving four gateways, the first of which involves presenting an initial idea to a group of PCT staff</li> <li>The idea gets more developed until final approval at gateway four</li> <li>GPs complain that it is cumbersome and cases go in but never come out</li> <li>The PCT encourages submission of business cases that fit with its priorities</li> </ul>	<ul style="list-style-type: none"> <li>Clear and developed governance structure for business case approval</li> <li>This starts with a PCT staff group commenting on ideas, which are then developed, sent to an advisory group if high risk or involving clinical governance, and finally approved by a sub-committee of the PCT board chaired by a non-executive director</li> <li>Some business cases have gone through the system and been implemented as pilots</li> <li>GPs can submit only business cases that fit with PCT and national priorities</li> </ul>	<ul style="list-style-type: none"> <li>One-page business case idea considered by the PEC</li> <li>If approved, the idea is developed by PCT staff and submitted to a sub-committee of the PCT board for final approval</li> <li>The PCT admits there have been difficulties with implementing business cases once they have been approved</li> <li>Five or six priority areas have been agreed by the PCT and GPs, and the PCT will provide full support to business cases developed in those areas only</li> </ul>
<b>Governance</b>	<ul style="list-style-type: none"> <li>Accountability structures not well defined</li> <li>Some GPs were concerned about lack of transparency in the GP support company</li> </ul>	<ul style="list-style-type: none"> <li>To deal with conflicts of interest, GPs must decide to be either a 'commissioner' or a 'provider'</li> <li>Providers are not allowed to sit on PBC boards</li> <li>Locally agreed incentive scheme and peer pressure from GPs were the main tools for performance managing GPs</li> </ul>	<ul style="list-style-type: none"> <li>In terms of accountability, the PCT relies heavily on peer review of referral data, which is rewarded in the LES</li> <li>No explicit concerns were raised about conflicts of interest – the PCT relies on transparency and honesty to avoid them</li> <li>Main concern was about defining core versus non-core GP work</li> </ul>	<ul style="list-style-type: none"> <li>LES implemented and designed to incentivise good outputs</li> <li>LES and GP peer pressure were the main tools for performance managing GPs</li> <li>The PCT relies on transparency and honesty to avoid conflicts of interest</li> </ul>
<b>Patient and public involvement (PPI)</b>	<ul style="list-style-type: none"> <li>Patients involved in some specific initiatives, but no PPI in PBC commissioning</li> <li>Patients did complain about the referral management centre, and an overview and scrutiny committee investigation into that was completed, although it is not clear if this should be categorised as PBC activity</li> </ul>	<ul style="list-style-type: none"> <li>Small amount of PPI on specific PBC schemes, although PCT admits there could have been more</li> </ul>	<ul style="list-style-type: none"> <li>They have found it difficult to get patients involved and interested in PBC</li> <li>Some consultation with patient groups on specific schemes, but otherwise they rely on GP patient groups or GPs to represent patients' views</li> </ul>	<ul style="list-style-type: none"> <li>Well developed PPI structures</li> <li>PCT has committed considerable resources to developing a PPI toolkit, which GPs must use when putting business cases together</li> </ul>
<b>Relationships</b>	<ul style="list-style-type: none"> <li>There are relationship problems among some GPs and between PBC leaders and the PCT</li> <li>Some of these may have existed before PBC, but have been exacerbated by it</li> <li>Relations between all stakeholder groups are often characterised by an 'us and them' climate</li> </ul>	<ul style="list-style-type: none"> <li>There is a history of poor relationships between the PCT and the acute trust</li> <li>Recent changes in senior management seem to have altered this, and also to have improved the relationship between the PCT and GPs, which some now characterise as a positive one</li> <li>GPs and the PCT are working together to solve financial issues</li> </ul>	<ul style="list-style-type: none"> <li>Generally good relationships in the health economy before PBC</li> <li>The impact of PBC on these relationships has been marginal</li> </ul>	<ul style="list-style-type: none"> <li>Relationships between PBC leaders and the PCT had become poor by late 2007, but have improved since a series of workshops were held to clarify the purpose and processes of PBC</li> <li>Relationship of GPs and the PCT with the acute trust are generally good</li> </ul>

	Site A	Site B	Site C	Site D
<b>Progress</b>	<ul style="list-style-type: none"> <li>■ Few examples of schemes up and running</li> <li>■ A referral management centre is the biggest scheme, but there is debate about whether that constitutes PBC</li> <li>■ A paediatric A&amp;E triage pilot was run for three months but dismantled due to GP unrest – several GPs voiced concerns about governance</li> <li>■ There have also been discussions about ultrasound and other diagnostic projects, but nothing set up</li> <li>■ In phase two, it seemed that the site had fallen behind the others in terms of structures, with a lack of clarity over governance and accountability</li> <li>■ The hospital reported some drop in referrals as a result of the referral management centre, but not in relation to other schemes</li> <li>■ Some GPs claim impacts from the A&amp;E triage scheme, but these were very variable and others claimed no impact.</li> </ul>	<ul style="list-style-type: none"> <li>■ No schemes up and running, although anti-coagulation was nearly ready to be launched in phase two</li> <li>■ There were many different projects being discussed, the biggest being a review of urgent care services across the PCT; this is being led by the PCT, with GP involvement</li> <li>■ As in site A, there is debate about whether this emerged out of PBC or would have happened anyway</li> <li>■ LES schemes established by the clusters are setting the priorities, all must strictly adhere to the PCT's resource management programme</li> <li>■ No measurable impact on referrals/admissions</li> </ul>	<ul style="list-style-type: none"> <li>■ Perhaps the site with the most examples of schemes up and running, albeit in small-scale pilot form</li> <li>■ GPs have instigated three main programmes: appointment of a community geriatrician, a scheme that is being run in one cluster and is likely to be rolled out across others; ophthalmology triage, which is being evaluated; and a very small initiative on prostate cancer that involves around 20 patients in one practice</li> <li>■ No measurable impact on referrals/admissions</li> </ul>	<ul style="list-style-type: none"> <li>■ As in sites A and B, few examples of schemes that are actually up and running</li> <li>■ One small-scale dermatology pilot is running</li> <li>■ Several other schemes were in the pipeline, and almost ready to go</li> <li>■ In this site, some GPs have focused on public health, an area that has not featured elsewhere</li> <li>■ GPs have also been pursuing clinical areas common to all sites (eg, anti-coagulation, diabetes)</li> <li>■ No measurable impact on referrals/admissions</li> </ul>
<b>PCT's vision for PBC</b>	<ul style="list-style-type: none"> <li>■ Primarily a mechanism for demand management</li> </ul>	<ul style="list-style-type: none"> <li>■ Primarily a mechanism for demand management</li> </ul>	<ul style="list-style-type: none"> <li>■ Primarily a mechanism for innovation and quality improvement</li> </ul>	<ul style="list-style-type: none"> <li>■ Primarily a mechanism for demand management in phase one interviews</li> <li>■ A tool for small-scale innovation in phase two interviews</li> </ul>

SHA, strategic health authority

GP, general practitioner

PBC, practice-based commissioning

PEC, professional executive committee

A&E, accident and emergency department

PCT, primary care trust

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