



What the Doctor Ordered

A study of GP Fundholders
in England and Wales

The Audit Commission

. . . promotes proper stewardship

of public finances and helps those

responsible for public services

to achieve economy, efficiency

and effectiveness.

What the Doctor Ordered

1 Benefits for Patients



2 Managing Fundholding



3 Managing the Scheme



4 NHS Trusts



5 The Way Forward



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Preface



Fundholders are family doctors (GPs) who take on responsibility for purchasing some hospital and community care for their patients. General practitioner fundholding is at the centre of government policy for developing purchasing and moving towards a primary care-led health service and the scheme is growing and changing all the time. Yet it is not well understood by everyone within the NHS or by the public.

This is one of a series of reports by the Audit Commission about fundholding. Other work includes:

- ◆ a paper describing the scope of the scheme, charting its growth and analysing the budgets which fundholders manage (Audit Commission, *Briefing on GP Fundholding*, HMSO, 1995); and
- ◆ a digest of information from two large-scale surveys of fundholding practices (Audit Commission, *Fundholding Facts*, HMSO, 1996).

In addition, the Audit Commission's appointed local auditors are assessing whether health authorities' management of the scheme and fundholders' budget management and purchasing achievements give good value for money.

This report concentrates on what is happening **within** fundholding – how the practices differ and how they are evolving. A classification of patient benefits has been developed to allow fundholders' performance to be compared, pointing to when practice is good, and showing how it is achieved. The study has also assessed management of the scheme, both within the practices themselves and in the health authorities, and shows how this is linked to the achievement of benefits for patients.

It is important to be clear what the report does **not** do. Firstly it does not compare fundholding directly with non-fundholding. However desirable such a comparison might be, it would be unsafe for several reasons, principally because GPs choose to become fundholders and they differ from those who choose not to in several important regards. Any success or failure could therefore be attributable either to fundholding as a system or to the nature of the particular GPs operating it, and there would be no way of apportioning their relative influence. Secondly, the research and report are confined in the main to the role of GPs as purchasers of secondary services: the provision of primary care services is not covered (with the exception of prescribing and payments to practice staff which are included with the fundholding budget). Lastly, the report does not deal in any great depth with the way in which fundholding has impacted on NHS trusts. However, the Commission does recognise the importance of this issue, and may return to examine the issues faced by trusts (and described in Chapter 4) at some point in the future.

The study was carried out by Dr Richard Waite and Russ Phillips under the direction of Dr Jocelyn Cornwell and Dr Jonathan Boyce. Pauline Allen, Lara Bryant, Dr Alison Evans, Claire Kilmister, Angela Lane, Henrietta Lang, Lucy McCulloch, Dr Nigel McFetridge, Jo Marsh, Dr Penny Newman, Maire O'Sullivan, Susila Sivapathasundaram and Sumathi Sundram contributed directly as members of the study team or as consultants. Appendix 1 lists members of the advisory group, general practices, health authorities, NHS trusts and others visited during the study. The Audit Commission is grateful to them all. Responsibility for the contents and conclusions rests solely with the Audit Commission.

Introduction

- ◆ Fundholding is a voluntary scheme enabling GPs to manage budgets which pay for the drugs they prescribe, the staff they employ and 20 per cent of the healthcare their patients receive from hospital and community services, including outpatients and most planned surgery.
- ◆ About half of the population of England and Wales is covered by fundholding practices. The scheme has been controversial, with conflicting claims of major change for the better on one side and inequity on the other.
- ◆ It is difficult to compare the purchasing achievements of fundholders with health authorities because they operate under different rules.
- ◆ This report concentrates instead on comparing fundholders with each other and pointing to those achieving the most for their patients.
- ◆ The costs of administering the scheme have not been met by efficiency savings on budgets.
- ◆ The key question the report asks is whether fundholding has brought about enough improvements in the quality of patient care to tip the balance in its favour.

Policy objectives

1. General practitioner fundholding was introduced by the NHS and Community Care Act 1990. Although it was originally intended as a minor variation on the main theme of splitting purchasers and providers, subsequent policy changes and the focus on primary care have brought fundholding to centre stage in the NHS Executive's strategy for developing services. From April 1996, the newly constituted health authorities that have taken over the functions of district and family health service authorities are expected to involve *all* GPs in commissioning, with GP fundholding as the preferred method of doing so (Ref. 1).
2. GPs who volunteer for the scheme receive a budget to cover the costs of some hospital and community services, prescriptions for drugs and the salaries of non-medical practice staff. They are free to spend any savings they make in whatever way they think best within the regulations, provided it benefits their patients. Up to April 1996 they were entitled to make claims against an allowance to cover the additional administrative costs to the practice, including the costs of an information system which the practice is obliged to buy upon joining the scheme. From 1996/97 this allowance becomes part of the fundholding budget.
3. The scheme stems from an acknowledgement that by virtue of their clinical behaviour – making referrals and prescribing drugs – GPs influence important areas of NHS expenditure, and that their closeness to patients means that they are uniquely placed to act as purchasers on their patients' behalf. Fundholding aims to make GPs aware of the financial consequences of their clinical decisions and, by giving them an incentive to make and

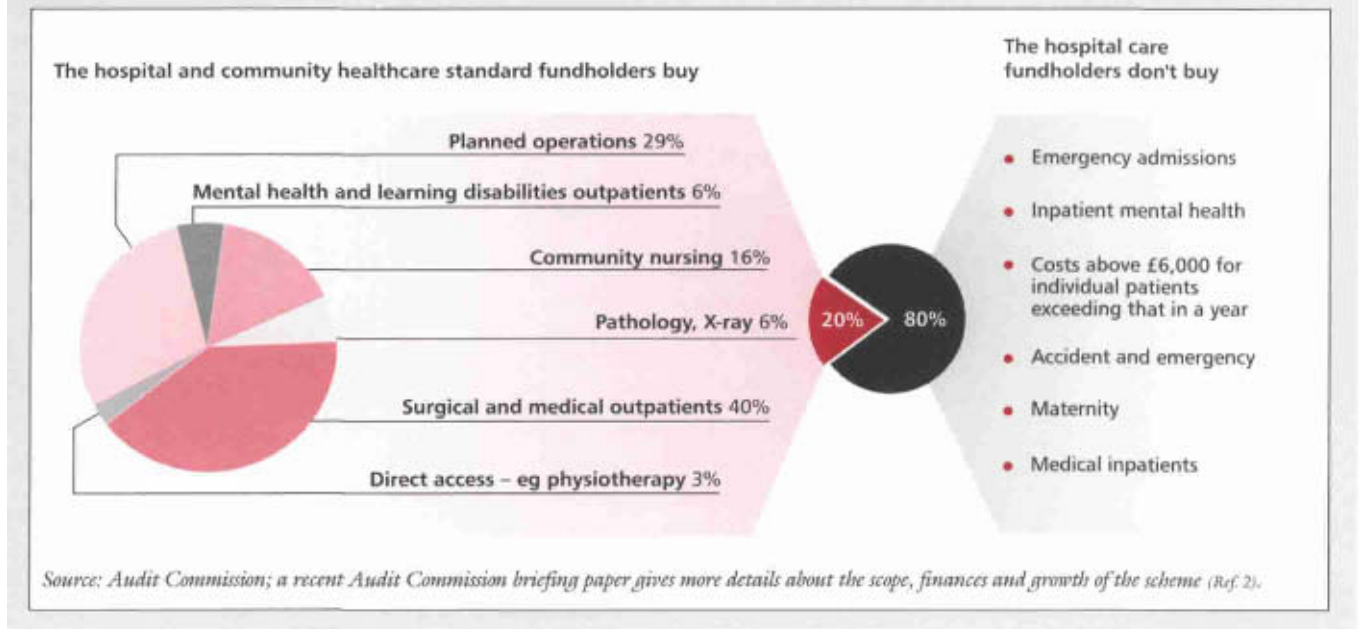
spend audited savings, to encourage them to consider the costs of different courses of action. The expectation is that this will lead to more economic and efficient use of hospital and community health services, and more rational prescribing. Giving GPs the power to contract with providers, and the freedom to choose between them, is intended to give providers – particularly hospitals and their consultants – an incentive to listen more carefully to what GPs have to say and to take steps to improve the quality of their services (Box 1).

Box 1
Fundholding – the balance sheet

Fundholders are GPs who take on responsibility for purchasing some hospital and community care for their patients. This has costs attached, and the key question is whether the benefits outweigh them.

Fundholders' budgets

The average standard fundholding practice has a budget of £1.7 million. This means that most fundholders have between £140 and £170 to spend per patient, but there is a threefold variation between the extremes. Hospital and community care account for about 55 per cent of a fundholder's budget; the rest is used to pay for the drugs prescribed by the practice's GPs (about 38 per cent) and for practice staff (7 per cent). Fundholders purchase about 20 per cent of their patients' hospital and community healthcare by value – mainly services that are planned in advance, rather than emergencies.



The costs and benefits of fundholding

Up to the end of 1994/95, practices had received a total of £232 million to cover the costs in staff, equipment and computers of managing fundholding. The scheme has also introduced new management and transaction costs in health authorities and providers. The £206 million efficiency savings made by fundholders over the same period, which the regulations allow them to retain to spend for the further benefit of their patients, do not match these costs.



What have fundholders achieved?

But fundholding was also intended to bring improvements in the quality of patient care, for example shortened waiting times, improved facilities, or a wider choice. Depending on how well fundholders have performed in this respect, the balance could tip in favour of fundholding. This report offers, for the first time, objective evidence about how many fundholders have been able to realise such benefits, and examines the link between management development and achievements.

Fundholding in 1996

4. Practices needed a minimum of 9,000 patients to be eligible for entry into Wave 1 of fundholding in 1991 (practices entering each year of the scheme are called a 'Wave'). Over the next five years, the regulations governing the scheme were changed, and in 1996 practices with 5,000 patients are eligible to join (Ref. 3). Over the same period the list of services that 'standard' fundholders can purchase has lengthened, and new forms of fundholding have emerged. Community fundholding allows practices with as few as 3,000 patients to purchase community health services, drugs and practice staff, but not hospital services (Ref. 4). At the opposite end of the spectrum, the total purchasing pilot projects extend far beyond standard fundholding to all hospital and community services, including emergency services, medical inpatients and maternity care (Ref. 5). Some small practices group together so that their joint list size makes them eligible to enter the scheme, while in a few areas of the country practices have grouped together as 'multifunds' under common management (discussed further in Chapter 2).

5. During 1995/96, one in three practices was involved in the scheme, forming a total of 2,200 funds within England and Wales. With more practices joining the new fundholding wave in April 1996, including the new community fundholders, about half of the population is now covered by the scheme. Presently standard fundholders manage about 7 per cent of all NHS expenditure on hospital and community services, while the total purchasing pilot practices (much fewer in number, but responsible for purchasing 100 per cent of their patients' care) account for a further 4 per cent. The total is expected to increase to about 15 per cent (£5.5 billion) during 1996/97. At the extremes, the few fundholders in Camden and Islington are managing only about 1 per cent of expenditure, and the health authority 99 per cent. But even in Kingston and Richmond, one of the areas with the most fundholders and which includes a total purchasing pilot, the health authority is responsible for the majority of expenditure (71 per cent).

'Although the debate over the introduction of a purchaser/provider split into the NHS has gradually quietened, the controversy about fundholding seems to have intensified.'

6. Although the debate over the introduction of a purchaser/provider split into the NHS has gradually quietened, the controversy about fundholding seems to have intensified. The scheme has champions and opponents, and both are equally convinced of their own view of its impact at all levels, from the quality of doctor/patient relationships to the integrity of the NHS as a whole. The main elements of controversy are summarised in Appendix 2. In most areas of public life the Audit Commission has welcomed budgetary devolution to the level where spending decisions are made, but fundholding has added to management costs in health authorities, regional offices of the NHS Executive, and hospital and community health trusts. In addition, up to 1994/95 fundholding practices received £232 million to pay for management, administration and computers. It is important to form a judgement about whether improvements in efficiency, effectiveness and quality of service to patients justify these costs.

What the report aims to do

7. The approach taken in this report is to examine fundholders' performance by comparing them with each other, pointing to where practice is good and showing how it is achieved. A number of studies (for example, by the National Audit Office and Glennester *et al* (Ref. 6)) have described fundholders' claims for a wide range of achievements, but to date there has been little objective measurement of what either health authorities or fundholders have achieved as commissioners (Ref. 7). This report offers objective evidence to build understanding about what can be achieved by delegating budgets to GPs, and about the levers for change that are available within the health system. Its purpose is to help fundholders achieve more for their patients by highlighting what it is possible to achieve, where fundholders have been less successful, and what the new health authorities will need to do to help improve fundholders' performance. The report is intended for members and senior managers of health authorities and trusts, GPs and other health professionals, and it will also be of interest to policy analysts in health and social services.

8. The details of the research on which the report is based can be found in Appendix 3. The main sources are:

- ◆ two national surveys of all fundholding practices, one during 1994/95 covering Waves 1 to 4, and the other in 1995/6 which included Wave 5;
- ◆ visits to 56 practices in 15 FHSAs, selected arbitrarily but with a view to ensuring a spread of early and late entrants to the scheme (Ref. 8);
- ◆ visits to 15 FHSAs (or, as in some cases, commissions merged informally in advance of legislation to create the new health authorities) and 12 trusts, selected arbitrarily within the constraints of geographical spread across England and Wales and grouped according to high, medium and low fundholding coverage; and
- ◆ information supplied by local auditors of FHSAs and fundholders appointed by the Audit Commission.

The evaluation challenge

9. Ideally evaluation would be made by comparing fundholders and non-fundholders for differences in costs, management and the benefits received by their patients. If the scheme had been introduced experimentally into a randomly selected sample of practices, matched with a set of non-fundholding controls, it might have been possible to attribute any differences observed to fundholding status. But practices that join the scheme are self-selected and fundholders differ significantly from other practices in ways that make it impossible to tell how much observed differences in benefits to patients are caused by the fact that they are fundholders and how much by their other attributes:

- ◆ Fundholders tend to come from suburbs and shires rather than inner cities and, as a natural corollary to this, tend to look after more affluent and less socially deprived patients. On average, about 5 per cent of the patients of fundholding practices live in areas attracting special deprivation payments under the regulations governing GPs'

remuneration, compared with about 8 per cent of patients of larger non-fundholding practices and about 14 per cent of smaller practices' patients(Ref.9). There is a considerable amount of variation, but the inverse relationship between the proportion of fundholding practices in an FHSA area and the average degree of social deprivation is highly significant statistically (Exhibit 1) (Ref. 10) . The benefits which fundholding can lead to, in terms of direct power to purchase secondary care, are least available to the patients whose usage of secondary care tends to be higher;

- ◆ In the early waves, membership of the scheme was restricted to comparatively large practices. Larger practices are more often housed in purpose-built premises, the GPs are more likely to belong to a primary healthcare team, and they tend to have more support staff and more equipment, including computers(Ref.11); and
- ◆ Fundholding practices also stand out from equally large non-fundholding practices as having more of the features normally associated with high standards and better quality. They tend on average to achieve higher targets for childhood immunisations and vaccinations, pre-school booster immunisations and vaccinations, and cytology screening. They are also more likely to be accredited to offer minor surgery and to be training practices (Exhibit 2(Ref.12)). As training practices, they are likely to be among the innovators because they have to achieve standards set by the Joint Committee on Postgraduate Training in General Practice and are expected to be well organised and up to date, irrespective of the extra leverage for change that the fundholding scheme provides(Ref.13).

Exhibit 1

Spread of fundholding and social deprivation

Fundholding is less common in more deprived areas. The benefits which fundholding can lead to, in terms of direct power to purchase secondary care, are least available to the patients whose usage of secondary care tends to be higher.

Note: the relationship is statistically significant:
 $r = -.38, p < 0.001$

Source: standard financial returns to NHS regions and Welsh Office

FHSA population registered with fundholders 1995/96

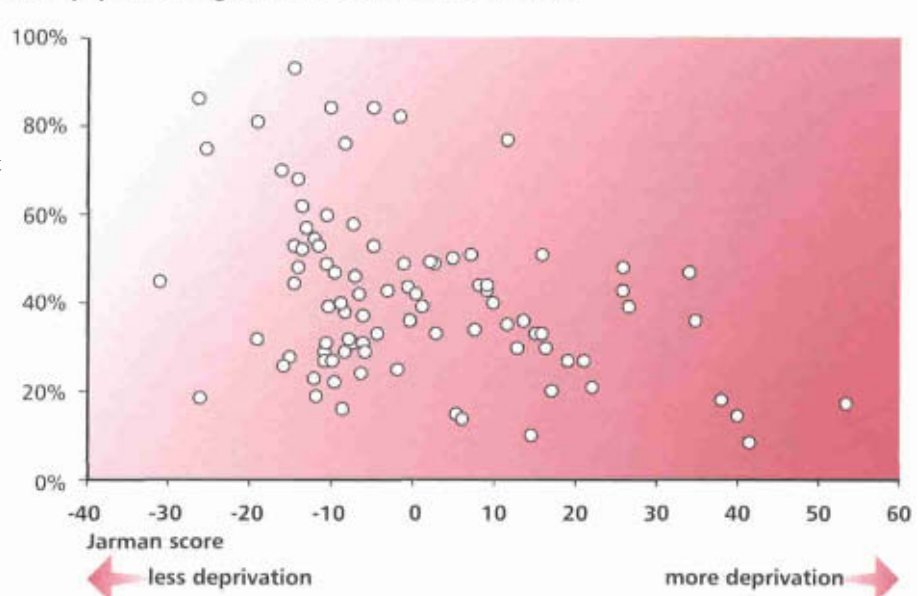
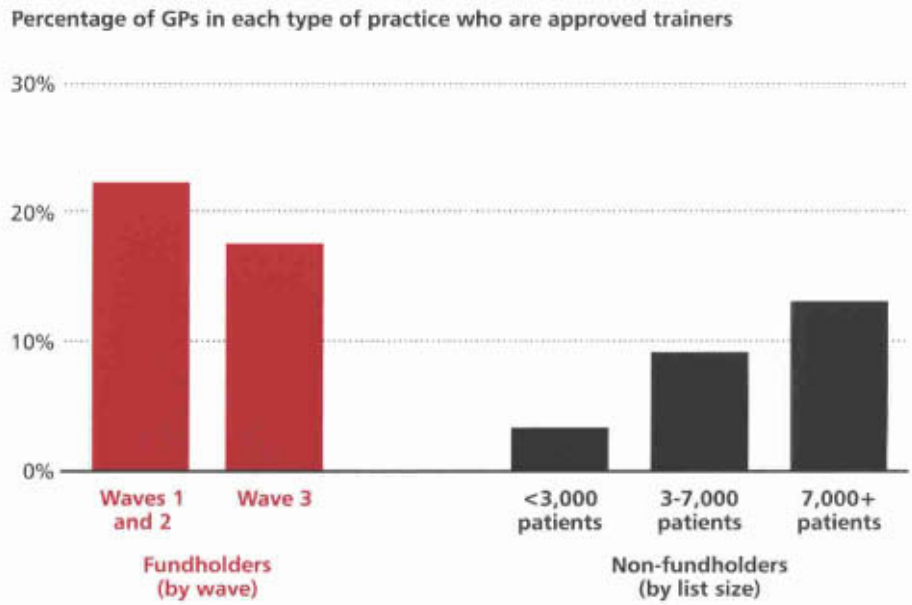


Exhibit 2
GP trainers in fundholding and non-fundholding practices

There are more trainers in fundholding practices.

Note: The difference between each group is statistically significant.

Source: Audit Commission analyses of 1993/94 NHS Executive GMS database: 9,687 practices in England



10. The alternative to comparing fundholders with non-fundholders would be to compare them with health authorities, who purchase 'fundholding services' for non-fundholders' patients, and all the remaining services for the entire resident population. Regrettably, this comparison would also be suspect because the two sets of 'players' are subject to different rules and it would not be comparing like with like. The bases on which fundholders and health authorities are funded are quite different, as are the accountability arrangements. Health authorities do not have accurate individual patient information available to them, and only an indirect, advisory influence over non-fundholding GPs' referral decisions. Fundholders, on the other hand, have detailed information on each patient, and they can change referrals directly should the partners agree to do so. They also have freedom to switch providers and to move money from one part of their budget to another, whereas health authorities, who were initially told to maintain a 'steady state' with their contracts, do not have the same budgetary freedoms.

11. Finally, it is always difficult to specify causal relationships in retrospect, particularly inside complex systems. Since 1990 every health service organisation, whether purchaser or provider, has been striving to improve efficiency and quality, to become more effective and to reduce costs. There are a few instances where it is possible to say who was responsible for a particular change, because all the parties involved acknowledge that the impetus came from a particular quarter. But often it is difficult to do so because everyone involved – individual fundholders, the health authority and the trust – claims responsibility, and it is likely that they have all contributed in some way (Ref. 14).

A guide to the report

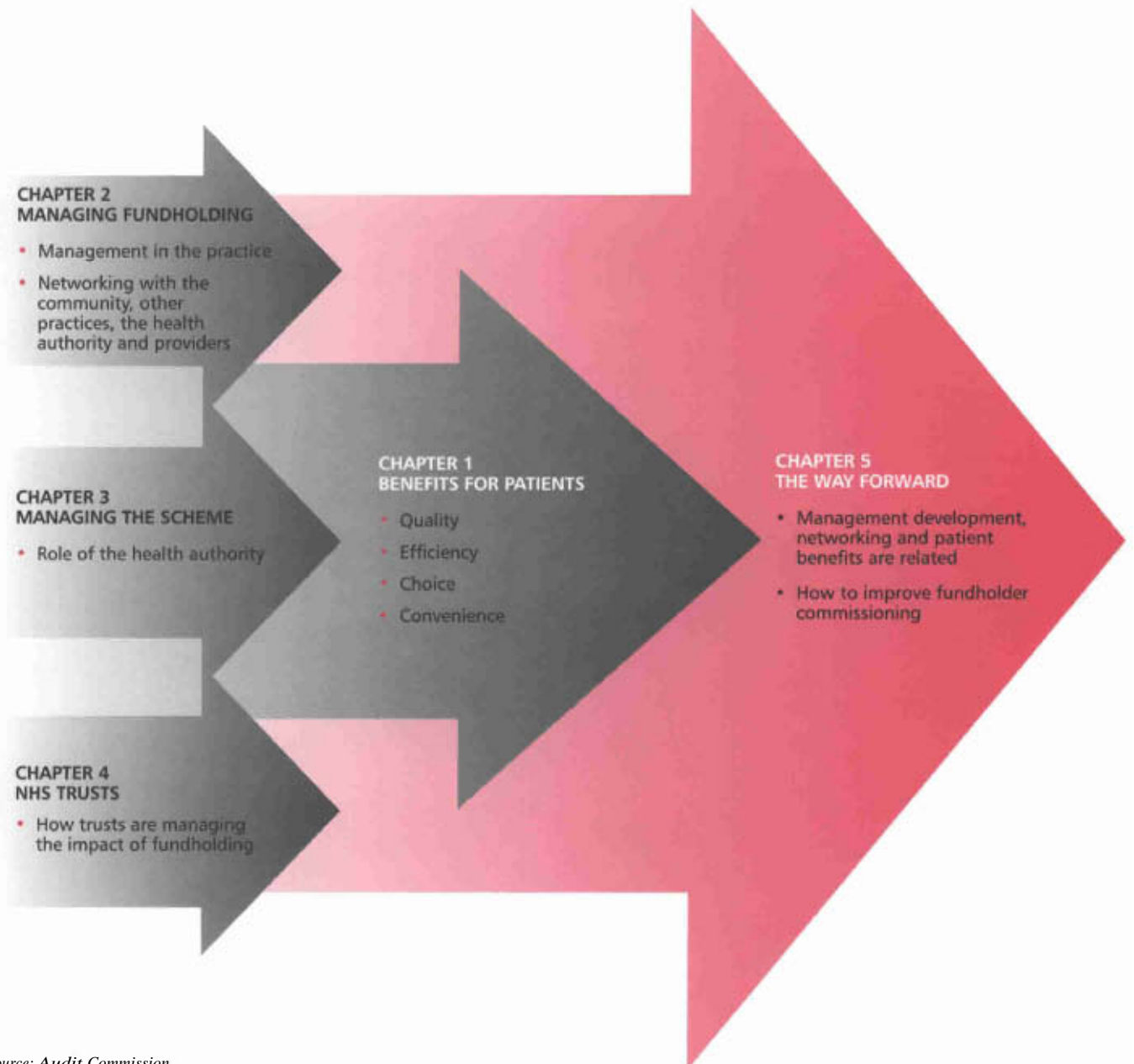
12. This report analyses benefits to patients, looks at how fundholding is managed, and finally considers the challenges that will arise as the scheme grows and changes:

- ◆ Chapter 1 puts forward a typology of measures of fundholders' performance. It describes the many different kinds of actions open to them to meet the scheme's objectives, and the extent to which fundholders' patients have benefited.
- ◆ Chapter 2 analyses factors linked to successful commissioning: management structures and processes inside the practice, and practices' involvement with the wider community, with other practices, health authorities and with service providers.
- ◆ Chapter 3 examines the role of the health authority in supporting and monitoring fundholders.
- ◆ Chapter 4 assesses the impact on NHS trusts and shows how the best are coping with the extra administrative work introduced by the scheme.

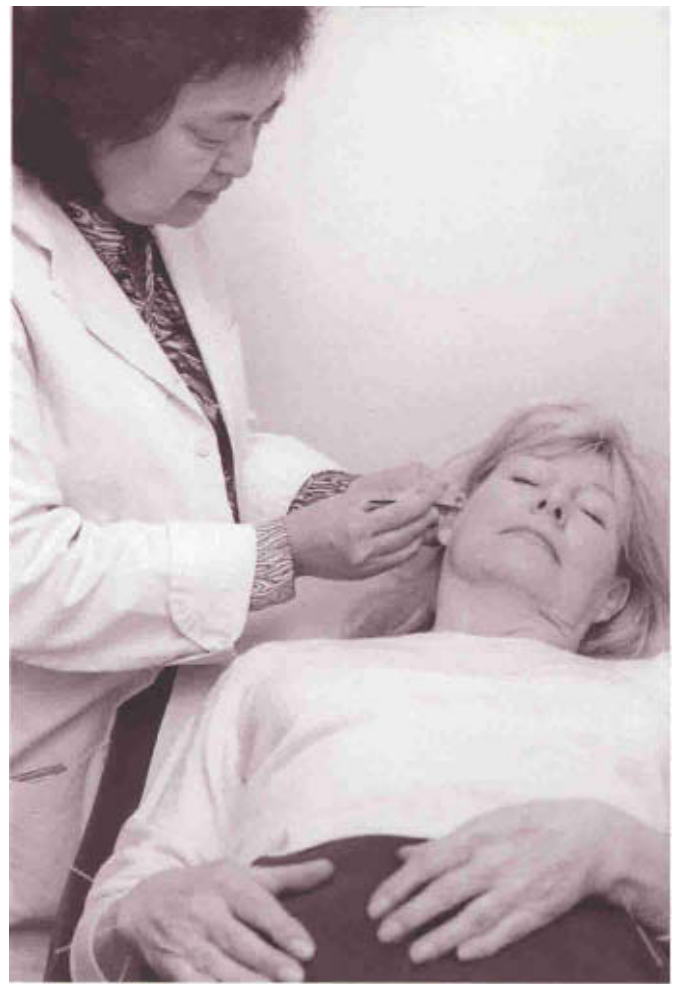
13. Fundholding is a complex subject. It has not been possible to include all the study's results in detail in this one report (accompanying publications give more information (Ref. 15)). For this reason, chapters 1–4 have the same structure, selecting key areas for detailed discussion, and ending with a summary box about the whole subject. Chapter 5 then provides an overall summary of the main conclusions in respect of patient benefits and the factors linked to change, and discusses some of the challenges that have come to the fore as a primary care-led NHS develops.

Exhibit 3
Map of the report

The key benefits that can arise for the patients of fundholding practices are depicted at the centre of the exhibit. The management environment that influences whether these benefits occur is drawn as a series of arrows to the left. The report describes how many benefits have appeared and how well managed the scheme is.



Source: Audit Commission



The breadth of the fundholding scheme potentially allows fundholders to seek many different kinds of benefits for their patients.

The most common changes have been improved communications with hospitals and consultants; expediting local changes which had proved difficult to achieve before; more rational prescribing; and budget savings.

The least common have been large scale changes to providers offering lower prices (or for other reasons); seeking increased day surgery; planning future developments with the health authority and providers; agreeing with consultants that the GP should manage the waiting list for non-urgent operations; and introducing guidelines designed to make healthcare more effective.

1 Benefits for Patients

'No detailed objectives for the fundholding scheme have been set by the NHS Executive, and so the approach taken in this study has been to develop ways of measuring benefits to patients and to describe how commonly they are found.'

14. It is widely accepted that in most parts of the country fundholding has altered the relationship between GPs and consultants. This change is generally ascribed to the leverage that comes with budgetary control. But has fundholding also led to tangible benefits for patients and to better control of costs? And if so, how many fundholders have realised such benefits? No detailed objectives for the fundholding scheme have been set by the NHS Executive, and so the approach taken in this study has been to develop ways of measuring benefits to patients and to describe how commonly they are found. This typology of potential patient benefits, some of which stem from the original aims set out in the 1989 White Paper (Ref. 16), and the rest from those which the best fundholders have since set for themselves, contains six categories:

- ◆ closer focus on individual needs – waiting lists managed with more sensitivity to individual patient's needs, and more timely and informative communication about patients from consultants (paragraphs 15-18);
- ◆ better quality services – for example, more responsive providers producing tangible improvements in care according to GPs' wishes, Patient's Charter targets being achieved, and reduced waiting times (paragraphs 19-22);
- ◆ more effective healthcare – self-audit by GPs of referral and prescribing differences leading to internal guidelines and the development of shared-care agreements with consultants; a further level of sophistication involves audit of providers linked to contracts specifying treatment in accordance with evidence-based guidelines (paragraphs 23-26);
- ◆ increased efficiency – managing the contract portfolio to purchase more activity at less cost, for example by reducing inappropriate outpatient follow-up appointments, more day surgery, using cheaper providers, better prescribing and benefiting patients via the use of budget savings (paragraphs 27-34);
- ◆ wider choice for patients – freedom to refer where the GP and patients wish (paragraphs 35-36); and
- ◆ developing services nearer to patients – introducing therapeutic services (for example, physiotherapy or counselling) and consultant outpatient clinics into the practice, community hospitals or other sites nearer to where patients live (paragraphs 37-39).

Closer focus on individual needs

15. GPs have longer-term relationships with patients than do most other health workers. Even in today's mobile society many patients are registered with the same practice for most if not all of their lives. The GP is therefore well placed to understand the need for hospital care in the context of an individual's general health, family and social circumstances. Despite this, GPs often 'refer and forget' because feedback from hospitals is poor. Good information can alleviate this problem, and fundholding provides a computer system (written to a standard specified by the NHS Executive (Ref. 17)) which records information about each person referred for an outpatient appointment, a diagnostic test or for treatment in a hospital or by

community service providers. Fundholders can use this information for purposes such as improving control over waiting lists for non-urgent operations, and monitoring the timeliness and quality of communications from hospitals (Ref. 18).

Improving GPs' control over the waiting list for non-urgent operations

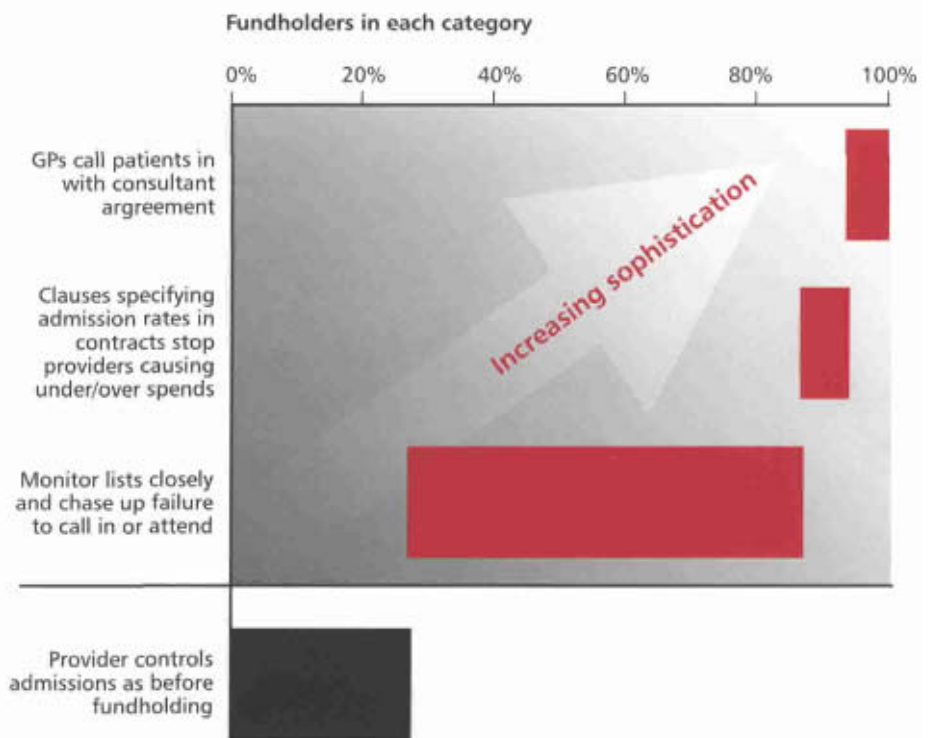
16. Patients requiring elective surgery are usually put on a waiting list by the consultant to whom they are referred and then called in by the hospital. Once the minority of urgent cases have been treated, the remaining patients are admitted in rotation according to the length of time they have been on the waiting list. Such a system is insensitive to the changing pain levels and social circumstances of patients whom the consultant will not see again until the day of their operation. It also poses a special problem for fundholders who pay for most of their patients' elective surgery, because the provider can decide how many of the fundholder's patients to treat to suit its own capacity and finances.

17. It is not surprising, therefore, that some fundholders have sought to exercise greater influence over the choice and rate of selection of patients from surgical waiting lists. They are better placed to review their patients' conditions while waiting and to keep them informed about what is happening (either themselves or via a nurse (Ref. 19)). Moreover, by controlling the rate of admissions they can balance waiting times with the ability to generate budget savings that may be spent on other benefits for patients. Three levels of increasing sophistication of influence are apparent (Exhibit 4):

- ◆ **Monitoring lists closely:** This is the most common method, used by nearly two-thirds of fundholders. The practice uses information from the fundholding IT system to identify patients who are still waiting beyond their appointment date, and tries to progress them through the system by negotiation. Many practices use wall-boards with coloured cards to display the current state of waiting lists.
- ◆ **Budgetary control by contract specifications:** In this method, used by 7 per cent of fundholders, the practice manages the rate of admission by stating how many patients the provider can call in during any one month, but the decision about which patients come in remains with the consultant. If the provider intends to vary the contract they must discuss this with the fundholder first. This gives the practice more control over budgets – the provider can neither leave them under-achieving on planned activity, nor force them over-budget by calling in more patients.
- ◆ **Calling patients in:** Some fundholders (6 per cent) establish agreements that they can specify not only how many patients, but also which non-urgent ones should be seen. This combines budgetary control with management of individual patient progress, and requires a high degree of trust on both sides if fundholders and consultants are to reach agreement on the process. It is more common among the earlier fundholding waves

Exhibit 4
Ways of influencing the waiting list for non-urgent operations

Three levels of increasing sophistication are apparent in the way fundholders have sought to influence waiting lists.



Source: Audit Commission visits and local auditor assessments of 244 fundholders across 53 health authorities

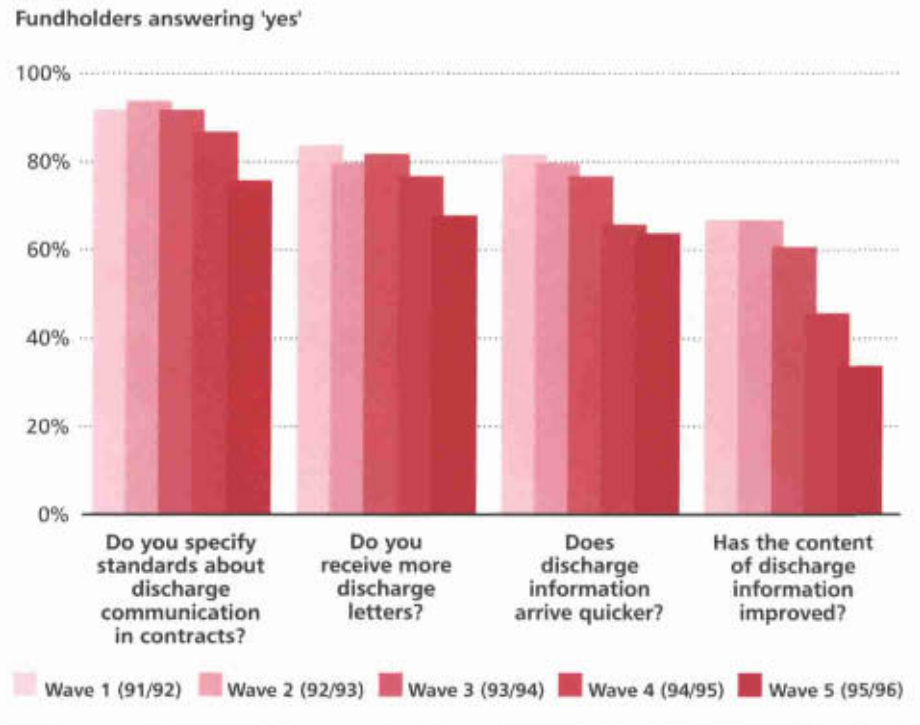
which have had time to develop positive relationships with providers. Some practices have even negotiated agreements whereby GPs can directly book operations for patients who meet protocol criteria, rendering initial specialist outpatient appointments unnecessary.

Improving clinical communication from hospitals

18. GPs need to be told quickly when a hospital discharges a patient, so that the practice can arrange any necessary aftercare. In order to play their own part in the patient's further treatment and care, they also need to know how the specialist views the problem, what treatment the patient has received and what the patient has been told. Yet GPs often complain that they do not get enough information about their patients from hospitals and that the information they do receive arrives too late. A good practice solution involves computer-generated notification of discharge, including the bare details of the patient's name and the date and nature of the episode. More detailed clinical information will be required for some patients, and the GP and consultant can agree guidelines about when this is appropriate. The delivery time standards vary greatly, from a note on the same day to one within 48 hours; and from a letter within seven days to one within fourteen days. Of course, to obtain any benefits for patients, GPs must themselves contact patients more quickly after discharge and ensure that their community needs are met. Most fundholders surveyed have sought

Exhibit 5
Discharge information sent by consultants about fundholders' patients

Most fundholders have sought improvements by specifying quality standards in contracts. Those in the earlier fundholding waves are more likely to report improvements.



Source: Audit Commission 1995/96 survey of 1,249 fundholders

improvements by specifying them in contracts, backed up by a refusal to pay for care unless communication standards are achieved (Ref. 20) (Exhibit 5). Those in the earlier fundholding waves are more likely to report improvements in performance as a result.

Better quality services

19. Most fundholders have adopted quality standards in contracts mirroring those negotiated between the lead local health authority and providers (Ref. 21). Some GPs have additionally used their leverage to persuade providers to tackle a wide range of specific local problems including long waiting times, inconvenient pathology collection times and occasional off-hand or discourteous staff (Ref. 22). Fundholders often comment that such simple changes were impossible to achieve in the past, but the leverage provided by the threat of withdrawing business has led to rapid solutions being found (Case Study 1). One of the most important and widespread quality improvements that fundholders and health authorities are attempting to achieve is the reduction of waiting times.

*Case Study 1***Examples of small-scale but locally important quality changes**

One practice had tried for years to change pathology collection from 12pm to 2pm, to fit in with surgery times and avoid some patients having to wait an extra day to receive results. On achieving fundholding status, the practice indicated that it would switch pathology provider unless something was done. Within a few months the change had been agreed. The fundholding GP comments that 'the key benefit of fundholding is that for the first time we are being asked for our views on services. I have no doubt this would instantly go without the direct control of budgets and contracting.'

A second practice had been unable to influence poor pathology turn-round times. The practice met with the laboratory's director and pointed out that it waited 12 weeks for cervical smear results. Within a year the waiting time had been reduced to one week. Improved communications also helped the practice understand that certain tests were batch-run. By organising these tests to fit in with the laboratory's timetable, the practice receives results much more quickly.

Matters are not always so simple, of course. One Wave 2 fundholder stated: 'We are the only fundholders here and the trust knows it. We have little influence over them'.

Source: *Audit Commission site visits*

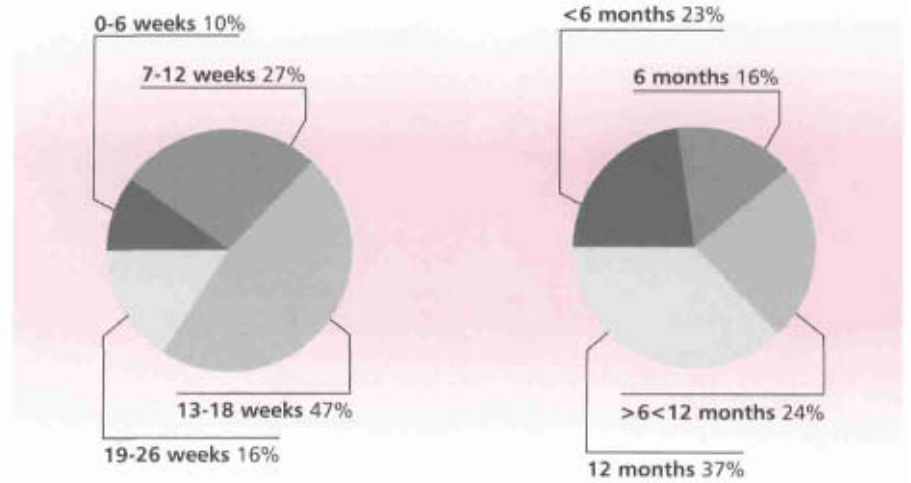
Shorter waiting times

20. Reducing waiting times is a common objective, not just of fundholding practices but also of health authorities and providers. Three-quarters of fundholders set specific targets which vary widely. Two-thirds of those who do so adopt the local health authority's targets, in turn often based on Patient's Charter standards (Ref. 23). Hospitals often do not meet these targets, and fundholders setting more generous targets are not necessarily more likely to have them met (Exhibit 6, overleaf). But fundholders have the potential to achieve shorter waiting times, and provided they have good information on who is on lists, why and for how long, there are a number of measures they can take (Box 2, overleaf). In one case, an ophthalmology business manager described how local fundholders had threatened to purchase cataract treatment from the private sector because of waiting times of well over a year. The trust made clear to the consultants the damaging impact of withdrawal of funding (the department was soon to move to new facilities for which they required funding). By changing case mix, re-organising lists between the consultants, increasing day case rates, and checking the appropriateness of outpatient follow-ups, the directorate reduced waiting times to nine months, and averted the threat of fundholder withdrawal.

Exhibit 6
Gynaecology target waiting times and whether providers meet them

Fundholders vary widely in the targets they set...

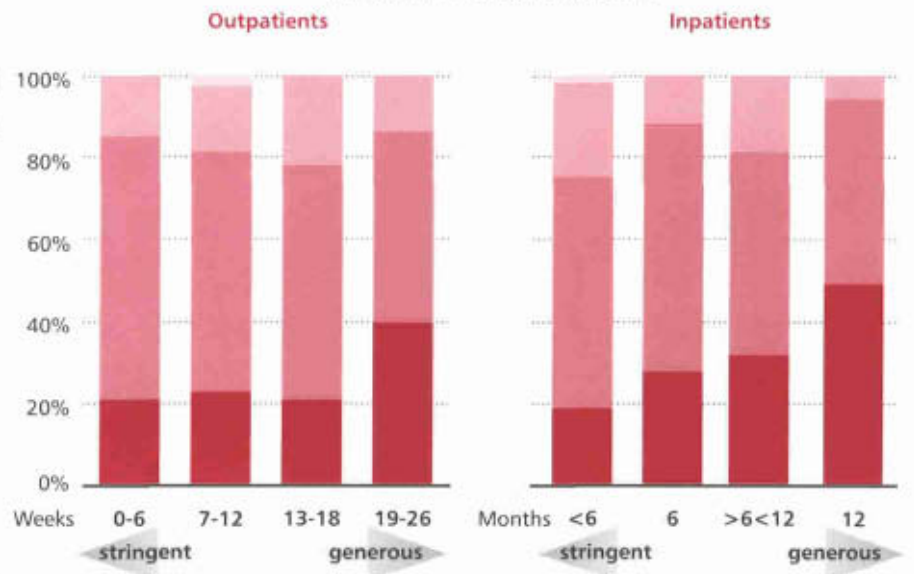
Percentage of fundholders setting each gynaecology target



...and four out of every five gynaecology providers always, or usually, met waiting time targets. Fundholders setting more generous targets are not necessarily more likely to have them met.

- KEY**
- Never
 - Sometimes
 - Usually
 - Always

Percentage of targets being met



Source: 439 replies to 1995/96 survey of fundholders; gynaecology is the specialty with the best waiting times of six for which data were collected.

Box 2
Examples of methods used by some fundholders to reduce waiting times

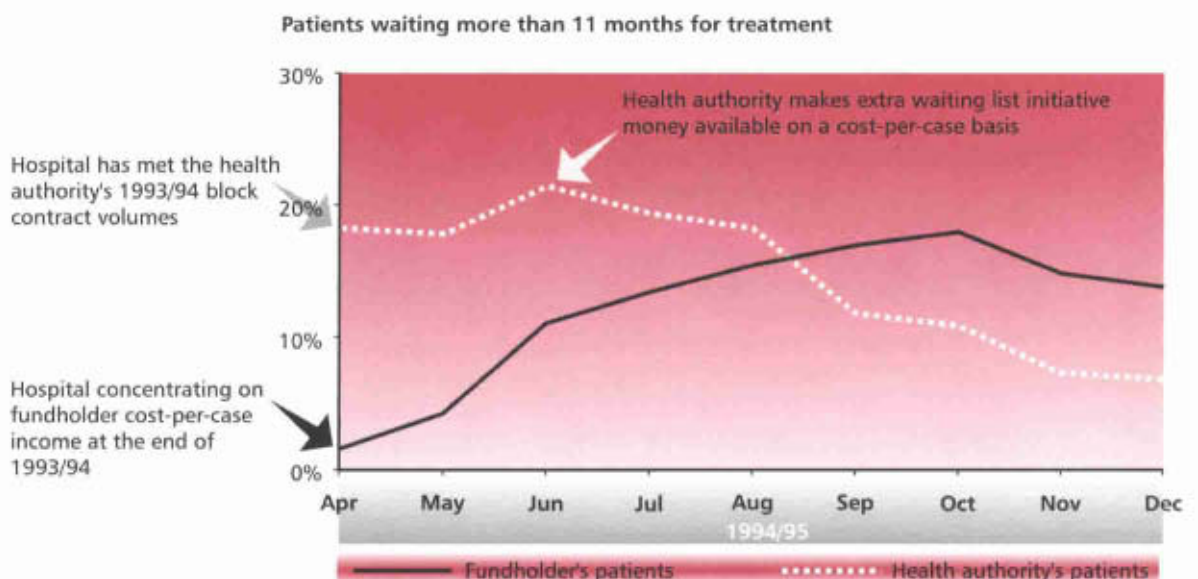
Source: Audit Commission site visits

- ◆ Set tight waiting time targets in contracts, or switch to a provider with lower waiting times, sometimes in the private sector.
- ◆ Hold outpatient clinics and provide simple treatments at the practice.
- ◆ Do pre-operative assessments at the practice to reduce did-not-attend (DNA) rate and reduce operations cancelled on arrival at hospital because the patient is in an unsuitable state.
- ◆ Chase up if patients do not get called in when expected, getting the hospital to offer another slot as soon as possible.
- ◆ Check lists carefully to ensure those waiting longest get called in before others with equal or lesser needs, and periodically review lists to ensure everyone on them is still genuinely in need of outpatient attendance or treatment.

21. Most fundholders do not apply the measures in Box 2 because they lack the relevant information about average waiting times or the number of patients waiting in particular specialties. This often stems from a failure to capture accurate data, and a reliance on providers' waiting list information. The result is that hospitals' waiting times for fundholder and health authority patients are usually similar overall, although their seasonal patterns may differ (Exhibit 7). Sometimes hospitals admit disproportionately more fundholder patients at the end of the financial year, maximising cost-per-case income once they have met the health authority's block volumes. And if health authorities make extra waiting list initiative money available during the year on a cost-per-case basis, the hospitals then concentrate on those patients.

Exhibit 7
One hospital's waiting times for fundholder and health authority patients

Although waiting times for fundholder and health authority patients are usually similar overall, their seasonal patterns may differ.



Source: Audit Commission site visits

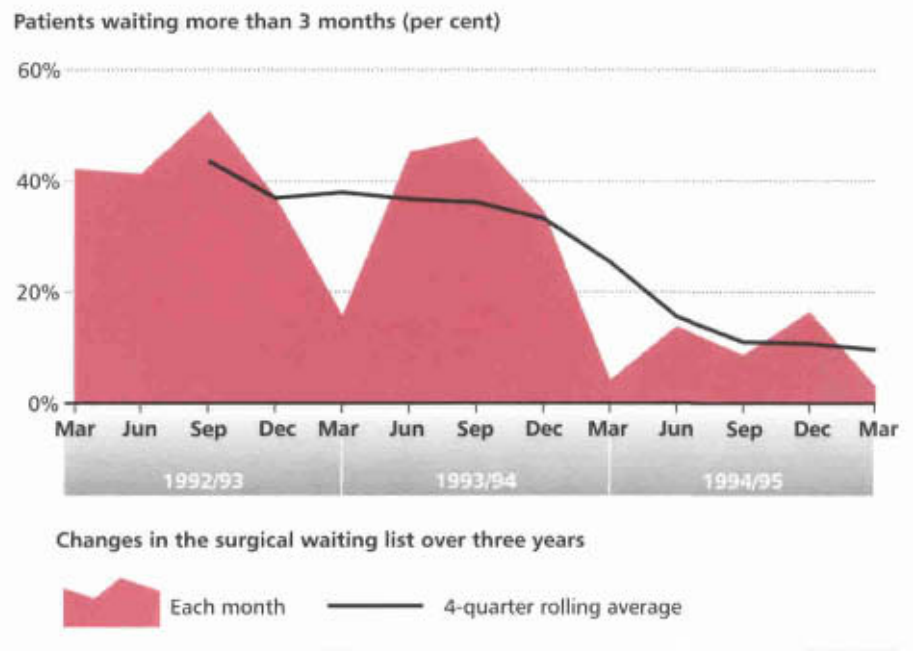
22. A few fundholders have solved these problems and attacked specific waiting lists in a systematic way, having agreed an objective of reducing waits to a certain target (for example, a few days or weeks for outpatients, and a few months for treatment, depending on the diagnosis (Ref. 24)). One Wave 1 practice, for example, switched orthopaedic operations to a different hospital at two-thirds the price. This produced a £40,000 saving, some of which the practice spent on more operations, reducing the waiting list. The same has been done with physiotherapy: 'We were given a budget of £42,794 for a three-month wait for physiotherapy at the hospital, which we used to fund a service where 90 per cent of patients were seen at the surgery within two weeks for £17,000.' (Ref. 25). The practice has also gradually reduced overall acute treatment waiting times over the first four years of fundholding, with most of the gain occurring in the most recent year (Exhibit 8).

Exhibit 8
Waiting times for a Wave 1 fundholder's patients

Waiting times across the major acute surgical specialties for this fundholder's patients have gradually reduced; most of the gain has occurred in the practice's most recent year of fundholding.

Note: The seasonal pattern occurs because the main provider concentrates on achieving the local health authority's block targets first before calling more cost-per-case fundholders' patients in towards the year's end.

Source: Audit Commission site visit



More effective healthcare

'A more sophisticated development comes when the GPs, as purchasers, begin to specify in contracts that consultants must change the way they do things in line with evidence and audit their performance.'

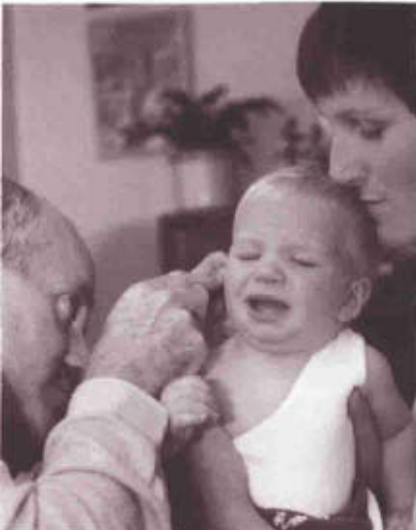
23. One of the 10 priorities for purchasers set out by the NHS Executive is to spend an increasing proportion of resources on interventions that are known to be effective and where outcomes can be monitored systematically, while reducing spending on interventions shown to be less effective (Ref. 26). Most medical practice is based on accumulated experience and lacks scientific evidence demonstrating its effectiveness, although in some cases the effectiveness is self-evident and beyond dispute. But as more evidence becomes available, demonstrating what does or does not work, purchasers can make use of it to specify service improvements. It might be supposed that GPs, as clinicians, are better placed to do this than health authority managers. This section describes how fundholders' use of information can improve commissioning choices, and then looks at the quality of commissioning for a range of conditions where evidence of effectiveness is well established (Ref. 27).

Laying the groundwork for effectiveness

24. Fundholders can use effectiveness information in various ways. They can start within the practice with the GPs auditing their own clinical performance and agreeing internal guidelines and shared-care agreements with consultants. A more sophisticated development comes when the GPs, as purchasers, begin to specify in contracts that consultants must change the way they do things in line with evidence and audit their performance. Specific processes available to fundholders include:

- ◆ **Using published information:** There is a growing body of published evidence-based information. Only a third of fundholders surveyed said the literature on evidence-based medicine had influenced their purchasing decisions (Ref. 28).
- ◆ **Disease registers:** These can be used to review and manage the care of patients with long-standing conditions. Most fundholders were able to ascertain how many patients with such conditions were registered with the practice (ranging from 35 per cent able to do this for glue ear to 66 per cent for schizophrenia (Ref. 29)). But only a few (17 per cent) had lists of the patients ready to hand, suggesting the GPs were not using them to actively manage patients' care.
- ◆ **Self-audit of referrals to hospital:** Referral rates vary widely between GPs. There are many underlying reasons, including different patient demands and needs, different availability of services and differing GP decision-taking, making it hard to separate out any effect of the fundholding scheme itself (Ref. 30). The better IT systems in general practice can help GPs audit their own referral practice, and the fundholding system can also cost differences in referral rates. Nearly half of surveyed fundholders said the practice's GPs had reviewed together variations in their referral rates since becoming fundholders (Ref. 31).

- ◆ **Clinical audit:** Fundholders should be specifying which services they have concerns about and wish to see audit results on. Otherwise they will base their purchasing decisions on cost and efficiency or assumptions about consultants' abilities, rather than on objective information about the quality and effectiveness of treatment. Few fundholders see clinical audit information (ranging from 7 per cent of fundholders seeing audit information about patients with serious depression to 21 per cent who see information on the treatment of back pain). Case Study 8 (in Chapter 5) describes a fundholding practice which does base its purchasing on audit evidence.
- ◆ **Guidelines:** 'Systematically developed statements to assist decisions for practitioner and patient about appropriate healthcare for specific clinical circumstances' (Ref. 32) can help to spread the introduction of evidence-based practice into healthcare, and increase consistency of treatment and referral decisions. While there will be ongoing debate about the relative merits of different guidelines (Ref. 33), currently the proportion of fundholders with written guidelines of any kind in place for the tracer conditions used in the study ranges from 4 per cent for schizophrenia and 13 per cent for cataract through to 41 per cent for diagnostic imaging. The guidelines that do exist are mostly about the GPs' referral decisions, rather than the approach the providers should take to treatment.



The extent of effective purchasing

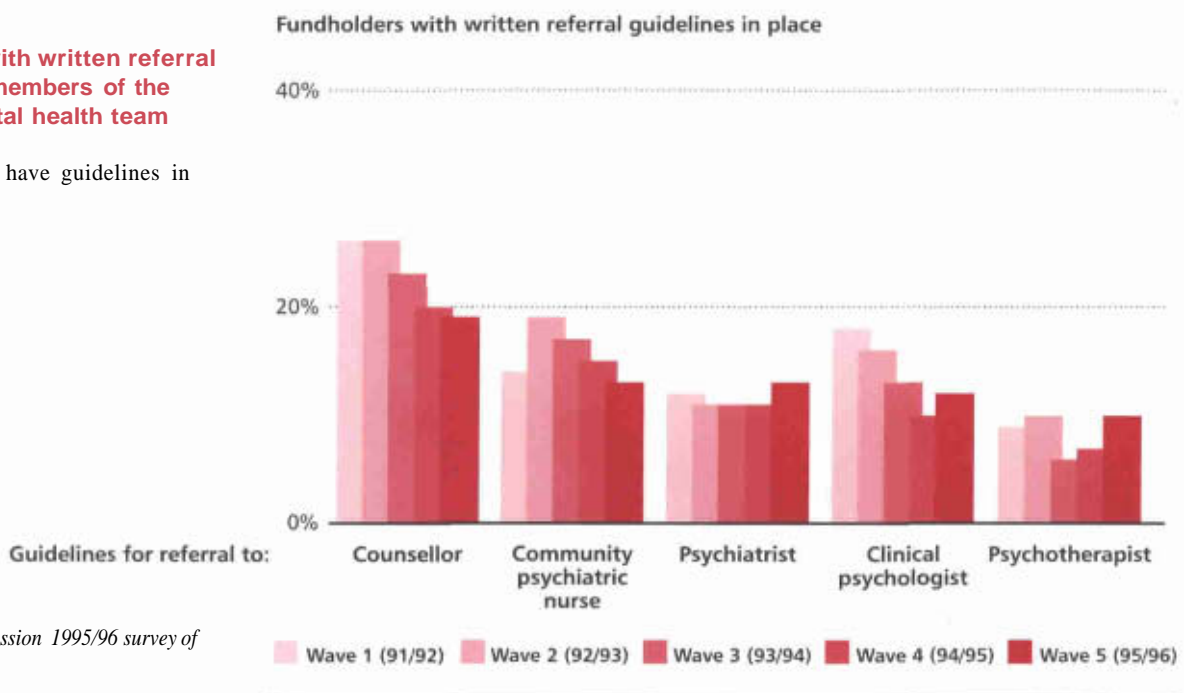
25. Fundholders' limited use of evidence on effectiveness is reflected in their purchasing decisions for specific conditions:

- ◆ **Glue ear:** A well-publicised Effective Health Care Bulletin has suggested a need to reduce levels of surgical intervention, and just over half of fundholders (55 per cent) say they have read it. The majority use 'watchful waiting', one of the key good practice concepts in the bulletin, but two-thirds of these practices did so before becoming fundholders. Fewer claim to offer patients an audiology test before the consultant sees them, although good practice suggests this.
- ◆ **Back pain:** New guidelines from the Clinical Standards Advisory Group (CSAG) suggest a need to reduce the number of referrals to orthopaedic consultants, and perhaps increase the use of therapists in the early stages of back pain. Few fundholders have read the guidelines, although almost all use a therapist for treating simple back pain cases and three in every five said they do this within a few days, as recommended by the CSAG. It has not always been possible to link greater use of therapists to decreases in orthopaedic referral rates to outpatients, although one practice with 10,000 patients has documented a saving of £27 per patient, or about £11,000 a year (Ref. 34). The great majority prescribe NSAIDs (non-steroidal anti-inflammatory drugs) for simple joint pain, even though most rational prescribing advice suggests that simple analgesics are as effective, cheaper and do not risk such dangerous side-effects.

- ◆ **Mental health:** Good practice requires fundholders to establish clear guidelines about how to treat their seriously mentally ill patients, and when to refer them on to a specialist mental health team. As purchasers they should consult with services users and their families and audit the treatment patients receive. But only one in ten fundholders have agreed criteria on when to treat depressed patients within the practice and when to refer them on to the primary healthcare team, and fewer than one in five fundholders have written guidelines covering referral on to the specialist mental health team members (Exhibit 9). One-third have agreed a policy on when to use tricyclic antidepressants and SSRI (selective serotonin re-uptake inhibitors) drugs, few have consulted on what services people with schizophrenia and their families want, and only half review schizophrenic patients registered with the practice even annually.
- ◆ **Cataract:** GPs should base referrals on an assessment of visual ability in the context of the patient's social circumstances and lifestyle and not just a threshold of visual acuity (such as optician's measurements made available to the GP). Just over half of fundholders stated that they refer on the basis of ability. A recent survey found that, when referring patients, few GPs choose consultants on the basis of whether they use intra- or extracapsular extraction techniques for removing the cataract, despite the likely quality differences between the two techniques(Ref.35).

Exhibit 9
Fundholders with written referral guidelines to members of the specialist mental health team

Few fundholders have guidelines in place.



Source: Audit Commission 1995/96 survey of 1,249 fundholders

'...most fundholders are not making full use of the increasing body of knowledge about clinical effectiveness to change the way they commission.'

- ◆ Leg ulcers: Practices can reduce expenditure and improve patients' recovery by the adoption of evidence-based procedures. Just over half of fundholding practices surveyed use Doppler ultrasound for assessment, the first stage of good practice. A similar proportion follow this up by using four-layer bandages and one-quarter report using tracing or photography to monitor the healing rate.

26. So far, then, most fundholders are not making full use of the increasing body of knowledge about clinical effectiveness to change the way they commission. One reason is that they face conflicting demands from their patients. As described later in *Developing services nearer to patients* (page 33), fundholders are increasingly purchasing physiotherapy, counselling and complementary therapies, services where effectiveness is not proven but which are popular with patients and may have benefits other than those demanded by a strict adherence to currently available scientific measurement. Early referral of patients with back pain to a therapist, for example, will not necessarily cure back pain, but it might speed relief of symptoms and return of mobility, and education about posture may prevent recurrence and reduce future calls on the GP's time. A second reason is that each individual GP, a generalist by definition, simply cannot keep up to date with all the evidence in all areas.

Increased efficiency

27. Fundholders have an incentive to make economies and efficiency savings, since this releases funds to spend in other areas. They can reduce the cost of commissioned services by more appropriate referrals, by specifying more efficient practices such as day surgery or by negotiating lower prices. One fund manager, for example, who was set a performance target of achieving 10 per cent more activity for 10 per cent less money achieved this largely by changing the balance of expensive inpatient treatment for day case work and by relocating some services in the practice premises. Fundholders can also make savings by more rational prescribing within the practice.

Reducing inappropriate follow-up outpatient appointments

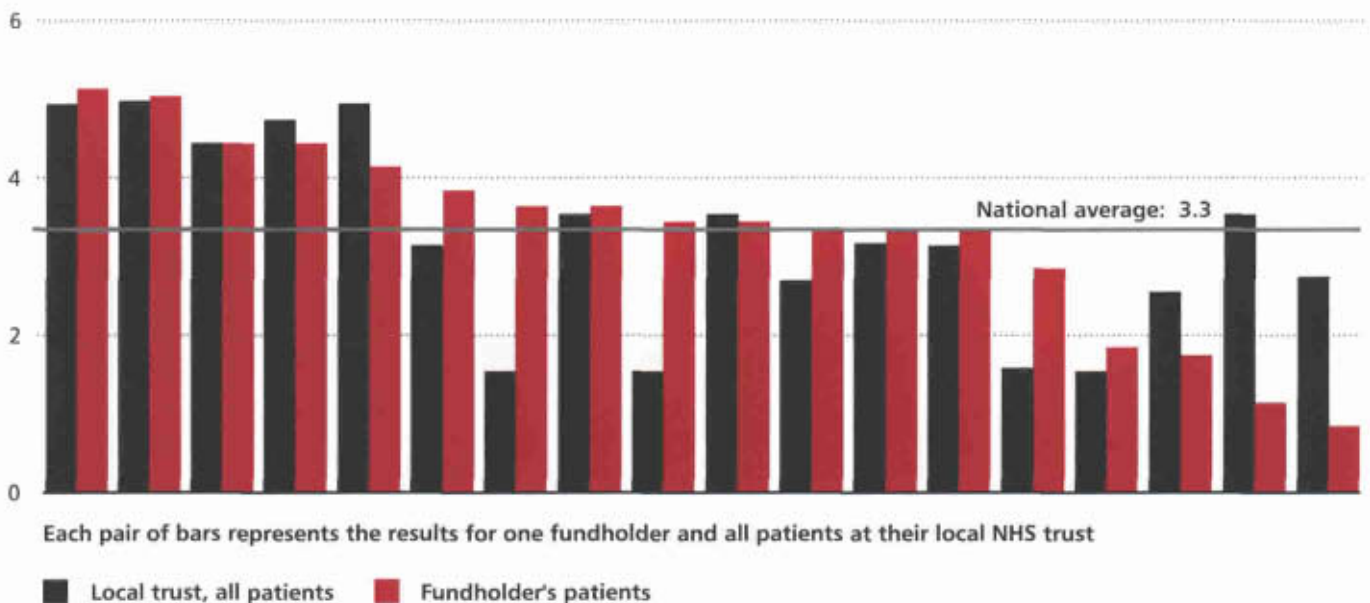
28. Patients attending outpatient clinics are either first attenders referred for a specialist opinion, or repeat attenders, usually for further treatment, tests or a check-up to assess the outcome of treatment. Repeat attendances have been gradually decreasing, and by 1991 for every one new patient referred for an opinion, 3.1 patients attended for follow-up after their treatment. One region's current target is 1:2. The reduction has occurred for a variety of reasons, including changes in medical technology and new arrangements for sharing care between hospitals and general practice.

29. One in five fundholders set limits on the number of repeat outpatient attendances, and some stipulate the maximum level of repeat attendances in contracts (Ref. 36). One practice allows one repeat attendance as standard, but for any more the consultant must provide a clinical management plan explaining its function. Fundholders can also reduce repeat attendances by holding clinics at the practice. Consultants usually run these clinics, who are more likely than junior doctors to discharge patients, and the GP can more easily discuss taking over care of a patient who might otherwise have remained with the hospital system. Fundholders wishing to make changes here will often be pushing at an opening door. But there are wide differences between fundholders, and no overall differences between the average number of repeat attendances for fundholders' patients compared with the average for all patients attending their local NHS trusts (the situation in ophthalmology is illustrated in Exhibit 10, but the pattern is the same in five other specialties examined). Very few fundholders have contracted for, and achieved, reductions in all specialties. Most health authorities visited also claimed to be seeking reductions in follow-ups via contract specifications, and trusts themselves may be partly responsible (Case Study 2, overleaf).

Exhibit 10
Ophthalmology outpatient follow-up attendances

Fundholders across the country differ greatly in the number of repeat outpatient attendances arranged for their patients by consultants, but there is no overall tendency for their patients to have fewer than other patients.

Average number of repeat ophthalmology outpatient attendances per patient



Source: Audit Commission site visits

Case Study 2

Reducing outpatient follow-up ratios

Source: Audit Commission site visits

In one area, both the health authority and some fundholders specified expected ratios in their contracts. But the trust also claimed to be leading the change. Over the years, one of its clinical directorates had developed a policy of appointing senior house officers who were training to be GPs locally, so they would then be familiar with the trust's approach when they entered general practice. They also subsequently appointed a number of the same trainees as clinical assistants (GPs who work part time in hospital clinics). The business plan of the clinical directorate that had made these changes claimed that it had 'the lowest ratio of follow ups to new patients (1.1 follow ups to 1 new) in the region....This could be reduced further by selecting certain community hospitals as centres of investigation...but a survey...of GPs met with a very mixed response. Further development along these lines must come from the general practice community themselves.'

More day surgery

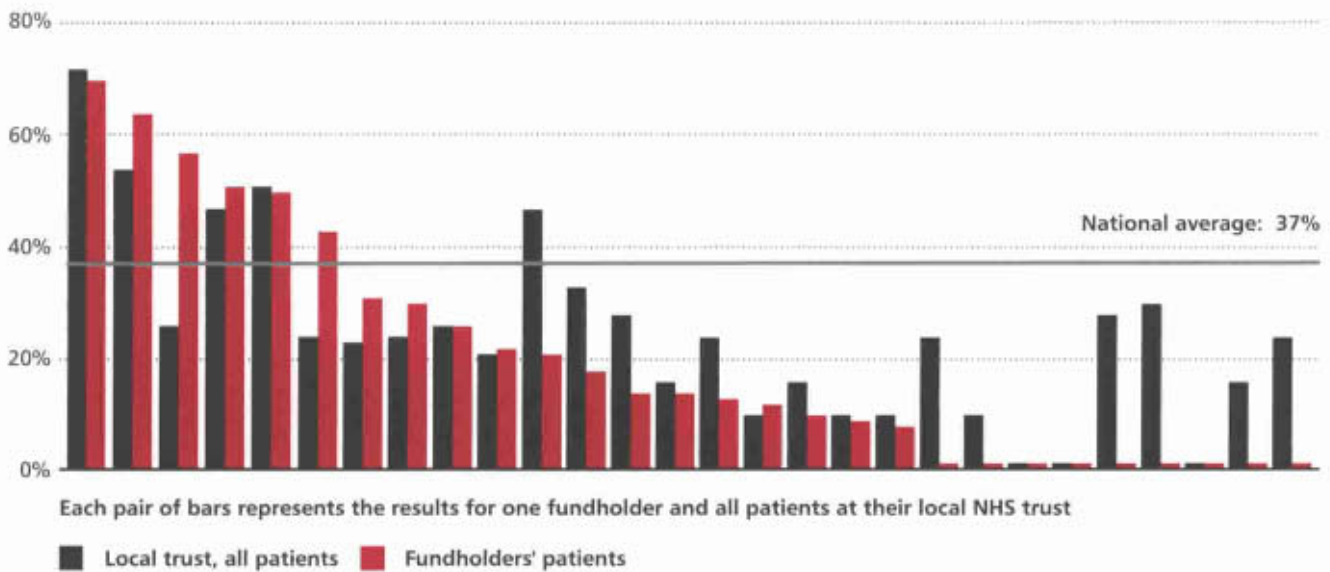
30. Day surgery is almost always cheaper than inpatient treatment, and is usually better for patients, especially children, since it removes the need to stay in hospital overnight (Ref. 37). Practices can maximise day surgery rates in various ways, by:

- ◆ specifying appropriate target day surgery rates in contracts;
- ◆ choosing alternative providers;
- ◆ carrying out their own pre-operative assessments to reduce the number of patients who arrive for day surgery in an unsuitable state for the anaesthetic, and are then sent home. The practice can then fill the pre-booked slot with another patient from the waiting list; and
- ◆ making special arrangements for aftercare in the community, allowing same-day discharge where otherwise the patient would need to stay overnight for safety.

31. Few fundholders meet NHS Executive day surgery targets (Ref. 38). For example, a minority of fundholders visited purchased above the national average day surgery rates for cataract surgery and, of those whose local trust carries out day surgery at a rate below the national average, few had switched to an alternative provider (Exhibit 11). Most are thus failing to maximise efficiency savings from day surgery (Exhibit 12, overleaf), with only 12 per cent saying they specified the proportion of patients to be treated as day cases in any specialty (Ref. 39). The main reason for not seeking better day surgery rates is that most fundholders leave day surgery suitability for consultants to decide – typical statements made by GPs visited included 'it's a consultant decision – that's why I refer to a consultant, for a decision' and 'as a GP I deal with each individual case, we don't contract for average rates – that's district health authority behaviour'. Reflecting this, only one in ten fundholding plans specifically mention day surgery; three-quarters of fundholders do not specify the rate of day surgery in contracts; and few (14 per cent) have made special arrangements for aftercare following cataract surgery (Ref. 40).

*Exhibit 11***Day surgery rates for cataract operations performed on fundholders' patients**

A minority of fundholders are purchasing a higher rate of day surgery than the national average. Of those whose local trust carries out day surgery at a rate below the national average, few had switched to an alternative provider.

Cataract operations performed as day cases

Source: Audit Commission site visits; national average from the NHS Executive's NHS Performance Guide 1994/95.

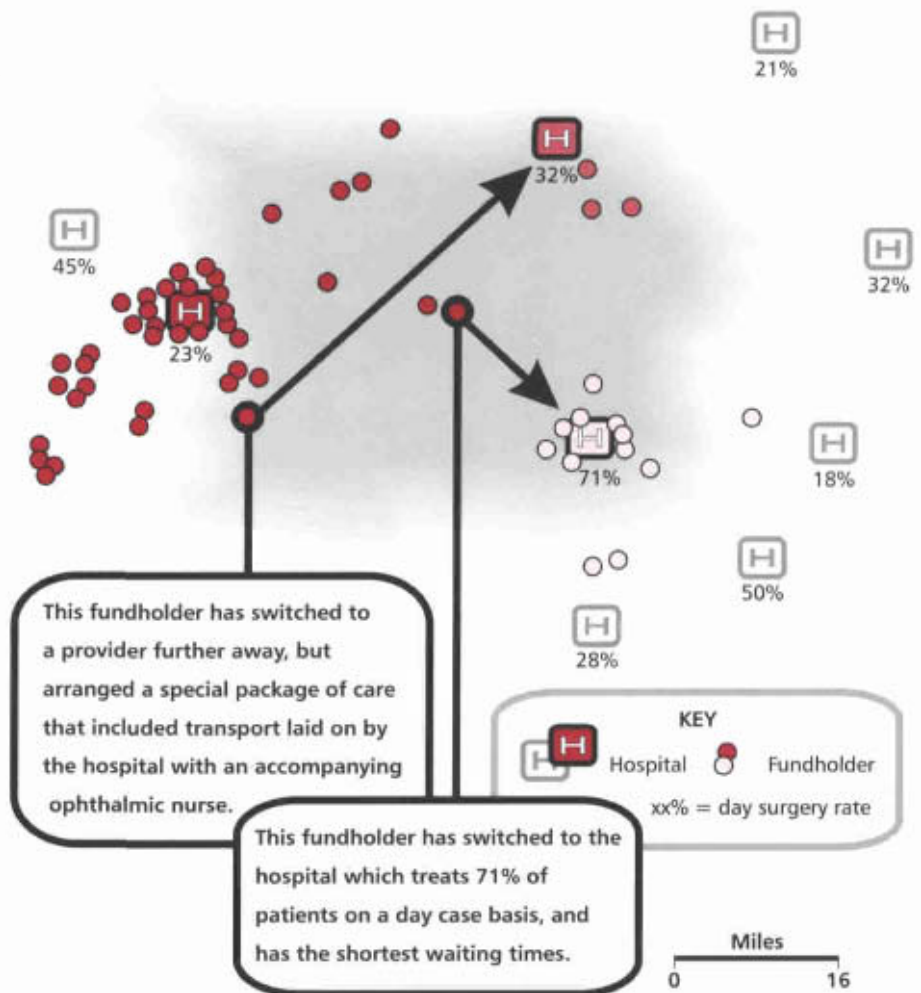
Lower prices

32. Published tariff prices can vary as much as twofold between providers, making significant savings possible for fundholders who are prepared to switch (unless the main provider, on whose prices the fund offer was originally based, is the cheapest). As well as changing provider, practices can gain lower prices by:

- ◆ making use of 'spare capacity' arrangements with trusts to treat extra patients at marginal (lower) prices;
- ◆ where block or cost-and-volume contracts are used, negotiating the same or better service as the previous year but for a discounted price; or having extra services provided for the published tariff price (for example, transport for patients from their homes to the hospital for day surgery, single overnight stays charged at day surgery rates, provision of outreach nursing back-up after day surgery); and
- ◆ avoiding hospital overheads by hosting services in the practice.

Exhibit 12
The degree to which fundholders switch between alternative providers of cataract day surgery

Despite potential budget savings and shorter waiting times, the map shows that only two fundholders in this area have switched providers, as indicated by the arrows.



Note: Each fundholder's position is shaded in the same style as the hospital to which it referred pre-fundholding. The percentages give the proportion of operations carried out on a day surgery basis, rather than involving an overnight stay, at each hospital during 1994/95.

Source: Audit Commission site visits.

33. None of the fundholders questioned had switched purely to buy at lower prices (Ref. 41). Switching, when it does occur, is usually based on quality considerations such as reducing waiting times. For example, one fundholding practice able to choose between competing providers, and which described itself as an aggressive contractor, nevertheless said access for patients and the GPs' relationships with consultants took precedence over price.

More cost-effective prescribing

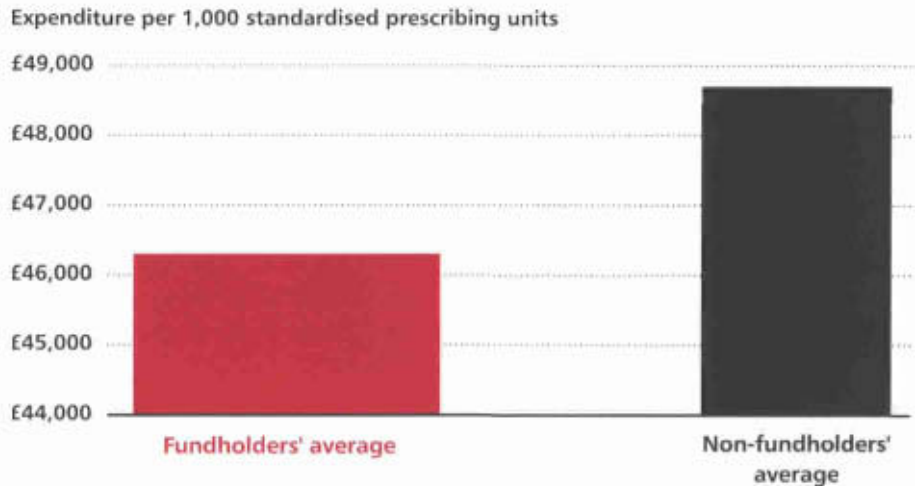
34. GPs can reduce expenditure and improve the quality of care through more rational prescribing, as described in a recent Audit Commission report (Ref. 42). In the early years of the scheme fundholders in general prescribed more rationally than GPs in non-fundholding practices. Fundholders spent 9 per cent less per prescribing unit (a standard measure weighted to reflect differences in the age structure of practice populations) in 1992/93, and the average growth in expenditure between 1991/92 and 1992/93 was 9 per cent for fundholders compared with 12 per cent for non-fundholding practices (broadly similar results have been described in Oxford, Mersey, Lincoln and Scotland (Ref. 43)). They achieved this mainly by prescribing more generics (drugs that are identical to more expensive branded products, produced when the original patents run out), fewer drugs of limited clinical value, and fewer antibiotics. Yet fundholders also on average prescribed more drugs for preventing asthma attacks that, although expensive, reduce the need for hospital admissions and, hence, overall treatment costs (Ref. 44). Updating this analysis shows that:

- ◆ two-thirds of fundholding practices surveyed have reviewed prescribing variations between their GPs and developed a practice formulary (although two in every five of these had them in place before becoming fundholders); and 43 per cent have agreed guidelines with hospitals about discharge arrangements;
- ◆ on average, during 1993/94, fundholders spent less than non-fundholders, but because of the great variability between practices, these differences are statistically significant only for Wave 1 fundholders (Exhibit 13, overleaf) (Ref. 45); and
- ◆ the main efficiency gains come in the first year of fundholding – Wave 3 fundholders spent at the same level as non-fundholders during their preparatory year, but their expenditure grew less over the next year (Exhibit 13). Information for 1994/95 confirms this pattern – the new Wave 4 fundholders saved 2.7 per cent on their prescribing budgets, while Wave 1 fundholders on average broke even (Ref. 46).

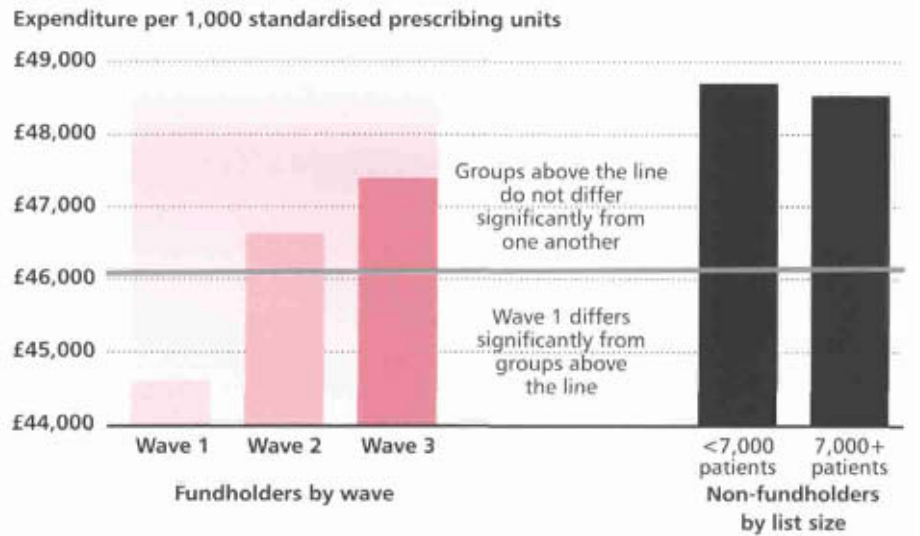


Exhibit 13
Prescribing costs in 1993/94

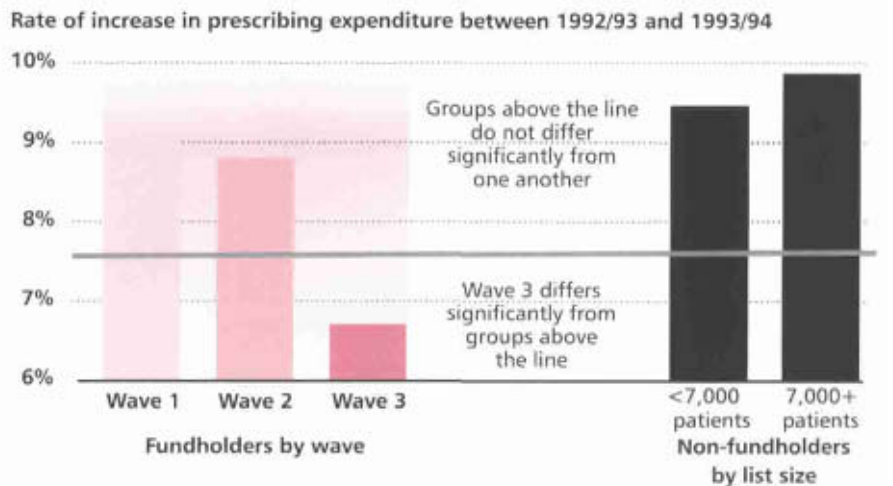
Fundholding practices on average prescribed more cheaply than non-fundholding practices...



...but because of the great variability between practices, only the difference between Wave 1 fundholders and other practices is statistically significant...



...and the main efficiency gains come in the first year of fundholding – Wave 3 fundholders spent at the same level as non-fundholders during their preparatory year (1992/93) but their expenditure grew less over the next year.



Note: Expenditure has been weighted to reflect differences in the age structure of practice populations.

Source: Audit Commission analyses based on Prescription Pricing Authority and Welsh Office data

Wider choice for patients

35. The 1989 White Paper made it possible for fundholders to refer wherever they wish, thus benefiting patients by extending choice. Fundholders can choose between providers on the basis of cost or quality, and have the powers to contract with any provider they choose, NHS or private, although community nursing services must be delivered by an NHS provider. By contrast, non-fundholding GPs can refer only to providers with which the health authority has placed a contract or has an agreement for extra-contractual referrals (ECRs). Fundholders often cite preserving their freedom of choice in the face of anticipated restrictions by health authorities as an important reason for joining the scheme. The White Paper also envisaged GPs competing for patients, and that patients would move to practices offering, or purchasing, the best services. There is no evidence that patients are changing practice in large numbers for reasons other than changing address (Ref. 47), although some fundholders gave a concern about this possibility as one of their reasons for becoming fundholders.

36. Despite their freedom, none of the fundholders visited has made major changes to where they refer. Most use many different providers, but this usually continues their pre-fundholding referral patterns. The majority of fundholders (55 per cent of 1,256 surveyed) have made changes in just one or two services, most commonly pathology and physiotherapy. Changes to acute specialty referral patterns are often temporary arrangements; for example, to clear a longstanding cataract waiting list. Some fundholders have changed their community services' management, but kept the same nurses and health visitors. And most fundholders have used the private sector at some point, usually in response to very long NHS waiting lists (as indeed have many health authorities (Ref. 48)). Some also describe using the private sector in relation to the tracer conditions used in this study, ranging from 14 per cent in the case of depression (largely to employ counsellors) to 38 per cent for cataract treatment.

Developing services nearer to patients

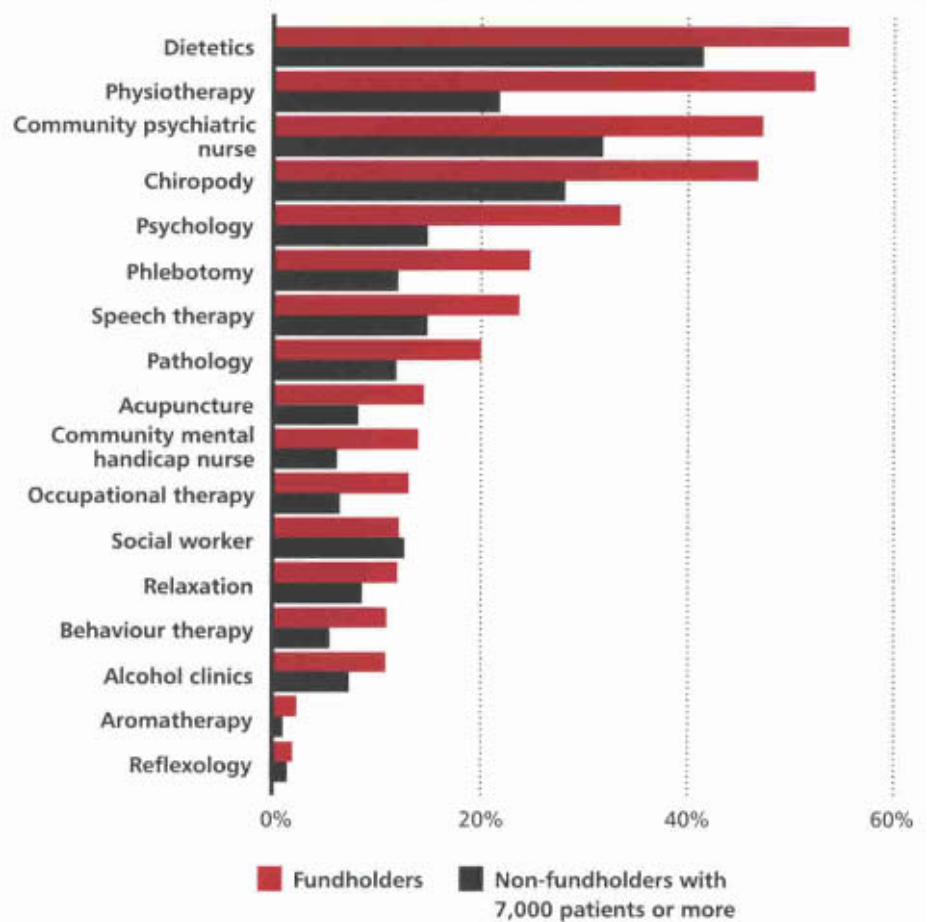
37. Fundholders can use their budgets to influence the shape of local services. Increasingly this is affecting the balance of care between primary, community and hospital services. General practitioners and health authority staff and members are largely in sympathy with a shift of care from hospital to community and practice settings (Ref. 49). Advances in medical technology are increasing the range of services that can safely be provided outside hospitals, patients prefer to be treated as near as possible to where they live and – although care within the patient's home may be as expensive – treatment costs are often lower outside big hospitals because of reduced overheads. Many GPs have begun developing the practice as a base for a wide range of provision. For some this is part of a planned development towards a polyclinic (an extended practice providing a much wider range of services, including some previously available only in hospitals). For others, the motive is greater convenience for patients with difficult journeys to the district general hospital, better quality and less daunting waiting and treatment areas, or access to services that, because of long waits, were in effect unavailable before (for example, physiotherapy in some areas).

38. Sometimes fundholders have used their budgets to extend the range of services at the practice premises, but often provision pre-dates their entry into fundholding – non-fundholders can pay for in-house services from practice income, by using GMS funds which some FHSAs earmark for such developments, or by persuading their health authority purchaser or provider trust to re-locate services into their practices. Fundholding practices are nevertheless more likely than non-fundholders to offer a wide range of services of all kinds, even when the size of the practice is taken into account:

- ◆ Fundholders are more likely to offer a range of community health services (Exhibit 14). For example, more than 50 per cent of fundholders provide physiotherapy at the practice, compared with less than 25 per cent of the larger non-fundholding practices. Only social workers are more commonly found at non-fundholders' premises. The proportion of practices offering these services declines with each successive Wave: more Wave 1 practices offer them than Wave 2, and so on down, with the larger non-fundholding practices offering fewer still.

Exhibit 14
Non-standard community services in GP practices

Fundholding practices are more likely to provide a wide range of less common community services than are their non-fundholding counterparts.

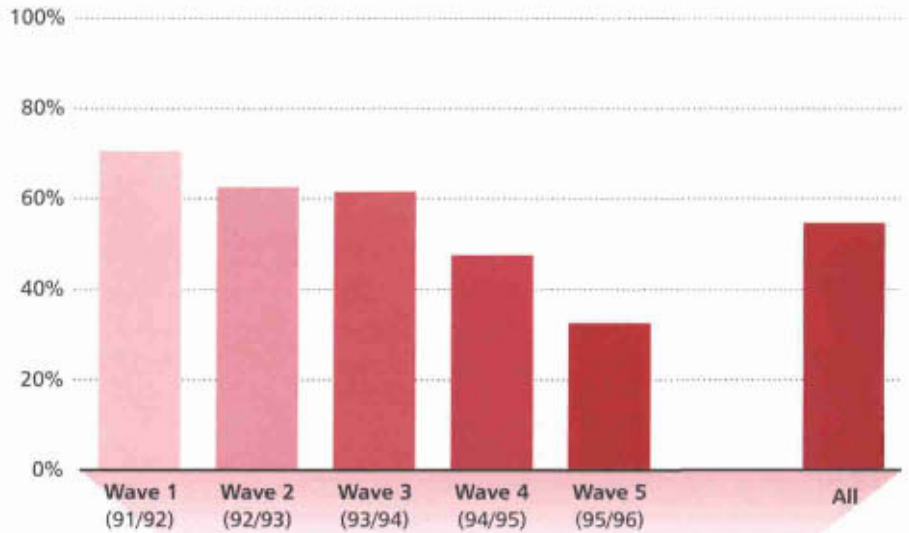


Source: Audit Commission survey of 2,419 practices 1994/95

Exhibit 15
Changes to district nursing services made by fundholders

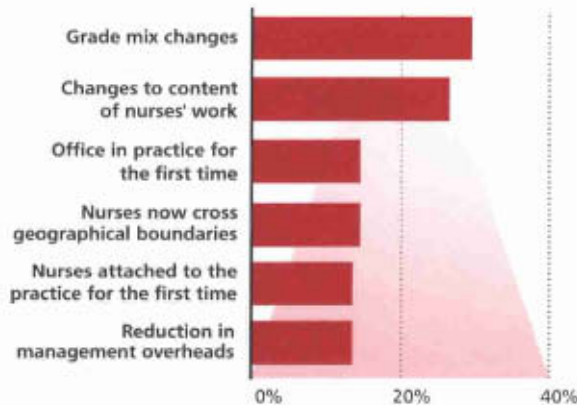
Half of fundholders have contracted for some kind of change, and this is more common in earlier waves...

Fundholders making any kind of change to the district nursing service since joining the scheme



...the most common specific change has been to alter grade mix.

Specific changes, average across all waves



Source: Audit Commission survey of 1,249 fundholders 1995/96

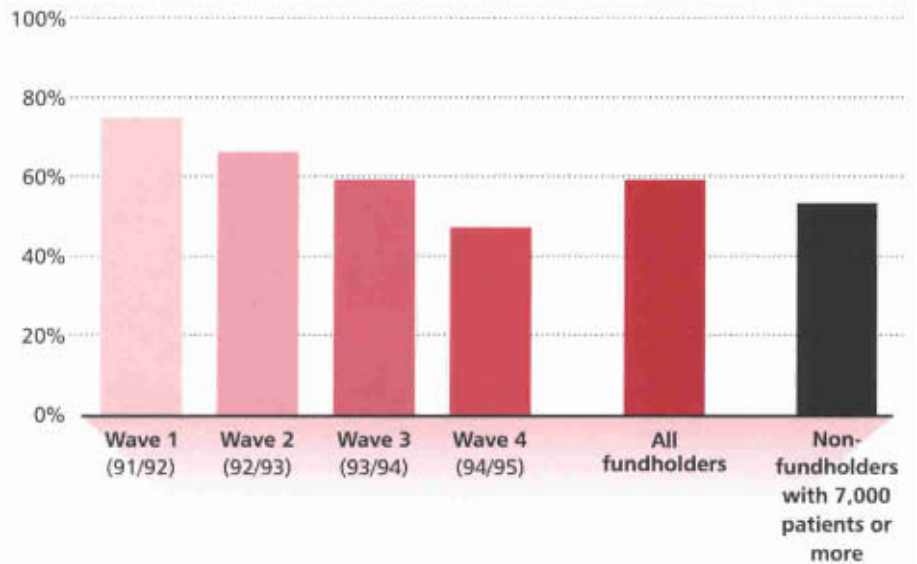
- ◆ Half of all fundholders have contracted for changes to district nursing services, a practice more common in the earlier waves (Exhibit 15). One quarter of fundholders have made alterations to grade mix, the single most common change. For some, this has been to introduce more 'pairs of hands' and reduce high grades. But others have done the opposite, acting against the local trust's attempts to rationalise skill mix across all practices.

Exhibit 16
Consultant outpatient clinics at the practice

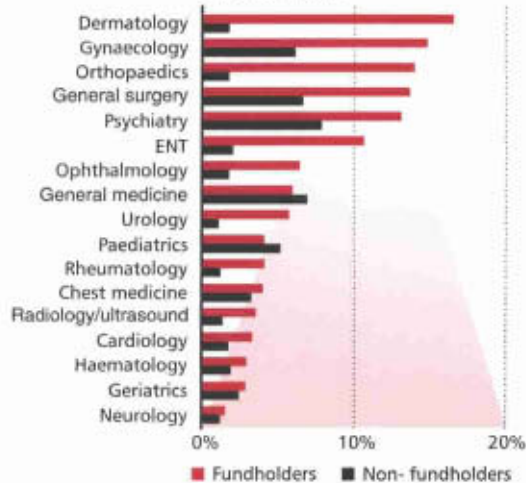
Fundholders are for the most part more likely to have outpatient clinics at the practice...

...although non-fundholders are more likely to provide clinics in general medicine and paediatrics.

Practices with an outpatient clinic in any specialty at the practice



Specific clinics



Source: Audit Commission survey of 2,419 practices 1994/95

◆ For the most part, fundholders are more likely to have consultant outpatient clinics at the practice (Exhibit 16). Even where these services are not provided at the practice, they are often available locally in a neighbouring practice, a health centre or community hospital, or if the district general hospital is close by. Of 18 fundholders visited, only one-quarter of outpatient services were provided at sites more than two miles away from the practice, and only one in ten community services.

39. Because many forces are all pushing in the same direction, it is hard to pinpoint the unique contribution of fundholders to developing the locality as a base for services when many other players are also claiming the credit. For most fundholders, some locally based services already existed prior to

fundholding. Only one in three fundholders visited had made changes to the location of community services since becoming fundholders, and one in five had changed the location of outpatient services. The question of whether increasing provision of practice-based services is cost effective is not straightforward:

- ◆ while patients prefer familiar and more local surroundings, practice-based outpatient clinics may have less equipment, testing facilities and staff support than those held in hospitals;
- ◆ fundholders' patients have guaranteed access when a service is provided at their own GP's premises, potentially a shorter wait before being seen, and a shorter wait on the day; but this could mean longer waits for patients of other practices, as there is only so much consultant time to go round;
- ◆ in one way efficiency may be increased, since the number of repeat appointments may reduce when a consultant, not a junior, sees patients and the GP is on hand to discuss aftercare; but inefficiency may be introduced if patients who do not need a consultant's skills take up consultant time;
- ◆ there may be duplication of expensive equipment costs, and equipment may be under-utilised; the costs of consultant time to travel to clinics, and effects on training junior doctors, also need to be considered; and
- ◆ the separate roles of health authorities and trusts are now clearly established, but fundholders are both purchasers and providers of care. 'Do what you can, buy what you cannot' is a phrase some GPs use as their practices develop further services. The fundholding scheme gives GPs the power to shift care previously given in a hospital setting into their own premises, and introduces the risk of 'empire-building', which could cloud judgement about whether such shifts are better for patients or better value for money. Fundholders could use their purchasing power 'collusively', preventing the market entry of rival organisations that might offer better value for money (Ref. 50).












Which changes are most associated with fundholding?

40. The wide range of actions that fundholders can take to improve the services their patients receive is summarised in Summary Box 1. As the detailed examples given in this chapter have shown, most of them have been applied by at least some fundholders. But there is also wide variation in the extent to which the individual actions have been applied. The most common changes have been improved communications with hospitals and consultants; kick-starting or speeding up specific local changes that had been difficult to achieve in the past; more rational prescribing; and making budget savings. The least common have been wholesale switching between providers (whether for lower prices or other reasons); seeking increased day surgery; planning future developments with the health authority and providers; agreeing with consultants that the GP should manage the waiting list for non-urgent operations; and introducing guidelines designed to make healthcare more effective.

Summary Box 1

A typology of benefits for patients

Fundholders, health authorities and service providers themselves can take many different actions to improve healthcare. The text discusses in detail some of the key ones. This box lists all those used during the study to assess the benefits which fundholders' patients receive, together with indicators used to measure success, and summarises how often the changes have occurred.

Fundholding scheme objective	Benefits (examples)	Indicators	Common or rare benefit?
Closer focus on individual needs	Waiting lists for non-urgent operations managed with more sensitivity to individual patients' needs	List managed by GPs with consultant agreement	
	Better information from consultants improving care of the patient when discharged from hospital	Quicker and more informative clinical letters	
Better quality services	Reduced waiting times	Improvements in <i>most</i> specialties; Charter targets achieved	
	Solutions to longstanding local problems such as access, lack of courtesy to patients, inconvenient pathology collection times, etc	Local difficulties solved; faster rate of change	
	Greater responsiveness from providers. Improved communication	Positive statements by GPs and trusts	
	Attainment of Patient's Charter targets (named nurse, waiting time to see a doctor in A/E, clinics, etc)	Charter standards specified in contracts and achieved	
	Appropriate skill mix (named consultant, nurse grade mix, junior doctor levels, etc)	Specified in contracts	
	Good hotel services (food, car parking, courtesy of staff)	Improvements stated in contracts; patient satisfaction surveys	
More effective healthcare	More appropriate referrals	IT system used to maintain disease registers and audit variation between partners in referral rates	
	More use of clinical guidelines covering hospital and community healthcare	Written guidelines agreed specifying how consultants will treat patients	
	Changed clinical practice – eg, watchful waiting for glue ear; basing cataract referrals on visual ability not just acuity; 4-layer bandages for leg ulcers	Contracts specify use of guidelines, and then providers audited to ensure compliance	

Fundholding scheme objective	Benefits (examples)	Indicators	Common or rare benefit?
Increased efficiency	Reduce inappropriate outpatient follow-up appointments	Reduced ratio of follow-up to new patients	
	More day surgery	Higher day surgery rates; specifying rates in contracts	
	Direct access to operating lists (eg, for hernia, vasectomy, female sterilisation) avoiding unnecessary outpatient clinic	Direct access agreed	
	Same activity for less money	Lower prices in most specialties	
	More cost-effective prescribing	Less inappropriate prescribing; more generics	
	Benefit patients via fundholder savings	Planned savings spent in line with regulations	
Wider choice for patients	Freedom to refer where GP wishes	Referral range protected/ increased	
	Offering patients a choice of provider depending on individual wishes	Changes to providers	
	Services made available where very long waits had previously denied access	Access improved (eg, counselling at the practice)	
Developing services nearer to patients	More conveniently located consultant outpatient clinics in familiar surroundings	Clinics at the surgery, community hospital or other site nearer where patients live	
	As above for therapy services (eg, physiotherapy, counselling)	As above	
	Better practice environment and facilities	Improvements to the practice fabric	
	Developing local providers	Investment in cottage hospitals or a favoured DGH	

Source: Audit Commission

Key (the chapter gives the detailed data):

Few fundholders

A substantial minority of fundholders

A majority of fundholders

41. Lack of progress can sometimes be ascribed to the past culture of general practice. Taking the reluctance to set higher day surgery rates as an example, GPs may have concerns about increasing their own workloads once the patient is discharged, they may risk losing patients to a competing practice if they advise day care when the patient expects an overnight stay, and they may also have concerns about liability should things go wrong. Health authorities, by contrast, have pushed for improvements in day surgery rates because their corporate contracts with regional offices require it. Some changes can clearly be attributed to fundholding, as when a practice switches to a new provider with the express intention of reducing the waiting time in one specialty, or the fundholder receives better information on discharge by refusing to pay invoices until receipt of a discharge note. But the causes of other changes are more difficult to disentangle. For example, wide-ranging waiting time reductions (where central attention has encouraged all stakeholders to play their part) or reducing repeat outpatient attendances could result from the actions of health authorities or providers.

42. While there is wide variation in application of individual actions, there is even more variation in the extent to which individual practices achieve change across the whole spectrum. In the Commission's experience, a few fundholding practices have achieved change in many of the areas listed. The majority, however, have focused on achieving one or two significant gains for their patients. It is therefore important to ask what it is about the way fundholding practices are organised, and the environment in which they operate, that could account for such differences.



Recommendations

Benefits for patients

- 1 To allow more sensitivity to the changing pain levels and social circumstances of patients, fundholders should:
 - ◆ know how long patients wait and the number who are waiting at any one time for planned operations;
 - ◆ actively monitor patients on the waiting list; and
 - ◆ agree with consultants that the practice can specify how many and which non-urgent patients should be seen.

- 2 To improve the quality of care patients receive from hospital and community providers, fundholders should:
 - ◆ specify the information they expect providers to give them about service quality, including information from clinical audit; and
 - ◆ use the information to make decisions about which providers and which consultants to send their patients to.

- 3 Fundholders need to make more use of the growing body of knowledge on effectiveness in medicine and should:
 - ◆ use information from the fundholding IT system to review and cost their own referrals; and
 - ◆ develop jointly with provider clinicians both protocols for referral, and guidelines about approaches to treatment. Local fundholders should collaborate by specialising in a particular area, making their knowledge available to other practices. Where it is appropriate, they should seek help from the health authority's public health department.

- 4 Fundholders should take note of the NHS Executive's annual *Planning and Priorities Guidance* and in particular:
 - ◆ set targets for day surgery with providers; and
 - ◆ specify in contracts how the acute provider, community nursing provider and the practice will share responsibility for and finance aftercare.

- 5 Fundholders should review their prescribing, and:
 - ◆ cost the differences in prescribing patterns between GPs in the practice;
 - ◆ reduce expenditure on drugs of limited value;
 - ◆ prescribe more generic drugs; and
 - ◆ keep abreast of guidance on rational prescribing.



2 Managing Fundholding

Fundholders can claim an allowance to cover the cost of managing and administering the scheme, but not all practices have used this to pay for an experienced manager. Many practices administer the scheme capably but do not actively manage their budgets.

Well-managed practices produce clear plans explaining how they will use the fund to seek benefits for their patients. They negotiate contracts that allow the GPs to determine the number of patients to be treated each month, rather than leave that decision to the provider, and take corrective action in good time if heading for an overspend. They monitor provider quality and take corrective action against failures.

The best practices involve their patients in decisions about how the fund should be spent, meet in informal local groups to share good ideas, jointly develop core contracts and share contract negotiations.

'...even where practices decide to manage fundholding on their own, they cannot really be successful in isolation – they need to develop links with their patient population, the wider community, the health authority and local providers.'

The fundholding practice

43. Fundholding introduces new demands on the practice, and those joining the scheme need to establish a firm organisational basis. They will then be ready to carry out the whole range of tasks involved in the annual commissioning cycle that can lead to patient benefits.

44. This chapter begins by assessing how practices integrate fundholding into their existing organisational arrangements, ensure that they have staff with the right skills, and foster a sense of commitment to success in both GPs and practice staff. Some practices, often the smaller ones, have decided to share the management effort by formally linking together to form 'multifunds'. But even where practices decide to manage fundholding on their own, they cannot really be successful in isolation – they need to develop links with their patient population, the wider community, the health authority and local providers. The chapter then assesses the commissioning cycle that any fundholder, whether stand-alone or in a multifund, must follow. It examines a sequence of three main stages:

- ◆ needs assessment and planning – systematically assessing the practice population's healthcare needs, translating these into specific fundholding objectives, and setting out how these will be achieved in a written plan;
- ◆ contracting and monitoring – gathering market intelligence with which to compare potential service providers, negotiating a contracts portfolio which can deliver the practice's fundholding aims, and monitoring how well providers deliver services; and
- ◆ budget management – making good use of IT to manage monthly expenditure, identify where savings can be made through increased efficiency, and provide the GPs with decision-support information.

45. Although they are part of the NHS, GPs are also independent contractors. Health authorities' relationships with them are based on facilitation and influence, rather than direct control. Many GPs practise on their own, although most who became fundholders in the first four years of the scheme are based in practices of two or more GPs. In several respects – size, independence and ownership by a partnership – practices have more in common with small law or accountancy firms than with other NHS organisations. Their independence makes it hard to make generalisations about them – they have unique histories, determined by the partners and the relationships between them. A practice's progress towards the objectives of the fundholding scheme will depend on the views of the partners, the degree to which there is consensus between them over fundholding, how they make joint decisions and the relationship between the lead fundholding GP and the others. It will also depend on the degree of computerisation, how many staff and managers are employed, and the extent and quality of facilities at the practice, all of which are very variable.

46. GPs have not traditionally had responsibility for large annual budgets, and their practices may lack the management and organisational capacity required to take on this new responsibility. Many small practices do not

employ what the rest of the NHS would recognise as a general manager. The profession of practice management is still developing even within the larger practices, and the fundholding scheme is helping to develop management within general practice and involving GPs in managing the wider NHS for the first time. It is difficult for those outside general practice to comprehend the huge cultural change this represents (Ref. 51).

Joining the scheme

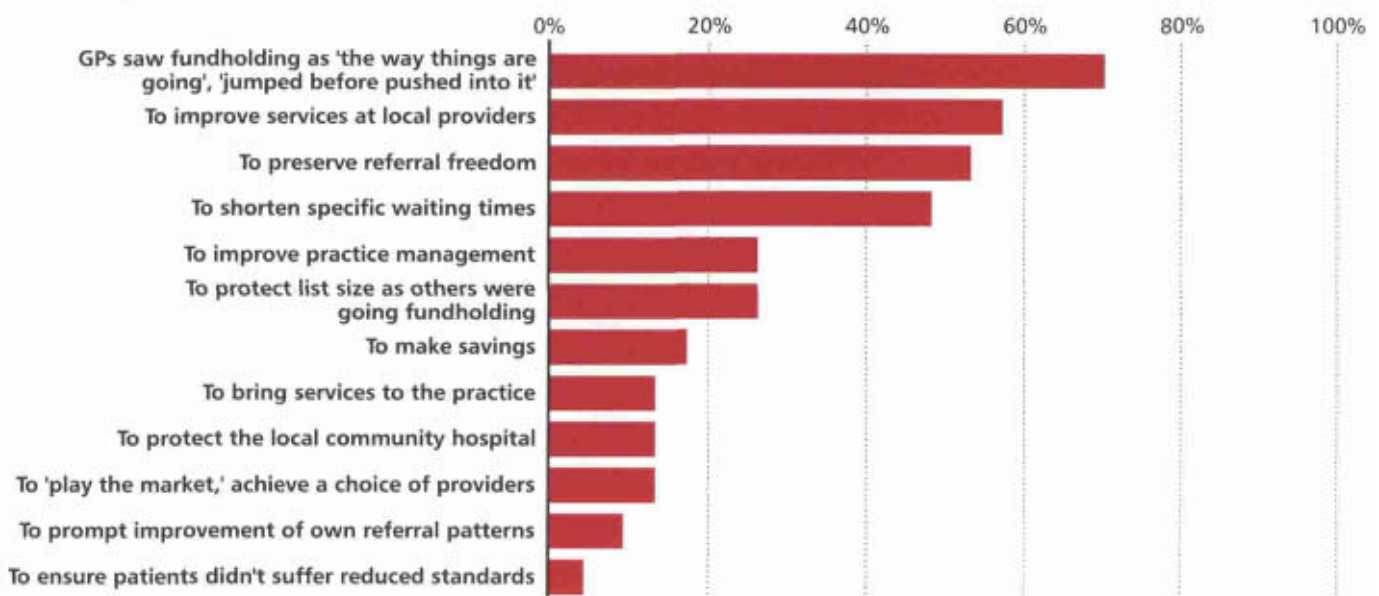
47. GPs have many motives for joining the fundholding scheme, including a desire to seek improvements for patients and to keep the practice up to date (Exhibit 17). The fact that a practice joins the scheme does not necessarily mean that all the partners are committed fundholders, and the way in which they handle any differences, and the manner in which they resolve them, affects what the practice is able to achieve with the fund. In just under 50 per cent of practices (Ref. 52) the decision to enter the scheme was unanimous; in a similar proportion, one or more of the GPs disagreed but were willing to put aside their reservations for the sake of the practice. In 10 per cent of practices the decision had caused partners to resign or provoked serious conflict.

Exhibit 17

Reasons for becoming fundholders

GPs have many motives for joining the fundholding scheme, including a desire to seek improvements for patients and to keep the practice up to date.

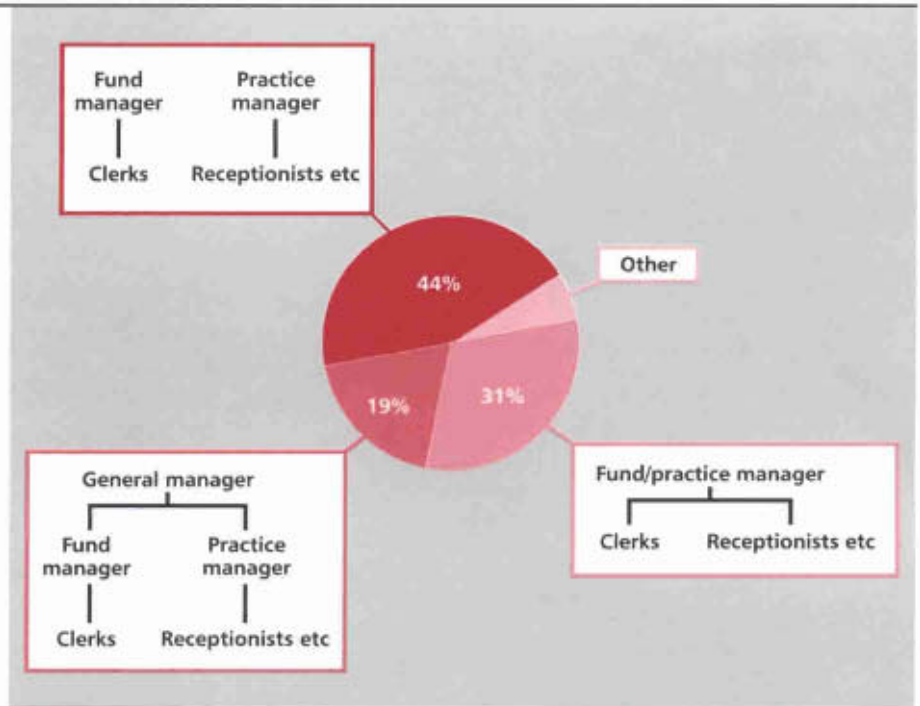
GPs could give more than one reason:



Source: Audit Commission site visits

*Exhibit 18***Three common management structures within fundholding practices**

The most frequent arrangement is to have separate fund and practice managers, but one in every five – mostly larger practices – have appointed a general manager.



Source: Audit Commission site visits

Integrating fundholding into the practice

48. Joining the scheme affects the whole of the practice. It brings new people and new equipment, the fundholding IT system, and often new types of work with patients. This all has to be accommodated and integrated into the practice premises, staffing structure and existing methods of working. If the practice has anything other than very limited ambitions for the fund and the GPs intend to change or develop services, most of the staff will be affected. For key individuals, notably the lead GP and the practice manager, fundholding can fundamentally change roles and relationships. Almost inevitably, the GPs and the practice manager will spend more time in meetings. The practice secretaries may have more typing and clerical work, and if the practice purchases one or more outpatient clinics in the surgery, the practice nurse may be called on to assist and the receptionists will be making more bookings. The practice manager may need to recruit new staff and is likely to become involved in buying new equipment.

49. Fundholding practices make a variety of arrangements for managing the fund (Exhibit 18). Half employ separate fund and practice managers, an arrangement that can work well but sometimes isolates fundholding from the rest of the practice. One-third of practices have added fundholding duties to the role of the existing practice manager, which in most cases means that fundholding does not receive sufficient attention. One in five – mostly the larger practices – have appointed a general manager with overall responsibility for longer-term development of both the fund and the practice, and delegated the day-to-day operational work to one or two

deputies. Among an array of other arrangements, the least productive is where the lead GP fundholder takes on the role of fund manager.

50. Managing a fund involves a wide range of duties and tasks, including strategic planning; drafting, negotiating and monitoring contracts with providers; producing reports for the GPs and the FHSA; and a daily round of administrative activity (entering referrals into the fundholding computing system; updating the information about patients on the system, checking invoices from providers and authorising them for payment) (Ref. 53). The lead GP and fund manager usually share some of the more important fund management tasks, but GPs generally take the lead in choosing providers, leaving non-medical staff responsible for daily operational matters (Exhibit 19). Success is unlikely if the GPs take little interest in what is happening to the fund, but a few doctors spend their time inappropriately in day-to-day running of the fund. Fifty per cent of fund managers spend some time inputting data, a task they feel others should be doing. Most fundholders are concerned about excessive bureaucracy, an issue addressed by a recent NHS Executivestudy(Ref.54).

51. Fund management demands a range of skills. Fund managers themselves feel that financial skills are most important (rated by 28 per cent as the most important attribute of 13 listed in an Audit Commission questionnaire), followed by organisational skills (24 per cent), knowledge of general practice

Exhibit 19
Who carries out fund management tasks

Most lead fundholding GPs take the lead in choosing providers, leaving non-medical staff to handle the routine administration. But a minority of GPs spend time on activities they should leave to competent fundholding staff.



Source: Audit Commission 1994/95 survey of 1,308 fundholders

(20 per cent) and business planning (15 per cent) (Ref. 55). The majority of fund managers feel well prepared, yet they differ greatly in their qualifications and experience. There has been a considerable influx of 'new blood' into fund management – two-thirds of fund managers were working outside general practice before beginning their new jobs. While some fund managers are well qualified (half have 'A' levels and one-quarter are educated to degree level; one-third have a practice management qualification, 13 per cent an accountancy qualification (Ref. 56)), many are not. Those promoted from within were more likely to have a qualification in general practice management, but less likely to have higher qualifications.

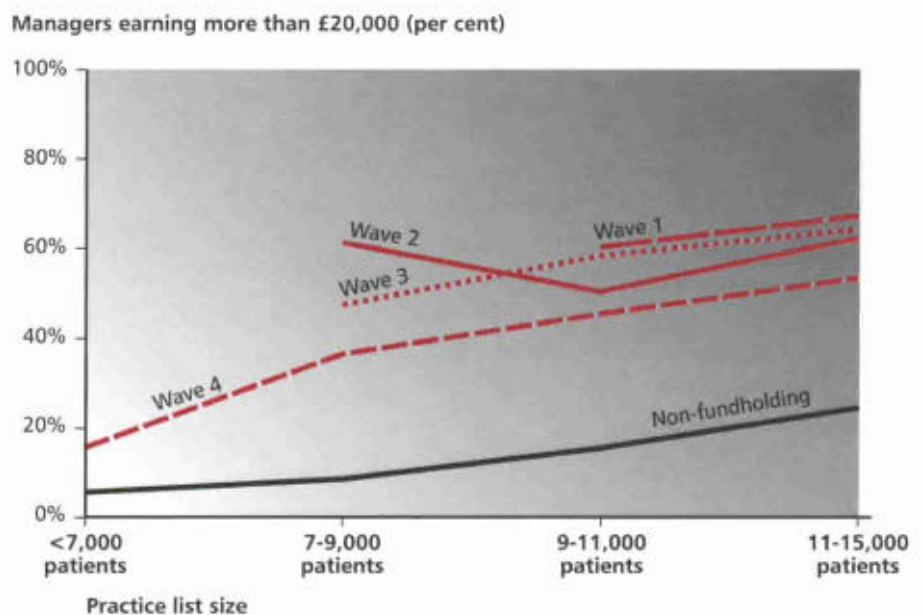
52. Practices can choose to pay their fund managers what they wish, although two FHSAs visited had issued guidance about appropriate salaries for fund managers which they expected practices to follow. Before fundholding, it was rare to pay a practice manager more than £20,000. Practices now pay fund managers more on average than non-fundholding practice managers, reflecting the different types of skills required and the different job markets from which many have been drawn (Exhibit 20). The more highly paid managers are generally to be found in practices that have in various ways given more emphasis to organisational development. For example, their practices are more likely to be considering becoming or are already 'paperless', and to have entered into formal schemes such as organisational audit and the Investors in People award. The managers are more likely to be involved with the practice as a whole, and their lead GP fundholders are less likely to be spending their time in the daily operational management of the fund.

Exhibit 20
Managers' salaries in fundholding practices of different size and in non-fundholding practices

Fundholding managers are paid more than non-fundholding practice managers, reflecting the different types of skills required and the different job markets from which many have been drawn.

Note: The following differences are statistically significant: 2-way ANOVA; both main effects significance; linear trend test for list size significance; post-ANOVA means tests show Wave 4 differs significantly from each of Waves 1-3, and non-fundholders from Waves 1-4.

Source: Audit Commission 1994/95 survey of 2,363 practices



'...some practices have succeeded in integrating fundholding into the workings of the practice as a whole. But others have merely bolted fundholding on.'

53. Practices are more likely to achieve their fundholding objectives and to limit the stress associated with change if the GPs and staff understand the plans and have the opportunity to comment on them. But fundholding practices manage the interface between the fund and the practice with varying degrees of success. In most practices joining the scheme boosts the level of practice management and can help the partnership learn to contain disagreements and accept majority decisions (Ref. 57). In others it has been a catalyst for major change, either positively or negatively (Case Study 3). In 70 per cent of fundholding practices, fund managers attend practice meetings with all the GPs and staff, and most fund managers consider themselves very involved in the rest of the practice (61 per cent) (Ref. 58). However, one-quarter say their involvement is limited and a further 16 per cent say they are not much involved at all. About a half of fund managers reported holding regular meetings with the lead fundholding GP. Where separate fund and practice managers were employed, only 20 per cent reported holding joint managerial meetings together without GPs present.

54. In conclusion, some practices have succeeded in integrating fundholding into the workings of the practice as a whole. But others, especially smaller practices, have merely bolted fundholding on. Some practices have tried to meet the demands created by fundholding by joining together with other practices to share the management effort. The next section describes these cooperative arrangements.

Multifunds

55. Some GP fundholders create multifunds by pooling together a proportion of their management allowances to pay for a secretariat and office which undertakes day-to-day administration of the funds, and may co-ordinate some commissioning activities. The individual funds remain separate entities. GPs have developed multifunds with varying support from their local health authority and without specific guidance from the NHS Executive (apart from a statement that responsibility for fund budgets is to be maintained at individual fund level (Ref. 59)). In some areas, most fundholding practices belong to a multifund, while in others as few as 10 per cent of the local fundholders are members. While the majority of multifunds fit within the boundary of their local health authority, even in big cities the distribution of practices belonging to multifunds tends to look more like Swiss cheeses than cheddars – that is, there are gaps on the map where the population is served by non-fundholding practices or independent fundholders who have chosen not to join the multifund.

The size of multifunds and their significance for small practices

56. There are at least 17 multifunds in operation (Ref. 60), covering a total registered population of around two million patients (about 4 per cent of the UK population) in over 350 practices. They vary considerably in size (Exhibit 21, overleaf) – the larger multifunds can involve up to 30 funds and 50 practices, while the smaller ones have only a few funds and less than 10 practices. A handful are approaching the size of an average health authority, but most cover 50-80,000 patients. The amount contributed to the central

Case Study 3

Effects on the practice of joining the fundholding scheme**(a) Full integration - fundholding issues are discussed by all within the practice and consensus views worked towards**

The general manager in this small practice (5,600 patients) takes overall responsibility for fundholding and the rest of the practice, and is an executive partner. The manager meets the GPs daily at coffee to air any pressing issues relating to either fund or practice. The manager and the lead fundholding GP meet weekly and all the GPs, plus the practice nurses and the general practice office manager, attend fortnightly fundholding meetings. The practice was well developed before fundholding; one partner is a professor of general practice, and all the others have undertaken RCGP fellowship by assessment. The partners feel that fundholding has allowed the practice to become better organised and increased staff have reduced the amount of paperwork done by the doctors. It has given them a feeling of greater control and boosted morale. They felt they were delivering good primary care before fundholding, but the change has prompted them to discuss their referral aims more.

(b) Not integrated – the practice has limited fundholding aims which it leaves to the lead GP and fund manager to implement

By contrast, this larger practice entered fundholding primarily to protect and develop services at the local community hospital. The local maternity hospital had just closed, and the GPs were afraid that the community hospital might follow. The partners were not all in agreement about fundholding, but wanted to protect the hospital and invest in it further. They have invested in new building at the hospital, but they now meet only every six to eight weeks to discuss fundholding, and not all the partners attend. The lead fundholding GP and fund manager are left to get on with working towards their agreed, limited, goal and the others express little interest in what is happening.

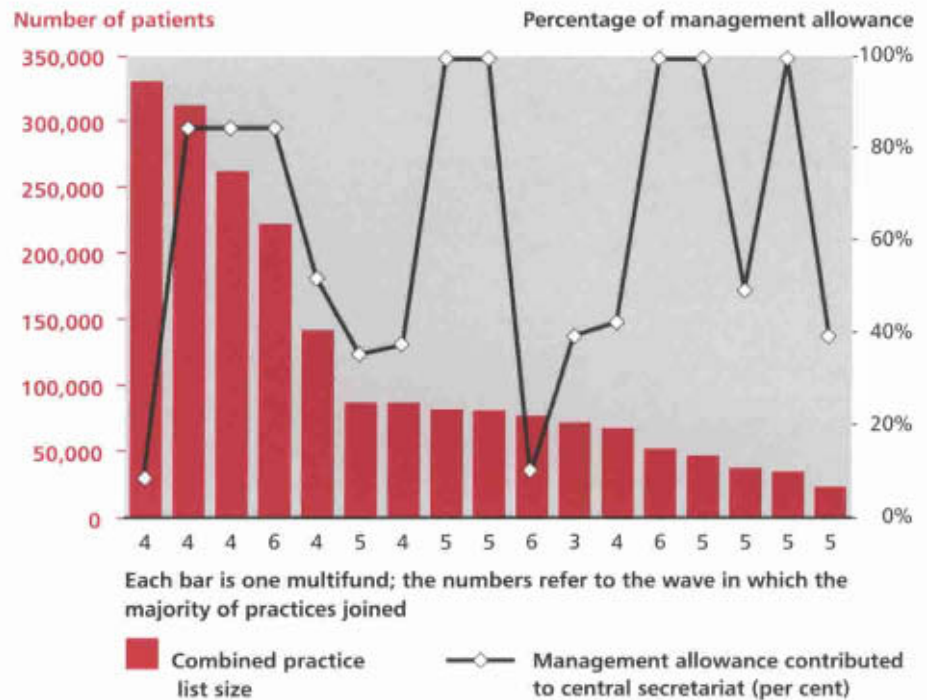
(c) Dysfunctional – insufficient management capacity and interpersonal problems are limiting achievements

A Wave 3 practice, also with academic links, began with a combined practice and fund manager. Over the first live year the manager delegated practice management to lower grade staff, and subsequently resigned all her practice management duties to concentrate on fundholding. The lead fundholding GP meets informally with the fund manager once a week, but carries out most fundholding work at home and communicates with her colleagues in writing, because her clinical and academic commitments make it difficult to meet during the day. The practice is currently operating without a practice manager. The fundholding team works on a different floor of the building from the rest of the practice. Overall the effect of joining the scheme has been very disruptive, and the lead fundholding GP said, 'fundholding is not one of our main achievements and is one of which we are least proud'.

Source: *Audit Commission site visits*

Exhibit 21**The size of multifunds in the UK, and how their management is funded**

There are at least 17 multifunds in existence and they vary greatly in size. The proportion of the management allowance contributed to cover central office costs varies considerably.



Source: Audit Commission survey of multifunds

office, as compared with that retained for management within the practice, varies considerably (from 9-100 per cent of the management allowance; Exhibit 21), and reflects fundamental differences in the character of multifunds as organisations. In most there is a tension between the degree to which the central office can relieve practices of the administrative burden, while keeping them sufficiently involved and sharing in their budgetary responsibilities. Nevertheless, multifunds have enabled some GPs to become involved in fundholding who would not have done so had they had to take charge of the management aspects themselves.

57. Multifunds are an important mechanism for bringing small practices into the fundholding scheme. In order to reach the minimum list size necessary to form a fund, smaller practices link together, usually in twos or threes. By April 1994, approximately 650 practices had combined to enter the scheme as about 280 funds. Such practices often join multifunds – four out of every five multifunds have more small practices within them than the national average for independent fundholders, and half have more single-handed practices (Exhibit 22).

How multifunds are organised

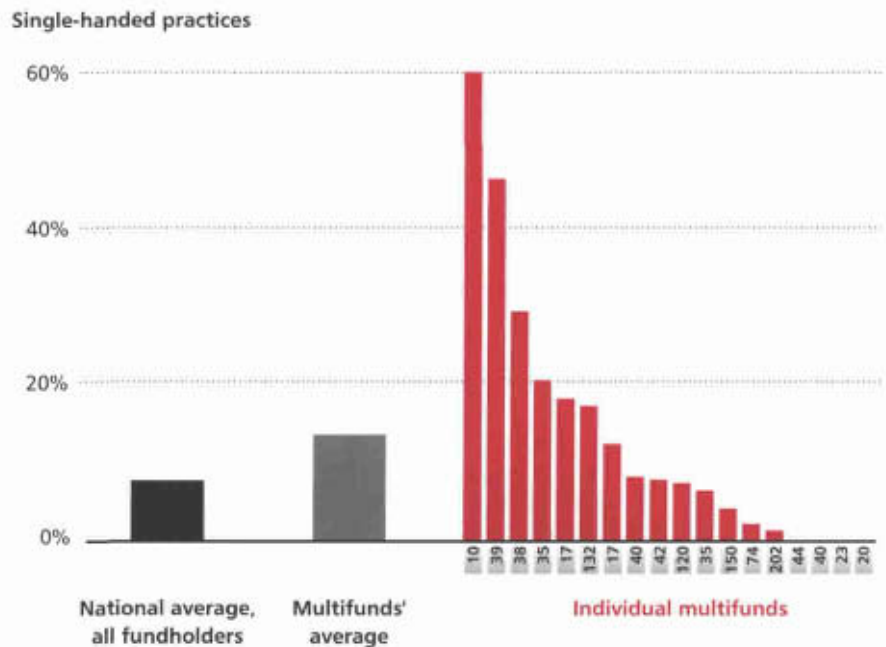
58. In all multifunds the main decision-making body comprises GPs who have a mandate to act on behalf of their colleagues and who oversee the activities of the central office management staff. Half of all multifunds have an executive group which includes GPs who take responsibility for a particular area such as finance. In the largest multifunds, GP sub-groups

Exhibit 22

Multifunds and small practices

Some multifunds have attracted a higher proportion of single-handed GPs into fundholding.

Note: the number below each bar is the total number of GPs in each multifund.



Source: Audit Commission survey of multifunds

undertake specific tasks, and two multifunds employ medical directors on a sessional basis. Multifunds have adopted a variety of approaches to keeping member practices informed of decisions and obtaining their views. Most have voting systems, and one-third circulate minutes of executive meetings or issue newsletters. Most hold practice manager meetings, but seldom invite practice managers, nurses, or representatives of FHSA, district health authority or non-multifund practices to participate in meetings.

59. Staff in the multifund central office carry out the day-to-day administrative work involved in fundholding, and may undertake commissioning functions in liaison with the GPs. The number of staff employed depends on the proportion of management allowance allocated from each fundholder, which in turn reflects the balance of work which member practices wish to carry out themselves. The smaller multifunds employ two or three staff and a chief executive or equivalent and often use practice staff for data entry and administration. The larger ones can employ as many as 30 people in the central office, who spend varying amounts of time in the practices. In the majority of multifunds the chief executive has either a background in management or finance from the private sector, or else significant experience in health authority management. As the number of central office staff increases, the mix of skills becomes more complex with middle grade staff being employed in addition to data clerks; and staff start specialising (for example, in IT support and contracting), and become organised into teams based on geographical areas. In theory, multifunds could produce economies of scale, and therefore savings in management costs. However, fundholders in most multifunds claim the maximum management allowance. Three multifunds have achieved 'savings' on their

'The main value of multifunds has been in allowing smaller practices, which on their own would lack the necessary management capacity, to benefit from fundholding status.'

budgeted management allowance spends which they have nevertheless chosen to claim and use to reimburse practices for GP time spent at meetings (Ref. 61). On the other hand, some multifunds have received extra start-up costs ranging from £10,000 to more than £100,000 plus free accommodation, from sources including health authorities, NHS Executive special initiatives and pharmaceutical companies (Ref. 62).

Added value of multifunds?

60. Multifunds are in one sense simply an alternative form of organising the management and administrative tasks involved in commissioning which all fundholders, irrespective of whether they group together, must undertake. There is as yet no evidence that multifunds are better at commissioning than stand-alone fundholders or deliver extra benefits for patients – but then most are quite recently formed, often starting from a low base within inner cities, and have yet to show their full potential. Their main value has been in allowing smaller practices, which on their own would lack the necessary management capacity, to benefit from fundholding status. By formalising communication arrangements between practices, the multifund might also become a vehicle for improving primary care.

Networking

61. As well as helping to boost management development within practices, fundholding encourages communication outside the practice and provides a way of engaging GPs in the wider planning and management of the whole NHS. Networking has important effects on the ability of a practice to gain benefits for patients but many practices still need to develop a more outward-looking approach. Aspects of networking include:

- ◆ meeting with other fundholders to share ideas and good practice – although many GPs have links through Local Medical Committees or professional arrangements for out-of-hours care, post graduate education or vocational training schemes, they often practise in relative isolation from their colleagues. Fundholding brings more frequent contact with other practices – managers from more than half of fundholding practices, for example, say they meet at least monthly with managers from other practices. Less than one-third of managers from non-fundholding practices do this (Ref. 63);
- ◆ meeting with other fundholders to develop core contracts with a provider – saving practices' and providers' time, and allowing each practice to take the lead in developing one aspect of the contract. Outside multifunds, few fundholders join together formally to place contracts – about a half of funds contract completely independently from other practices, with most of the remaining practices using a common core developed by a trust, and about 10 per cent contract jointly with other fundholders (Ref. 64) (Case Study 4). Only a third of Waves 1 to 3 liaise with the district health authority during the development of contracts, and only 18 per cent in Wave 4;

*Case Study 4***Improving the contracting process by joint working**

Source: *Audit Commission site visits and NHS Executive, Anglia and Oxford Region (Ref. 65)*

In one area, GPs from different fundholding practices take the lead on individual specialties or providers and negotiate on behalf of other fundholders, reducing the time spent in liaison with providers. Fund managers also combine to agree a list of efficiency indicators and divide responsibility for monitoring providers among themselves. They pool the results, providing each fundholder with more detailed information than they could obtain working alone. In a second area, fundholders meet together to agree the areas they want to improve at one trust and write these into their contracts with the trust. One GP takes the lead on each of the specified areas, working with the provider to develop the service and monitoring achievements.

Fundholders can also use the health authority's expertise in contracting to save time and improve the drafting of contracts. One FHSA has set up a Contracts Agency, financed by each fundholder contributing £5,000 from the management allowance. The Agency provides advice and assistance to fundholding practices from the preparatory year onwards. It develops standard contracts, personalised for individual fundholders.

- ◆ involving patients and the wider community in fundholding – it is rare for fundholders to include a patient on the decision-making 'board' and, while patient participation groups are somewhat more common, only 14 per cent of practices have held them (Ref. 66). They are more common where the health authority promotes and supports their formation, and one authority visited helped finance the running of such groups. The community health councils have a limited role in general practice, but some fundholders do consult with them or work with them to carry out surveys of patients' views (a half of fundholders have carried out some sort of patient survey). One-quarter of practices keep patients informed about fundholding matters via newsletters or leaflets, and only one-third of fundholding plans described how the practice intended to consult patients and keep them informed; and
- ◆ joint planning – working with the health authority and local providers to develop a commissioning strategy for the whole area. This can temper the independent decision-making powers of each practice by avoiding wasteful duplication of services and inequity in their distribution. It also helps proper planning of the long-term development of services (dealt with in Chapter 3).

The commissioning cycle

62. With appropriate organisational structures in place and external networks created, the fundholding practice is then ready to manage the annual cycle of commissioning activity which leads to the delivery of patient benefits. A distinction may be made between administration and management. It is unlikely that a practice will be able to buy better healthcare without being good at the routine administration of entering all patient referrals into the IT system, checking invoices and sending monthly reports in to the health authority on time. On the other hand, it is quite possible for a practice to meet all the administrative requirements, yet carry on prescribing and referring exactly as before. Good administration is a necessary but not

sufficient requirement for achieving change within providers, and extra benefits for patients. The missing ingredient is effective management. This includes needs assessment and planning, gathering good intelligence about different providers leading to effective contracting and monitoring of provider achievements, providing decision-support for the GPs by presenting management information from data on the fundholding system, and actively managing the budget. The remainder of this chapter considers how well fundholders are managing these processes.

Needs assessment and planning

63. One of the main advantages attributed to fundholding is that GPs are close to patients and therefore know what they want and need. In fact, most of the published research suggests that GPs' and patients' opinions often diverge (Ref. 67). One reason is that a GP's normal mode of work is to focus on the needs of the individual in front of them during a consultation. However, as fundholders with an annual budget for their practice population, they have to begin to balance the needs of all their patients, which requires forward planning and decisions about priorities. Where fundholders are committed to formal approaches to needs assessment and translate their conclusions into their purchasing plans, they can achieve a great deal for patients. But currently less than half of fundholders say that they do this (Ref. 68).

64. A first step is to produce profiles of the practice's registered population – demography, deprivation, morbidity, etc. – often making use of the skills of health visitors (Ref. 69). Some practices then use semi-structured interview techniques such as 'rapid appraisal' to ascertain what the practice's GPs and other clinical staff think their patients need. Practices must then consider whether the needs revealed are met by the services currently provided or whether more patients could benefit from a higher volume of service, or a differently organised one (an example of a fundholding practice which has done this and set out its objectives in a plan is described in Case Study 5).

65. It is important to involve patients directly in the needs assessment process and priority setting. There are many decisions in which the practice can involve patients. For example should the practice's fund be spent on IVF or tattoo removal? Which services do patients want to see developed at the practice? Would patients rather see savings spent on improving the practice premises, or on an MRI scanner for their local district general hospital? Do patients want the fund spent in the private sector? In addition to involving patients in decisions of principle, fundholders also need to find out what they think of their hospital and community care. One-third of fundholders visited had carried out surveys of patients' views of their secondary care, but methods were often poor and it was seldom clear how the findings had influenced commissioning. Only 4 per cent of fundholders' plans contained a description of what the practice's patients thought about hospital and community services, and what the practice intended to do about the results (Ref. 70). A common choice facing fundholders, and one where it would be

Case Study 5

A fundholding plan which sets out health gain targets relating to Health of the Nation

The practice has written a very full health plan with clear aims, including a five year mental health strategy and a commitment to reduce waiting times in all specialties to the practice's own targets, which are more stringent than Patient's Charter or local health authority standards. It has also produced a separate practice profile document which analyses the social make-up of the population and epidemiological data. The plan sets local targets for each of the Health of the Nation's key areas in a detailed way. Examples include:

- ◆ Current regional accident-reduction targets are described, compared with actual local rates, and new targets appropriate for the practice are set; current accident-prevention work by the primary healthcare team is described, and new proposals set out.
- ◆ As a result of comparing local breast cancer rates with national and regional averages, and asking for patients' views on the current service, the practice developed a new service at a provider ten miles further away than their usual one, but reasonably accessible, and with a consultant who was keen to develop a 'one stop' clinic. Patients have tests and discuss the results, their diagnosis and proposals for treatment all on the same day, which reduces their anxiety and the time they spend on repeat visits to hospital. There is also a nurse counsellor specialising in breast cancer present at the clinic.

Source: Audit Commission site visit

helpful to know what patients think, concerns the trade-off between travel distance and waiting times for hospital appointments or admissions. Few fundholders describe having such discussions with their patients, but a good example is described in Case Study 6.

66. Once needs have been assessed, the next step is to develop a written purchasing plan which shows practice staff and patients where the practice is heading, what it is trying to achieve, and how each member of the team will contribute. The NHS Executive's Accountability Framework for fundholders requires them to have an annual plan setting out how the practice intends to use its fund and demonstrating the contribution to national priorities. They must announce major shifts in purchasing intentions and produce a brief annual report setting out performance against plan and highlighting significant developments. Many fundholders will have to improve considerably to meet these requirements. One out of every six visited had no written fundholding plan, and one-third only had either an out-of-date plan from the preparatory year, or a plan they had just written a year or more after entering the scheme. Some fundholders make no use of their own plans and write them only to satisfy what they see as a bureaucratic demand. Half the plans state the practice's main fundholding objectives, but only

Case Study 6

Helping patients make informed decisions about the trade off between travel distance and waiting times

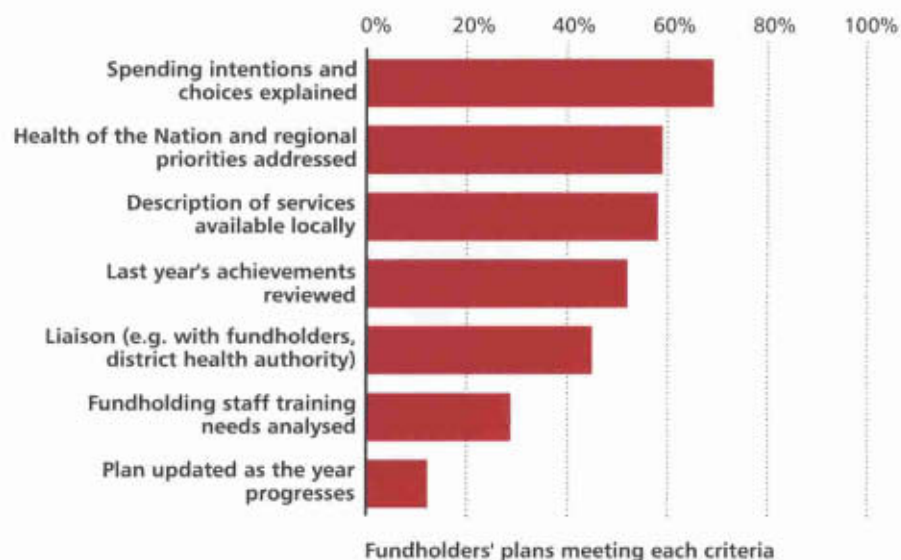
One practice asked patients to give their views in a questionnaire. As a result, the practice arranged additional gynaecology and ophthalmology outpatient clinics with a different provider. The GPs give patients a choice – those prepared to travel for a shorter inpatient waiting time attend the new clinic, while patients not willing to travel attend the nearby hospital as normal. In fact, 95 per cent of patients said they were prepared to travel. During an individual patient's consultation, the GP uses a list of local providers' waiting times to make a joint decision with the patient about where they wish to be treated.

Source: Audit Commission site visit

Exhibit 23

Fundholders' plans – key indicators

Most plans rated poorly against good practice criteria and the demands of the new Accountability Framework.



Source: Audit Commission site visits and local auditor assessments of 229 fundholders from 51 FHSAs

one-quarter describe the values or guiding principles that the practice intends to apply to its fundholding activities, although such statements would be important information for the reader. Most plans rated poorly against good practice criteria and the demands of the new Accountability Framework (Exhibit 23).

Contracting and monitoring

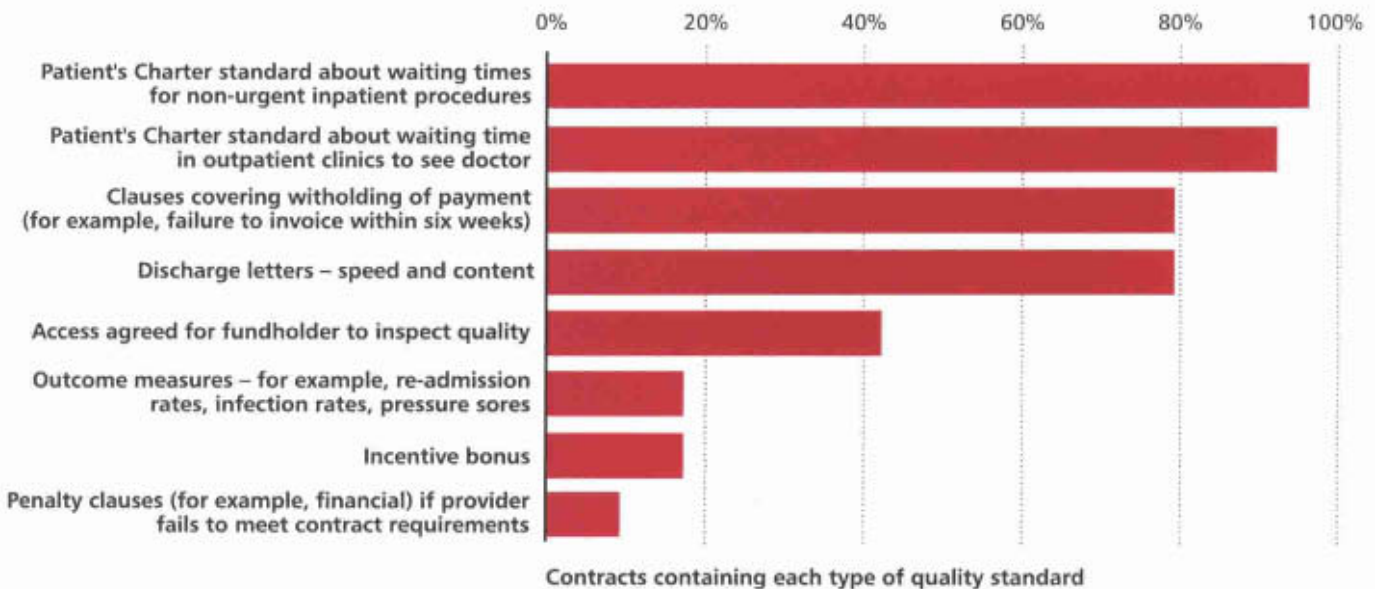
67. Once needs have been assessed and priorities established, the GPs must take decisions about how to achieve the aims described in the fundholding plan. The fundholder must choose service providers and negotiate a contracts portfolio that will achieve the practice's aims within budget. The contract itself is not necessarily the main catalyst for change. More important is the leverage which comes from holding a budget which might be placed elsewhere, combined with communication between GPs and consultants, fund managers and clinical directorates, which allows discussions to occur (often for the first time) about how to improve services. Nevertheless the contracting process imposes a regular, annual discipline on the communication process taking place between fundholder and provider, and makes the outcomes of discussions explicit by writing them into contract specifications, which the practice can then use as a record of aims against which to monitor achievement. In addition while contracts within the NHS are not legally enforceable, those covering services bought by fundholders in the private sector should be well drafted against contract law principles to safeguard public money. Most fundholder contracts met at least half of the principles of good contract drafting (Ref. 71).

68. On average, fundholders contract with four acute providers, but many will have ECR-like arrangements for occasional cases (Ref. 72). There are three main types of contract for services, each offering different advantages and disadvantages to fundholders (Appendix 6). Which type is best will vary according to the local context and fundholders' objectives. For example, where the main aim is encouraging greater efficiency (for example, reducing repeat outpatient attendances), or improving information, then cost per case or cost and volume contracts might be required. When purchasing routine services in bulk, or where the fundholder wishes to support and develop a local service by giving stability, a block contract may be more appropriate.

69. Most fundholders rely on the Patient's Charter and the standards the providers themselves offer to purchasers in the form of core contracts, as a mechanism for improving the quality of hospital and community health services. But a few use quality standards over and above those in the Patient's Charter, and some develop their own knowledge of the quality of a provider's service by including outcome criteria (Exhibit 24).

Exhibit 24
Examples of quality standards specified in fundholder contracts

Most fundholders use Patient's Charter standards, but few include outcome measurement.



Source: Audit Commission site visits; 24 acute contracts from 22 fundholders in 10 health authorities

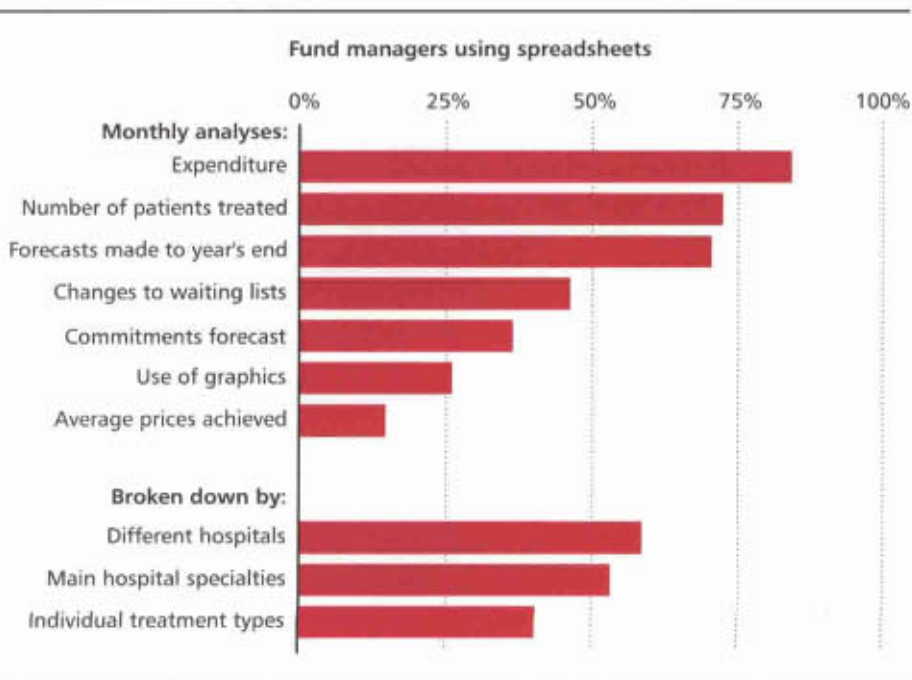
Budget management

70. Fundholders must manage their budgets well if they are to achieve their priorities and meet patients' needs. Indeed, making budget savings, while purchasing an appropriate level of healthcare, can be one of the main benefits of fundholding for the practice's patients, since they may spend savings on extra services or improved facilities. Budget management in fundholding practices has been patchy and the pattern of overspends does not suggest that it improves with experience – one in five fundholders overspent during 1994/95, and more Wave 1 fundholders (22 per cent) overspent than the new fundholders in Wave 4 (18 per cent) (Ref. 73). GPs need good information to understand why expenditure varies from budget, if they are to take active control of the situation. Without such decision-support they will continue to refer and prescribe as before, finding out the budgetary effects only when it is too late to do anything about the end-of-year results. It is the fund manager's job to analyse information about activity and expenditure to provide the GPs with the necessary 'user-friendly' management information (Ref. 74). Although most fund managers monitor overall spend against budget each month, far fewer carry out the more sophisticated analyses needed to help their GPs take within-year decisions (Exhibit 25).

Exhibit 25

Use of customised budget management spreadsheets by fund managers

Although most fund managers monitor overall spend against budget each month, far fewer carry out the more sophisticated analyses needed to help their GPs take within-year decisions.



Source: Audit Commission site visits and local audits; 203 fundholders within 44 FHSAs

What makes for success?










71. There is clearly variation in the extent to which fundholders have established the necessary management arrangements from which to deliver their fundholding objectives (Summary Box 2). While many fundholders have met the new management demands well, some need to improve substantially to make the most of the opportunities offered by the scheme. Most practices need to work more on developing links with all the different bodies involved in fundholding outside the practice. The next two chapters consider the role of two of these which can make a direct impact on the success of the scheme – the health authorities and service providers.












Summary Box 2

Managing fundholding – what makes for success?

Fundholders need to establish a firm basis from which to manage fundholding, both internally and via links with the wider world. They are then ready to manage the annual commissioning cycle. Some of the key management challenges have been discussed in detail in this chapter. This exhibit sets out these and other factors examined in this study, and summarises how commonly fundholders are meeting new management demands.

Management action by fundholders	Indicators	Common or rare
Establishing a firm basis:		
(a) Organisational development		
Fund management skills	<ul style="list-style-type: none"> ◆ Experienced/well qualified manager in post ◆ Enthusiastic lead fundholding GP ◆ Appropriate role differentiation between manager and GP 	
Administrative efficiency	<ul style="list-style-type: none"> ◆ Appropriate clerical staff number and skill mix ◆ Good procedural notes 	
Personnel management	<ul style="list-style-type: none"> ◆ Appraisal in use ◆ Job descriptions; contracts of employment 	
Integration within the practice	<ul style="list-style-type: none"> ◆ Fund staff involved in meetings ◆ Agreement about fundholding between partners ◆ Clear management structure 	
(b) Networking		
Communicating with patients	<ul style="list-style-type: none"> ◆ Patient participation groups held ◆ Satisfaction with secondary care surveys ◆ Patient newsletter 	
Develop providers	<ul style="list-style-type: none"> ◆ Longer-term service developments planned or occurring 	
Joint planning with the health authority	<ul style="list-style-type: none"> ◆ Jointly agreed local development plans exist ◆ Both sides describe improved liaison 	
Links with other practices	<ul style="list-style-type: none"> ◆ Local group exchanges ideas and market knowledge ◆ Developing joint core contracts 	
	<ul style="list-style-type: none"> ◆ Share management demands by formally linking with other practices in multifund arrangements 	

Management action by fundholders	Indicators	Common or rare
The commissioning cycle:		
(a) Needs assessment and planning		
Assess health needs	◆ Systematic methods used and results translated into fundholding aims	
Agree aims between the partners	◆ Joint statement of agreed fundholding aims exists	
The fundholding plan	◆ Up-to-date plan exists ◆ Meets good practice planning criteria	
(b) Contracting and monitoring		
Choosing future providers	◆ Market intelligence gathered and compared	
Contracts	◆ Contracts well drafted against good practice criteria	
	◆ Contracts specify use of agreed clinical guidelines which set out how consultants must treat patients	
Monitoring providers	◆ Monitors against contract and takes action as required	
(c) Budget management		
Budget performance	◆ Budgets balance or savings made	
	◆ Savings planned in advance	
Tools for managing the budget	◆ Good use of IT, eg, budget-forecasting spreadsheets	
	◆ GPs given decision-support information	

Source: Audit Commission

Key (the chapter gives the detailed data):



Few meet the criteria



A substantial minority meet the criteria



A majority meet the criteria

Recommendations

Managing Fundholding

- 1** The fundholding GP should take the lead in fund management, but should not be spending time on day-to-day administration. Practices should:
 - ◆ employ experienced and competent managers and provide them with opportunities for training and development; and
 - ◆ if they have not used the management allowance to pay for an experienced manager, they should review their staffing structure.

- 2** To ensure clear aims are agreed and achieved, fundholders should:
 - ◆ produce clear plans based on an assessment of needs and priorities in their practice population which explain how they will use the fund to seek benefits for their patients;
 - ◆ specify the number of patients to be treated each month in contracts, rather than leave it to the provider to decide; and
 - ◆ make sure they receive regular information from the provider that helps them judge the quality of the service, and take corrective action against failures.

- 3** Fund managers should:
 - ◆ improve financial management of the fund and actively monitor activity and expenditure together on spreadsheets, so that the GPs can take corrective action in good time if they are missing their activity targets or heading for an overspend.

- 4** Long-term and sustained achievements come from involving people from outside the practice in plans and decisions. Fundholders should:
 - ◆ find out what their patients think about fund-spending decisions and about the care they receive from the practice and from other providers by making use of formal surveys, patient groups and consultation with the community health council and other local voluntary organisations. To do this effectively, they should consider carefully the kind of information they need from patients and the most suitable method of obtaining it. Every patient should have the opportunity to comment on their individual care; and
 - ◆ build relationships with other fundholders locally to share information and experience, and wherever possible reduce the time involved in negotiating contracts by sharing out the work between them.



The NHS Executive's Accountability Framework for fundholding sets out the health authority role – they must pull together GPs' views into a commissioning strategy for the area as a whole, set budgets and administer the scheme, support and develop fundholders' purchasing and management skills, and monitor performance.

Few health authorities and fundholders work closely together to develop joint commissioning strategies, and although most manage routine financial monitoring well, few health authorities query how wisely fundholders are spending their budgets.

The budget-setting process is wasteful of staff time, and anomalies in the way different authorities set budgets has led to inaccuracies.

3 Managing the Scheme

'The new health authorities will need to have clear aims for the scheme that are agreed at board level, set out in a written strategy and translated into specific policies.'

National guidance, local policies

72. Since the fundholding scheme began, statutory responsibility has rested with regional health authorities, with day-to-day operational responsibilities delegated to FHSAs, which gave way in April 1996 to the new health authorities. This chapter assesses how well health authorities have managed the fundholding scheme to date, and explains the improvements the new health authorities will need to make in respect of (Ref. 75):

- ◆ joint commissioning strategy – health authorities should tie fundholder purchasing in with their own purchasing to avoid the risk of fragmentation that may arise where many small, independent purchasers operate. They should also be enabling all GPs to contribute to the development of the authority's purchasing plans (the wider involvement of all GPs in commissioning is the subject of a separate Audit Commission paper);
- ◆ supporting fundholding – health authorities must administer the scheme, including setting fundholders' budgets on behalf of the regional offices and paying invoices;
- ◆ performance review and monitoring – the new health authorities are to have an important role in holding fundholders to account and making sure they purchase in the interests of patients and local people, following the devolution of purchasing responsibilities from the old district health authorities to fundholders; and
- ◆ developing fundholders – health authorities must help develop fundholders' management and purchasing skills, and support them in discharging their new purchasing responsibilities.

73. The regulatory framework for fundholding expects authorities to interpret general central guidance. How they do so has direct consequences for practices, for example affecting whether they are allowed to join the scheme, the size of their fundholding budgets and their freedom to spend savings as they wish. The new health authorities will need to have clear aims for the scheme that are agreed at board level, set out in a written strategy and translated into specific policies. In four out of five of the old FHSAs, fundholders felt their authority had a positive attitude towards the scheme (Ref. 76). But the new authorities where this was not the case do not have an easy task ahead. One of those visited had previously stated publicly in an annual report that it did not support fundholding, and the authority now faced a major culture change before it could agree a future direction. Less than half the authorities that had been informally working together in advance of merger legislation had written strategic statements about fundholding, few gave regular reports on fundholding to their boards, and only one of those visited had identified a non-executive director to take the lead in fundholding issues (Ref. 77).

74. The problems health authorities face in specifying local policies can be illustrated by the first decision they must make when a practice applies to join the scheme. The regulations state that a practice accepted into the fundholding scheme must be, 'in the opinion of the Regional Health Authority, capable of managing an allotted sum effectively and efficiently and, in particular...possesses, or has access to, the equipment, such as computers, and expertise necessary to enable it to do so' (Ref. 78). But some practices do not manage the fund well (see Chapter 2), suggesting that these criteria have not always been applied very rigorously. The NHS Executive provides no detailed definition of effectiveness and efficiency in management, and none of the FHSAs visited had written criteria which stated explicitly how they would interpret this general statement locally. A typical FHSA response was that their officers knew all the practices well and could use 'gut feeling' as to whether they were capable of managing fundholding.

75. One regional health authority had issued an interpretation of the national guidance and required FHSAs to rate applicants from A to D, with D meaning not ready for entry into the scheme. But these criteria are less stringent than, for example, the criteria for acceptance as a GP training practice, and the same authority had targets in its priorities and planning document to increase the population coverage of fundholding from 50 per cent in 1995/96 to 75 per cent by 1996/97. The region cascaded these targets down to health authorities, making it difficult for them to restrict entry to the scheme on the basis of the recruitment criteria. Instead of refusing entry to applicants who they judge to have inadequate management capacity, some FHSAs will insist on the appointment of a fund manager from outside the practice as a condition of entry. Others will defer entry until a later fundholding wave. Yet others allow the GPs to appoint whom they like, but put extra effort into training them, or expect practices to use part of the management allowance on consultancy fees to ensure that accountancy expertise, for example, is available at regular intervals.

Management arrangements within authorities

76. The new authorities must integrate the fundholding functions of the old FHSAs into their management structures. Those with a preponderance of staff from the old district health authorities will need to ensure they have the necessary skills to work with GPs. They need to develop close links between staff who are involved variously in planning, purchasing, primary care and fundholding, but integration was uncommon in the authorities that were working together in advance of merger legislation.

77. With the rapid growth of fundholding, some health authorities express concerns about the level of resources available to carry out their duties. FHSAs have used definitions drawn up by the Audit Commission to estimate the costs of administering the fundholding scheme, differentiating between invoicing staff, internal audit and those working on fundholding for more than half their time (typically fundholding managers and fundholding accountants). These estimates measure direct costs, and do not include the opportunity costs of, for example, the chief executive spending time on fundholding matters which would have been available to spend on other things had the scheme not existed.

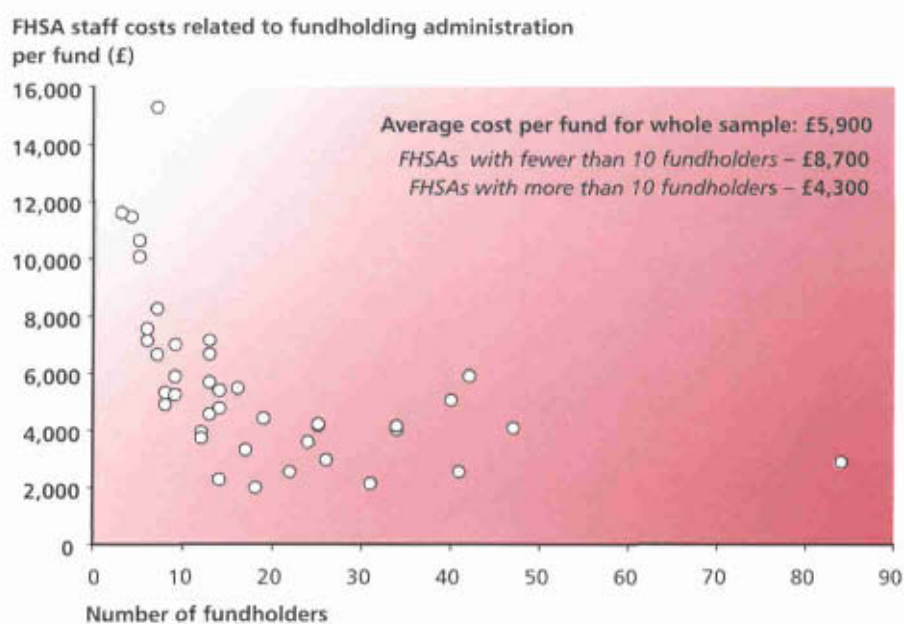
78. On average, these direct costs (*pro rata* to the percentage of time spent on fundholding duties) amount to £5,900 per fund, with 14 per cent of the cost related to invoicing staff, 5 per cent internal audit, and the remainder to management and accounting staff. FHSAs also estimated the costs of other staff who spend a significant amount of their time (between 20 and 50 per cent) on fundholding. These estimates are less reliable, but on average bring the cost per fund up to more than £6,000. There is a strong indication of economies of scale, with authorities with fewer than 10 funds spending almost twice as much per fund as larger authorities (Exhibit 26). However there is no clear relation between costs per fund and the degree of fundholder satisfaction with the way in which the FHSA discharges its duties – when fundholders were asked to rate their degree of satisfaction with 27 aspects of FHSA scheme management, economical FHSAs were as likely to receive a good rating as the more expensive authorities.

Exhibit 26
The costs of administering fundholding within FHSAs

There are economies of scale in the costs of administering the scheme: authorities with fewer than 10 funds spend almost twice as much per fund as authorities with more fundholders.

Each point on the graph represents the staff costs in one FHSA; only staff spending more than half their time on fundholding are included.

Source: FHSA estimates during local audits, based on Audit Commission guidelines (Ref. 79)



Joint commissioning strategy

79. Fundholders and health authorities independently make purchasing decisions which affect the pattern of local healthcare. All parties need to work together to ensure that the overall effect of their individual decisions is beneficial, and the longer term development of providers is planned coherently (Case Study 7). Close linkage between the purchasing plans of fundholders and the health authority is currently the exception rather than the rule. Only one in ten fundholders' purchasing plans mention the local health authority's priorities or describe the part the practice intends to play in local provider development (Ref. 80). And none describe in any detail how their purchasing intentions relate to the plans of other local fundholders and the health authority.

*Case Study 7***Contrasting attitudes to planning long-term provider development**

With the devolution of purchasing responsibilities from a single health authority to many individual fundholding practices comes a risk of fragmenting policies, potentially making it harder to reach strategic decisions about, for example, acute-sector rationalisation and developing tertiary or mental health services. Three contrasting planning scenarios are described here – in the first, fundholders are working together with the health authority and trust to plan the future; the second suggests a risk to long-term planning; and in the third, fundholders are questioning whether the health authority's long-term strategy is correct.

Working together: At one trust, having used cost per case in earlier years to detect problems and encourage change, a majority of fundholders have agreed cost and 80 per cent volume contracts. With a smaller percentage of trust income variable, some development spending in advance of delivering service changes can occur. The health authority has established five localities, and each has written a development plan in close discussion with GPs. Specific examples of joint purchasing include extra orthopaedic services, and the financing of a young persons' drop-in service. Some fundholders have now expressed an interest in three year contracts as a way of further contributing to long-term development.

A risk to planning? In the second example, another trust has experienced contrasting attitudes from the health authority and fundholders during contract negotiations. The health authority begins with the amount of money it is prepared to spend with the trust that year, enabling the trust to understand the impact on its overall viability and development. It then tells the trust how much (always more) activity it expects to see in the year, and negotiates over the detail of how it will achieve this, and the quality standards it expects. The fundholders, on the other hand, focus on standards and occasionally the details of special price-quality arrangements which they are seeking. But they do not wish to commit themselves in terms of either total activity, or a total sum of money.

Protecting community hospitals: Two in five fundholders say one reason for entering the scheme is to protect small hospitals from run-down or closure. Sending outpatient referrals there and developing community services can provide a more convenient service for patients and protects GP medical care beds. But it can also counteract years of health authority strategy to rationalise services on cost grounds, specialisation, safety, and equity of distribution about the district. This could be seen as a danger of devolution. But the fundholders see it as a way of giving local people the power to decide their own destinies after years of failing to make the health authority listen and change its policies.

Source: *Audit Commission site visits*

80. The picture in the health authorities is much the same. Most authorities visited asked fundholders for statements of purchasing intent, but rarely collated them into a summary report. Few health authorities refer in any detail to fundholders' purchasing intentions in their own purchasing plans, and less than one-third of fundholders state that their health authority involves them in the development of its purchasing plan. The explicit inclusion of this requirement in the new health authorities' role should lead to improvements, but coming to a consensus about area-wide commissioning issues will be difficult for some fundholders after five years of purchasing freedom at practice level.

Support functions

81. Health authorities' finance functions include setting budgets, paying invoices and authorising fundholders' claims against the management allowance. Most fundholders are satisfied with the way their health authorities settle invoices, but rate them as less than adequate at meeting budget-setting deadlines, producing accurate budget offers or being flexible in their budget-setting approach (Ref. 81).

Budget setting

82. Fundholder budgets are based on actual referral and prescribing patterns recorded during the preparatory year. Capitation formulae or benchmark methods based mainly on the age and gender of patients registered with the practice (and other information in Wales (Ref. 82)) have been developed with the intention of gradually reducing the variation by moving high and low spending practices closer together through the use of indicative budgets. The advantage of this method is that, assuming some degree of year-on-year stability exists in spending patterns at practice level, practices are not suddenly faced with managing a budget markedly different from that implied by their past behaviour and the demands of their patients. But the method has disadvantages:

- ◆ it rewards practices with expensive referral or prescribing patterns due to poor clinical practice rather than patient need. They receive larger budgets and, if they then begin to improve their performance, can generate savings more easily. By contrast, practices which in the past have been economical referrers or prescribers receive relatively small budgets and have fewer opportunities to improve further and make savings;
- ◆ the process is very time-consuming for all involved (GPs, FHSA, district health authority, trusts), and a great deal of top-level staff time is spent gaining agreement between all parties; and
- ◆ comparability between budgets is reduced because different health authorities are moving towards capitation-based targets at different speeds.

'...average fundholder savings vary significantly between authorities, from a few thousand pounds in some FHSAs to more than £150,000 in others...'

83. Although three-quarters of FHSAs have calculated capitation benchmarks, they are not all using them to move fundholders away from budgets based on historical referral patterns (Ref. 83). Those which are doing so may increase rather than reduce inequality, because capitation does not take account of private healthcare. Private referral rates can vary from 3 per cent to 50 per cent of referrals between fundholding practices (Ref. 84). But reliable data are difficult to obtain and none of the authorities visited took account of it when moving practices towards capitation benchmarks, meaning that those with high private referral rates will be overfunded (because they will receive funding for patients who do not draw on the fund) and those with low rates underfunded.

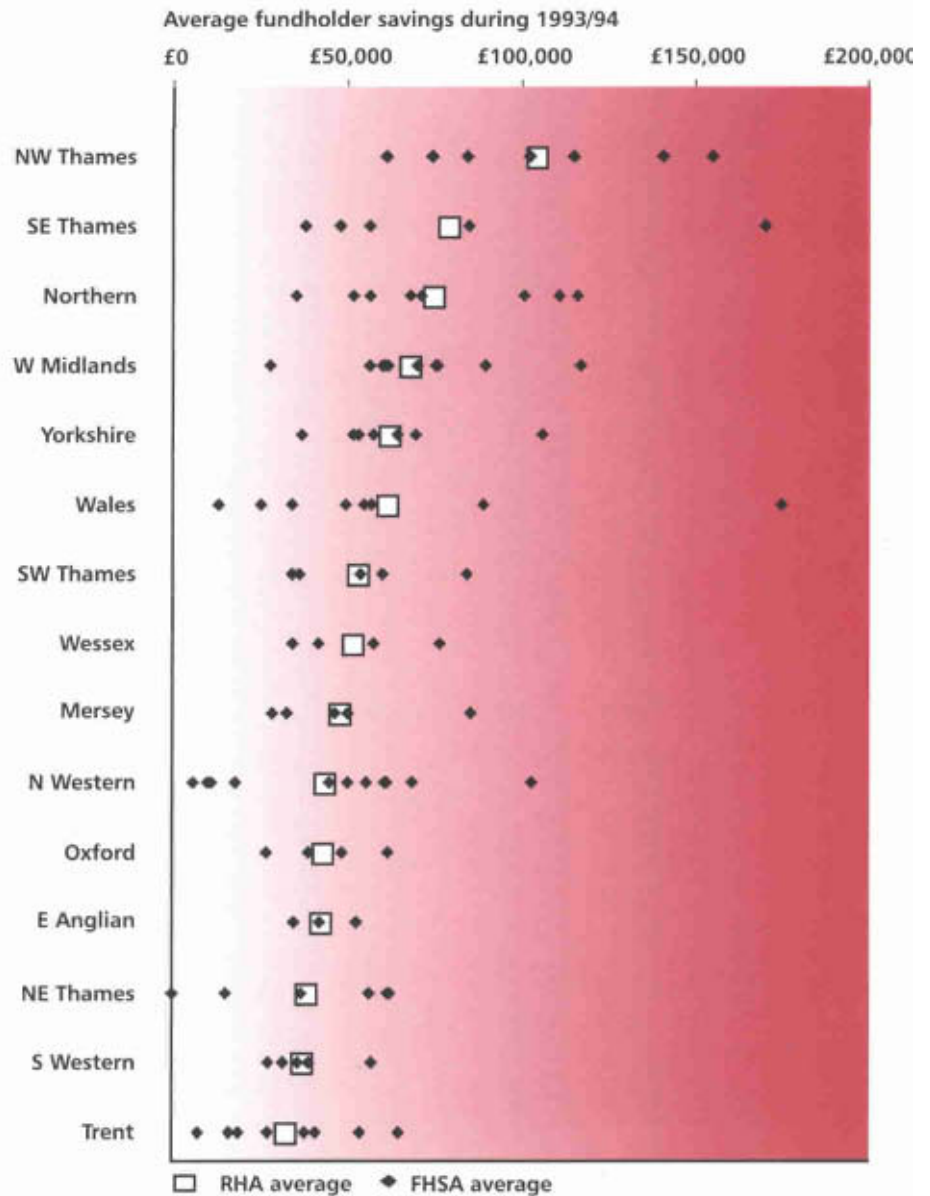
84. Health authorities also vary in the accuracy of information available to them about past patterns of patient care (Ref. 85), in whether they adjust budgets within year if actual patient load can be shown to be very different to that on which the fund offer was based, and in their methods for determining prescribing and staff budgets. Local flexibility and differences in the way budgets are set might mean that fund allocation is more sensitive to local needs. But if this were the case, the likelihood of fundholders under or overspending, and the amounts involved would be similar in all health authorities. In fact, average fundholder savings vary significantly between authorities, from a few thousand pounds in some FHSAs to more than £150,000 in others (Exhibit 27, overleaf) (Ref. 86), suggesting that local flexibility introduces systematic errors into the budget-setting process:

- ◆ **Overfunded?** The highest average savings have been made in the former NW Thames region, where the region's own analysis of whether its fundholders were under- or overfunded concluded that high savings resulted from fundholders receiving a higher share of per capita funding (Ref. 87). One health authority within this region subsequently involved fundholding practices in an exercise to calculate indicative budgets based on capitation, and renegotiated reductions in budgets of about £1.5 million.
- ◆ **Underfunded?** By contrast, Oxford region adjusted each fundholder's activity for age/sex and expressed this as a percentage of expected activity compared with the average for all GPs in the area, both fundholding and non-fundholding. This exercise indicated that, in four of the five health authority areas in the region, the majority of fundholders would have received larger budgets had funding been done solely on a capitation basis (Ref. 88). Fundholders in the region generated among the lowest average savings from their budgets (Exhibit 27, overleaf).

Exhibit 27

Average fundholder savings in the English Regional Health Authorities (RHAs) and Wales 1993/94

Average fundholder savings vary between different authorities.



Note: A 1-way analysis of variance shows that the differences between regions are statistically significant; post-ANOVA means tests reveal that the two regions described in the text – NW Thames and Oxford – differ significantly from one another.

Source: Audit Commission evaluation of standard financial returns on FHSA accounts to RHAs

Fundholder savings

85. A fundholding practice which makes an overall audited saving can retain this money for up to four years to spend 'for the benefit of the patients of the practice' (Ref. 89). Savings can arise for a number of reasons, and the NHS Executive expects health authorities to differentiate between three sources of fundholder savings (an example of how one practice made savings is given in Exhibit 28):

- ◆ efficiency savings due to more rational prescribing, more appropriate referrals, cheaper prices obtained by switching provider, or higher day surgery rates;
- ◆ underspends arising from a fortuitous drop in patient demand; and
- ◆ windfalls arising from providers failing to meet the six-week invoicing deadline after treatment, failing to invoice at all, or problems with budget setting (Ref. 90).

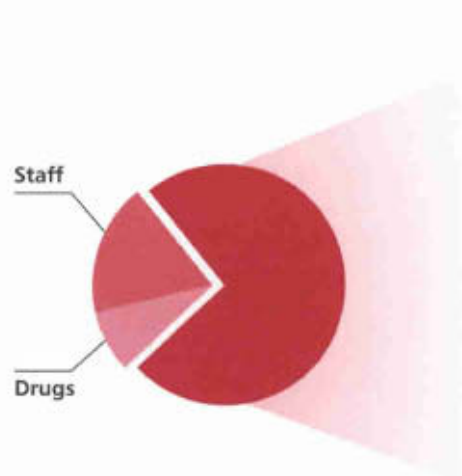
86. Only efficiency savings are true savings to the whole system. Unexpected drops in demand for one practice will probably be matched by rises due to random variations in other practices, although the money will not be released to meet these rises. And windfalls, from late invoicing for example, will result in higher prices elsewhere in the NHS unless they act as a stimulus for the trust to improve its efficiency. One way to ensure savings are 'genuine' efficiency savings is to make fundholders plan them in advance, and some FHSAs insist on this. But only just over one-third of fundholders' plans describe how they planned to make savings for the coming year (Ref. 91). While health authorities have no formal power within the regulations to

Exhibit 28

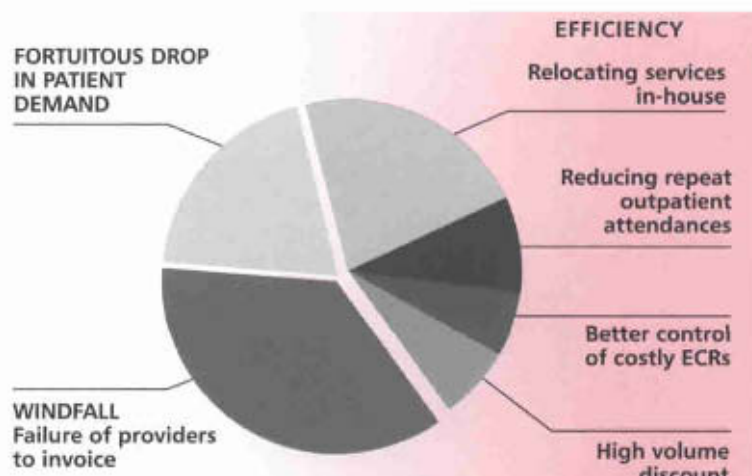
Sources of fundholder savings – an example from a Wave 1 practice in its fourth year of fundholding

Most savings came from the hospital budget, but the practice planned less than half of them.

1994/95 total savings: £78,600



Hospital and community services savings: £57,300



Source: Audit Commission site visit

'claw back' any underspends, the NHS Executive expects them to negotiate the return of chance savings where these are clear-cut. The extent to which fundholders have returned windfalls is variable, and often depends on the relationships between fundholders and their local trusts. Fundholders who perceive their trusts as making little attempt to improve the quality of information about patients are usually less inclined to return windfalls arising because trust information systems are inadequate.

87. During 1994/95 fundholders overall made £95 million in savings, equivalent to 3.1 per cent of budgets. They spent £31 million of previous years' audited underspends, and carried forward £156 million as yet unspent to 1995/96:

- ◆ The average practice making a saving underspent by £83,000 (Ref. 92). The sources of fundholders savings vary, but on average four-fifths were derived from the original budgets they were given. Of this the bulk (70 per cent) came from the hospital budget (the biggest of the budgets at 47 per cent of the total fund) and 29 per cent from prescribing (38 per cent of the total fund). A small proportion came from community nursing (5 per cent from a relative budget size of 8 per cent), while they made an overall loss on practice staffing (-4 per cent against a relative budget size of 7 per cent). The remaining one-fifth of the underspend came from other sources including extra allocations due to patients costing in excess of £6,000, increases in list size or similar reasons, and planned use of previous years' savings.
- ◆ Of those fundholders overspending, the average cost was £60,000. The health authorities met three-quarters of this, 20 per cent was met from the other sources just described, and 4 per cent by fundholders voluntarily using previous years' savings to offset this year's loss. In addition overspending fundholders spent on average £15,000 of previous years' savings during the overspend year, and carried forward to 1995/96 a further £23,000 unspent, rather than use it to meet the 1994/95 deficit.

88. Spending within the rules, whether national or local, is one matter. Spending savings wisely is quite another. In most health authority areas there is debate about how fundholders have spent savings and whether spending represents good value for money. Some authorities have tried to define this in local policies (77 per cent have a written policy about savings, and 81 per cent have issued guidance to fundholders on how savings may be spent (Ref. 93)). During 1994/95 fundholders reinvested 16 per cent of their savings in extra hospital and community healthcare, and differences in local savings policies show up in how they spent the remainder. While on average 60 per cent of expenditure went on premises improvements, office furnishings and equipment, the range between different authorities is from 0 to 100 per cent (Ref. 94). One health authority expects fundholders who make savings as a result of falls in patient demand to spend them firstly on reducing waiting lists. The NHS Executive takes the view that although authorities have adopted different approaches to managing underspends, savings have 'in the main' been spent in the interests of patients (Ref. 95).

'One fundholding practice has drawn up an agreement whereby premise extensions paid for via fundholder savings are held in trust and cannot add to GPs' personal wealth when they leave the practice.'

89. Fundholders are supposed to produce a savings plan for the health authority to approve. In fact half of fundholding plans do not contain any mention of how the practice will spend savings. Other FHSAs have accepted practices' own decisions about the relative priorities of direct care and premises investment. Although some GPs may benefit personally from capital investment in premises when they come to sell their interest in the practice, this can be avoided. One fundholding practice has drawn up an agreement whereby premise extensions paid for via fundholder savings are held in trust and cannot add to GPs' personal wealth when they leave the practice.

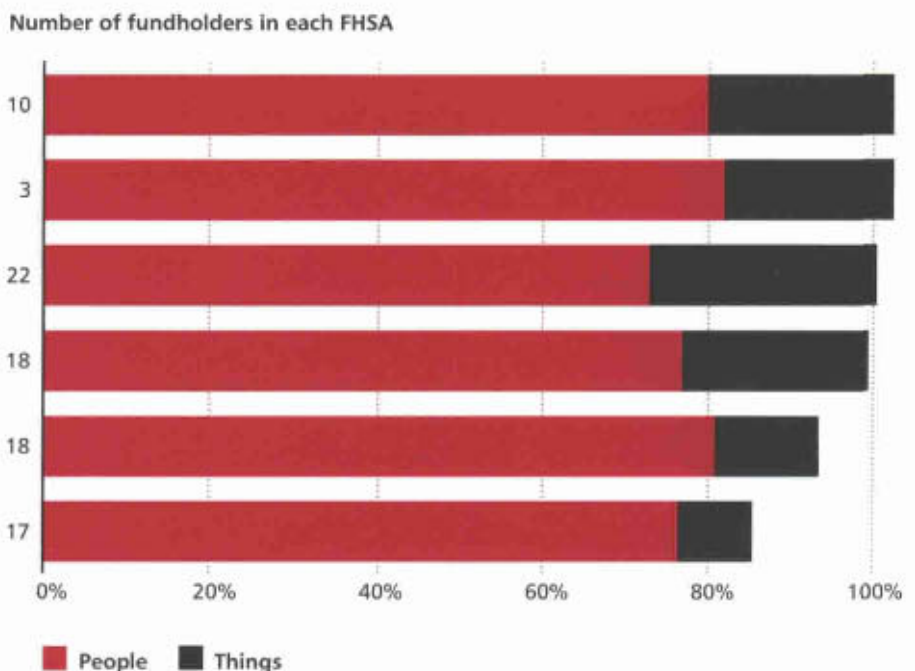
The management allowance

90. In the first five years of the scheme, fundholding practices received £232 million to cover the staff, equipment and computing costs of managing fundholding, equivalent to about 4 per cent (2.5 per cent excluding computer costs) of their budgets. FHSAs are charged with ensuring that the reimbursement of agreed expenses against the management allowance represents good value for money (Ref. 96). But they vary in what they allow fundholders to spend the management allowance on, and the amounts they allow practices to claim. In all FHSAs most claims against the management allowance are for staff (and also consultancy, training, and locum cover), but the amount for non-staff items varies from 9 per cent to 27 per cent. A few FHSAs allow claims which exceed the maximum theoretically payable, while at the opposite end a few encourage parsimony amounting to a 'saving' of £90,000 and £45,000 (Exhibit 29). Obviously, there is a danger that a marginal saving on the management allowance could lead to poor fund

Exhibit 29
Claims against the management allowance in six FHSAs

Two FHSAs allowed claims over the maximum allowed by the regulations, while two encouraged parsimony.

Note:
People: staff, training, consultancy.
Things: equipment, premises, consumables.



Source: Audit Commission site visits

management, and may be counterproductive. Some FHSAs try to use the management allowance available within the fundholding scheme to promote improvements to primary care through management development.

Performance review and monitoring

91. While fundholders are responsible for managing their own budgets, the health authority is responsible for monitoring their actions and holding them to account. Performance review is an important mechanism for ensuring good use of resources and quality of work by those with devolved responsibilities. It is especially important with GP fundholders since general practice is outside the accountability structure which in the past has controlled expenditure on hospital and community health services (Ref. 97). Most health authorities visited monitor activity and expenditure monthly against budget expectations, but most fundholders say that their health authority does not set them specific performance targets. The NHS Executive has instructed the new health authorities to ensure that GPs purchase in the interests of patients and local people (Ref. 98). None of the authorities visited had yet developed explicit systems for judging whether fundholders' purchasing represents good value for money, although many included some discussion of purchasing achievements in meetings.

92. Within a persuasive relationship, comparison with peers is one of the best methods of performance management, as emphasised by the Committee of Public Accounts (Ref. 99). Providing comparative performance indicators would enable fundholders to see how they are doing in relation to other practices, but only 13 per cent receive comparative feedback on the financial and activity reports they submit each month. Health authorities could use fundholders' routine reports to calculate benchmarks such as comparative day surgery rates, number of repeat outpatient attendances, and prices paid (Ref. 100). None of those visited had set up indicators of this kind, but a group of health authorities in the West Midlands is currently engaged in the task.

93. The Accountability Framework expects health authorities to meet at least annually with each fundholder to review performance. Preferably they should carry out reviews by visiting the practice, not by calling GPs and managers to the health authority's premises, and should use the opportunity to review performance against purchasing plan objectives. Fundholders should receive written feedback after annual review meetings, including a plan stating what actions the health authority expects the practice to take as a result of the review. With growing numbers of fundholders this will be costly in senior management time – for example, just visiting 30 fundholders for a half-day meeting equates to a month's full-time work, including time to prepare, to produce an action plan, and to follow up whether improvements are made. Half of the practices questioned by the study team had not been visited by the FHSA for any reason at all during the previous year, and only half of health authorities said they met formally with individual fundholding practices to review achievements.

Developing and training fundholders

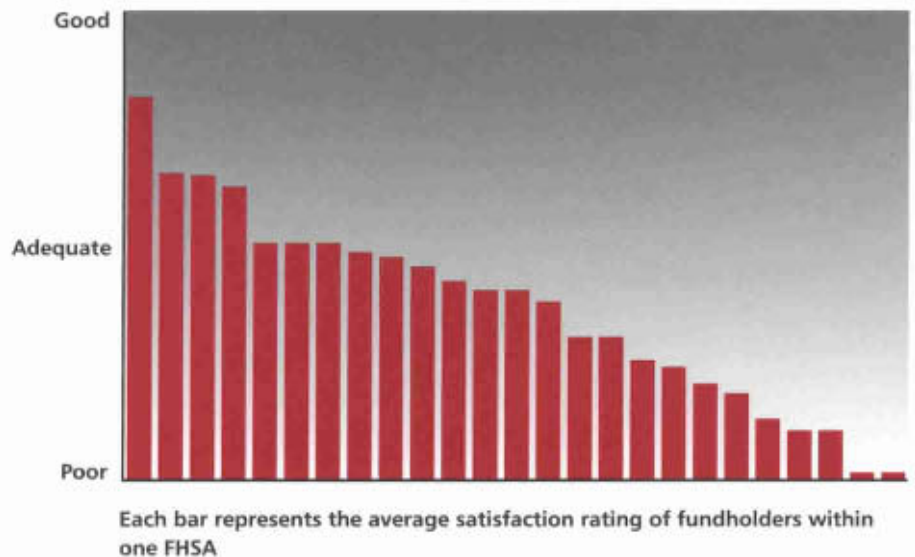
94. The new health authorities are required to provide 'support to GP teams, both as providers of primary care and as GP fundholders through advice, investment and training' (Ref. 101). There are many facets to developing fundholders. Fundholders need help with the basics in the early stages, while established fundholders have more advanced development needs. A practice in its preparatory year may need help with appointing a fund manager, while a Wave 3 practice may want to have greater control over its waiting lists. The health authority needs to be able to meet all development needs. FHSAs have varied in how they carry out their development responsibilities – some see these as being merely to query whether their fundholders are seeking the necessary training; others as being to carry out training needs assessment and foster the availability of suitable courses; and yet others go beyond that to the provision of training and specialist advice itself. Most fundholders feel that their health authorities deal with specific requests for advice or help adequately on a one-to-one basis. But less than half think their authority could meet their specific training needs (Ref. 102), and most rate the overall training provision as less than adequate (Exhibit 30).

95. One of the main sources of advice should be the public health departments of the new health authorities, whose statutory responsibilities will include:

- ◆ ensuring that public health considerations drive the authority's purchasing and commissioning activities;
- ◆ improving the effectiveness and value for money of clinical and non-clinical interventions; and
- ◆ ensuring that local GP fundholders and all providers of primary, hospital and community care, including those in the voluntary and private sectors, have access to adequate and appropriate public health advice (Ref.103).

Exhibit 30
Fundholders' satisfaction with the training provided by their FHSA

Most fundholders rate the provision of training by their health authority as less than adequate.



Source: Local audits at 25 FHSAs

96. Public health departments grew up in district health authorities which did not have responsibility for primary care, and for this reason most of the departments visited had only recently begun to develop links with GPs. Fundholders visited in the study were making little use of their local health authority's public health department. One department had begun to produce practice profiles, and was using them to help an inner-city fundholder to assess needs. Another had developed a practice-based needs assessment process suitable for fundholders, with the aim of reflecting assessments in contracts and measuring success by outcome. But in two other areas visited, fundholders were buying public health advice from outside the district because they thought their local departments lacked expertise in primary care-led purchasing.

Is the scheme well managed?

97. While some FHSAs have managed the scheme well in the past, there is much room for improvement as the new health authorities take up their role, especially in the areas of training and developing fundholders, and in holding them to account for the wisdom of their purchasing decisions (Summary Box 3). This will pose significant challenges, since many fundholders feel they know more about ground-level purchasing than do health authority staff, and health authorities will be hard pressed to find the resources needed to ensure that their staff have the skills to help fundholders improve their performance. But the limited achievement of patient benefits by many fundholders, described in Chapter 1, makes the issue of training for commissioning crucial to the future success of delegated purchasing in the NHS. The final chapter takes up this theme again, but before that the impact of fundholding on NHS provider trusts is assessed.

Summary Box 3

Managing the fundholding scheme – the role of the health authority

Most health authorities have done well in developing local policies and monitoring monthly expenditure against fundholding budgets, but few are reviewing the wisdom of fundholders' purchasing decisions or meeting their training and development needs.

Management action by health authorities	Indicators	Common or rare
Joint commissioning strategy	◆ Bottom-up involvement of GPs, going beyond consultation on a draft written by health authority staff	
	◆ Involvement of fundholders in joint investment schemes	
Scheme strategy	◆ Written document on intentions to develop scheme	
Policy development	◆ Policies covering recruitment criteria, savings, etc.	
Management arrangements	◆ Management costs below average and reasonable fundholders' satisfaction rating	
Budget setting	◆ Consistent approach to use of capitation	
Recovering windfalls	◆ Windfall savings identified and return negotiated	
Managing overspends	◆ Overspends are rare, and only occur when demand rises unavoidably and unpredictably	
Management allowance	◆ Value for money of management allowance claims closely assessed	
Paying invoices	◆ Weekly payment runs without undue difficulty	
Financial monitoring	◆ Monthly expenditure checked against budget	
Performance review	◆ Review includes wisdom and value for money of fundholders' purchasing decisions	
	◆ Review visits occur at least annually	
	◆ Comparative feedback provided with an action plan	
Developing and training fundholders	◆ Fundholders' training needs assessed	
	◆ Written training plan for each fundholder	
	◆ Provides or facilitates provision of training	

Source: Audit Commission

Key (the chapter gives the detailed data):

Few meet the criteria
 A substantial minority meet the criteria
 A majority meet the criteria

Recommendations

Managing the Scheme

- 1** The current method of setting fundholder budgets is time consuming and risks rewarding high-spending practices and penalising efficient practices. Health authorities urgently need guidance from the NHS Executive on acceptable methods for setting practice level budgets that are equitable, and on workable mechanisms for sharing risk (similar to the £6,000 rule).

- 2** The NHS Executive should change the regulations on savings:
 - ◆ it should review the six-week rule. It provides an incentive for trusts to improve their information systems and a formal mechanism for writing off lost invoices, but allows fundholders to make windfall savings and causes unplanned shifts of funds from providers to fundholders;
 - ◆ windfalls resulting from unexpected drops in demand should be returned to the funding authority or used to offset fortuitous rises in subsequent years; and
 - ◆ as the number of fundholders grows, and the amount of healthcare they purchase increases, there is a risk that fundholders' overspends will undermine the health authority's purchasing plans. The regulations should require overspends to be carried over and offset against accumulated or future savings.

- 3** The NHS Executive should require health authorities to:
 - ◆ have a written policy with regard to fundholder savings which contains explicit criteria for judging 'windfall' savings that should be returned; and
 - ◆ seek agreements from practices which spend savings on premises that assets funded from the scheme are held in trust and cannot add to GPs' personal wealth when they leave the practice.

- 4** Health authorities should have an agreed written strategy that sets out their aims in relation to the scheme. This should make clear:
 - ◆ the criteria practices must meet to join the scheme, which should then be applied rigorously; and
 - ◆ the internal structure and staff resource the health authority will devote to managing the scheme.

- 5** Health authorities should agree a joint commissioning strategy with fundholders. They should:
- ◆ work closely with fundholders on their purchasing plans, and involve GPs in the creation of the authority's own purchasing plan, rather than consulting them on finished drafts; and
 - ◆ have a written purchasing strategy that sets out the relationship between GP fundholders' purchasing plans and their own.
- 6** Health authorities should develop systems for reviewing and improving fundholders' performance and should have a written plan for developing the commissioning expertise of every fundholder. They should:
- ◆ set performance targets for fundholders, including targets for patient benefits (based on those set out in this report) and not just budgetary performance, and review them annually;
 - ◆ measure fundholders' performance against targets and feed comparative information back to them so they can see how well they are doing in relation to their peers;
 - ◆ hold annual reviews at the practice and provide the fundholder with written feedback and a development plan, including timescales, after the meeting; and
 - ◆ write development plans which specify priority areas for improvement and details of what the authority will do to help the fundholders improve on performance.
- 7** Health authorities should make the expertise of their medical advisors and public health departments available to fundholders.



Both hospital and community trusts are dependent on fundholders for significant and growing proportions of their income. Some trusts have contracts with 50 or more fundholders, introducing substantial transaction demands.

Some trusts lose income by failing to invoice for all work done.

This study has not covered the ways that fundholding affects trusts in any detail – the time and resources were not available to carry out the systematic research needed. But the Commission recognises the significant workload that fundholding has imposed on some trusts, and this chapter summarises the issues that became apparent during the course of the study – many of which urgently need further work.

4 NHS Trusts

*'Many trusts are now
reliant on fundholders for
as much as 20 per cent of
their total income...'*

98. Many trusts are now reliant on fundholders for as much as 20 per cent of their total income, and most are expecting further growth. Fundholding affects the various types of trust in different ways:

- ◆ in acute trusts, most directorates receive some income from fundholders. Surgical directorates in areas with high fundholder coverage now receive most of their income from fundholder contracts. The main issues for acute trusts to manage are unpredictability of income where fundholders use cost-per-case contracts; transaction costs; and opportunity costs for consultants' time spent in discussions with fundholders;
- ◆ for community trusts, with community nursing income known in advance because of the contracting rules, the main issues are a widespread downward pressure on management overheads by fundholders, and how to preserve community-wide services such as child protection; and
- ◆ mental health trusts receive much of their outpatient and community income from fundholders, and they share the concerns of other trusts just described. A particular issue for these trusts is the balance between funding services for the seriously ill, who are treated mainly by the secondary services, and for the 'worried well' who present to primary care.

99. For the average trust, fundholder income grew threefold between 1992/93 and 1994/95, with the number of fundholder contracts increasing fourfold to reach 16. Some trusts, however, have more than 100 contracts (Ref. 104). This chapter describes how trusts can respond to the challenges introduced by the scheme, in terms of appropriate management arrangements, liaison and marketing skills, managing the contracting effort, and transaction efficiency.

Trust management arrangements

100. The growing number of fundholders and the volume of queries has meant that most trusts have had to put extra resources into their administrative functions. For example:

- ◆ a community trust in an area of high fundholding coverage, where all the fundholders negotiate independently, employs a full-time director and deputy, with part-time support, to deal exclusively with fundholders: and
- ◆ two acute trusts with a below-average number of fundholders both estimated that the equivalent of one clerical-level full-time post is entirely taken up by fundholders, with over 1,000 telephone queries a year about letters of attendance, invoices, prices and disputes about whether or not a specific treatment is covered by the scheme.

Liaison and marketing

101. Most trusts have a directory/guide for GPs, which covers services, key contacts and telephone numbers, and which needs to be updated regularly (Ref. 105). But few trusts have developed active marketing much beyond this. In some, a team (including, for example, the GP liaison officer, representatives from finance and contracting, and the medical director) conducts co-ordinated 'marketing' visits to fundholding practices.

Contracting

102. The advantages of improved communications between GPs and consultants have been referred to in earlier chapters and about half the fundholders surveyed say that they meet directly with consultants during contract negotiation. A potential disadvantage for the trust is that consultants may spend more time in meetings and less in direct clinical work and other activities. For the trust as a whole, the number of fundholders determines the cost of contracting with them, the fundholders' preferences for different types of contract and the degree to which they combine together in groups. At one extreme, one community trust has nearly 500 contracts with fundholders for different elements of services, all negotiated separately. The trust acknowledges that contracting with fundholders has promoted innovation, but has found it difficult to introduce discussions about longer-term service development. Another community trust estimated that negotiating contracts with 13 fundholders for 4 per cent of its income cost four times as much as contracting with the health authority for 91 per cent.



Transaction efficiency

103. Trusts need to make sure that they identify the patient contacts chargeable under the scheme, and must invoice within six weeks of the patient being seen or treated, or they may not receive the payment due (Ref. 106). Half the fundholders visited said that their main acute provider failed to meet the six-week rule, and a similar proportion that their main community provider failed to meet this deadline. Some trusts lose income by failing to invoice for all fundholding activity – half made many errors on invoices, and only one fundholder reported 'few or no errors'. In one instance, a single fundholder retained £500,000 from a trust which had failed to issue invoices in time, and numerous smaller examples were given during study visits (Ref. 107). More research is required on transaction costs, and how to minimise them. Fail-safe administration of transactions with fundholders is not easy:

- ◆ patient turnover rates between GPs is very high in some places (12 per cent annually in one of the home counties, plus 5 per cent staying with the same GP but changing their address), making it difficult to keep track of which patients are chargeable under the scheme;
- ◆ trusts are vulnerable to inaccuracy in recording of consultations and procedures by doctors and nurses, and subsequent coding errors. Every mistake in coding and lapse of memory by clinical staff, may cause the trust to lose income. Such problems do not occur to the same degree with health authority block contracts, which do not require individual patient episodes to be monitored with such accuracy; and
- ◆ trusts with good IT systems set up algorithms to translate clinical coding into activity codes that are chargeable within the rules of the scheme. Trusts that do not have this kind of IT support, especially many community trusts, have to rely on staff identifying and manually flagging chargeable procedures, which can cause errors and omissions.

Summary

104. The growth of fundholding has introduced a significant administrative challenge for trusts, but those that are well organised, with good IT systems, are coping better with the extra work (Summary Box 4). This chapter and the two preceding it have shown that some practices, health authorities and trusts are meeting the management challenges due to fundholding better than others. The next chapter returns to the relationship between benefits for patients and success in tackling the management issues, and then looks at what needs to be done in the future.

Summary Box 4

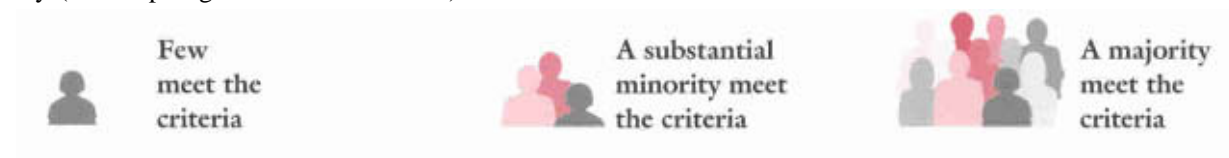
How well are NHS trusts managing their involvement in the fundholding scheme?

Most trusts have developed a marketing arm that liaises with fundholders, but they have a great deal to do to reduce the transaction costs.

Management action by NHS trusts	Indicators	Common or rare
Management arrangements	<ul style="list-style-type: none"> Business plans state the trust's (and clinical directorates') intentions with respect to fundholders Management costs minimised by appropriate IT, etc Single person with overall responsibility for co-ordinating the response to fundholders 	
Liaison and marketing	<ul style="list-style-type: none"> Each fundholder has a 'one-stop' contact who can deal promptly with problems Response time to queries Services brochure; liaison activities 	
Contracting	<ul style="list-style-type: none"> Core contract available for fundholders Consultants attend negotiations 	
Transaction efficiency	<ul style="list-style-type: none"> Meet the 6-week rule for issue of invoices Computer algorithms minimise invoicing mistakes 	

Source: Audit Commission

Key (the chapter gives the detailed data):

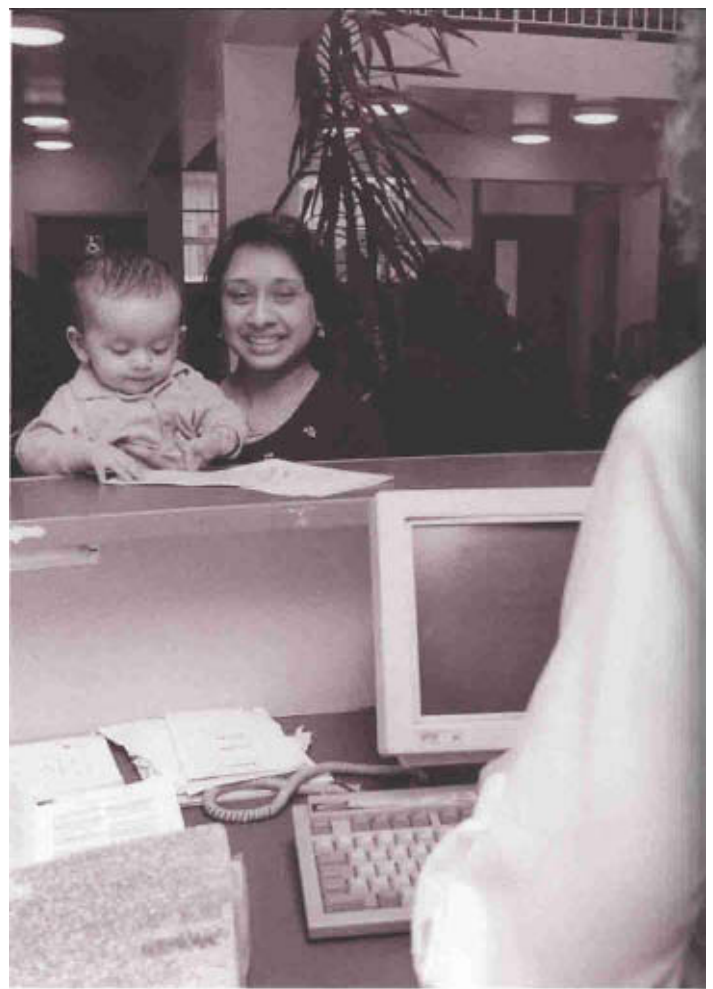


Recommendations

NHS Trusts

- 1** Trusts need to make sure that fundholders can meet clinicians, but that they do not waste clinical time. They should:
 - ◆ keep a record of the amount of time consultants spend in contract-related meetings;
 - ◆ make sure that meetings are about clinical and service matters rather than administration; and
 - ◆ make sure that meetings result in action where it is needed.

- 2** Some trusts are losing income by failing to invoice for all work done. They need to:
 - ◆ make sure that arrangements for training clerical and coding staff are adequate; and
 - ◆ invest in IT systems that will automatically identify fundholders' patients and chargeable procedures, keep errors to a minimum and make sure they meet the six-week deadline on invoicing.



5 The Way Forward

The best managed and outward-looking practices achieve most benefits for their patients. A few fundholders have made achievements across the board and are at the leading edge of purchasing; but the majority have achieved only a small proportion of the benefits potentially available for their patients.

The current system of limited checks and balances has not prevented poor performance and it will probably be necessary to strengthen the accountability arrangements. Other policy options include accrediting practices as purchasers and creating a contract between fundholders and the health authority.

105. This study has shown that fundholding practices differ in two main ways:

- ◆ **The extent to which their patients have benefited:** does the practice focus on the needs of individual patients, work with providers to improve the quality of services, purchase more effective healthcare, encourage more efficiency in trusts, offer patients more choice and bring services closer to where they live?
- ◆ **How well the practice is managed and working with others:** does the practice plan its purchasing and take part in the longer term decisions affecting the pattern of services available locally, by sharing with other practices, helping develop local providers, and working with the health authority?

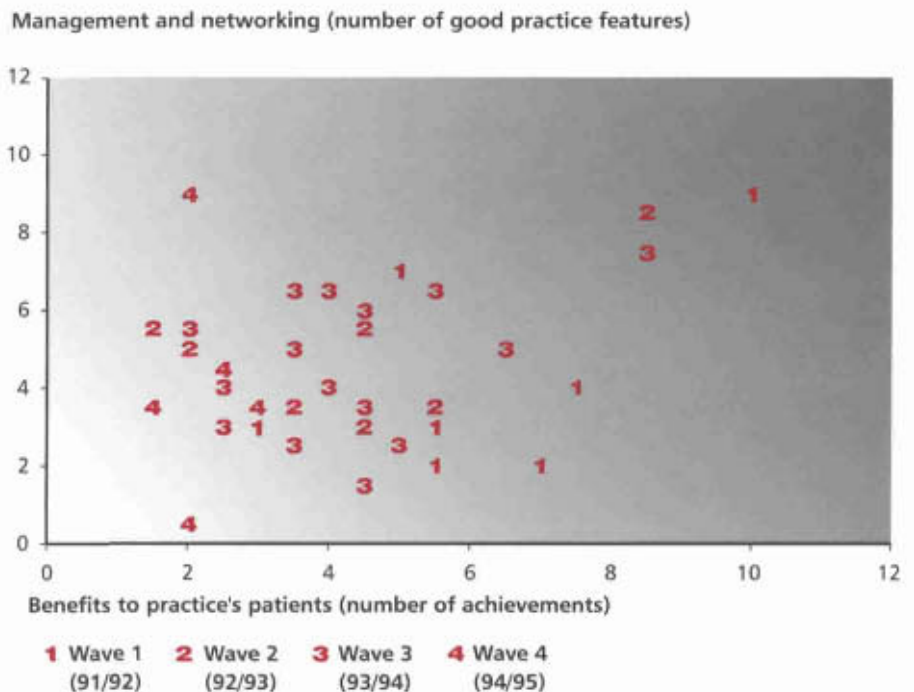
106. It is relatively easy to recognise the best practices – they have thought carefully about what they can achieve by becoming fundholders, are well managed and achieve a lot for their patients (Box 3, overleaf). Based on the criteria outlined in this report, it is the better-managed and outward-looking practices that tend to achieve significantly more benefits for their patients (Exhibit 31) (Ref. 108). But such practices are rare, and a more important question concerns the others. The majority of fundholding practices do not appear to be especially good at management and networking or achieving a large number of benefits for patients.

Exhibit 31
Management development and benefits to patients

The better-managed and outward-looking practices tend to achieve more benefits for their patients. But the relationship is far from straightforward, and the majority of fundholding practices do not appear to be especially good at management and networking or achieving a large number of benefits for patients.

Note: Each point on the exhibit represents one fundholder rated on 24 good practice criteria (listed in Appendix 5), according to the benefits that have come about for their patients, and the degree to which they plan and manage their budgets well and are playing their part in the wider healthcare community. The relationship is statistically significant: $r = .31, p < 0.05$

Source: Audit Commission site visits



Box3

What does a good fundholding practice look like?

Manages individual patient's care

- ◆ Manages waiting lists so that individuals are treated when needed
- ◆ Does not 'refer and forget' but manages the whole spectrum of care
- ◆ Co-ordinates health and social service provision

Improves the efficiency, quality and effectiveness of hospital and community services

- ◆ Improves waiting times, prices, day case surgery rates, first/follow-up outpatient ratios
- ◆ Negotiates changes with consultants (for example, one-stop clinics, reporting times)
- ◆ Uses clinical guidelines for referral, secondary care, discharge, aftercare
- ◆ Demands 'hotel' improvements (car parking, food, courtesy of staff)

Facilitates appropriate development at the practice

- ◆ Provides a range of services
- ◆ Considers the wider costs/benefits of introducing new services

Prescribes more rationally

Is well managed

- ◆ Maintains good control over budgets
- ◆ Has clear fundholding objectives
- ◆ Has planned expenditure, and updates budgeting plans during the year
- ◆ Assesses providers and makes choices between them
- ◆ Develops a contract portfolio to deliver purchasing objectives
- ◆ Audits and monitors providers and takes action if objectives are not being achieved

Encourages teamworking within the practice

- ◆ Involves the primary healthcare team (nurses, therapists, practice staff) in setting objectives
- ◆ Reviews variations in referrals and prescribing between the practice's GPs and agrees guidelines
- ◆ Integrates fundholding fully into the whole practice

Is locally based

- ◆ Works with the local community
- ◆ Consults patients and involves them in decisions
- ◆ Assesses local community healthcare needs
- ◆ Maintains up-to-date fundholding plans, reports out-turn, and makes the documents publicly available

Works with others outside the practice

- ◆ Develops whole area strategy with the health authority
- ◆ Works with the health authority and social services on integrated care programmes
- ◆ Works with local providers to shape their long-term development
- ◆ Networks with other fundholders to share ideas and save on transaction time

Uses the practice staff budget to buy a skill mix appropriate to the job

All of which should lead to: better health for patients...

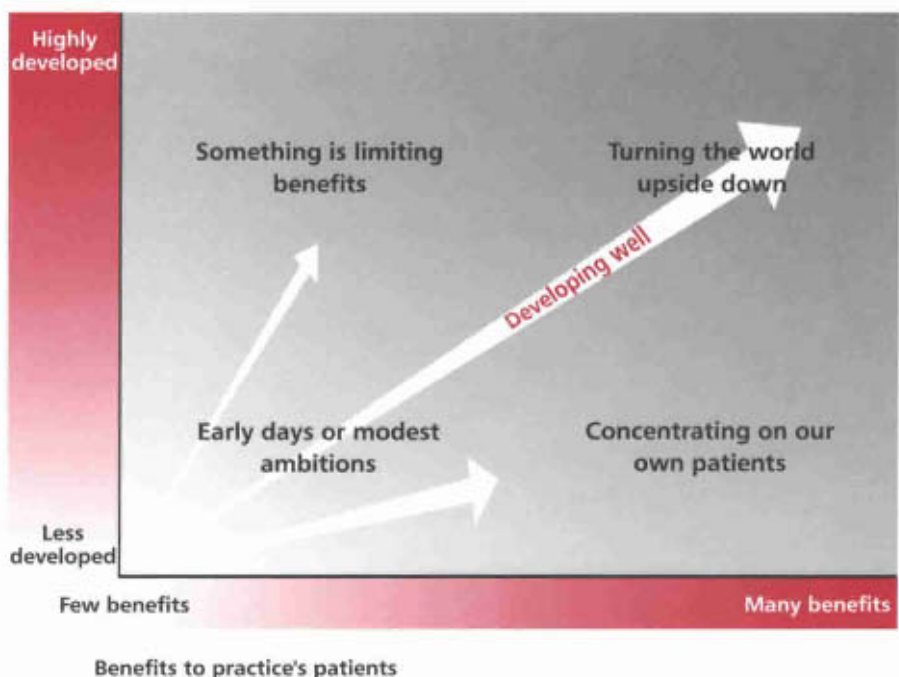
107. When a practice takes on fundholding status it is a 'purchasing novice'. It will begin life in the bottom-left corner of Exhibit 31, and should over time move into the top-right, developing its management abilities, working together with the wider community and seeing a range of benefits accruing to its patients. In this phase, active management replaces simple administration, practices begin to audit the way providers treat patients, and to specify changes based on effectiveness information. These are the practices that are 'turning the world upside down' (Ref. 109) at the leading edge of purchasing (Case Study 8, overleaf). In reality, however, only a few fundholders have developed in this way, with others moving away from the bottom-left corner in two unpredicted directions (Exhibit 32):

- ◆ some have begun to develop their management and networking, but something is limiting the benefits appearing for their patients, perhaps because changes have not had time to work through, or because they are in an area with few fundholders and unresponsive providers (Case Study 9, overleaf); and
- ◆ others have seen some increase in patient benefits without developing their management capacity or their involvement in the wider world of NHS management to any great degree. Several Wave 1 fundholders are in this category, but the number of benefits appearing are not as great as in the few practices which also score highly on the management scale. These practices are concentrating on their own patients and the focus stays mostly within the practice (Case Study 10, overleaf).

Exhibit 32
Fundholder development

Some fundholders develop in one of three directions as they mature as purchasers. But most fundholders remain in the 'modest ambitions' category in the bottom-left corner of the exhibit.

Management and networking



Source: Audit Commission

Case Study 8

A fundholding practice 'turning the world upside down'

This Wave 1 practice is situated in an industrial town, about 5-10 miles from two district general hospitals. It has six partners and 12,000 patients. The practice is involved in the total purchasing pilot scheme.

Benefits for patients

The 1994/95 contracting intentions document states that the practice 'has a clear intention to contract for measurable improvements in outcomes and delivery of services...in particular to purchase for agreed clinical protocols'. For example:

- ◆ An audit of gastroscopy services revealed several problems: long waiting times; inconsistent follow-up arrangements (for example, some patients with negative results were discharged to their GP, some given a follow-up appointment for the consultant, some given repeat gastroscopies after a few months); the absence of some treatment alternatives (for example, testing and subsequent eradication therapy for *Helicobacter pylori* to reduce ulcers); and inappropriate drug regimes. A disease-management protocol was agreed with a consultant, specified in the contract, and referrals now go to this one named consultant. In the subsequent year, more patients were discharged to the GPs for management, repeat gastroscopies reduced and more appropriate treatment given. They claim the result is substantially improved quality of life for patients no longer undergoing inappropriate treatment or suffering persistent *H.pylori*-related dyspepsia, and reduced costs. The practice is working in a similar way with providers and the local department of public health to develop guidelines for other conditions, including breast lumps, recurrent tonsillitis, glue ear, back pain and joint replacements.
- ◆ Guidelines for the GPs' referrals for X-rays were agreed based on good-practice principles such as 'spinal views rarely help with management', or 'be specific about part to be X-rayed'. The GPs set a target of a 10 per cent reduction in the number of referrals, with the aim of avoiding unnecessary exposure to radiation, reducing waiting times, speeding up the issuing of reports and reducing costs. A reduction of 28 per cent occurred in the following year, while the number of positive results remained the same.

Management and planning

The partners take the lead in different areas – one leads on fundholding, one on clinical audit, etc. There are separate practice, fund and information managers, with the former taking the lead in strategic management and practice development. The practice aims to manage its staff to 'Investors in People' standards. The practice has devolved responsibility for nursing costs – both staff and equipment/dressings – as a budget to the nursing team co-ordinator.

Working together

The practice has stated an intention to work closely with purchasing authority managers and public health. It is experimenting with a 'corporate contract' with the health authority, to make itself more accountable for the primary care which it provides. It has agreed objectives under a social care project with the local council. A patient sits on the practice's decision-making board, and a health forum is held where both patients and local stakeholders (councillors, etc.) can give feedback to the practice.

Source: Audit Commission site visit

*Case Study 9***Something is limiting change**

This well-established practice (five partners and 10,300 patients) in a growing town became fundholding in Wave 4 once all partners were agreed – some partners had wanted to join Wave 1.

Source: *Audit Commission site visit*

Benefits for patients

The practice took on fundholding because it felt the main local providers were not responding adequately to the GP forum. But being positioned only a few miles from the large local acute hospital, and with only one other fundholder in the area (also Wave 4), the practice has not yet been able to get the local trust to make many changes (their main achievement has been to get pathology collection times changed to fit in with surgery hours). With space in the current practice premises at a premium, there is little scope for introducing new services. The practice did not score highly on the Audit Commission's probes into whether the practice purchases for effectiveness (although a self-audit of leg ulcer treatments, reported in the plan, has led to a change to more effective techniques). Being so close to the main provider means there is only limited chance to switch providers, but they have switched one specialty to another trust. While the practice reports a better working relationship with the main provider, it expects other improvements to take time.

Management and planning

The fund manager is a very experienced retired senior manager from the public sector and analyses fundholding system information in ways which help the GPs make decisions about how to manage the fund within year. He has already worked with the GPs to produce a fundholding plan with clear objectives for the fund. But the practice has yet to see clinical audit results from its providers

Working together

The practice has always played an active part in the local GP forum which liaises with the main local providers and the health authority.

*Case Study 10***Concentrating on our own patients**

This Wave 1 practice is in a small, rural city, and has six partners serving 10,000 patients.

Source: *Audit Commission site visit*

Benefits for patients

Waiting lists have reduced in the majority of specialties. The practice planned to make savings by bringing some services into the surgery, specifying reduced follow-up outpatient appointments, increasing in-practice pathology testing and reviewing prescribing. They spent some of the savings on improvements to the premises and paying for in-practice services. They have also used savings to develop the primary healthcare team by part-funding an attached social worker, a nurse practitioner with wider experience than the average practice nurse and a midwife. The practice does not see clinical audit results from its main providers and has not agreed guidelines for treatment. However it scored above average on Audit Commission probes into the introduction of evidence-based changes to treatment approaches. And outside the scope of the fundholding scheme, the practice has reduced inappropriate medical referrals to hospital by having them vetted by an ex-hospital doctor attached to the practice. The GPs claim that this review of cases has brought about a two-thirds reduction in referrals.

Management and planning

There is no separate fund manager – the practice manager took on the extra duties. She does not interpret standard IT system reports in ways that could help the GPs plan changes within year. The lead fundholding GP makes most of the decisions on how to spend the fund, and does most of the contract negotiating. There is no written purchasing plan.

Working together

The practice joined the fundholding scheme because it felt ignored by the local health authority which, in its view, had proved itself incapable of making providers change. Relations with the authority remain distant.

108. The majority of fundholders, however, remain in the 'modest ambitions' category in the bottom-left corner of the exhibit (Case Study 11). Their aims are succinctly expressed by a Wave 1 GP who said, 'we're not really asking that much'. The question that must be asked of fundholders in this quadrant, particularly those in early waves, is whether they are providing sufficient improvements to justify their costs. There are several possible explanations for a failure to develop and change:

- ◆ some fundholders may not have made changes because they saw no need to do so ('if it isn't broken, don't fix it'), or because they have purposely avoided changes where the benefits are debatable (for example, spot-buying which might undermine provider stability or thwart local strategic development). However, if little change is needed locally, the administration and transaction costs of these practices entering the scheme may not be justified;

Case Study 11

Modest ambitions

This Wave 3, six partner, 12,500-patient practice is situated in a country town, a mile from a district general hospital.

Benefits for patients

The practice sends most patients to the local provider (94 per cent of outpatients and 91 per cent of acute inpatients/day cases), and the numbers referred elsewhere have not changed substantially since becoming fundholders. There is little spare space in the practice, and because the district general hospital is so near the practice has not tried to develop new services at the premises, other than to provide counselling. The practice does not manage its own waiting lists and relies on the provider to decide how many patients will be treated in any one month. Nevertheless, waiting lists in most specialties have been slowly shrinking during 1994/95. In the fund manager's view, the practice's best achievement has been to reduce physiotherapy waiting times to one day by switching to a nearby private provider. In more than half of specialties, the ratio of follow-ups to first visits has reduced. The only instance of evidence-based purchasing is a paragraph on the self-management of back pain in the practice leaflet which conforms with good practice recommendations.

Management and planning

A recent majority vote relieved the lead fundholding GP of fundholding responsibilities, and the senior partner has taken over the role. Although not a small practice, the practice manager acts as fund manager, supported only by clerical staff and receptionists. The practice overspent in its first year, but is on target this year. Although the fundholding plan scored well against some Audit Commission criteria, the practice has done little needs assessment and does not receive clinical audit information from providers. The practice used management consultants to carry out a survey of patients' satisfaction with the practice's own services, but did not believe that a survey of views on hospital care was necessary, preferring to rely on anecdotal feedback from patients seen after discharge. The GPs believe the local hospital 'does its best'.

Working together

Despite the availability of health authority funding, the practice does not run a patient participation group or produce a newsletter describing its fundholding aims or decisions. The practice has little contact with the health authority over purchasing issues and contracting. It has informal links with other fundholders, but draws up contracts and negotiates independently.

Source: Audit Commission site visit

- ◆ others may have poor records of achieving short-term change because they are trying to develop a constructive relationship with providers, and have important long-term quality gains in mind which they have yet to realise; and
- ◆ fundholders differ when they enter the scheme. Those starting from a low base may appear to be performing comparatively poorly in a snapshot assessment, despite having made significant improvements.

Where fundholder purchasing is going

109. The findings of this study suggest that the key to a practice achieving a wide range of benefits for its patients is for it to invest in top-level management. In industry and commerce the purchasing function has grown in importance, developing from basic ordering and invoicing work through to close involvement in the redesign of supply channels by working with suppliers. Similar stages are readily identified within the healthcare sector, and can help trace the development of fundholder purchasing (Box 4, overleaf).

110. Many fundholders have yet to develop much beyond the basics typified by Stage 1, including some who have been in the scheme since the early days. Although administratively efficient, they often lack planning and needs assessment, and usually carry on referring as before, missing opportunities to develop new and better services. Poor contracting and inadequate monitoring of activity and spend against budget during the year can result in the budget being overspent by providers pulling in patients to meet their own financial needs. Conversely, the practice's patients may not receive the care for which they have been referred if a provider has more work than it can cope with in any one month.

111. As practices develop they start to review their own referral and prescribing behaviour. Some have progressed to Stage 2 by concentrating largely on gaining short-term advantages for their own patients. But as more healthcare becomes relocated in the future within primary care, there will need to be more co-development to ensure that the distribution of facilities, staff and resources optimises the care provided both in the short and long-term to all patients. To reach Stage 3 and begin to 'turn the world upside down', general practice-based purchasing will need much closer joint development with secondary providers, with enough knowledge about each area of specialist healthcare provision to enable it to lead providers and not merely follow in their wake. General practice – the specialism of generalism – cannot do this without access to wider sources of knowledge, experienced managers and the expertise of leading edge public health departments. The potential for change is great, going beyond simply reducing waits from 20 weeks to 10, or improving day surgery rates from 30 per cent to 40 per cent. At this stage practices could be replacing whole services with more cost-effective ways of provision by basing referrals and treatments on evidence of effectiveness, and re-locating services. Stage 3 gains from 'upstream' activities, such as thinking about how a service can be re-designed

Box 4:

A developmental model of GP fundholder purchasing

Ideally fundholders will move through three stages in their development as purchasers.

1 Early days or modest ambitions			
	Stage is characterised by...	Activities	Skills needed
	<ul style="list-style-type: none"> • 'Running a tight ship' • 'The GPs don't need to know we (the administrative staff) are here' • Separateness from rest of the NHS 	<ul style="list-style-type: none"> • Inputting data on referrals • Chase up invoicing errors • Chase up failure to offer patients an appointment/treatment date • Daily administration involved in running the fund 	<ul style="list-style-type: none"> • Clerical • Logistical • Book-keeping
all of stage 1 plus...	2 Developing well		
	Stage is characterised by...	Activities	Skills needed
	<ul style="list-style-type: none"> • Cost-per-case contracts • Switch providers for a few specific services • 'Starting to flex our muscles' • Getting tough with providers over the specifics of price, etc. • ...But the clinical approach is left to the consultant to decide 	<ul style="list-style-type: none"> • Reviewing variations in partners' referral and prescribing decisions • Gathering and comparing intelligence about providers • Reducing specific waiting times • Developing services at the practice, even if they duplicate provision at the hospital • Negotiating formally with providers in concert with other fundholders 	<ul style="list-style-type: none"> • Analytical • Basic management • Negotiation • Co-ordination • Clinical knowledge - general practice
all of stages 1 and 2, plus...	3 Turning the world upside down		
	Stage is characterised by...	Activities	Skills needed
	<ul style="list-style-type: none"> • Close liaison with consultants and the health authority • Investing in provider development • Involving patients and the community • Continuous improvement • Polyclinic • 'How can we solve this together' 	<ul style="list-style-type: none"> • Needs assessment • Purchasing for outcomes • Challenge consultants' way of doing things • Stop buying inappropriate care • Accredited providers • 'Make versus buy' decisions which complement not duplicate other providers • Identify where co-development should occur • Joint contracting • Making use of public health and other specialist knowledge 	<ul style="list-style-type: none"> • Strategic vision • High level management • Audit/research • Credibility with specialists • Selection of partners suited for long-term co-development • Leading providers forward

Source: Audit Commission, based on Cammish & Keough (1991) (Ref. 110)

'GPs who have understood the potential that fundholding offers them to take control of some aspects of their patients' secondary care, use it to influence and reshape services to the benefit of their patients.'

by co-operating with providers, are of a different order to the marginal improvements that spring from negotiating within the current framework.

112. Fundholders reaching Stage 2 often do so because one or more GPs enthusiastically take them there. But it is impossible to move into Stage 3 by relying solely on the practice's working GPs who simply do not have enough time to do all the development work. This is where the practice needs higher-level management skills, along with the support and influence of the health authority. Stage 2 can be a challenge for GPs. If fundholding appears to be progressing well in the short term, with tangible benefits for patients such as reduced waits in specific specialties, and savings made on the budget, why invest in a high-level manager who may shake up the practice and challenge their ways of working? The key to reaching Stage 3 is for GPs to see the potential, and make that investment, recognising that fundholding is not an adjunct but central to the practice's purpose of managing the provision of all types of healthcare for its patients as part of a wider community.

113. GPs who have understood the potential that fundholding offers them to take control of some aspects of their patients' secondary care, use it to influence and reshape services to the benefit of their patients. It has brought them an unprecedented involvement in the wider NHS and helped them resolve historic problems in their relationships with providers. But even though fundholding offers a comparatively simple experience of purchasing, because the hospital treatments it covers are not difficult to cost, and demand for them is predictable and can be contained, yet only a minority of fundholders have made the most of it. Most have mastered the considerable administrative burden, but in purchasing terms they are only maintaining the status quo. They make changes at the margins, but continue purchasing the same services, in the same quantity, from the same providers as the health authority purchased on their behalf before they became fundholders. It takes time to develop fundholding skills, but some Wave 1 fundholders have not developed enough. The key issue for the future must be how to make sure the purchasing performance of the majority comes up to the level of the best. Can improvements within the existing framework of rules and regulations achieve this? Or does the scheme itself need to change, and if so, how?

Improving performance within the current regulations

114. A number of measures can be taken within the current regulations that might improve fundholders' purchasing performance:

- ◆ better management in the practices;
- ◆ better training and opportunities for development; and
- ◆ regular feedback of comparative information about performance and peer pressure.

115. Although the skills, qualifications and experience of fundholding staff and the arrangements practices make for managing funds vary widely, there

'The new health authorities should be able to identify their 'leading edge' practitioners and to use their experience and skill to help GPs who are new to the scheme or underachieving. '

is a demonstrable relationship between better fund management and networking, and more benefits for patients. The wide differences between practices in the relative roles of lead GP fundholders and fund managers make it impossible to prescribe from the outside the in-puts appropriate to fund management. But practices are reimbursed for the additional costs they incur managing the scheme and should be able to show that, over time, they are improving in areas where their performance has been low – whether that is in consulting patients, forward planning and priority setting, or financial management. This will not require an increase in resources, but wiser investment of the management allowance.

116. Both formal training and other opportunities for development are crucial for lead GP fundholders and fund managers, but fundholders generally rate the training FHSAs provide as less than adequate (Chapter 3). Most authorities offer limited training in topics such as accountancy and the mechanics of budget holding, but they have not set out to develop fundholders' purchasing skills. The authorities may not feel confident that they have either the staff or the expertise inhouse to lead a programme of purchasing development, but as they are charged with involving all GPs in commissioning, it is an area that cannot escape attention. Simply sending busy GPs the latest effectiveness bulletin is insufficient, and expecting them to keep up-to-date with all the latest developments in treatment alternatives is unreasonable. They should be creating opportunities for their own staff and GPs to benefit from joint learning and making expertise in areas such as public health, IT and financial management, and the experience of other fundholders accessible. The Royal College of General Practitioners could have an important role to play here.

117. Peer pressure can also be a powerful method for changing professional behaviour. The NHS Executive has not specified a detailed set of objectives for the fundholding scheme, and FHSAs have had a poor record on feedback to fundholders. In consequence fundholding practices have lacked a clear model of what they might aim at, and often lack knowledge about what others have achieved. The new health authorities will have the opportunity this year to build on the work of their local auditors, who will be assessing their fundholders' purchasing performance using the measures developed in this report. They should collect and use comparative data to demonstrate to their own fundholders the range of achievements possible in the local context. They should also be able to identify their 'leading edge' practitioners and to use their experience and skill to help GPs who are new to the scheme or underachieving.

Improving performance through changes to the scheme

118. These positive measures may help to bring about change, but what if they prove either too slow or insufficient? The new health authorities are relatively small organisations with many responsibilities; it may be unrealistic to expect them to improve the training and development of fundholders much beyond what the FHSAs were able to provide in the past. The current system of limited checks and balances has not prevented poor performance and it may be necessary to change it. Two possible options are:

- ◆ strengthening the accountability arrangements; and
- ◆ introducing an accreditation system for practices.

119. The Accountability Framework sets the standards required of fundholders, but health authorities have no powers to take action if fundholders fail to meet them. The only sanction available is to recommend to the regional office of the NHS Executive that a practice be removed from the scheme; the decision rests with the region. To date, the sanction has been applied rarely and only in instances of financial mismanagement. The existing standards could be strengthened by introducing new targets, or raising the existing ones. Fundholders, for example, are currently encouraged but not obliged to consult their patients, and although expected to incorporate Health of the Nation and Patient's Charter targets into their contracts, these are not strict requirements. However, the content of the standards is less important than providing a mechanism that makes it possible to take remedial action in cases of poor performance. Fundholders' compliance with even the minimum requirements of the current framework has generally been poor (Chapter 3). Failure to comply should lead the way to a graduated system of penalties and warnings and ultimately, to removal from the scheme.

120. The problem with strengthening the accountability arrangements in this way is that it risks replacing ground-level innovation and freedom with health authority control, contradicting the principles of devolution. The NHS Executive expects the new health authorities to be light-handed in their use of regulation, and to facilitate rather than control. An alternative to greater regulation might be to grant devolved purchasing powers only to those who can demonstrate their capacity for managing well and delivering patient benefits, through a system of accreditation.

121. As a first step, the criteria for entry to the scheme would be tightened, and practices would have to show that they met the scheme's standards. There could be different levels of accreditation, to match the different types of purchasing (standard and community fundholding, total purchasing) that already exist. Once practices were accredited, they would be accountable for the wisdom and probity in their management of the budget via a contract. In some places a single, well-developed practice might prove itself to be the best purchaser. Elsewhere, the right combination of GP enthusiasm, interpractice agreement, managerial ability and geographical coherence might allow purchasing for all services to take place with minimal outside involvement, as in some of the total purchasing pilot sites. In other areas, for

'...an accreditation system would introduce competition between potential purchasers...'

example where there are many single-handed or small practices as in innercities, the right structure might resemble the multifunds described in Chapter 2. But for some GPs successful purchasing will be more likely in a health authority led and supported 'locality' arrangement.

122. Over the last five years diverse, experimental arrangements have arisen, in the nature of '100 flowers set to bloom'. But because these structures have arisen in an *ad hoc* way across the country, they perform with varying degrees of success. Although it is too early to be very specific about the most appropriate arrangement for any one area, an accreditation system would introduce competition between potential purchasers, with assurance for the public that the best and most cost-effective structure for the local area had won the right to purchase care on their behalf (Ref. 111).

123. The consequences of strengthening the role of the health authority in relation to fundholders would need careful thought, as would the question of who would be the accrediting agency. In some areas, the new health authorities will have their work cut out to establish their own credibility as purchasers *vis-a-vis* the GPs and, as they are responsible for setting budgets and the fundholders sometimes perceive them to be direct competitors, they may not be suitable. An independent agency or inspectorate may be required. Leaving aside important questions of cost and the uncertainty about whether these measures would work, the danger in any proposal to strengthen accountability arrangements is that it might drive out innovation and add weight to the 'dead hand of bureaucracy'.

124. None of this will be simple or straightforward. The resource implications of the investment required to improve fundholders' performance and to help persistently poor performers leave the scheme would be considerable. But a substantial sum is already invested annually in fundholding staff and systems, and it should be better targeted. The challenge is to devise economic and efficient methods that can work effectively with more than 3,000 purchasers.

125. A large part of the rationale for developing fundholders' management of the scheme would be to improve their planning and priority setting, and to help them take a wider, and more strategic view of their responsibilities as purchasers, taking account of national and local health strategies. But it is entirely possible that, after careful planning, their priorities would not be the same as the health authority's, and their decisions might restrict the authority's ability to achieve its own plans, and meet the efficiency and activity targets set by the region which include the impact of fundholders' purchasing. Two fundamental questions of principle remain unresolved: when, if at all, should it be possible to contest fundholders' purchasing decisions? And who should have that authority?

Recommendations

The Way Forward

- 1** Fundholders should learn from the best practice of their peers and:
 - ◆ invest in high calibre management within the practice, involve their patients and the local community in decision taking, purchase a wide range of benefits for their patients and take up difficult challenges such as evidence-based purchasing.

- 2** The new health authorities should invest in training and develop support mechanisms for their fundholders. Specifically, they should:
 - ◆ measure fundholders' performance against indicators of patient benefits including those listed in this report;
 - ◆ use performance indicators to set individual targets for fundholders to improve their management of the fund and their approach to purchasing;
 - ◆ identify leading-edge fundholders in their area and find ways of involving them in developing their peers;
 - ◆ create opportunities for their own staff and GPs to benefit from joint learning; and
 - ◆ make expertise available to fundholders in areas such as public health, IT and financial management.

- 3** The NHS Executive should consult further on proposals to change the Accountability Framework and the regulations governing the scheme. In particular, they should aim to make fundholders:
 - ◆ provide evidence that they are taking note of their patients' priorities and consulting them about their purchasing plans;
 - ◆ incorporate Health of the Nation and Patient's Charter targets into their contracts; and
 - ◆ take account of local health priorities in their plans.

- 4** The NHS Executive should consider urgently the policy changes needed to improve fundholder purchasing. The options include:
- ◆ tighten – or expect health authorities to tighten – the criteria for entry to the scheme and require practices to show how they meet the scheme's standards;
 - ◆ introduce contracts between health authorities and fundholders as a mechanism for making sure that fundholders use the fund efficiently and effectively; and
 - ◆ introduce either an accreditation system or an inspectorate that will give an independent judgement on practices' suitability to become, and remain, budget holders.

Appendix 1

Acknowledgements

The advisory group

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Devon FHSA

Dudley FHSA

East Sussex FHSA

East London and City HA

Grampian Health Board

Gwent Health Commission

Health Commission for Wiltshire & Bath

Hereford & Worcester FHSA

Hertfordshire Health Agency

Kent FHSA

Leeds FHSA

North Birmingham Health Commission

North Thames RHA

Nottingham Health

Oxford & Anglia RHA

St Helens and Knowsley FHSA

South Staffordshire Health Commission

Stockport Health Commission

Suffolk DHA

Suffolk FHSA

Surrey FHSA

West Midlands RHA

Worcester and District HA

NHS trusts

Addenbrooke's NHS Trust, Cambridge

Allington NHS Trust, Ipswich

Dudley Group of Hospitals

Hastings and Rother NHS Trust

Ipswich Hospital NHS Trust

Kent and Sussex Weald NHS Trust

Lifespan Healthcare – an NHS Trust

NE Worcestershire Community Trust
Nottingham City Hospital NHS
Plymouth Hospitals NHS Trust
Priority Health NHS Trust, Dudley
Royal Cornwall Hospitals Trust
Royal United Hospital Bath NHS Trust
S Derbyshire Community Health Services NHS Trust
Worcester Royal Infirmary

Practices

Adcroft Surgery, Trowbridge, Wilts
Albany Surgery, Newton Abbot, Devon
Beech House Surgery, Denbigh, Clwyd
Bellevue Surgery, Newport, Gwent
Birmingham Multifund, Birmingham, West Midlands
Burley Park Medical Centre, Leeds
Burton Multifund, Burton-on-Trent, Staffordshire
Cantilupe Surgery, Hereford
Dr Cartwright, Holly Hall Clinic, Dudley
Central London Multifund, London
Chippenham Surgery, Monmouth, Gwent
Davenal House Surgery, Bromsgrove
Eastleigh Surgery, Westbury, Wiltshire
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Haslemere Health Centre, Haslemere, Surrey
Hathaway Surgery, Chippenham, Wiltshire
Ivybridge Health Centre, Ivybridge, Devon
Kingston and Richmond Multifund
Landsdowne Surgery, Devizes, Wiltshire
Larwood Health Centre, Worksop, Nottinghamshire
Dr Lias and Partners, Kingston, Herefordshire
Limes Surgery, Lye, Stourbridge, West Midlands
Lingholme Health Centre, St Helens, Merseyside
Mill Street Medical Centre, St Helens, Merseyside
Marches Medical Centre, Broughton, Clwyd
Medical Centre, Collingham, Newark, Nottinghamshire
Medical Centre, Wetherby, Leeds

Moorfield House Surgery, Garforth, Leeds
Mote Medical Practice, Shepway, Maidstone, Kent
Mount Surgery, Pontypool, Gwent
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Shotton Lane Surgery, Clwyd
Sneinton Health Centre, Sneinton, Nottingham
Somerset Grove Health Centre, Stoke Newington, London
Stamford Hill Group Practice, Stamford Hill, London
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The Surgery, Gwersyllt, Clwyd
Valley Surgery, Chilwell, Nottingham
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Others

We are grateful for informal discussions with many other GPs, fund managers and others within the NHS, and with local auditors.

Appendix 2

Controversies

Fundholding has been controversial from its introduction. Despite the potential advantages described in this report, opponents of the scheme, including many GPs, have made a number of claims about possible negative effects. This box sets out some of the opposing arguments.

Some say this	Others offer an alternative view
Agent for change	Change was possible before
The leverage of holding a budget has made hospitals and community services respond in a new way, kick-starting change which GPs and health authorities have found impossible to achieve in the past...	...Innovative GPs, health authorities and providers worked together before fundholding to bring in desirable changes; some of the changes which fundholders ask for via contracts are debatable value for money.
Bottom-up influence on policy	Policy vacuum
The scheme is an experiment in bottom-up, flexible change ('100 flowers set to bloom') freed from the limitations of bureaucracy. The close involvement of GP fundholders with the NHS Executive on a continuous basis has led to quick change and development which closely reflects the feelings of those involved at ground level, rather than responding after the event to each proposal from the centre...	...Policy is being made on the hoof, untested and unevaluated. The detail of how the scheme operates and what it includes is being changed all the time, while the concept of a primary care-led NHS remains ill-defined. No specific statement of the objectives of fundholding has been issued since the brief statements in the 1989 White Paper.
Policy fragmentation	Accountability Framework
If purchasing is split between many small purchasers, taking strategic decisions about large capital investments and other long-term service development is jeopardised...	...There is as yet no systematic evidence to show that future planning has been damaged in this way. The Accountability Framework expects health authorities to develop close links with fundholders to ensure that this does not happen.
GPs are best at allocating resources	Others should take rationing decisions
If anyone is to manage limited resources, then it is best if doctors are closely involved...	...Holding a budget will force doctors to take decisions about rationing healthcare which should be taken by health service managers or politicians.
HAs have greater budgetary freedom	Emergency care takes precedence
Fundholders are allocated a budget which they can only spend on treatment which falls within the scope of the scheme. Health authorities can potentially spend more money on elective care, and less on other areas of care, should they wish to. One fund manager said: 'We may have to leave fundholding to obtain non-capped clearance of our inpatient waiting lists via the health authority – non-fundholders can 'spend' as much as they like'...	...Elective care for fundholders' patients is protected via their ringfenced budgets. Should emergency care show a sudden increase, HAs may need to reduce spending on non-fundholders' elective care to balance budgets. In an area of high fundholding the health authority will have little elective surgery money left with which to offset any sudden fluctuation in demand for emergency services, which could make them overspend or cut back on emergency services.
Working strategically	Health authorities will not be neutral
The spirit of the Accountability Framework expects health authorities to involve GPs in strategic commissioning, and fundholders can have recourse to arbitration if disputes with the health authority cannot be resolved...	...The new health authorities will set fundholders' budgets and hold them to account for budgetary performance; but they will also compete with them as purchasers and may have a vested interest in reducing fundholders' budgets.
Lack of accountability	Accountability framework
GPs can do what they like without reference to lay people on a health authority board or to a community health council; patient empowerment is left out of the equation...	...The NHS Executive's Accountability Framework introduces a requirement for fundholders to publish plans, and some practices voluntarily consult with the community health council or involve patients in fund decision making.

Some say this	Others offer an alternative view
Money diverted from care into premises	HAs also have virement powers
Fundholders can spend savings to the benefit of their patients; spending on improvements to practice premises may not be the highest priority for an area as a whole and represent bad value for money...	...Health authorities have similar incentives and freedoms – they may also, within certain constraints, choose to spend their allocations as they wish, and the onus is on both fundholders and health authorities to spend with regard to value-for-money considerations.
Doctor-patient relationship	Local empowerment
Fundholding could damage the doctor-patient relationship by introducing money into the equation, if patients perceive that their doctor might make decisions about their care based on cost rather than need...	...There has been no systematic research to show whether a significant number of patients feel this way, nor whether there is any actual deleterious effect on the health of any patients who do think this way.
Two-tiers	Local empowerment
Fundholders 'fast-track' their patients ahead of others on the waiting list, going against the principle of equity of access. There are local differences in access and waiting times for services as demonstrated in the Patient's Charter 'league table' booklet. Some fundholders have described how major NHS providers have 'fast-tracked' their patients in return for extra income or the provision of extra equipment (for example, an ophthalmic auto-refractor, an orthopaedic day bed unit)... (Ref. 112)	...The NHS Executive believes that such instances have not been to the detriment of the patients of non-fundholding practices, since they make use of spare capacity. The interpretation of any differences introduced by fundholding is not straightforward – many 'tiers' have always existed due to variations in, for example, GPs' referral decisions, health authority purchasing and investment decisions in the past, provider efficiency at treating patients quickly, consultants' approaches to treatment and abilities or private treatments rates. The fundholding scheme gives GPs the power via budgets to set their own local priorities and have the leverage to get them achieved. Interpretation becomes a matter of choice – unacceptable inequality because some patients are seen and treated quicker, or empowering GPs and health authorities to make their own choices between local priorities?
Cost-cutting	Sound budget management
Fundholders might under-refer or under-prescribe in order to make savings...	...The regulations state that savings can only be spent 'to the benefit of patients' and thus if a practice decided to divert money from the hospital or prescribing budgets it would be making a decision about relative priorities for its patients.
Activity hiking	Unlikely to happen
Because budgets are set on actual activity during the preparatory year, a practice which artificially boosts prescribing or referrals could make a saving by returning to normal when managing its first budget...	...This would require a practice's GPs to conspire to treat patients against their best interests, and the budget-setting health authority to fail to spot an unnatural one-year change.
Inequity in budget size	Could cut both ways
If through errors in budget setting fundholders were given a larger proportion of a district's healthcare allocation than is justified on past patterns of referral, then less would be left to spend on the healthcare of non-fundholders' patients...	...But the opposite would be the case should fundholders' budgets be underestimated.
Cream skimming	Unlikely morality and little incentive
Fundholders might remove expensive patients from their lists or refuse to take on expensive patients, thus making savings by not providing the care patients really need...	...There is no published evidence that this is occurring on a systematic basis and none of the FHSAs visited during this study thought it occurred in their area. In fact, the scheme's regulations offer little incentive to do it, even should a practice's GPs and fund manager conspire to act against a fundamental moral principle of general practice. Fundholding budgets are based on past patterns of expenditure and, if referral patterns change dramatically to increase costs, health authorities have the power to add to budgets within-year. In addition, there is a ceiling of £6,000 on the annual costs of an individual patient, after which the health authority meets costs from contingency reserves which it manages for that purpose.

Some say this	Others offer an alternative view
Fundholding is growing fast	Only some patients can benefit
<p>The scheme is growing and changing all the time – by 1994/95, 41 per cent of the population were covered by the scheme, and about 8 per cent of health services' annual revenue expenditure was channelled through fundholding practices. This is a significant feat, given the past lack of involvement of GPs in the management of the wider NHS and their status as small, independent businesses. Total purchasing pilots now commission 100 per cent of healthcare...</p>	<p>...Over half the country's patients remain outside the scheme, unable to benefit directly from whatever advantages the scheme can bring, and missing out on those advantages for the past five years. The 51 total purchasing pilots cover only 4 per cent of the population. With the fundholding scheme likely to remain voluntary for the foreseeable future, it is difficult to see how this can be resolved within current structures and regulations.</p>
High costs	Cost-effective
<p>The scheme has increased spending on managers, data clerks, computers and facilities within the fundholding practices, management costs within the health authorities and extra contracting and transaction costs for trusts. These costs are not offset by efficiency savings, since underspends do not have to be returned by the practice – they are available for the practice to spend to the benefit of their patients, while overspends must be met by the health authority...</p>	<p>...The fundholding scheme was not designed to be an exercise which could reduce management and administration costs; it was intended to produce patient benefits which would outweigh new costs. Most of the extra costs of involving fundholders in purchasing are related to the gathering of information about secondary care. Health authorities do not collect individual patient episode data to the same degree of detail as is required under the fundholding scheme. Whereas they rely on provider data of variable accuracy, the fundholding management allowance is used to pay for a computer system and to employ clerical staff to enter details of every referral as it happens, and record what has happened to patients.</p>

Source: Audit Commission

Appendix 3

Data sources

National survey of fund and practice managers 1994/95

A 16-page questionnaire was sent to every known fundholder in England and Wales (one questionnaire per fund), addressed to the fund manager. The questionnaire covered manager qualifications, skills, pay and experience; staffing levels and turnover; communications; GP involvement; contracting; IT; direct access; community and outpatient services at the practice. Questionnaires were mailed in late summer 1994, with reminders mailed during the autumn. In addition, a questionnaire was sent to all known non-fundholding practices of list size 7,000 or over, addressed to the practice manager. The Commission sent out 5,101 questionnaires and 2,419 usable questionnaires were returned. Overall, 1,308 usable questionnaires were returned from fundholding practices. Excluding some duplicates or non-existing practices, responses rates were:

Wave 1	79%		
Wave 2	75%		
Wave 3	70%	Non-fundholders	24%
Wave 4	65%	Overall	49%

While the response rates of fundholding practices were high, making this is the largest survey yet carried out of fundholding practices, only 24 per cent of the non-fundholding practices replied. As a partial check on response bias we compared the characteristics of those replying to the 100 per cent sample available on the NHSE GMS database. There were no significant differences.

National survey of fundholders 1995/96

A 12-page questionnaire was sent to all Wave 1-5 fundholders in England and Wales as part of local external audits between November 1995 and January 1996 (one questionnaire per fund). The questionnaire covered the following purchasing issues: referrals; waiting times; day cases; discharge letters; district nursing and leg ulcer treatment; mental health; evidence-based purchasing; prescribing; contracting and communications; involving patients; commissioning and the health authority. The fund manager was asked to complete most of the questionnaire, and the lead fundholding GP the clinically oriented questions. The response rate, from 1,256 usable replies, was 56 per cent.

Audit Commission financial profiles, based on standard financial returns

The Audit Commission regularly analyses NHS financial returns, both preliminary results and audited accounts. The information is accessed via NHS regions.

Request to NHS Executive regional offices

There is no centrally held information on fundholder numbers and population coverage, disaggregated to FHSA level by each year of entry. The Audit Commission obtained this information directly from regional offices, and the Welsh Office.

Survey of audited fundholder accounts

Information on fundholder budgets, list size and underspends/overspends was gathered by auditors appointed by the Audit Commission during the audit of accounts 1993/94 and 1994/95. Fund budgets amounting to £1.1 billion are represented in the survey, out of the £1.8 billion being managed in England in total during 1993/94. The average fund size was £1.6 million, with an average 'pound per patient' budget of £151 – both are the same as the national averages for that year (source: Parliamentary Answer). Information for 665 fundholders (54 per cent) from 53 FHSAs across England and Wales is available for 1993/94; and for 1,156 fundholders (63 per cent) from 80 FHSAs for 1994/95.

Survey of multifunds and consortia

There is no central list of all the existing multifunds and consortia. The Audit Commission survey of multifunds and consortia included all the organisations that had publicly declared themselves to be multifunds.

A questionnaire was sent in mid-1995 to 23 known addresses of multifunds, either live or preparing for Wave 6; 16 replies were received, of which one was predominantly made up of Wave 3 funds, six mainly Wave 4, eight Wave 5 and three Wave 6.

NHS Executive GMS database, 1993/94

The GMS database is a computerised register of general medical practitioners who are in contact with FHSAs. Information is supplied to the NHS Executive via the FHSAs and is collected bi-annually. Each census provides details relating to numbers of partners, list sizes, trainees and assistants, practice staff, services offered and target achievements. An anonymised file aggregated to practice level was used for the analyses reported here.

The database contains information on 9,830 practices (9,687 excluding 143 with no unrestricted principals – for consistency with the DOH's regularly

published *Statistical Bulletins*, analyses have been made on this latter figure), covering 53,448,000 patients.

To make for more meaningful comparisons between fundholders and non-fundholding practices, the latter are grouped into different list size bandings:

- ◆ non-fundholding practices with list sizes of less than 3,000 patients (3,212 practices with an average list size of 1,894 patients);
- ◆ non-fundholders with list sizes between 3-7,000 (3,528 practices with average list size of 4,775);
- ◆ non-fundholders with list sizes of more than 7,000 (1,834 practices with average list size of 9,992);
- ◆ Wave 1 and 2 fundholders (577 practices with average list size of 10,900 patients; it was not possible to distinguish between the first two waves on the database); and
- ◆ Wave 3 fundholders (679 practices with average list size of 8,692).

Prescribing

Information was derived from Audit Commission analyses of base data supplied by the Prescription Pricing Authority and Welsh Office. Sources and sampling methods have been described in the Audit Commission report, *A Prescription for Improvement: Towards More Rational Prescribing in General Practice*, HMSO, London, 1994.

Audit Commission site visits

Listed in Appendix 1:

- ◆ 56 practices in 15 FHSAs, selected arbitrarily but with a view to ensuring a spread of early and late entrants to the scheme, were visited during 1994/95. Because of constraints on GP and fund manager time, not all questions were asked at each practice, nor all documents (for example, plans, contracts) collected. The references indicate sub sample sizes for each analysis.
- ◆ 15 FHSAs (or as in some cases, commissions working informally together in advance of merger legislation) and 12 trusts, selected arbitrarily within the constraints of geographical spread across England and Wales, and grouped in areas of high, medium and low fundholding coverage.

Appendix 4

Clinical tracers

A number of 'tracers' were chosen to cover the main areas of the fundholding budget and to raise effectiveness issues.

Cataract	Opaqueness which can seriously impair vision; most common in older people; the cloudy lens is removed, and often replaced by an artificial lens
Budget	Hospital and community services

Reason for choosing the condition as a tracer

- ◆ Common elective procedure – the sixth most frequently performed operation in recent years
- ◆ One of the conditions chosen as a Patient's Charter day surgery indicator, and providers differ greatly in use of day surgery
- ◆ Considerable price variations between providers
- ◆ Variation in techniques and use of local/general anaesthetic
- ◆ Varying waiting times between different providers
- ◆ Management of waiting list important as social conditions of patients (most are elderly) will affect degree to which they benefit from treatment and whether they can travel for surgery
- ◆ Aftercare implications for the primary healthcare team
- ◆ Makes up the great majority of most fundholders' ophthalmology budget

Good purchasing guide

- ◆ Deciding when to refer for treatment is not straightforward because visual impairment increases gradually, and need differs with social circumstances (eg, whether the patient has a partner to help in their care, whether still at work, etc); practices should therefore develop referral guidelines based on assessment of visual ability in relation to social circumstances, rather than only on reaching a particular threshold on a test of visual acuity
- ◆ Extracapsular extraction is the commonest method; a few ophthalmologists still routinely use the older, more risky, intracapsular technique
- ◆ Day surgery and use of local anaesthetic is increasing; there are wide variations around the 1994/95 national average of 37 per cent treatment on a day basis
- ◆ A follow-up check the day after surgery is common, and some patients may require attention during the evening or night; day surgery therefore requires provision of suitable nursing cover in the community, and a convenient location for the next-day check
- ◆ Where cataracts occur in both eyes, they should be treated one at a time in case of infection, but an over-long time gap between operating on each eye will create difficulties for the patient
- ◆ Eyesight should be tested about three months post-operatively, and new glasses ordered if required

Cataract continued

Key results from Audit Commission site visits	
<ul style="list-style-type: none"> ◆ Changes in cataract service introduced since fundholding (52 per cent of 29 fundholders) ◆ Disease register held (59 per cent; 45 per cent held an active register without having to specially interrogate the computer system to answer the question) ◆ Clinical audit results from providers seen (14 per cent) ◆ Written guidelines in use (13 per cent) ◆ Referrals based on visual ability not just acuity (54 per cent) ◆ Private sector used (38 per cent) 	
Key references	
<p>Potamitis, T, et al, General Practitioners' Awareness of Different Techniques of Cataract Surgery: Implications for Quality of Care <i>British Medical Journal</i>, 1994, 308:1334-5. An Effective Healthcare Bulletin about cataract is due for release during 1996.</p>	

Glue ear	Common condition among children; middle ear filled with viscous substance; hearing loss mild to severe
Budget	Hospital and community services, tests

Reason for choosing the condition as a tracer	
<ul style="list-style-type: none"> ◆ Treatment by surgery is a common elective procedure – the eighth most frequently performed operation in 1992/93. Makes up a large proportion of most ENT budgets ◆ Oft-debated effectiveness issues, aired in an Effectiveness Bulletin ◆ Important GP co-ordination role – eg, tympanometry testing at the practice and audiological testing, assessment of progress or distress levels at school/home, ensuring 'watchful waiting' periods are used, becoming involved in decisions by consultants over whether to operate ◆ Fairly common outpatient clinic to have at the practice – the sixth most common in our survey, about 11 per cent having it at the practice 	

Good purchasing guide	
<ul style="list-style-type: none"> ◆ Glue ear can affect speech, language, learning and behaviour; it can lead to emotional difficulties, loneliness, lack of confidence, bullying and social isolation; some paediatricians think this may have long-term affects on development, but there are few published studies demonstrating such links ◆ About half of cases resolve without treatment within three months; hence 'watchful waiting' should be used, together with assessment for pain, degree of hearing loss and speech/language development ◆ Parents, worried about language development and progress at school, may put strong pressure on GPs to take action rather than wait; practices will need to have determined how they will respond to this ◆ Non-surgical treatments include analgesia to relieve pain; some limited success in clearing has been claimed for antibiotics; success has been claimed for a 'new' technique involving the patient inflating a balloon via one nostril while the other is closed ◆ Surgical intervention is most commonly myringotomy with insertion of grommets; this often leads to improved hearing, but the effects may disappear within a year and the condition recur 	

Glue ear continued

Good purchasing guide
<ul style="list-style-type: none"> ◆ Patients should be referred for an audiology test before being referred to an ENT surgeon and, if there is a long wait before surgery, the GP should ensure patients are retested (audiology/tympanometry) shortly before surgery to avoid operating on those whose conditions have improved while waiting ◆ Sometimes myringotomy is used with adenoidectomy or tonsillectomy; trials suggest removal of adenoids can reduce the need for further surgery, but tonsillectomy adds no benefit and GPs should therefore have discussed which treatment combination will be used with the consultant ◆ Day surgery has increased until most surgeons, if carrying out only myringotomy and grommet insertion, will do so on a day case basis; however, if done simultaneously with (eg) adenoidectomy, an inpatient stay becomes more likely ◆ GPs need to have decided how they will co-ordinate the different treatment options available - ie, how long to employ 'watchful waiting', when and how to use audiometry and checks on language development, and if/when to refer to an ENT surgeon
Key results from Audit Commission site visits
<ul style="list-style-type: none"> ◆ Changes in approach introduced since fundholding (35 per cent of 29 fundholders) ◆ Disease register held (35 per cent; 31 per cent held an active register without having to specially interrogate the computer system to answer the question) ◆ Clinical audit results from providers seen (11 per cent) ◆ Written guidelines in use (24 per cent) ◆ Read the Effectiveness Bulletin (55 per cent) ◆ Employ watchful waiting (90 per cent) ◆ Refer to audiologist (86 per cent) ◆ Audiology test before being seen by consultant surgeon (38 per cent) ◆ Patients retested (audiology/tympanometry) shortly before surgery (32 per cent) ◆ Grommets plus adenoidectomy (76 per cent) ◆ Private sector used (17 per cent)
References
<p>'The Treatment of Persistent Glue Ear in Children', <i>Effective Healthcare</i> (1992) Drug and Therapeutics Bulletin (1995), 'Glue ear', 33:13-15. 'Children with Hearing Impairment', NHS Executive, 1994.</p>

Back pain	Pain levels and degree of disablement varies; 'simple' back pain 95 per cent of cases; more serious (eg, nerve root pain, connective tissue disorders) 5 per cent of cases
Budget	Hospital and community services, tests, direct access, prescribing

Reason for choosing the condition as a tracer

- ◆ Over 20 per cent of all visits to GPs are for musculoskeletal complaints; back pain is one of the most common of these
- ◆ The annual cost to the NHS for treatment is estimated to be nearly £½ million, plus nearly half as much again for the costs of non-NHS treatment
- ◆ An episode of back pain can be very costly for individual patients and for the economy in terms of weeks of lost working time and social security benefits (estimated at over £5 billion annually) – better management can reduce this
- ◆ Communications and teamworking issue; involving links between GP, physiotherapist, consultant and practice nurse as to who does what
- ◆ Orthopaedics is the third most common consultant outreach clinic bought for provision at the practice (provided at 14 per cent of fundholding practices responding to our national survey, behind only dermatology and gynaecology), and physiotherapy the commonest of the direct access services (provided at more than half the fundholding practice premises)
- ◆ It is one of the commonest areas where money has been vired in-year, and/or accumulated savings have been used to buy quick-access therapist services
- ◆ Having a physiotherapist at the practice should be reflected in lower referral rates to orthopaedic consultants, should be cheaper and enable quicker treatment for patients
- ◆ Inappropriate prescription of NSAIDs (non-steroidal anti-inflammatory drugs) rather than simple analgesics is unnecessary expenditure

Good purchasing guide

- ◆ Simple back pain usually treated by prescribing drugs and prolonged bed rest; if pain persists beyond two weeks a back X-ray may be taken and the patient referred to an orthopaedic consultant and/or physiotherapist
- There is some evidence that this approach is inappropriate:
- ◆ If pain-relief is prescribed it should be simple analgesics – comparatively costly NSAIDs are no more effective and have higher side-effect risks
 - ◆ Orthopaedic consultants often have long waiting lists and anyway do not need to see simple back pain cases; back X-rays are of little value
 - ◆ There is some evidence that mobility immediately or within a day or two (rather than long bed rest) can lead to quicker recovery
 - ◆ While there is no strong evidence that the use of therapists (physiotherapist, osteopath or chiropractor) improves recovery, referral within a few days may ensure appropriate symptom relief and return of mobility; education about posture (etc) may reduce recurrence and savings on GP consultation time may occur
 - ◆ Referral to a consultant orthopaedic surgeon should occur for a few cases only where back pain may be due to a serious disease, or if the therapist/GP management fails
 - ◆ Practices need to develop guidelines related to the above

Back pain continued

Key results from Audit Commission site visits
<ul style="list-style-type: none"> ◆ Changes in approach introduced since fundholding (45 per cent of 29 fundholders) ◆ Disease register held (41 per cent; 31 per cent held an active register without having to specially interrogate the computer system to answer the question) ◆ Clinical audit results from providers seen (21 per cent) ◆ Written guidelines in use (15 per cent) ◆ Read the CSAG guidelines (17 per cent) ◆ Use a physiotherapist to treat simple back pain (100 per cent); chiropractor (45 per cent); osteopath (46 per cent) ◆ Refer to therapist within a few days (60 per cent) ◆ Prescribe NSAIDs (92 per cent) ◆ Most prescribed ibuprofen, the cheapest NSAID ◆ Private sector used (21 per cent)
References
<p><i>Back Pain</i>, Clinical Standards Advisory Group, HMSO, 1994.</p> <p>Barker, M E, <i>The Management of Back Pain in General Practice</i>, Royal College of General Practitioners, London, 1995.</p> <p>Royal College of Radiologist guidelines for requesting back X-rays.</p> <p><i>Back Pain: Its Management and Cost to Society</i>, Centre for Health Economics, York University, 1995.</p> <p>Bandolier, 1995 No.9</p> <p>Hemingway, H & Feder, G, 'Bad Backs, Good Policy?', <i>British Journal of General Practice</i>, 1995, 45:456-7.</p> <p>Howie, J G R et al, 'Evaluating Care of Patients Reporting Pain in Fundholding Practices', <i>British Medical Journal</i>, 1994, 309:705-10.</p> <p>Meade, T W et al, 'Randomised Comparison of Chiropractic and Hospital Outpatient Management for Low Back Pain: Results from Extended Follow Up', <i>British Medical Journal</i>, 1995, 311: 349-51.</p>

Anxiety	Most common neurotic state
Depression	Serious neurotic illness
Budget	Hospital and community services, prescribing, counsellors via virement or savings

Reason for choosing the condition as a tracer

- ◆ Perhaps 10-33 per cent of all GP consultations have a psychiatric component, though patients may present a physical reason for attendance
- ◆ Anxiety symptoms may include worry, tension, over breathing and giddiness, leading to significant distress or disability; depression may appear as recurrent, major disruptions preventing a normal life and may lead to suicide attempts – 50-150 cases on average GP list
- ◆ Major depressive disorder is common – prevalence in the community has been estimated as high as 5 per cent
- ◆ Definition of patients suffering from depression, rather than anxiety, is difficult – perhaps half of those presenting remain undiagnosed by GPs – 2-3 people on average GP list diagnosed and receiving treatments
- ◆ Treatment is largely within the community and requires teamworking between GP, practice-based counsellor, CPN and consultant as to who should do what
- ◆ It has been suggested that two-thirds of patients with major depression can obtain rapid relief from easily available treatment
- ◆ Counselling is one of the most commonly provided direct access services at the practice, and increasingly CPNs are being attached to practices
- ◆ Drugs are expensive and there is controversy over the relative merits of tricyclic antidepressants and SSRIs (selective serotonin re-uptake inhibitors)

Good purchasing guide

- ◆ Anxiety is usually treated by stress counselling; mild cases by the GP, others by counsellor, CPN or clinical psychologist
- ◆ Other 'talking treatments' include psychotherapy, family therapy, group therapy, cognitive therapy, social skills training, etc
- ◆ The effectiveness of counselling and other therapies has not been systematically evaluated; eg, the few studies about the relationship between counselling and drug prescriptions show conflicting results, some showing a decrease in prescribing for those counselled, but others showing no effect or even increased prescribing
- ◆ Serious depression is usually referred to the secondary service
- ◆ Drug treatment for depression is usually either tricyclic antidepressants or SSRIs (the most well known of which is Prozac); the latter appear to have fewer adverse side effects, but are much more expensive
- ◆ ECT may be used as a treatment for severe depression which has not responded to other forms of treatment, but is the subject of ethical debate
- ◆ Counsellors vary in training/qualifications, arrangements for supervision and updating skills; the practice should ensure these issues are dealt with in the contract
- ◆ Practices need to avoid wasteful use of CPN time by referring only appropriate cases and avoid asking insufficiently skilled/trained counsellors to take on those with serious conditions
- ◆ Practices need guidelines to help decide who should be treated within the practice, and who referred on to the secondary psychiatric provider
- ◆ There is often dispute between providers and GPs about (eg) sectorisation vs. specialism/choice of consultant psychiatrist, attachment of CPNs to practices, division of resources between in-practice treatment of the anxious and the seriously ill in hospitals or hostels; thus practices need to have discussed and agreed how they will manage the mental health resource

Anxiety and depression continued

Key results from Audit Commission site visits
<ul style="list-style-type: none"> ◆ Changes in approach introduced since fundholding (59 per cent of 29 fundholders) ◆ Disease register held (anxiety 48 per cent, depression 62 per cent; 38 per cent held active registers without having to specially interrogate the computer system to answer the question) ◆ Clinical audit results from providers seen (anxiety 4 per cent, depression 7 per cent) ◆ Written guidelines in use (anxiety 7 per cent, depression 13 per cent) ◆ Use a clinical psychologist (75 per cent); a counsellor (66 per cent); a psychotherapist (46 per cent) ◆ Use a CPN (93 per cent) ◆ GP involved (93 per cent); practice nurse involved (39 per cent) ◆ Agreed criteria on when to treat within the practice, and when to refer on to the mental health team (10 per cent) ◆ agreed policy on the use of tricyclic antidepressants and SSRIs (38 per cent) ◆ Private sector used (24 per cent)
References
<p>Department of Health, <i>Mental Illness: What Does It Mean?</i>, Health of the Nation booklet, 1995.</p> <p>Effective HealthCare Bulletin, <i>The Treatment of Depression in Primary Care</i>, University of Leeds, 1993.</p> <p>Fletcher, J et al, 'Relationship Between the Provision of Counselling and the Prescribing of Antidepressants, Hypnotics and Anxiolytics in General Practice', <i>British Journal of General Practice</i>, 1995, 45:467-469.</p> <p>Tylee, A et al, 'How Does the Content of Consultations Affect the Recognition by General Practitioners of Major Depression in Women?', <i>British Journal of General Practice</i>, 1995, 45: 575-8.</p> <p>Tyre P, Higgs R & Strathdee G, <i>Mental Health and Primary Care: A Changing Agenda</i>, Royal College of Psychiatrists, Gaskell, 1993.</p>

Schizophrenia	Psychotic illness; may lead to bewilderment and fear; daily living and social acceptance difficulties
Budget	Hospital and community services, prescribing
Reason for choosing the condition as a tracer	
<ul style="list-style-type: none"> ◆ On average each GP has only 2-3 patients on their list; the practice needs to understand enough to make good purchasing decisions while acknowledging that treatment will be by others and contact rare ◆ Involvement of users and carers in decisions about treatment is especially relevant ◆ Both Community Care and Health of the Nation key areas ◆ GP should know about the health authority's mental health strategy and how it has developed with the provider trust over a long period, to make sure the fundholder purchasing does not put this at risk 	
Good purchasing guide	
<ul style="list-style-type: none"> ◆ Approximately one-third of people with schizophrenia experience only one episode, another third have recurrent episodes and a further third experience it as a chronic condition they have to live with all the time ◆ Not treated within general practice; referrals are to psychiatric consultants with longer-term treatment (eg, drug regimes, individual and family assessment, support) often delivered by CPNs ◆ Psychiatric practice tends to be biased towards prescribing drugs; antipsychotic drugs (major tranquillisers) are often used, and can have adverse effects which are dose-related, meaning that treatment programmes should be reviewed regularly ◆ CSAG provides a 20-element protocol purchasers can use to audit provision – purchasers should consider writing a requirement into contracts to use this ◆ The practice should be reviewing at least annually what service is being delivered to each patient for whom it is purchasing services ◆ The practice should be consulting users/carers on what services they want 	
Key results from Audit Commission site visits	
<ul style="list-style-type: none"> ◆ Changes in approach introduced since fundholding (7 per cent of 29 fundholders) ◆ Disease register held (66 per cent; 48 per cent held active registers without having to specially interrogate the computer system to answer the question) ◆ Clinical audit results from providers seen (4 per cent) ◆ Written guidelines in use (4 per cent) ◆ Consulted on what services people with schizophrenia and families want (0 per cent) ◆ Review patients registered with the practice at least annually (45 per cent) ◆ Private sector used (0 per cent) 	
References	
<p>'Schizophrenia (Vols 1&2), Clinical Standards Advisory Group, HMSO, 1995. Jenkins R, Field V & Young R, <i>The Primary Care of Schizophrenia</i>, DoH, HMSO, 1992.</p>	

Leg ulcers	Tissue breakdown on leg/foot
Budget	Hospital and community services, community nursing, prescribing, practice nurses (staff budget)

Reason for choosing the condition as a tracer

- ◆ Though a common problem for many elderly people, GPs often do not know how, nor how effectively, district nurses are treating leg ulcers
- ◆ Important teamworking issue, involving links between practice and district nurses about who does what, and where
- ◆ One of the key areas in which the new nurse prescribers are involved, making the control of costs more obvious to nurses and allowing them to avoid wasting time by making an assessment, then going to the GP to ask for a prescription for the appropriate dressing, before going back to the patient to carry out treatment
- ◆ Time spent by district nurses on assessment and treatment constitutes a large part of the community nursing staff budget
- ◆ Dressings for leg ulcers form one of the biggest elements of the drugs budget, and there are a number of different types available differing in price
- ◆ There is a knock-on effect to the practice staff budget as more practice-based clinic treatment of leg ulcers begins to develop, involving practice nurses as well as district nurses

Good purchasing guide

- ◆ Ulcer problems are often recurring and episodes can last a long time, with wounds/ulcers open for a year or more and half of patients seen at least twice weekly and more than 20 per cent treated daily; yet appropriate treatment can clear ulcers away
- ◆ Using four-layer compression bandages (or elastic compression), with non-absorbent dressings changed no more than weekly, has led to recovery claimed for a high percentage of patients (60-80 per cent within a year) where little healing occurred before
- ◆ Doppler ultrasound equipment is needed for assessment of the ulcer and training of nurses; healing should be monitored by photography or tracings
- ◆ While the four-layer dressings are expensive in themselves, reduction in overall dressings used (due to recoveries) can lead to overall drug budget savings, plus savings in nurse time
- ◆ Nurses need training in the correct use of these techniques
- ◆ Most GPs leave the treatment of leg ulcers to district nurses, but they should know what types of dressing are being used and how much they cost; practices should have discussed and agreed the best mix of treatment by district nurses, practice nurses and at home or in clinics
- ◆ Practices should have considered devolving responsibility for a notional dressings budget to the senior nurse, since nurses' decisions are the main causes of variation in spend
- ◆ Practices should expect district nurses to record the amount of time they are spending on leg ulcer treatment and be asking for clinical audit information about the outcome of treatments; nurses should be using tracing or photography to record progress

Leg ulcers continued

Key results from Audit Commission site visits	
◆	Changes in approach introduced since fundholding (38 per cent of 29 fundholders)
◆	Disease register held (41 per cent; 34 per cent held active registers without having to specially interrogate the computer system to answer the question)
◆	Clinical audit results from providers seen (14 per cent)
◆	Written guidelines in use (29 per cent)
◆	Use Doppler ultrasound for assessment (55 per cent of 1,174 fundholders surveyed)
◆	Four-layer compression bandages (59 per cent)
◆	Tracing or photography to monitor changes (25 per cent)
◆	Private sector used (3 per cent of 29 fundholders)
References	
Bosanquet, N et al, 'Community Leg Ulcer Clinics: Cost Effectiveness', <i>Health Trends</i> , 1993, 25(4):146-148.	

Diagnostic imaging	X-rays, ultrasound, magnetic resonance imaging (MRI), etc; helps diagnose and monitor patients
Budget	Hospital and community services, tests

Reason for choosing the condition as a tracer	
◆	Radiology services comprise about half of the diagnostic tests and investigations budget, and form about 1 per cent of an average fundholder's total fund budgets
◆	Many requests are made inappropriately, and not within guidelines issued by the Royal College of Radiologists. Will holding a budget make GPs make more appropriate requests?
◆	There is an increasing tendency to provide services more locally, both within the practice and at community hospitals; what do patients think of this, and how cost effective is this trend?
Good purchasing guide	
(a) Unnecessary X-rays	
◆	The ability to audit referral appropriateness will depend on how information is recorded; practices with non-attributable block contracts will have little information, some record individual referrals but not the type of examination, some record both the individual and some degree of test detail (eg, radiology A, B,...F), but few record individual test types
◆	Perhaps one-fifth of X-ray examinations are unlikely to yield useful information for patient management, and many GP requests run counter to Royal College of Radiologist guidelines; practices should have guidelines designed to avoid this
◆	Since all X-ray testing carries a risk of accumulating radiation, GPs should be warning patients requesting X-rays of the dangers of unnecessary X-ray examinations
◆	Radiology departments vary in the speed with which reports are sent to GPs; speed should be part of contract specifications and achievements monitored
(b) Hospital quality standards	
◆	Patients' views about the location of services, length of time waiting at the department, attitude of staff and communication of information are important
◆	Some departments restrict the range of examinations that GPs may request directly; however, GPs should have rights similar to those enjoyed by hospital consultants (joint Royal College of General Practitioners/RCR report)

Diagnostic imaging continued

Good purchasing guide continued
<p>(c) Community-based services</p> <ul style="list-style-type: none"> ◆ Many GP requests are for routine examinations which can be delegated to a radiographer to perform under a suitable protocol, and thus can be carried out wherever equipment is available ◆ Services are best provided where there are already outreach clinics in specialties which rely heavily on them; conversely, there is little point in holding orthopaedic outpatient clinics locally if many patients are then sent on to the hospital for an X-ray ◆ Most examinations are carried out in hospital departments, though a few practices now have basic X-ray and/or ultrasound equipment; cost effectiveness in relation to the rational development of testing facilities and equipment within the local area as a whole should be considered. There are examples of radiographers travelling to practices, or of practices contracting with private individuals ◆ The most common practice-based service is ultrasound, often operated by a GP. Direct GP use remains controversial, because of their limited experience. Equipment may be based in the practice but since ultrasound equipment is portable some practices contract with a travelling service (NHS or private) ◆ Equipment for other diagnostic imaging is probably too expensive to be installed in a practice. The fund will still need to contract with a major hospital for complex examinations such as fluoroscopy and angiography. Some GPs report delays or shortfalls in these services, and funds do have the option of using savings to help the hospital purchase equipment ◆ Medical X-rays are subject to stringent health & safety regulation, and if provided in the practice it is vital that staff are aware of, and adhere to, statutory requirements
Key results from Audit Commission site visits
<ul style="list-style-type: none"> ◆ Changes in approach introduced since fundholding (46 per cent of 29 fundholders) ◆ Clinical audit results from providers seen (7 per cent) ◆ Written guidelines in use (41 per cent); if not written, base referrals on Royal College of Radiologists (68 per cent) ◆ Private sector used (21 per cent)
References
<p>Audit Commission, <i>Improving Your Image</i>, HMSO, 1995. Royal College of Radiologists, <i>Making the Best Use of a Department of Clinical Radiology: Guidelines for Doctors</i>, (2nd edition), 1995. Charterhouse College of Radiographers, <i>Imaging Opportunities in Primary Care</i>, 1995. Royal College of General Practitioners, <i>Radiology and the Patients of GPs</i>, 1993.</p>

Appendix 5

Practice assessment criteria

Criteria used to rate fundholders' overall achievements described in Chapter 5.

A score of 1 was given where the practice had achieved each of the criteria listed below, and a 0 where not. For some criteria a score of 0.5 was given for partial achievement (for example, meeting three of the six purchasing requirements listed under benefit A1).

Each practice visited during the study was plotted on the visual map of achievements, using the fundholder's total score on each of the two dimensions – out of a maximum score of 12 on 'direct benefits' and 12 on 'management and networking'.

(A) Benefits to the practice's patients

1. Purchasing in line with good clinical practice – scoring 'yes' on the majority of these probes:
 - Cataract: base referral on visual ability not just acuity
 - Glue ear: employ watchful waiting
 - Back pain: refer to therapist within two weeks if not improving
 - Anxiety/depression: agreed drug policy exists
 - Schizophrenia: at least annual review of each case
 - Leg ulcer: four-layer compression bandages used
2. Reduced waiting times in majority of specialties
3. Reduced follow-up outpatient visits in most specialties
4. Sees provider clinical audit results (for majority of tracer conditions)
5. Referral/prescribing variations between partners reviewed
6. Written guidelines in use for majority of tracers
7. Cataract day surgery rate at least at national average (37 per cent)
8. Day surgery requirements specified in contracts
9. Has bought economically (ie, more activity per pound than for which funded)
10. A direct access or outpatient clinic at the practice directly funded via fundholding
11. The practice manages waiting lists for non-urgent operations with local consultants' agreement
12. Introduced a practice formulary since becoming a fundholder

(B) Management and networking

1. Fundholder states that joint planning/liaison with health authority is occurring and worthwhile
2. The practice meets with other fundholders to share ideas
3. Liaise with other fundholders to develop (at least) core contracts
4. GPs meet with consultants during contract negotiations
5. Patient satisfaction with secondary care assessed via questionnaire
6. Patients involved in fund decisions – eg, via patient participation groups
7. Patients informed about fund issues – eg, via newsletter
8. Purchasing plan based on practice population needs assessment
9. Plan explains how the fund will be spent and why priorities were chosen
10. Fund manager states they are involved in the practice as a whole
11. Spreadsheets used monthly to bring together activity and spend against budget
12. Contracts are well drafted against good practice criteria

Appendix 6

Contract types used by fundholders

The most common type of contract used by fundholders with their main acute provider is cost per case. Different contract types have advantages and disadvantages in different circumstances.

Block

Purchaser pays a lump sum for any activity within the year (used by 16 per cent of 1,217 fundholders as the basis for the contract with their main acute provider).

Advantages to fundholders: simplicity attractive in first year; data often unreliable at first so safer – avoids being overspent; only one invoice to deal with each month; less difficult to price; copes with random variations – risk of over- and underactivity shared between fundholder and provider; attractive to those fundholders concerned about 'fast-tracking'; some providers more willing to make service improvements in return for regular income.

Disadvantages to fundholders: reduces potential for making savings; tends to maintain status quo; very general contracts lack specificity on quality/outcomes; does not reduce referral-entry administrative load – the practice still has to input each patient referral on to the system.

Cost and volume (C&V)

Purchaser pays a lump sum for activity up to a defined level (eg, 80 per cent of anticipated annual activity) and then pays for each case individually (31 per cent of fundholders)

Advantages to fundholders: more control over budget than cost per case; more leverage over provider than block; helps build good relationship with main provider as it shows commitment of large percentage of budget.

Disadvantages to fundholders: greater administrative burden than block contracts as referral rates have to be monitored; if based on poor information, and contracted levels exceeded, then fundholder makes financial loss.

A cost and zero volume contract is a way of getting the leverage and flexibility of a cost per case contract, but added to the advantages of an annual contract, which can specify uniform quality standards for all patients.

Cost per case (CPC)

Each individual episode is paid for separately and there is no commitment to annual activity rates (44 per cent of fundholders):

Advantages to fundholder: GPs can refer widely; offers greatest savings potential; pay only for work done; care can be tailored to individual needs; leverage over providers because of the threat of easy switching; allows easy switching within year if providers do not deliver.

Disadvantages to fundholders: high information requirements – sometimes limited by flexibility of fundholding software; high administrative costs; may need to pay premium prices to gain access to services; can provide incentive for fast tracking; providers may give priority to other purchasers offering lump sums.

Combination of contract types (10 per cent of fundholders)

There are many variants within these basic types – for example, over half of those with cost per case or cost and volume contracts pay for each individual outpatient attendance, 19 per cent make a single payment for each treatment and the associated outpatient attendances, while 23 per cent pay for outpatients as a block. Making single payments for a treatment and associated outpatients is more common in the earlier waves.

Source: Audit Commission

Notes and References

1. NHS Executive Letters, *Developing NHS Purchasing and GP Fundholding*, EL(94)79; and *An Accountability Framework for GP Fundholding*, EL(95)54; Welsh Office, *Accountability Framework for GP Fundholding in Wales*.
2. Audit Commission, *Briefing on GP Fundholding*, HMSO, 1995. Full details of exactly what services are within the scope of the scheme can be found in NHS Executive, *General Practice Fundholding: A Primary Care Led NHS*, DoH, 1995.
3. 4,000 in Wales.
4. No limit in Wales.
5. There are currently 51 total purchasing pilots in England and Wales. Technically they differ from standard and community fundholding because they are experiments whereby the health authority remains accountable for the money involved that falls outside that governed by the standard fundholding regulations. They are not the same as multifund arrangements, which are based on standard fundholding, but they do include an element of shared management. These pilots are subject to an extensive evaluation programme funded by the NHS Executive and are not considered further in this report.
6. The National Audit Office has examined some aspects of the management of the scheme by the NHS Executive, regions and FHSAs, but not the management of funds by fundholders, and the report relies for its assessment of the value of the scheme on fundholders' views (National Audit Office, *General Practitioner Fundholding in England*, 1995, HMSO). The most comprehensive description of the early years of fundholding is by H Glennester et al (*Implementing GP Fundholding: Wild Card or Winning Hand?*, OUP, Buckingham, 1994), but again, this relies on fundholders' own assessments of their achievements rather than on any measurement of how frequently different benefits have occurred. The King's Fund *Purchasing Innovations* database also lists fundholders' own descriptions of their achievements.
7. Dixon, J & Glennester, H, 'What Do We Know About Fundholding in General Practice?', *British Medical Journal*, 311: 727-30, 1995.
8. The study was carried out before the new health authorities came formally into being in April 1996. Throughout the report the term 'FHSA' (family health services authority) has been used when referring specifically to functions associated with the management of the fundholding scheme up to April 1996; 'district health authority' when referring to the authority which was responsible for purchasing care on behalf of non-fundholding GPs but which had no formal responsibilities relating to the management of the fundholding scheme; and 'health authority' has been used to refer to the new authorities.

9. Source: Audit Commission analyses of the NHS Executive's GMS database of 9,687 practices in England; fundholding Waves 1-3 compared with non-fundholders in 1993/94.
10. As measured by Jarman UPA, the most readily available index of deprivation. In one FHSA where another measure was available for each fundholder - Townsend score - the two were very closely correlated. There are, of course, exceptions to this rule, as described in the Audit Commission's earlier paper, *Briefing on Fundholding* – in the rural south west, for example, coverage is low, and in one FHSA visited fundholding was actually slightly more likely in areas of higher deprivation; while in some large cities, including Leeds and Birmingham, the proportion of the population covered by fundholding is up to as high as the national average.
11. Leese B, Drummond M & Hawkes R, *Medical Technology in General Practice in the UK: Will Fundholding Make a Difference?*, University of York, 1994. Leese B & Bosanquet N, 'Family Doctors and Change in Practice Strategy Since 1986', *British Medical Journal*, 310:705-8, 1995.
12. Source: Audit Commission analyses of the NHS Executive's GMS database 1993/4; results for 9,687 practices in England.
13. Baker, R & Thompson, J, 'Innovation in General Practice: Is the Gap Between Training and Non-training Practices Getting Wider?', *British Journal of General Practice*, 45: 297, 1995.
14. Eg, Coulter, A, 'Evaluating General Practice Fundholding in the United Kingdom', *European Journal of Public Health*, 5: 233-9, 1995; Ham, C & Shapiro, J, 'The Future of Fundholding', *British Medical Journal* 310:1150-1, 6 May 1995; Committee of Public Accounts, *General Practitioner Fundholding in England* (27th report), HMSO, 1995; Treasury Minute on the 27th report from the Committee of Public Accounts 1994/95, HMSO, 1995.
15. Audit Commission, *Briefing on GP Fundholding*, HMSO, 1995; *Fundholding Facts*, HMSO, 1996.
16. Department of Health, *Working for Patients*, 1989.
17. Practices may claim reimbursement of up to £25,000 (75 per cent) for the costs of computing hardware, with running costs met from the management allowance.
18. Oxford RHA has developed bolt-on software to help with waiting list management, with a number of commercial systems also available.
19. Patients often lack information about when they will be called to hospital and what will happen to them (Oxford and Anglian RHA, *Life In the Slow Lane: The Experience of Waiting for Treatment*, 1995).
20. Source: Audit Commission 1995/96 survey of GP fundholders.
21. Source: Audit Commission site visits.
22. A database of this kind of diverse achievement has been established recently (King's Fund, *Purchasing Innovations Database*).

23. Source: Audit Commission 1995/96 survey of fundholders.
24. Source: Audit Commission site visits.
25. Smith, R, 'Purchasing in Practice', *Health Service Journal*, 1 April 1993, pp 28-9.
26. *NHS Executive Letter, Priorities and Planning Guidance for the NHS: 1995/96*, EL(94)55; *Improving the Effectiveness of the NHS*, EL(9474).
27. Throughout the report, fundholders' achievements are related to a number of specific clinical 'tracers'. These were chosen to cover the main areas of the fund, a high proportion of the total spend, and a range of different purchasing issues. They were selected in discussion with doctors and are listed in Appendix 4.
28. Source: Audit Commission 1995/96 survey of 1,249 fundholders.
29. Source: Audit Commission site visits. The percentages given in the section on effectiveness are based on a sample of 29 fundholders.
30. Eg, Coulter, A & Bradlow, J, 'Effect of NHS Reforms on General Practitioners' Referral Patterns', *British Medical Journal*, 306:433-7, 1993.
31. Source: Audit Commission 1995/96 survey of 1,249 fundholders.
32. Institute of Medicine Guidelines for Clinical Practice, cited in Barker, R & Fraser, R C, 'Development of Review Criteria: Linking Guidelines and Assessment of Quality', *British Medical Journal*, 311: 370-3, 1995.
33. McKee M & Clarke A, 'Guidelines, Enthusiasms, Uncertainty and the Limits to Purchasing', *British Medical Journal*, 310:101-4, 1995.
34. Howie, J et al, 'Evaluating Care of Patients Reporting Back Pain in Fundholding Practices', *British Medical Journal*, 309:705-710, 1994; Howie, J G R et al, *General Practice Fundholding: Shadow Project – An Evaluation*, Department of General Practice, University of Edinburgh, 1995.
35. Potamitis T, et al, 'General Practitioners' Awareness of Different Techniques of Cataract Surgery: Implications for Quality of Care', *British Medical Journal*, 308: 1334-5, 1994.
36. Source: Audit Commission 1995/96 survey of fundholders.
37. Audit Commission, *A Short Cut to Better Services: Day Surgery in England and Wales*, HMSO, 1990; *Children First: A Study of Hospital Services*, HMSO, 1993.
38. Source: Audit Commission site visits and 1995/96 survey of fundholders. The most recent day surgery targets are given in NHS Executive Letter, *Priorities and Planning Guidance for the NHS: 1995/96*, EL(94)55; while trust performance is given in the NHS Executive's *NHS Performance Guide 1994/95*. In Wales targets are set in *Caring for the Future*.
39. Source: Audit Commission 1995/96 survey of fundholders.
40. Source: Audit Commission site visits.
41. Source: Audit Commission site visits.
42. Audit Commission, *A Prescription for Improvement: Towards More Rational Prescribing in General Practice*, HMSO, 1994.

43. Bradlow, J and Coulter, A, 'Effect of Fundholding and Indicative Prescribing Schemes on General Practitioner Prescribing Costs', *British Medical Journal*, 307:1186-9, 1993; Stewart-Brown, S et al, 'The Effects of Fundholding in General Practice on Prescribing Habits Three Years After Introduction of the Scheme', *British Medical Journal*, 311:1543-7, 1995; Maxwell, M et al, 'General Practice Fundholding: Observations on Prescribing Patterns and Costs Using the Defined Daily Dose Method', *British Medical Journal*, 307:1190-4, 1993; Wilson R P H, Buchan I & Walley T, 'Alterations in Prescribing by General Practitioner Fundholders: An Observational Study', *British Medical Journal*, 311:1347-50, 1995; Whynes D K, Baines D L & Tolley K H, 'GP Fundholding and the Costs of Prescribing', *Journal of Public Health Medicine*, 3:323-9, 1995.
44. Audit Commission, *A Prescription for Improvement: Towards More Rational Prescribing in General Practice*, HMSO, 1994.
45. Analysis of variance, both main effects (type of practice and year) significant; post-ANOVA means tests were used to check for differences within the main effects.
46. Source: Local auditor survey of fundholders' accounts 1994/95.
47. Thomas K, Nicholl J & Coleman P, 'Assessing the Outcome of Making It Easier for Patients to Change General Practitioner: Practice Characteristics Associated with Patient Movements', *British Journal of General Practice*, 45: 581-6, 1995.
48. Anglia and Oxford RHA, *Pulling the Right Levers*, 1994.
49. National Association of Health Authorities & Trusts (NAHAT), *Reshaping the NHS: Strategies, Priorities and Resource Allocation*, Research Paper 16, 1995.
50. NHS Executive *The Operation of the NHS Internal Market: Local Freedoms, National Responsibilities*.
51. Huntington J, *Managing the Practice: Whose Business?*, King's Fund/Radcliffe, Abingdon, 1995.
52. 34 fundholders were asked this question during Audit Commission site visits. Similar results are reported by a larger-scale survey in *Fundholding*, 10 January 1996, pp18-19.
53. The scale of the administrative task can be illustrated from information contained in the Birmingham Multifund's 1994/95 Annual Report, where the average administrative workload per fund unit included:

Contract prices entered into computer	2,465
Contracts created	40
Patient details entered into computer	9,657
Age-sex registers set up	2
Fundholding software upgrades	1
Referrals input	9,121
Accruals input	8,501
Committed referrals	9,027
Invoices checked	1,204

54. NHS Executive, *Efficiency Scrutiny – General Practice*.
55. Source: Audit Commission 1994/95 survey of fundholders.
56. More details are described in Audit Commission, *Briefing on GP Fundholding*, HMSO, 1995; and *Facts About Fund and Practice Management*, HMSO, 1995.
57. Huntington J, *Managing the Practice: Whose Business?*, King's Fund/Radcliffe Medical Press, Abingdon, 1995.
58. Source: 1994/95 Audit Commission survey of 1,308 fund managers.
59. NHS Executive, *GP Fundholding Consortia*, EL(92)92.
60. Including agencies and consortia – which make up only a small proportion of the grouped organisations in existence (source: Audit Commission survey). There is no central register of multifunds.
61. The word 'savings' was used by the multifunds although under the regulations the concept is invalid – at the time, the management allowance was not a budget, but a centrally held fund against which fundholders could claim for agreed expenditure.
62. Source: Audit Commission survey of multifunds and site visits.
63. Source: Audit Commission survey of 2,223 practices 1994/95.
64. Source: 1994/95 and 1995/96 Audit Commission surveys of 1,225 and 1,249 fundholders.
65. NHS Executive, Anglian and Oxford, *Pulling the Right Levers: How Health Authorities and GP Fundholders Aim to get the Best Out of Providers*, 1994.
66. Of 1,256 fundholders surveyed in 1995/96. A closely similar result (13 per cent) was found by the Consumer Association, 1995 NHS Survey, which found that non-fundholding GPs were half as likely to form such a group.
67. Audit Commission, *What Seems To Be the Matter: Communication Between Hospitals and Patients*, HMSO, 1993.
68. Source: Audit Commission site visits.
69. Royal College of Nursing, *The GP Practice Population Profile: A Framework for Every Member of the Primary Healthcare Team*, 1993.
70. Source: the fundholding plans of 30 practices visited by the Audit Commission were made available for evaluation.
71. Source: 24 contracts made available during site visits were assessed, using a checklist developed for the Audit Commission by an expert in contract law.
72. Source: Audit Commission 1994/95 survey of fundholders.
73. Source: Local auditors' analyses of fundholder final accounts; the same pattern was found in 1993/94 (more details in Audit Commission, *Briefing on GP Fundholding*, HMSO, 1995).
74. Sundram S & Minchin C, 'Summarise Your Fund Data', *Fundholding*, 21 February 1994, pp34-5.

75. NHS Executive Letters: EL(94)79, *Developing NHS Purchasing and GP Fundholding*; EL (95) 54, *An Accountability Framework for Fundholding*; and EL(95)24, *The Creation of the New Health Authorities*. Welsh Office, *Accountability Framework for GP Fundholding in Wales and Fresh Start* (roles and relationships of the new HAs in Wales).
76. Source: local audits by external auditors appointed by the Audit Commission.
77. Source: Audit Commission site visits.
78. Statutory Instrument 567, National Health Service, England and Wales: *The National Health Service (Fundholding Practices) Regulations, 1993*.
79. Includes invoicing staff, internal audit and others spending more than half their time on fundholding; costs are pro rata to the time spent on fundholding duties, and include employers' add-on costs.
80. Source: 29 plans made available during Audit Commission site visits were assessed .
81. Source: local audits at 25 FHSAs.
82. DH/NHS Management Executive, EL(94)84, *General Practice Fundholding: Guidance on Setting Budgets for 1995/96*. The original intention was that fundholders' budgets should be set by weighted capitation in a similar way to health authorities' allocations – ie, by a formula that takes account of the number of patients weighted for the likelihood of those patients needing to use NHS acute care. But the task of devising weightings for small populations and for a limited list of services has proved to be technically difficult (York University, *Weighted Capitation Budgets for GP Fundholders*, 1994). Age and gender were able to explain only a little over one-quarter of the variation in actual GP referral patterns. Information about patients' health status, socio-economic status and the availability of hospital services was able to explain only a further 20 per cent of the differences in actual GP referral rates and was deemed too unreliable to use as part of a formula. Capitation benchmarks are currently calculated for inpatient and daycase treatments only, and not for outpatient or community services. In Wales the capitation formula includes, for example, deprivation information, demography and relative morbidity (Welsh Office, *Guidance on Budget Setting in Wales*).
83. Source: Audit Commission site visits.
84. Bradlow J, Coulter A & Brooks P, *Patterns of Referral*, University of Oxford Health Services Research Unit, 1992; Brogan, S, 'Who Says Fundholders are Loaded?', *Health Service Journal*, 4 March 1993, p22.
85. The NHS Executive has agreed that in some areas inaccurate data has led to faults in the resource allocation process (Committee of Public Accounts, *General Practitioner Fundholding in England* (27th report), HMSO, 1995, pXI).
86. The tendency to overspend varies in a similar way, ranging from no overspends in some FHSAs, to two authorities where four in every five

fundholders overspend. Fundholders are not required to carry forward overspends into the next year - regions must meet the cost of overspends and the slate is wiped clean for the start of the next year. Locally, FHSAs vary in the action they take within year if fundholders are heading for overspends - some take no action while others expect the fundholder to reduce referrals. The 1989 White Paper, *Working for Patients*, stated that a practice overspending by 5 per cent or more would be the subject of a thorough audit by the FHSAs, 'including a review by other doctors of any medical judgements which seem to be causing budgetary problems'. Overspends in excess of 5 per cent for two successive years might result in ejection from the scheme. These proposals were not subsequently incorporated into the fundholding regulations and, although some health authorities use mentor fund managers or GPs to help other funds heading for overspends seek solutions, most do not. Health authorities can develop budget management software for fund managers to help give early warning of overspends, allowing within-year corrective action, but only two of 10 visited had done this.

87. Dixon, J et al, 'Distribution of Funds Between Fundholding and Non-fundholding Practices', *British Medical Journal*, 309: 30-4, 1994.
88. Brogan, S, 'Who Says Fundholders are Loaded?', *Health Service Journal*, 4 March 1993, p22.
89. NHS Executive regulations allow fundholders to retain any audited underspends on their budgets, while overspends must be met by the funding body. Savings may be carried over financial years; currently for up to four years. Statutory Instrument 567, National Health Service, England and Wales: The National Health Service (Fundholding Practices) Regulations, 1993.
90. FDL(94)48 and National Audit Office, *General Practitioner Fundholding in England*, HMSO, 1995. In Wales, Welsh Office letter, 13 May 1994.
91. Source: Audit Commission evaluations of 30 fundholding plans made available during Audit Commission site visits to fundholders across 10 FHSAs.
92. Source: auditor information from 1,156 fundholders' end of year accounts across 80 FHSAs.
93. Source: 53 FHSAs visited by the Audit Commission or by local auditors.
94. Across England, fundholder underspends in 1993/94 totalled £64 million, about 3.5 per cent of budgets, but there is great variation between individual fundholders. Levels of savings and an analysis of what savings have been spent on have been given in Audit Commission, *Briefing on GP Fundholding*, HMSO, 1995.
95. Committee of Public Accounts, *General Practitioner Fundholding in England* (27th report), HMSO, 1995.
96. NHS Executive, HSG(94)56, *GP Fundholding Management Allowances*.
97. 'GP fundholders are statutorily accountable to the NHS Executive (through its regional offices) but day-to-day management contact for

- fundholders will normally be through the new health authorities', NHS Executive Letter EL(95)54.
98. NHS Executive Letter, *Developing NHS Purchasing and GP Fundholding*, EL(94)79.
 99. Committee of Public Accounts, *General Practitioner Fundholding in England* (27th report), HMSO, 1995
 100. Source: 1,308 fundholders surveyed by the Audit Commission 1994/95.
 101. DH/NHS Management Executive, EL(94)79, *Developing NHS Purchasing and GP Fundholding*.
 102. Source: Audit Commission 1994/95 survey of fundholders.
 103. DH/NHS Management Executive, EL(95)24, *The Creation of the New Health Authorities*.
 104. Audit Commission, *Briefing on GP Fundholding*, HMSO, 1995; National Association of Health Authorities & Trusts (NAHAT) survey of 107 trusts.
 105. Source: Audit Commission site visits.
 106. NHS Executive, *GP Fundholding Cost Per Case Activity* (introduction of a 6-week invoicing deadline from 1 April 1994), FDL(93)77.
 107. Committee of Public Accounts, *General Practitioner Fundholding in England* (27th report), HMSO, 1995.
 108. The criteria on which fundholders have been rated do not constitute a scientific index and the measures are not fully exhaustive, since some aspects of management and patient benefits are difficult to measure (the details are in Appendix 6). But the ratings are based on extensive measurement and discussion within each practice, and provide performance indicators which raise many questions.
 109. The concept of a primary care-led NHS has been described by the health secretary as turning the NHS system upside down in order to see it from the patient's perspective (speech at Conservative Party conference, October 1995).
 110. Cammish, R & Keough, M, 'A Strategic Role for Purchasing', *The McKinsey Quarterly*, No.3, New York, 1991.
 111. Eg, GMSC, *Which Way Forward?*, BMA, 1994; Henry S, 'A New Way Forward for all GPs', *Fundholding*, 21 May 1994, pp33-4; Irvine, D & S, *The Practice of Quality*, Radcliffe Medical Press, Oxford, 1996; Welsh Office, GP fundholder/health authority performance agreement, DC81, 1996.
 112. Smith, R, 'Purchasing in Practice', *Health Service Journal*, 1 April 1993, pp28-9.

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