

# Commissioning in health, education and social care

Models, research bibliography and in-depth review of  
joint commissioning between health and social care  
agencies

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**Commissioning in health, education and social care: Models, research bibliography and in-depth review of joint commissioning between health and social care agencies**

**TECHNICAL REPORT**

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The results of this systematic review are available in two formats:

## REPORT

Includes the background, main findings, and full technical details of the review

## DATABASES

Access to codings describing each research study included in the review

This report can be downloaded at: <http://eppi.ioe.ac.uk/reel/>

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## **List of abbreviations**

ADASS	The Association of Directors of Adult Social Services
AEI	Australian Education Index
ASSIA	Applied Social Science Index
BEI	British Education Index
DOH	Department of Health
EMOs	Educational Management Organisations
EO	Economics of Organisation
GP	General practitioner
HMIC	Health Management Information Consortium
HMOs	Health Management Organisations
IBSS	The International Bibliography of the Social Science
IPC	The Institute of Public Care
JSNA	Joint Strategic Need Analysis
NHS	National Health Service
NIE	New Institutional Economics
NIHR SDO	The National Institute for Health Research Service Delivery and Organisation programme
NOMS	National Offender Management Service
PBC	Practice-Based Commissioning
PCGs	Primary Care Groups
PCTs	Primary Care Trusts
SSCI	Social Science Citation Index
WoE	Weight of Evidence

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# Executive summary

## Background

The way that public services are organised and work has changed considerably over the last 25 years. One of the main changes has been to divide the function of public agencies into service purchasers which ‘commission’ or ‘purchase’ services on behalf of the public and service providers which provide the services. This change has been introduced across all public sectors in many different countries.

There have been a number of ‘reviews’ of specific types of commissioning in the health care sector.<sup>1-5</sup> But there do not appear to have been any comprehensive systematic reviews of the research evidence on the impact of commissioning and/or reviews that consider the models of commissioning used and evidence about impacts across different sectors.

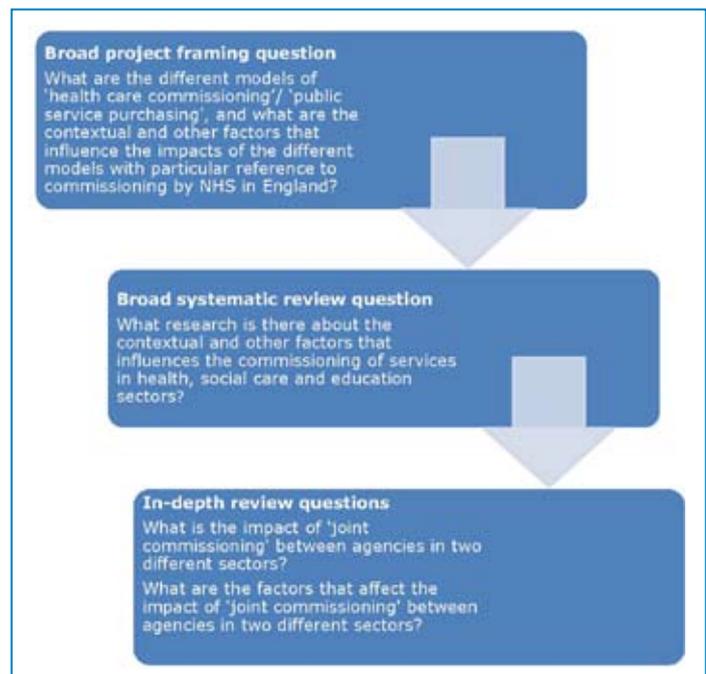
## Aims

This project began with a very broad review question that was focused as the review progressed (see Figure 1).

## Methods

The project was completed in three stages consistent with the research questions addressed.

**Figure 1:** Review process of the project



A scoping literature review and an online stakeholder questionnaire on models and theories of commissioning provided information on practices, and models and theories of commissioning.

The systematic review questions were addressed using systematic review methods:

- Comprehensive and systematic searching for empirical research evidence on the impact of commissioning using multiple sources.
- The selection of studies for the review based on pre-specified criteria.

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\* All footnotes refer to the studies in Chapter 7: References, which start on page 51

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- Selection of a subset of studies for inclusion in the in-depth review that address the question of the impact of joint commissioning between health and social care agencies and factors that affect impact.
- Detailed data extraction and quality assessment of the selected subset of studies.
- Narrative synthesis of impacts and factors affecting the impact of joint commissioning between health and social care agencies.

## Results

### Models

Commissioning as a form of praxis draws on and or expresses a range of concepts and ideas principally from three areas:

- The process of commissioning;
- The role of markets and competition;
- Commissioning relationships.

Any discussion, analysis or policy on commissioning may focus on one or more of these aspects but it would appear to be fairly rare to find literature that integrates all three.

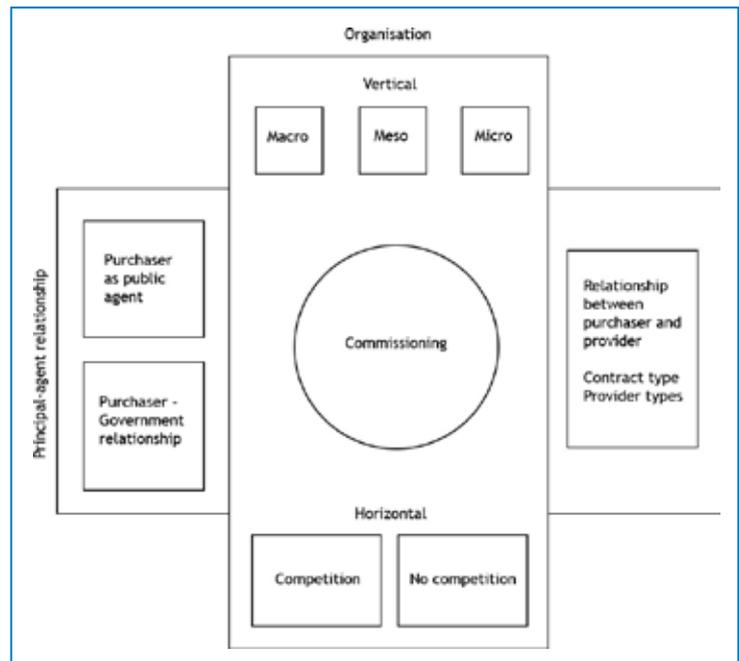
There seems to be a common idea of the process of commissioning that operates across the public and private sectors internationally. That is of a staged process within which certain sub-stages or activities take place. This process generally has four stages:

- Analyse - for example needs assessment;
- Plan - for example develop service specification;
- Do - for example manage contracts/market;
- Review - for example monitoring performance.

Policy and practice discussion also focuses on the organisation of commissioning, or more specifically, who does the commissioning at what level. It is argued that these policy initiatives, whilst usually not explicitly linked to any underlying theory or concept of

commissioning, can be analysed or understood by reference to the analytical framework put forward by Robinson and colleagues,<sup>6</sup> which is illustrated in Figure 2.

**Figure 2:** An analytical framework for strategic purchasing (after Robinson and others, 2005<sup>6</sup>)



This analytical framework provides a way in which different models or types of commissioning can be identified and compared. This approach is illustrated in the main report with reference to the 'practice-based' and 'levels' of commissioning literature.

### Systematic review findings

Six hundred research studies about the impact of commissioning were identified for the map. This is a far greater number of studies than has previously been identified and is a considerable resource for additional review and synthesis work on commissioning.

Of these, 446 were in health, 149 in social care/services and 59 in education. At least half of the studies were from the UK. The studies included appear to cover a range of 'types' or aspects of commissioning including:

- fund holding;
- primary care trusts;
- commissioning for older people, in mental health, in children's services;

- all stages of the commissioning process.

### ***In-depth review***

Twenty-five studies were identified that investigated the impact of joint commissioning between commissioners in different sectors. With one exception all studies were from the UK.

### ***Impact***

The quality of the studies that answered questions relating to the impact of joint commissioning was judged overall to be low. This means that we had little confidence that the impacts claimed for joint commissioning were in fact 'caused' by joint commissioning and not by some other factor not investigated or controlled for in the studies.

The positive impacts of joint commissioning perceived by study respondents identified from studies included this review can be summarised as:

- reduced duplication of services and cutting out waste;
- saved money;
- provided better services;
- improved in working relationships and efficiency;
- improved staff morale and commitment;
- improved patient outcomes.

The negative impacts of joint commissioning perceived by study respondents identified from studies included this review can be summarised as:

- increased transaction costs;
- staff demotivation and decreased job security;
- the 'takeover' of one sector by another rather than partnership between them.

### ***Factors affecting impact***

The quality of the studies that answered questions about the factors that affected the impact of joint commissioning was judged overall to be medium. This means that we

are reasonably confident that the factors identified in the research do have an effect on joint commissioning. The factors affecting impact can be divided into four linked categories:

#### a) Inputs

- leadership;
- prior history of working together;
- resources.

#### b) Context

- geographical boundary issues;
- policy initiatives;
- legal issues.

#### c) Internal (within each separate agency)

- communication;
- accountability;
- management of incentives;
- information management;
- Organisational structure.

#### d) Relationship between partners

- Communication;
- trust and understanding;
- shared goals, culture and priorities;
- integration of systems;
- partnership dynamics.

## **Conclusions**

This project identified a far larger evidence base for service commissioning in health, education and social care than was previously known. The proposed loose typology of commissioning will if adopted make it easier for future primary and secondary research to identify which type or types of commissioning are being investigated. The in-depth review

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provides an exemplar case study of the future potential of using the research identified and included in the database.

The in-depth review on the impacts of joint commissioning between agencies in sectors identified a comparatively small number of studies, the quality of which was judged to be low. The evidence about the impacts of joint commissioning cannot therefore be regarded as compelling.

The evidence about the factors that affect commissioning was judged to be of better quality. On this basis it is argued that this evidence can provide some useful indications for policy makers and practitioners about the sort of things that need considering if any joint commissioning initiative is to be successful. The results highlight the importance of:

- trusting relationships between commissioners, and how these are built up over time by continuity of staff;
- Clarity over responsibilities and legal frameworks, particularly in the context of any shared or pooled financial arrangements;
- The importance of coterminosity between organisational geographical boundaries;

- The development of clear structures, information systems and communications between stakeholders.

Given the importance of joint working between local health boards and the new GP consortia proposed in 'Liberating the NHS',<sup>86</sup> it is clear that these findings have resonance for the development of structures and relations and practices in the new NHS commissioning landscape. Furthermore, and perhaps most importantly, the new reforms provide the opportunity for the conduct of much-needed rigorous evaluative research on the impacts of different forms of commissioning. However, in order to realise this, it is imperative that any proposed changes are introduced in such a way as to create the conditions for rigorous comparative evaluative research on a sufficient scale to begin to address questions about the impact of different types of commissioning.

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## CHAPTER ONE

# Background

### 1.1 Aims and rationale for the current review

The way that public services are organised and work has changed considerably over the last 25 years. One of the main changes has been to divide the function of public agencies into service purchasers who ‘commission’ or ‘purchase’ services on behalf of the public and service providers who provide the services. This change has been introduced across all public sectors in many different countries.

The broad aim of this research was to identify research evidence on ‘commissioning’ or ‘public service purchasing’ in the UK and other countries in order to investigate the factors which influence the impact of different approaches to public service purchasing and to identify lessons for health care commissioning policy and practice.

This evidence may be helpful in improving the practice of commissioning and/or undertaking better quality research on commissioning in the future.

### 1.2 Commissioning

One way of describing this change is to understand it as a change in the transactional relationship between the public whose needs are to be met and the public agencies whose role is to meet those needs<sup>7</sup>. Put simply, the role of the public agency has been separated into two parts. The primary responsibility of one part is ‘purchasing’ the services that the public needs and that of the other part is to provide those services.

A variety of terms are used to describe the processes or mechanisms used on the demand side of this new set of economic organisational arrangements, including ‘commissioning’, ‘purchasing’, ‘procurement’, ‘contracting’, ‘strategic purchasing’ and ‘competitive tendering’. ‘Health care commissioning’ has become a commonplace term used in both the policy and practice literature on health service organisation and management in the UK. However, there is no one standard definition of either the concepts or practices; rather the terms are used in a very general way to cover a set of processes, relationships, and structures which facilitate decisions or choices about the allocation of resources<sup>8</sup>.

In the context of health and social care, ‘commissioning’ includes assessing needs, setting priorities, allocating resources, influencing providers, involving patients and the public, minimising transaction costs and managing financial risk.<sup>1,9,10</sup> Similar processes are described for other public services.<sup>11</sup> However it has been suggested that internationally there is a high degree of variation in both the concept and practice of what might be called ‘health care commissioning’.<sup>12</sup> The international survey of ‘public procurement’ carried out by the International Research Study of Public Procurement (which included UK health service commissioning) also reported high levels of variation in models, economic organisation, practices, frameworks and management within and between different public sectors in different countries.<sup>13</sup>

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There are a number of apparently different definitions of ‘commissioning’ used in health and social care organisations, government bodies and public service entities. For example, the Audit Commission has defined commissioning as ‘the process of specifying, securing and monitoring services to meet people’s needs at a strategic level’.<sup>14</sup> This applies to all services, whether they are provided by a local authority, the National Health Service (NHS), other public agencies or the private or voluntary sectors. In education, commissioning is defined as ‘a cyclical process that happens strategically across a population as well as individually for a particular young person and family’,<sup>15</sup> and as a process for ‘deciding how to use the total resource available for children, young people, parents and carers in order to improve outcomes in the most efficient, effective, equitable and sustainable way’.<sup>16</sup> According to the Department of Health for England, ‘commissioning is the process by which primary care trusts (PCTs) secure best value and deliver improvements in health and care services, to meet the needs of the populations they serve’.<sup>17</sup>

The aims of the wider National Institute for Health Research (NIHR) Service Delivery Organisation (SDO) programme of which this project was a part were to: identify the principal approaches taken to ‘health care commissioning’ and wider ‘public service purchasing’; to identify the research evidence on these approaches to ‘health care commissioning’ and ‘public service purchasing’ in the UK and other countries; to investigate the contextual and other factors which influence the impact of the different approaches; and to identify lessons for health and social care commissioning policy and practice, primarily of relevance to the operation of the English NHS.

### **1.3 Why joint commissioning matters**

The in depth review reported here focuses specifically on ‘joint commissioning’. The health and social care needs of people are interconnected and the maintenance of health and well being requires effective co-ordination between health and social care agencies. However, in England, as in many other countries, it is argued that divisions between

health providers and social care providers have hampered such co-ordination. Since 1948, ‘sick people’ with health needs have received care free at the point of delivery through the NHS, while social care, including residential care for ‘frail people’ has been largely means tested, and paid for and delivered through local government. This separation has resulted in the development of parallel services with different organisational structures, geographic boundaries, planning cycles, methods of allocating resources and approaches to assessing performance.

Joint commissioning is one among a range of policy responses to a longstanding concern in health and social care in the UK that the health services provided through the NHS and the social care services provided through local authorities are poorly co-ordinated, while the needs of individuals, particularly older people and children, bear no relationship to the bureaucratic distinctions between the scope of different agencies. Particularly since the early 1970s, but arguably from the inception of the NHS in 1948, a series of measures have been introduced to improve the co-ordination and efficiency of health and social care at local level. Joint commissioning is one such approach.

In the last decade, the former Labour Government developed a vision of a system marked by far greater ‘integration’ of health and social care than had previously been the case in order far better to meet the needs of individuals requiring care and treatment. As early as 1998, the first Blair Government discussion document, *Partnership in Action*,<sup>18</sup> proposed a system with improved strategic planning, co-ordinated commissioning and joint delivery of services. It advocated the increased use of pooled budgets between NHS and local authorities, and lead commissioning to enable this. The 1999 Royal Commission on Long Term Care<sup>19</sup> reiterated many of these recommendations with further refinement in the *National Service Framework for Older People* in 2001.<sup>20</sup>

The creation of Primary Care Groups (PCGs) in 1997, followed by Primary Care Trusts (PCTs) in 2004, established local NHS agencies commissioning and providing health services to populations coterminous with local authority

boundaries, simplifying the process for collaboration on service provision. Since 2006, about 70 percent of PCTs have been coterminous with local authorities with social services responsibilities.

The White Paper of 2006, *Our Health, Our Care, Our Say*<sup>21</sup> stated that by 2008 all PCTs and local authorities were to establish joint health and social care teams to help with long-term needs. It proposed joint teams to support people with long-term conditions, the streamlining of budgets and planning cycles between PCTs and local authorities, a shared performance framework, joint assessment and inspection and more joint health and social care appointments. The 2008 NHS Next Stage Review laid out proposals for the reconfiguration of health services in England, with integrated teams of care providers working more in community settings.<sup>22</sup>

Alongside these policy statements, there have been a number of more specific initiatives to remove legal, administrative and financial barriers to greater service integration. The Health Act 1999, implementing the proposals of Partnership in Action, introduced a 'duty of partnership' on all NHS organisations (while the Local Government Act 2000 empowered local authorities to work more closely with health agencies). The Act created three mechanisms (initially known as Section 31 flexibilities under the Health Act 1999 and then Section 75 flexibilities under the NHS Act 2006) to allow:

- the pooling of budgets by health and local authority agencies to commission services for clients;
- the delegation of commissioning of health and social care services to a 'lead' agency;
- the integration of health and social care professionals into a single organisation.

These were designed to get health and social care agencies to work across existing organisational boundaries. The NHS Plan 2000 took this a step further with the creation of the Care Trust; a single statutory organisation with fully integrated health and social care functions. The Department of Health (2001) described the Care Trust as a way to 'create a stable organisational framework for long-term

service and organisational continuity and the kind of joined up personal contact needed to improve services.'<sup>20</sup> The establishment of Care Trusts was voluntary, but there were reserve ministerial powers to impose one where health and social services are perceived to be failing in their duty to integrate voluntarily.

Earmarked funding has been made available to promote integration. Examples linked to integration include:

- £300 million in 1997 to reduce 'winter pressures' on health and social care services, with a requirement that this be used to improve joint working;
- £650 million in 1998 over three years to promote integration between health and social care organisations with a focus on extending rehabilitation services and reducing 'unnecessary' hospital admissions and institutionalised care;
- £900 million under the NHS Plan 2000 to enable localities to develop integrated intermediate care services to promote independent living at home and reduce hospital admissions and to encourage pooled budgeting;
- ring-fenced funding of £520 million in 2008 to social services departments to support the implementation of the White Paper *Our Health, Our Care, Our Say* with more early intervention work with clients integrated with the NHS.

A number of policy initiatives either assumed a momentum towards, or were designed as extra levers to promote closer integration. These included:

- a Single Assessment Process, introduced in the NHS and social care organisations in April 2004, to unify the assessment of health and social care needs and introduce personal care plans;
- joint inspections of health and social services organisations by Commission for Health Improvement, the Audit Commission and the Social Services Inspectorate, with a joint inspection authority (the Care Quality Commission) established in 2009;

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- proposed Personal Health and Social Care Plans and integrated social and health care records (under the government White Paper in 2006, *Our Health, Our Care, Our Say*);
- a new local performance framework (under the Local Government and Public Involvement in Health Act 2007), establishing a duty on local authorities to undertake joint Strategic Needs Assessments for clients;
- the Commissioning Framework for Health and Wellbeing in 2007 that advocated joint commissioning of health and social care services;
- increasing emphasis on personalised models of care and an increase of choice and self-directed support and individualised budgets, with more people able to commission their own services and ‘in so doing create partnerships around themselves without the need for inter-agency working’.

The importance attached by government to improving the co-ordination of both commissioning and provision between the NHS and local authorities continued in the July 2010 White Paper, *Equity and Excellence: Liberating the NHS*.<sup>23</sup> The Coalition Government proposes establishing so called ‘health and wellbeing boards’ either within local authorities or within existing strategic partnerships between health and local government to take the lead on ‘joining up the commissioning of local NHS services, social care and health improvement’. These health and wellbeing boards allow local authorities to take a strategic approach and promote integration across health and adult social care, children’s services, including safeguarding, and the wider local authority agenda’ (para 4.17). The White Paper continues: ‘We will simplify and extend the use of powers that enable joint working between the NHS and local authorities. It will be easier for commissioners and providers to adopt partnership arrangements, and adapt them to local circumstances’ (para 4.18).

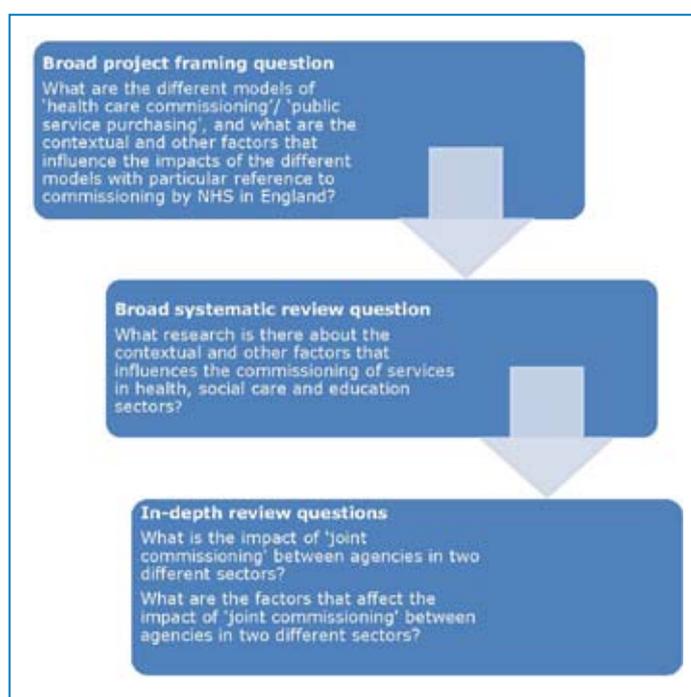
#### 1.4 Authors, funders, and other users of the review

This research project is funded by The National Institute for Health Research Service Delivery and Organisation (NIHR SDO) programme.

#### 1.5 Review questions

This project began with a very broad project framing question that was focused as the project/review progressed (see Figure 3).

**Figure 3:** Review process of the project



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## CHAPTER TWO

# Commissioning theory and practice

This chapter discusses the theory and practices of commissioning as evidenced by a scoping review of largely UK literature and responses to an electronic consultation exercise held for stakeholders in the UK. It is based on descriptions of commissioning given in the studies which investigated joint commissioning that are reviewed in the next chapter.

### **2.1 Methods for the scoping exercise**

The scoping review of the practice and theory of commissioning was carried out using two approaches: a literature review and a stakeholder survey.

#### **2.1.1 Literature review**

Identifying relevant studies

At this stage the literature review aimed to identify different concepts and meanings of 'commissioning' in different literatures on the topic. Searching for literature was guided by the following inclusion criteria:

To be considered in the initial scoping review, studies had to:

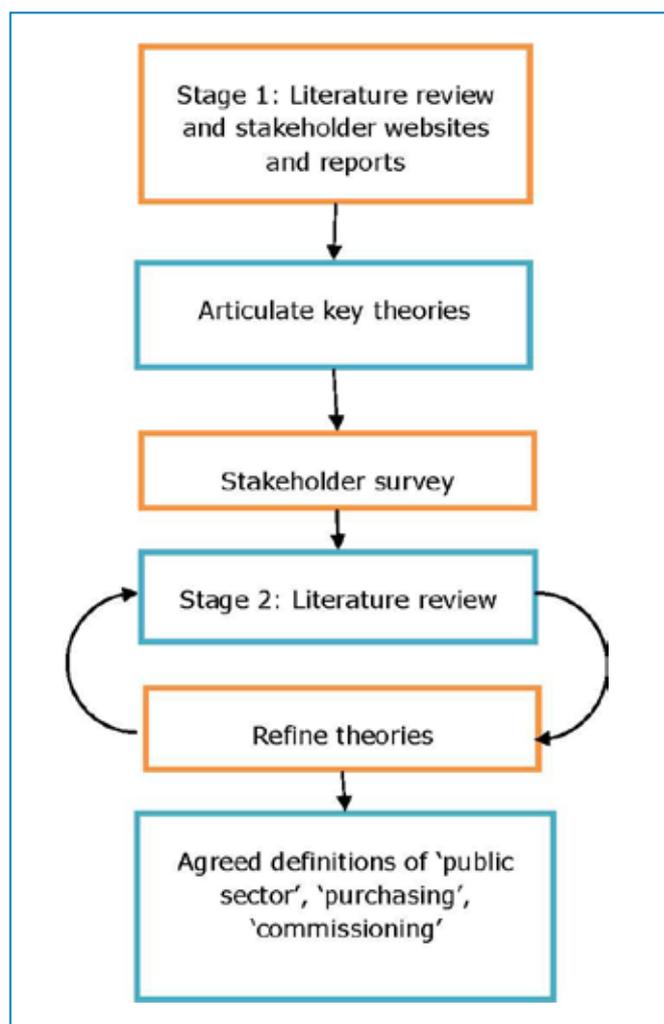
- define or conceptualise the terms of 'commissioning', 'purchasing', 'public sector' for public sector services;
- be published in English;
- be published during or since 1989, when the first NHS White Paper was published which articulated a separation between the provision and purchasing/commissioning sides of the NHS.<sup>24</sup>

At a later stage, a purposive literature searching strategy was used to deliberately seek out and refine conceptualisations that extend or contest key stakeholder definitions (see Figure 4).

Details of the search sources used are given in Appendix 1.2. The search strategy used was broad, including academic and grey literature, and employed snowballing techniques as a fruitful method of uncovering new ideas. The search included the websites and information provided by commissioning agencies such as the NHS, the Department of Health and local authority bodies and thus should be considered to be a form of stakeholder analysis as well.

The process of searching and refining theories continued until theoretical 'saturation' was reached. This refers to the point at which no new information was identified that added to our understanding. Each document found in the search was explored for ideas about the concepts and/or practices of commissioning with the main information highlighted, noted and labelled (according to which theory they address). At the point of saturation, the conceptualisation of key terms had undergone continual refinement and thus constituted a form of 'synthesis'.

**Figure 4:** Scoping exercise process



### 2.1.2 Stakeholder survey

After the initial literature review, stakeholders were contacted to provide feedback and comments on the definition and model of commissioning derived from the literature review stage using an online questionnaire/survey. A comprehensive model (The Institute of Public Care (IPC) model) and definition of commissioning<sup>25</sup> was presented in the survey for comments from the stakeholders. They were also asked for their views on the definition of public sector, the outcomes of commissioning and issues that were of interest. Details of the recruitment and data collection process are given in Appendix 2. Service users' views were not obtained as there was an extant survey-based study by Catton and Platt<sup>26</sup> that involved a large sample of health care users and public perspectives on the definitions, advantages and disadvantages of local health care commissioning. Since this

study fulfilled our purpose, we obtained data from this survey directly instead of repeating the task.

### 2.1.3 Synthesis of literature review and stakeholder feedback

The review team synthesised the information gained from the stakeholder feedback and the literature review in order to refine the definitions, models and theories of commissioning, purchasing and public sector embedded in the different stakeholder discourses. This task involved a series of iterations and the development of ideas that were shared amongst the research team. The team included two 'expert' stakeholder voices: Professor Nick Mays, an expert in health policy and author of a number of studies on commissioning, and Tony Roberts, an NHS commissioner from Teesside.

## 2.2 Results of scoping exercise

Findings of the scoping exercise have been organised under the following thematic topics:

### Stakeholder survey

- 2.2.1 The commissioning model and the definition of commissioning
- 2.2.2 Theoretical underpinnings of commissioning
- 2.2.3 Defining the public sector
- 2.2.4 Outcomes of commissioning

### Literature review

- 2.2.5 Commissioning as praxis
- 2.2.6 The process of purchasing
- 2.2.7 Stages of commissioning
- 2.2.8 The role of markets and competition
- 2.2.9 Relationships of commissioning
- 2.2.10 Levels of commissioning
- 2.2.11 Practice-based commissioning
- 2.2.12 An analytic framework for commissioning
- 2.2.13 Towards a loose typology of commissioning

### 2.2.1 The commissioning model and the definition of commissioning

The commissioning model (see Appendix 2) was considered comprehensive by some of the respondents with some additional comments.

These include:

- Individual-level commissioning through processes such as personalisation, self-directed care or individual budgets was not included in the model.
- Another shortcoming of the model was that it portrayed ‘commissioning’ as a simplistic process and complex issues around ‘values’ were not explicitly shown as part of the model. It was recommended that there needs to be a visual portrayal of the discussions and decisions on how to balance priorities and trade-offs.
- The commissioning model and the definition should emphasize the process through which the needs of service users are assessed and the role that they play in influencing the process of commissioning.
- Others referred to a process termed ‘Joint Strategic Needs Assessment’ where health care agencies (PCTs) and the local authorities collaborate to assess local/community needs.
- It was suggested that issues such as public policy, public management and policy making around specific issues should also be incorporated into the model.

### 2.2.2 Theoretical underpinnings of commissioning

When asked about the theoretical underpinnings of commissioning, some respondents referred to theoretical knowledge on supply and demand through market mechanisms. For example:

*“Neo-classical micro-economics’ normative theories that consider competitive equilibrium in perfectly competitive markets and theoretical recognitions, from Arrow onwards that health care markets don’t empirically approximate to perfectly competitive markets. So the theoretical task is to arrive at a ‘second best’ model that approximates as closely of the circumstances of health systems allow to the neo-classical model and its outcomes.”*

*“Commissioning is driven by a neo-liberal and new-managerialist approach to delivering welfare through market means, without necessarily directly ‘purchasing’ services. It can involve a multiplicity of stakeholders, not all of whom have equal access to resources nor equal involvement in the outcomes.”*

*“Some elements of the choice and competition debate apply.”*

*“The use of market economics to frame the ways in which one might organise the funding, planning, and service delivery processes in health care.”*

Other concepts related to commissioning referred to by the respondents include:

- continuous quality improvement theory;
- socio-legal theory;
- transactions costs economics;
- strategic management and business management.

### 2.2.3 Defining the public sector

Respondents were also asked to define what they considered to be the scope of the public sector.

From an economic perspective, some supported the view that the public sector can be seen as any part of the economy that spends public taxes. Therefore, it includes third/voluntary sector or for-profit providers that use public money to provide government services in health, education or social services. However, some pointed out that defining the public sector as state-funded firms and organisations could potentially include the whole of the economy. It is therefore beneficial to define the public sector as anything which is majority state-owned.

Specifically, social care/social services, health care, education, local government, defence, railways and criminal justice were considered by the respondents to fall under public services. Along with this, specific welfare and social services, such as child protection, supported housing, rehabilitation, probation, sports, arts, culture, science and other activities for community building were also considered to public services.

### 2.2.4 Outcomes of commissioning

When asked what the measurable outcomes of commissioning were, some respondents suggested that outcomes for users or providers of the service that is being commissioned should also be seen as the outcomes of

commissioning. For example the effectiveness of commissioning can be measured through assessing patients' health status or other health indicators. One respondent suggested that an appropriate outcome measure would be to assess the overall development of individuals in the sector in which the service commissioning is taking place.

Most agreed that process indicators were also suitable for determining the effectiveness of the commissioning process. The following outcomes are suggested by the respondents:

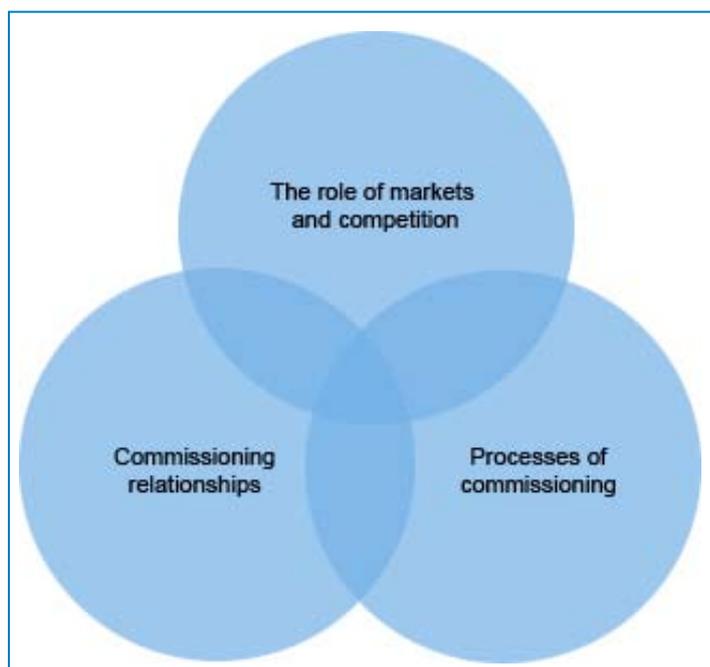
- cost-effectiveness, cost-benefit (direct costs, indirect costs, per-unit cost, rentier costs and transaction costs);
- technical efficiency: quality of services delivered and the types of activity provided by the individual/organisation commissioned to provide the service;
- the ability of partners to work together and effective joint working
- indicators such as waiting time involved in accessing services. also, whether access to goods and services is on the basis of need (as opposed to Pareto-optimality);
- indicators relating to changes in the management of chronic disease;
- user and provider satisfaction and experience;
- The nature and difficulty of the service provided: to assess whether private sector 'cherry-picks' the easy and profitable work, leaving the residue to the public sector;
- The transparency of provision to public scrutiny and control;
- The efforts made by the commissioned individual/organisation to measure the quality of the processes and outcomes of care.

### 2.2.5 Commissioning as praxis

It is argued that commissioning is praxis in the sense that it is the enactment or practice of a series of linked theories and ideas. Whilst the terminology used and the degree of emphasis given may differ, it is argued that these

theories/ideas coalesce into the three broad areas illustrated in Figure 5. In any discussion of commissioning, whilst these areas overlap, they are also distinct. For example, there is literature about markets and competition in the public sector that does not discuss processes and organisation. Conversely there is literature about processes and organisation that does not discuss the role of markets.

**Figure 5:** Conceptual influences on commissioning praxis



### 2.2.6 The process of commissioning

A variety of terms are used to describe the processes or mechanisms of commissioning including 'commissioning' (used only to describe the process), 'purchasing', 'procurement', 'contracting', 'strategic purchasing' and 'competitive tendering'. Whatever the exact terms used, the emphasis in these discussions was on commissioning as a process. This emphasis is common across the public and private sectors (see Table 1).

**Table 1:** Example of commissioning definitions

Sectors/ organisations	Commissioning definitions
Health	'Commissioning is the process by which primary care trusts (PCTs) secure best value and deliver improvements in health and care services, to meet the needs of the populations they serve.' <sup>17</sup>
Local government	'Commissioning refers to a series of interlinked processes, based on a robust analysis of needs in a defined area that enable the purchasing of services that vulnerable people need in a timely, efficient and acceptable manner, at a quality and affordable price that meets stated minimum requirements. It involves developing policy, service models and delivery capability to meet the identified needs in the most appropriate and cost effective way; and then managing performance and seeking service improvement through parallel management of various relationships with providers and commissioning partners.' <sup>25,p.7</sup>
Public order	'Commissioning -This involves separating the specification of services to be delivered from the delivery of those services.' <sup>27,p.31</sup>
Public management	'The use of the word 'commissioning' has traditionally referred to procurement of public services by local authorities, accompanied by management of contracts with the providers of these services.' <sup>28,p.4-7</sup>
Education	'Commissioning is a cyclical process that happens strategically across a population as well as individually for a particular young person or family.' <sup>15,p.10</sup>
Audit commission	'The process of specifying, securing and monitoring services to meet people's needs at a strategic level. This applies to all services, whether they are provided by local authority, NHS, other public agencies or by the private or voluntary sectors.' <sup>14</sup>
Private sector	'Commissioning defined as a set of procedures, responsibilities and methods to advance a system from static installation to full working order in accordance with design intent (Yoder and Kaplan, 1992). In broad terms, commissioning can extend from design reviews through operations and maintenance planning and training. With such a broad scope aimed at the entire building life cycle, commissioning developed and executed to ensure that all building systems function as intended' <sup>29,p.1-2</sup>

### 2.2.7 Stages of commissioning

The literature on commissioning as a process emphasises the idea of steps or stages in the commissioning process, often using the notion of a loop or spiral to emphasise the continuity of the process. The stages and characteristics identified across the literature are largely indistinguishable. These characteristics were well represented in the Institute of Public Care (IPC) commissioning model (Figure 6). This model makes a clear distinction between 'commissioning' (the dark shaded circle) and 'purchasing and contracting' (the lighter shaded circle), illustrating the view that the process of commissioning is closely related to the procurement cycle. In other accounts this may

be viewed as a distinction between strategic and operational aspects of commissioning and in others the distinction is not visible.

These four stages in the IPC model are common to most accounts of the commissioning process, the foundations of which can be seen in both the quality improvement and planning literatures. The four stages of the cycle are:

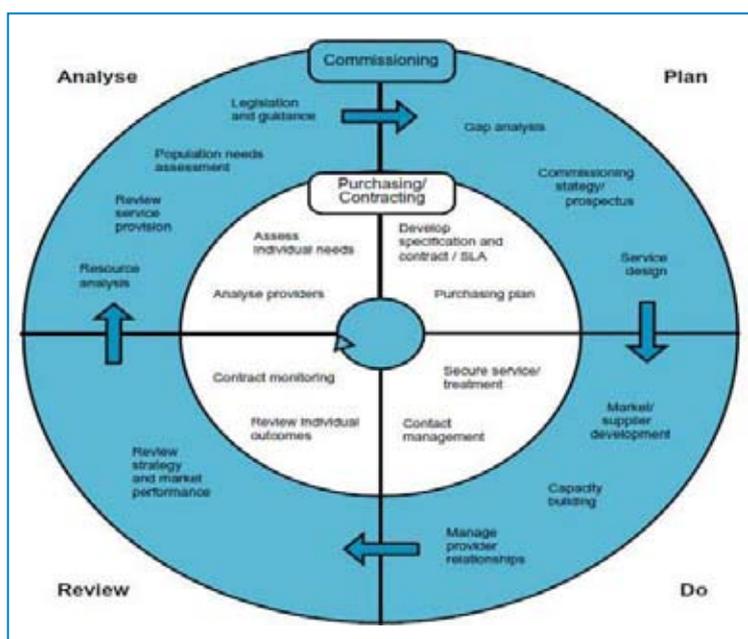
- a) Analyse: this stage involves risk assessment, analysis of the needs and views of service users, clarifying priorities, identifying existing resources and services and agreeing what outcomes should be achieved.
- b) Plan: this stage involves planning how the gaps in needs and available resources/services

will be addressed. Services to meet needs are designed, or a commissioning strategy is designed to identify how the services will be developed and how their effectiveness will be assessed. Workforce-related plans can also be developed at this stage, such as the skills or training that might be needed.

c) Do: this stage involves taking appropriate action to meet the targets set out in the previous stage. Service quality is ensured. New services are commissioned and those that do not meet population needs are decommissioned.

d) Review: this involves monitoring the impact of the services against expected outcomes and developing systems that assist in doing so; assessing whether priorities and needs have been met or if new needs have arisen in the population; and identify the revisions needed before moving through the cycle again.

**Figure 6:** Stage of commissioning  
DCLG, 2008 <sup>25,p.22</sup>



### 2.2.8 The role of markets and competition

Another strand in the discussion of the conceptual basis of commissioning is concerned with the role of markets and competition. It is commonplace that commentators on commissioning argue that the terminology used to describe the ‘commissioning’ process in the public sector, including ‘purchasing’, ‘contracting out’,

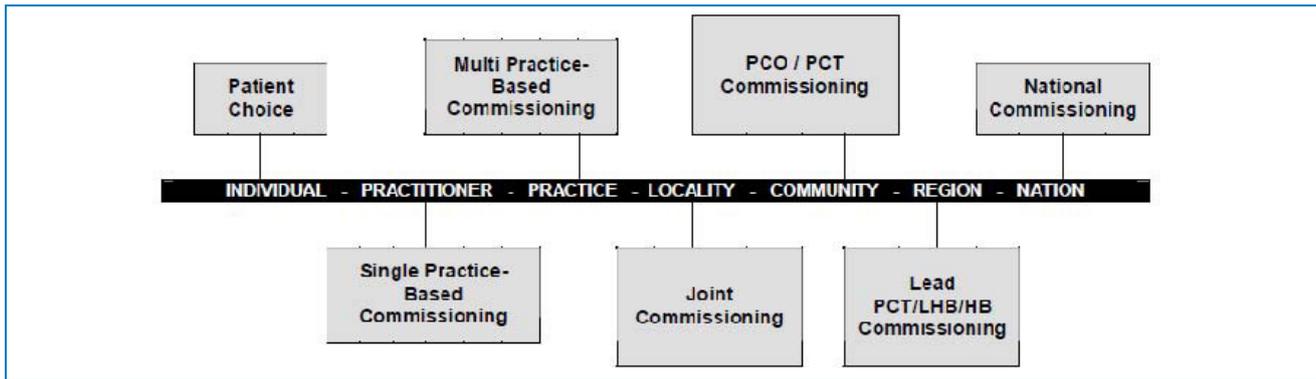
‘procurement’ and ‘privatisation’ is indicative of attempts to introduce competition as a model into the public sector.<sup>30,31</sup> There are those who argue that competition means privatisation and that this will offer increased efficiency and effectiveness in public service provision.<sup>32</sup> There are others who, whilst agreeing that commissioning is part of a process of privatisation, argue that this will lead to negative rather than positive outcomes (see for example in Pollock).<sup>33</sup>

However, within the ‘how to do commissioning’ perspective, the main content of discussion on this topic seems to be the extent to which market conditions do or do not exist in the UK Health Service. Dopson and Locock<sup>36</sup> argue that health care in the UK conforms minimally to free market assumptions of ‘perfect competition’, ‘no market failure’, ‘negligible transaction costs’ and ‘perfect information’. Bartlett<sup>34</sup> points out that while NHS reforms aim to introduce quasi-market mechanisms that attempt to increase cost efficiency through improving competition, when the reforms are carried out in markets characterised by ‘uncertainty’, ‘bounded rationality’ and ‘imperfect information’, the transaction costs become substantial. Exworthy and others<sup>35</sup> point out that other free market assumptions are also difficult to meet as the NHS controls funding and regulates competition that may result in inequitable health care impacts.

It is not always clear if discussions of the presence or absence of market conditions is linked with discussions of commissioning per se or indeed whether commissioning is necessary to the operation of the market. Although the IPC model shown above has as one of its activities strategic development of the market, not all writers would agree that a market is a necessary condition for commissioning. Rather it appears that there must be a relationship or partnership of some kind which is governed by trust and collaboration, within which there may or may not be competition to become one of the agents in the relationship.<sup>36</sup>

### 2.2.9 Relationships of commissioning

The third strand in the discussion of the conceptual basis of commissioning is

**Figure 7:** The levels of commissioning (Smith and colleagues, 2004)<sup>1</sup>

concerned with what superficially appears to be a discussion about ‘who’ does it. For example, the recent (July 2010) White Paper *Equity and Excellence: Liberating the NHS*<sup>23</sup> gives emphasis to giving General Practitioners (GPs) a greater role in commissioning. This ‘who’ emphasis also appears to be very much in evidence in the research in the field, probably because much of it has been commissioned in response to a policy initiative that changes ‘who’ does or ‘leads’ commissioning. The policy focus on who does the commissioning is not usually explicitly linked with any conceptual or theoretical justification. GPs for example, are supposedly closer to patients and therefore are in better position to judge their needs than for example health authority managers. However the underlying conceptual issue would appear to be to do with relationships. It is also argued that because GPs commit NHS resources through clinical decisions (predominantly referral, admission and prescribing decisions), giving them the lead for commissioning aligns budgetary and clinical responsibility. This justification is more obviously linked to economic arguments about the efficiency and operation of markets.

### 2.2.10 Levels of commissioning

A common argument in the more policy oriented literature on commissioning is that different services and populations require commissioning at different levels or scales and that different types of commissioning have developed in response to this. For example, the National Offender Management Service (NOMS) commissions services for adult offenders and identifies three levels of commissioning: local, regional and national. Local commissioning aims to deliver services that best meet local need, whilst at regional and national level, commissioning aims to provide effective and

efficient services to regional and national populations.<sup>27</sup> The literature review of multi-level commissioning done by the Office for Public Management<sup>28</sup> broadly grouped commissioning into five levels: national, regional, strategic, operational and individual. The review of health care commissioning by Smith *et al.* locates different types of commissioning on different levels (see Figure 7).

The rationale for national or regional-level commissioning is often provided in the form of an argument about a specialist type of service that will not be needed by all. Thus this argument contains within it an economic efficiency argument which presumably is viewed as being more important than the ‘local knowledge’ justification of micro-level commissioning such as ‘practice-based commissioning’, as described below.

#### 2.2.11 Practice-based commissioning

Practice-based commissioning is carried out by GPs. The arguments put forward for this approach coalesce around a theme that GPs know best about their patients, know best about healthcare, and therefore will be able to obtain for their public better and more efficient health care.<sup>28,37</sup> There are several different models or types of practice-based commissioning including: GP Fund Holding, Total Purchasing (TPPs), Practice-based Commissioning (PBC) and GP multi-funds.<sup>38</sup> The different types of practice fundholding each in their different ways attempted to provide GPs with the tools and/or incentives to undertake a commissioning role in an effective and efficient manner whilst seeking to find accommodation between ‘locality level’ and individual patient-level concerns.

### 2.2.12 An analytic framework for commissioning

Work at the European Observatory on Health Systems and Policies suggests a theory that appears to connect with this policy focus. This group argues that New Institutional Economics (NIE) or Economics of Organization (EO) provide an appropriate framework for understanding commissioning.

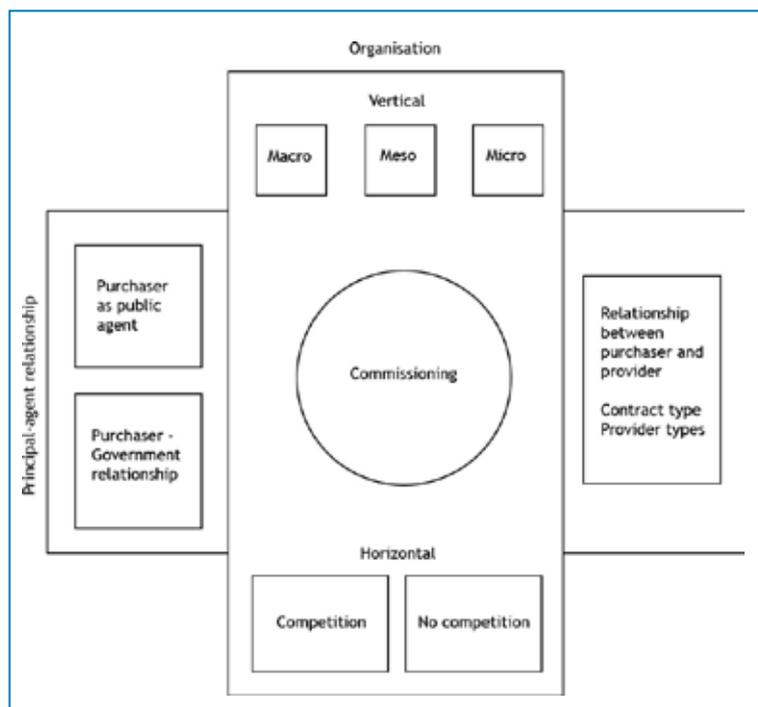
Economic Organizations are a result of specialisation and are defined as ‘created entities within and through which people interact to reach individual and collective goals’.<sup>8</sup> Purchaser organisations in health care are a good example of these. They co-ordinate how, when, where and what health care services are provided. Built into their function is also the system of providing incentives and rewards to ensure motivation and co-ordination by providers. Understanding the transactions between the providers and purchasers which are contract driven is at the core of this theory. Transactions are a multi-dimensional process. Their features include: measurement, bargaining and monitoring costs; costs arising from rent seeking and shirking; contract completeness; frequency, duration and reputation in carrying out transactions, complexity and uncertainty; competition and contestability; and the role of the social context. Good governance lies at the heart of this process and ensures that these processes are carried out efficiently.<sup>7</sup>

Robinson and others<sup>6</sup> use this theory as the basis for an analytical framework for a series of case studies of strategic purchasing in Eastern and Western Europe. The framework is illustrated in Figure 8. It suggests that ‘commissioning’ consists of two linked dimensions. ‘Organisation’ is represented by the vertical and the ‘Principal-Agent Relationship’ is represented by the horizontal box.

Organisation comprises of two aspects: ‘Vertical organisation’ and ‘Horizontal organisation’. Vertical organisation is concerned with the level at which purchasing takes place: macro, roughly corresponding to national and micro, roughly corresponding to local. The authors emphasize that these are not watertight distinctions, and often

elements of commissioning happen at more than one level simultaneously. Horizontal organisation is concerned with the extent to which there is competition between purchasers.

**Figure 8:** An analytic framework for strategic purchasing (after Robinson and others, 2005<sup>6</sup>)



The principal-agent relationship dimension has three components: The relationship between the purchaser and the public; between the purchaser and the government; and between the purchaser and the provider. The relationship between the purchaser and the public concerns the degree to which the public has a voice in purchasing decisions and the degree to which the public is free to exit if the purchaser does not perform satisfactorily. The relationship between the purchaser and the government is concerned with the degree to which the purchaser is responsible for developing health policy, regulating the health sector and collecting and using information. The relationship between purchaser and provider has two aspects: ‘contracting’ refers to the type and nature of the contractual relationship between the purchaser and provider; and the type of provider, which is linked but not synonymous with the type of contract. The authors argue that this can be divided into four types or categories:

1. 'Budgetary', which refers to systems where the government is set by the government and management is centrally controlled; the pre-reform NHS may fall into this category.
2. Autonomous organisations are those in which funding is based on global budgets but with elements of performance-related payments. Managers may have responsibility for day-to-day decision making but are directly accountable to government for their actions.
3. Corporate organisations have had their ownership transferred from the state to publicly owned but independent organisations. There is usually a local board to which managers are accountable and the board is accountable to government. NHS Hospital Trusts and Foundation Trusts fall somewhere into categories 2 and 3.
4. Private organisations are independent from the state and may be for profit or not for profit.

This comprehensive framework would seem to offer the advantage of linking the three sets of concepts - processes, relationships and markets - to the recent policy discussion which seems to have given prominence to the principal-agent relationship (although this language is not used).

However, its application in practice as a typology seems likely to be problematic. For example there could be as many as six different types of (high level) contract<sup>39</sup> x four types of provider organisation x two different types of purchaser competition x three levels of vertical organisation x at least three components of purchaser-government relationship ('at least' because in each one there is more than one possible position) x at least two components of the purchaser-public relationship ('at least' because in each one there is more than one possible position). This would result in at least 864 variants of commissioning. It is not clear if the authors intend the framework to be conceptualised or used in this way. Their own case studies of purchasing in different European countries do not provide anything like this sort of detail.

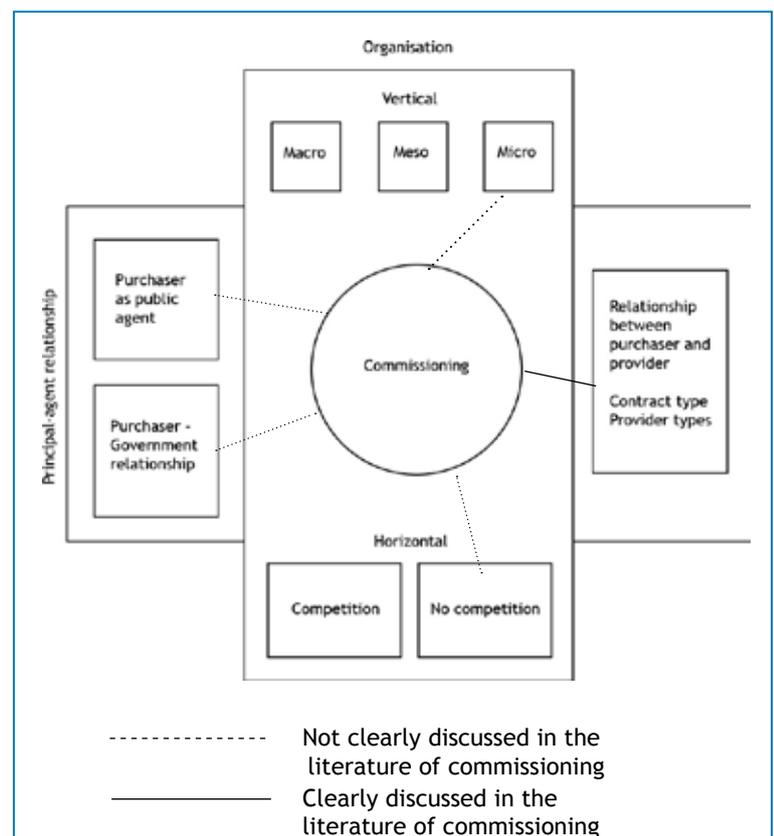
Notwithstanding this problem, our preliminary analysis of the research literature that

investigates commissioning suggests that at least some aspects of the framework have been used in some studies of commissioning. For example, studies by Sheaff and Lloyd-Kendal<sup>40</sup> and Baxter, Weiss and Le Grand<sup>41</sup> both use the concept of the principal-agent relationship as a framework for analysis. The overall analytic framework may be useful at least at a macro level in identifying commonalities and distinctions between types of commissioning. This is illustrated in the next section.

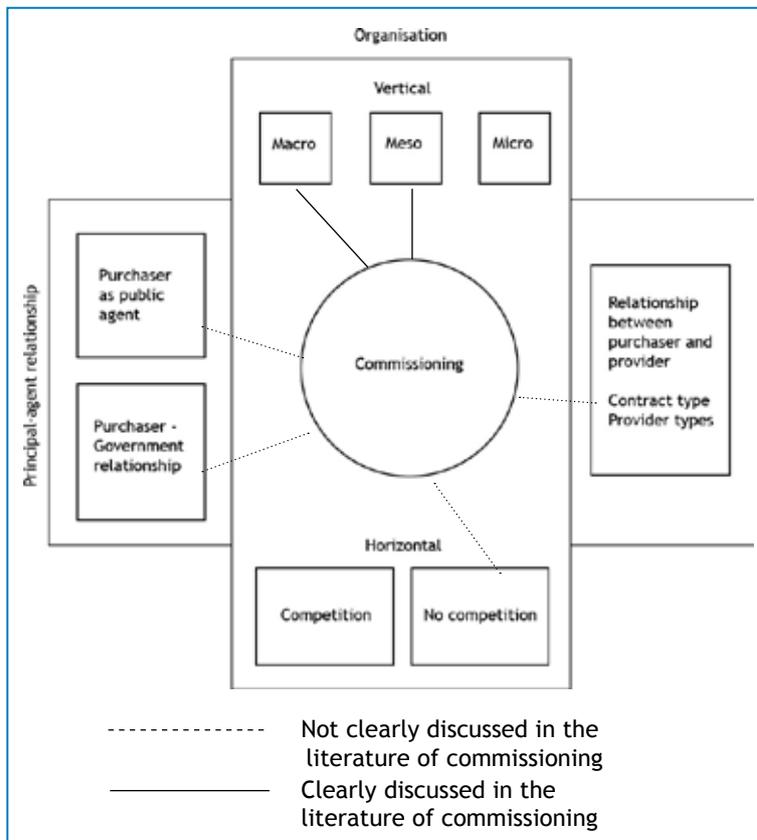
### 2.2.13 Towards a loose typology of commissioning

It is suggested that the issues emphasised in the commissioning literature can be mapped on to the analytical framework of the organisation of commissioning in ways that begin to allow recognition of common types of commissioning at a macro level but that also highlight the information that is absent from research reports and descriptions of commissioning. This is illustrated for these two types of commissioning in Figures 9 and 10 below.

**Figure 9:** Dimensions of commissioning emphasised in 'practice-based commissioning' literature



**Figure 10:** Dimensions of commissioning emphasised by ‘levels’ of commissioning literature



In both diagrams, the heavy black arrows indicate the specific aspects of commissioning that are emphasised in the literature on the particular type of commissioning. The lighter dashed arrows indicate aspects of commissioning that are present but are not emphasised or discussed in any great detail. In the ‘practice-based commissioning’ literature, greater emphasis is put on the relationship between purchaser and provider whilst in the ‘levels of commissioning’ literature greater emphasis is put on vertical organisation. Whilst the other components maybe present, they are not presented as the main differentiator between the types of commissioning. Indeed it is possible that on all the other components in the model, the practices, organisation and relationships of commissioning may be the same.

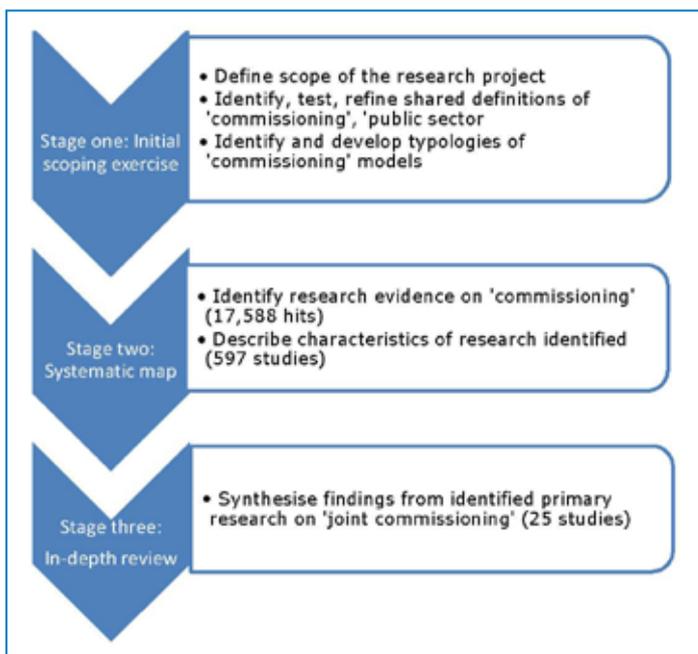
Whilst at one level this type of analysis might appear self-evident, it does not appear to be the type of conceptualisation attempted in most research on commissioning. It was not found for example in any of the studies of joint commissioning that were included in the in-depth review reported here. It is argued that this kind of approach could be useful for comparisons across sectors and between countries in that it will facilitate the grouping and comparison of commissioning at least at a macro level. To some extent, it could be argued that this is what was attempted by Robinson and others<sup>6</sup> at a European level. However this study, though proposing and using this framework, did not appear to analyse the various countries’ different purchasing systems at the level of detail proposed in the framework or to characterize the various types of purchasing that operate in the same country. This may well be because such information was not available to the authors and it is likely that this will be the case for studies of commissioning. However, the framework may present a way of building a typology for the future by indicating the components of commissioning that need to be described by researchers on the subject.

## CHAPTER THREE

# Methods used in the review

This chapter describes the methods used in the systematic review. This was carried out in three main stages: initial scoping exercise, systematic map, and in-depth review (see Figure 11). The initial scoping exercise methods and results are reported in Chapter 2.

**Figure 11:** Three main stages in the systematic review



### 3.1 Systematic mapping

The second stage of the review involved identifying research studies that were relevant to the scope of the review that emerged from the first stage. A limited descriptive analysis of the identified studies informed the focus of the third stage in this review.

#### 3.1.1 Defining relevant studies: inclusion and exclusion criteria

Literature searching for studies was guided by inclusion criteria which were developed iteratively and were refined by the findings from the initial scoping exercise. The following inclusion criteria were applied to screen for studies to include in the systematic map:

- a) Study was published in English.
- b) Study was published during or since 1989.
- c) Study focused on the process of commissioning, assessing, planning, purchasing and evaluation of services for a particular individual or population.
- d) Study focused only on one or more of the three sectors: health, education and social care.
- e) Study was about the commissioning of services that are delivered directly to service users.
- f) The commissioning process was led/managed by government agencies, i.e. directly elected officials and/or their agents.
- g) Study was about services bought by agencies on behalf of individuals or population.
- h) Study was an empirical primary study.
- i) Study was not an audit report or monitoring report.
- j) Study was not a country-level case study.
- k) Study reported relevant outcomes of commissioning.

A more detailed account of the exclusion criteria is presented in Appendix 3.

### **3.1.2 Identification of potential studies: search strategy**

Details of the search strategy are given in Appendix 4. A search was carried out using multiple sources in order to identify all possible relevant empirical evidence, both published and unpublished, which might be appropriate to answer the second stage review question(s). Search methods included a variety of sources and approaches, both electronic and manual. The searches were conducted in the following databases:

- a) Medline
- b) CINAHL
- c) PsychINFO
- d) The Cochrane Central Register of Controlled Trials
- e) Applied Social Science Index (ASSIA)
- f) The International Bibliography of the Social Science (IBSS)
- g) Health Management Information Consortium (HMIC)
- h) Social Policy and Practice
- i) Social Service Abstracts
- j) Social Science Citation Index (SSCI)
- k) Econlit
- l) ERIC
- m) British Education Index (BEI)
- n) Australian Education Index (AEI)

Searches were also carried out on relevant websites of organisations and research centres, Google and Google Scholar, and of relevant peer-reviewed journals. Reference lists from relevant systematic or other reviews were checked to identify further studies. Experts working in the area of UK health commissioning were also contacted and asked to recommend any potential relevant literature in the field.

The search strings for bibliographic databases were developed iteratively. Initially, sensitive searches were carried out to identify all potentially relevant terms and concepts on the topic. Search strings were developed for each database using combinations of the main terms and their synonyms, using both controlled (indexed) term and/or free text searches. At the third in-depth review stage, further purposive searches were carried out to identify any additional studies that addressed

the in-depth review questions on joint commissioning, using more specific search terms. Searches were carried out between mid-January and mid-February 2010.

### **3.1.3 Screening studies: applying inclusion and exclusion criteria**

The broad scope of the review and the use of sensitive search strategies generated over 17,000 citations. This very high number meant that it would not be possible within the resources and time available to manually screen citations, which is the traditional approach for identifying potentially relevant research studies for inclusion in a systematic review. Therefore an innovative approach using a text data mining technique was adopted.

The screening procedure for the 17588 citations identified through searching process described in section 3.1.2 was carried out as follows:

- a) Identifying a sample of potentially included studies: 100 randomly selected studies were manually screened by two reviewers based on title and abstract using the inclusion criteria. After the moderation exercise, 32 studies (32 percent) were identified as potential includes. To these were added the 86 potential includes identified through handsearches and reference checking of relevant systematic or other reviews, yielding a total of 118 potential included studies.
- b) Excluding studies using a neural network technique (text mining): the sample of 118 potentially included studies was used by the text mining technique to categorise the remaining studies (17,470) as 'include' or 'exclude' to the review. As a result, 10,973 studies were excluded from the review and 6,497 studies were included for manual screening.
- c) Manually screening of 6,497 studies: inclusion criteria were manually applied successively to titles and abstracts. Full reports were then retrieved for those studies that appeared to meet the inclusion criteria or where there was insufficient information to make a decision. The review team undertook a moderation exercise to ensure consistency.

The screening was carried out independently by individual review members, and the principal investigator double-screened samples as a quality assurance process.

### **3.1.4 Characterising included studies**

We initially proposed that all studies identified in the systematic mapping exercise would be coded for conceptual, practical, contextual and methodological information. However, the complexity of the searching and selection process and the unexpectedly large number of studies included in the systematic map (n=597), about 20 times more than in any previous reviews of commissioning, meant that it was not possible within the time and resources available to do so. Instead a limited automated coding of the titles and abstracts of the documents were undertaken using our review software EPPI-Reviewer 4. Full references of the 597 identified studies are provided for further consultation and presented in Appendix 7, and are available in an online data base at <http://eppi.ioe.ac.uk/webdatabases/Intro.aspx?ID=22>.

## **3.2 Moving from broad question to in-depth review**

The third stage of the review aimed to systematically synthesise findings from the primary research included in the review to address the more focused in-depth review question. The plan of the review initially included the detailed mapping of the research literature on the topic that was identified by the search strategy. However such was the complexity and volume of the literature that it was not possible to code the studies to this depth. Thus an alternative approach was used to identify in-depth review questions. The review team developed potential in-depth review questions based on:

- a) the limited coding of the systematic map using automated text mining technology to group studies into ‘clusters’ of ‘apparently similar’ studies based on subject;
- b) identifying the gaps and limitations in existing systematic or other relevant reviews (see Table 2);
- c) the suggestions made by stakeholders in the survey during the scoping exercise;

d) reviewers’ understanding of the gaps in the literature and of the common themes that emerged during the manual screening process.

From this information, nine potential in-depth review questions were identified (see Table 3). After consultation within the research team and feedback from the policy strategy directorate at the Department of Health, the questions selected focused on the impact of ‘joint commissioning’ and factors affecting the impact of joint commissioning (questions 2 and 7). These questions were chosen as they: a) provided the opportunity to consider the impact of commissioning across sectors, allowing for the possibility of learning lessons about the joined-up work between health and social care domains; b) responded to the stakeholder survey; c) addressed the gaps in the existing reviews; and d) emerged as a prominent theme in the existing literature (see Table 3). The decision was also based on a careful consideration of the aims and objectives of the research project, stakeholder requirements and availability of resources.



**Table 3:** Potential in-depth review questions

Potential in-depth review questions	Methods used to develop potential review questions	a) Across public sectors	b) Responding to stakeholder surveys	c) Addressing gaps in the literature	d) Themes emerged from the existing literature
1) Impact of payment mechanisms (e.g. <i>incentive/outcome-based/payment methods/Pay for performance</i> ) on commissioning related outcomes	A) Clustering B) Existing systematic reviews	✓	x	x	✓
2) Impact of particular commissioning model(s) on commissioning related outcomes (e.g. fund holders, joint commissioning, primary care led commissioning)	A) Clustering B) Existing systematic reviews C) Stakeholder exercise	✓	✓	✓*	✓
3) Impact of data driven/information management interventions on commissioning related outcomes	B) Existing systematic reviews	✓	x	x	x
4) Impact of commissioning in relation to different types of providers' characteristics on relevant outcomes (e.g. ownership, locations, organisation structure and management styles)	A) Clustering B) Existing systematic reviews	✓	x	x	✓
5) Impact of commissioning in different market environments (e.g. competition or market conditions) on relevant outcomes (e.g. performance/cost)	B) Existing systematic reviews C) Stakeholder exercise	✓	✓	x	x
6) Stakeholders' views (e.g. commissioners/providers/users) on the impact of contracting out and/or privatisation across public services	B) Existing systematic reviews D) The review team understanding	✓		✓***	✓
7) Impact of joint commissioning between health and/or social care joined up work, international evidence	A) Clustering C) Stakeholder exercise	✓	✓	✓	✓
8) Impact of commissioning in education (charter school) on school/student outcomes	A) Clustering B) Existing systematic reviews	x	x	✓****	✓
9) Impact of 'commissioning' on the following outcomes: prescription cost, efficiency gain and consumer choices	A) Clustering	✓	x	✓	✓

\*Although we found at least four systematic reviews focusing on effective models of commissioning, (1, 2, 44, 45) all were carried out in health and UK contexts and none was specifically on joint commissioning. \*\* Although extensive evidence on contracting out in public services was identified, we found no systematic reviews on stakeholders' views on the impact of contracting out. We also identified three studies that investigated the effectiveness of contracting out primary health services in developing countries(49-51) \*\*\* One non-systematic review of education policies was identified. (52)

### 3.2.1 Selection of studies for the in-depth review

The 597 studies in the systematic map were manually screened on the basis of full texts to identify studies using the following inclusion criteria:

a) A study had to be about joint commissioning as defined in Box 1:

**Box 1:** Definition of joint commissioning

‘Joint commissioning is the process in which two or more commissioning agencies act together to coordinate their commissioning, taking joint responsibility for translating strategy into action.’<sup>53</sup>

This collaboration could be at different levels: 1) locality- or area-based, i.e. joint health and social services commissioning forums based on the area or locality; 2) practice-based, where a practice or a group of practices allow both health and social services professionals to contribute their expertise; or 3) patient-level, where professionals in both health and social care form a single practice-based team, carrying out assessments, recommending services, and providing continuing management of care for patients.<sup>54</sup>

b) A study had to be across sectors or with inter-sector collaboration (e.g. between health and social services departments).

Intra-sectors such as PCTs, Foundation Trusts and Ambulance Trusts, where two or more health agencies had combined to form a trust were not in the scope of the in-depth review.

c) A study had to investigate or explore the following aspects/types of joint commissioning even if they did not explicitly refer them by the given terms: lead commissioning, financial integration, pooled budgets, integrated management, joint steering groups and Joint Strategic Need Analysis (JSNA). Other terms such as integrated care, partnership and collaboration, were also considered to be relevant to the review. Studies that investigated or explored agencies that have an integrated structure with single management, such as children’s trusts, care trusts and mental health trusts could also be included in the review.

Twenty-five studies met this criterion and were included in the in-depth review. Figure 12 summarises the process carried out to identify these studies.

### 3.2.2 Detailed description of studies in the in-depth review

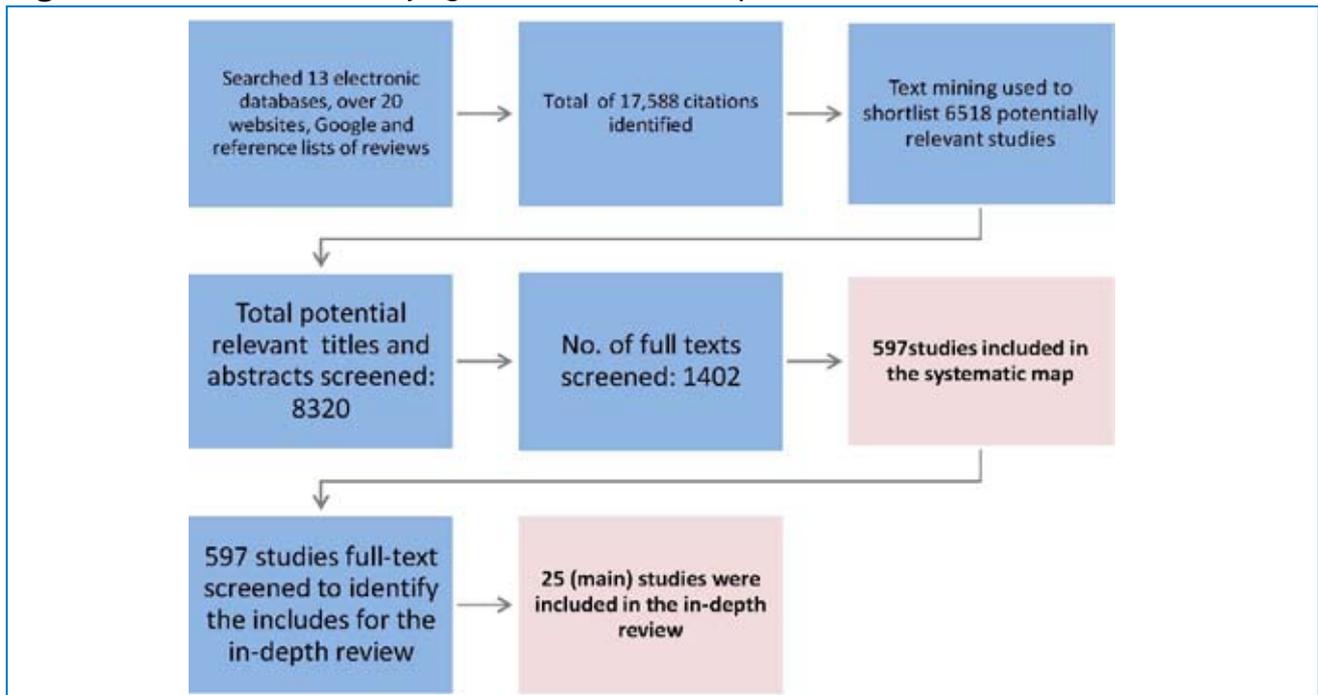
In the third stage of this review, a detailed level of coding was undertaken using a pre-developed and piloted coding tool. This process provided detailed information about the studies included in the in-depth review and was necessary for the purpose of description, quality assessment and synthesis. Descriptive data about the aim of the study, types of commissioning, the services commissioned, the population commissioned for, the factors influencing commissioning and the results of the study were coded (See Appendix 5 for the coding tool). The coding was done by one reviewer with a confirmatory coding being done by a second reviewer. Differences were discussed and resolved. Where differences could not be resolved, a third reviewer was approached for their opinion.

### 3.2.3 Study quality

Studies included in the in-depth review were also assessed for quality and relevance details of the approach used are given in Appendix 7. This approach used the EPPI-Centre’s Weight of Evidence (WoE) framework.<sup>55</sup>

The framework assesses quality on three dimensions:

- WoE A: This dimension assessed the quality of the execution of the studies and whether this could lead to confidence in its findings. In this review, the WoE A assessment considered:
  - o the representativeness of the study sample;
  - o the trustworthiness of data collection tools;
  - o the rigour of the data analysis.
- WoE B: This dimension assessed whether the study used an appropriate design to answer the research question. This criterion was different for impact and factor studies. The impact studies were assessed using a framework provided by the Maryland Scientific Methods Scale<sup>56</sup> in which research designs with control groups were given greater weight. The WoE B quality assessment for the factors affecting the impact of joint

**Figure 12:** Process of identifying studies for the in-depth review

commissioning was based on whether the design of the study led to confidence that the results were an authentic representation of participant views. Studies that employed qualitative data collection and analysis approaches for measuring stakeholder views about barriers and facilitators to joint commissioning were given greater weight.

- **WoE C:** This assessed whether the study provided sufficient information about and/or had a particular focus on joint commissioning.
- **WoE D:** An overall weight of evidence. This was an average of WoE A, B, and C. The overall weight of evidence could not be higher than WoE A or WoE B. Because the studies were assessed using different WoE criteria for impacts and factors, the studies were given two different overall WoE Ds, one for their quality in relation to measuring impact and the other on their quality in relation to factors.

### 3.2.4 Synthesis of evidence

‘Synthesis’ refers to the process or methods used to combine and explore the results of the individual studies included in the second stage in-depth review to generate ‘new’ knowledge or results from the review. The methods or approaches to synthesis used are driven by the research question, the types of studies/data that are included in the review, the detail and

quality of reporting in these studies and their heterogeneity.

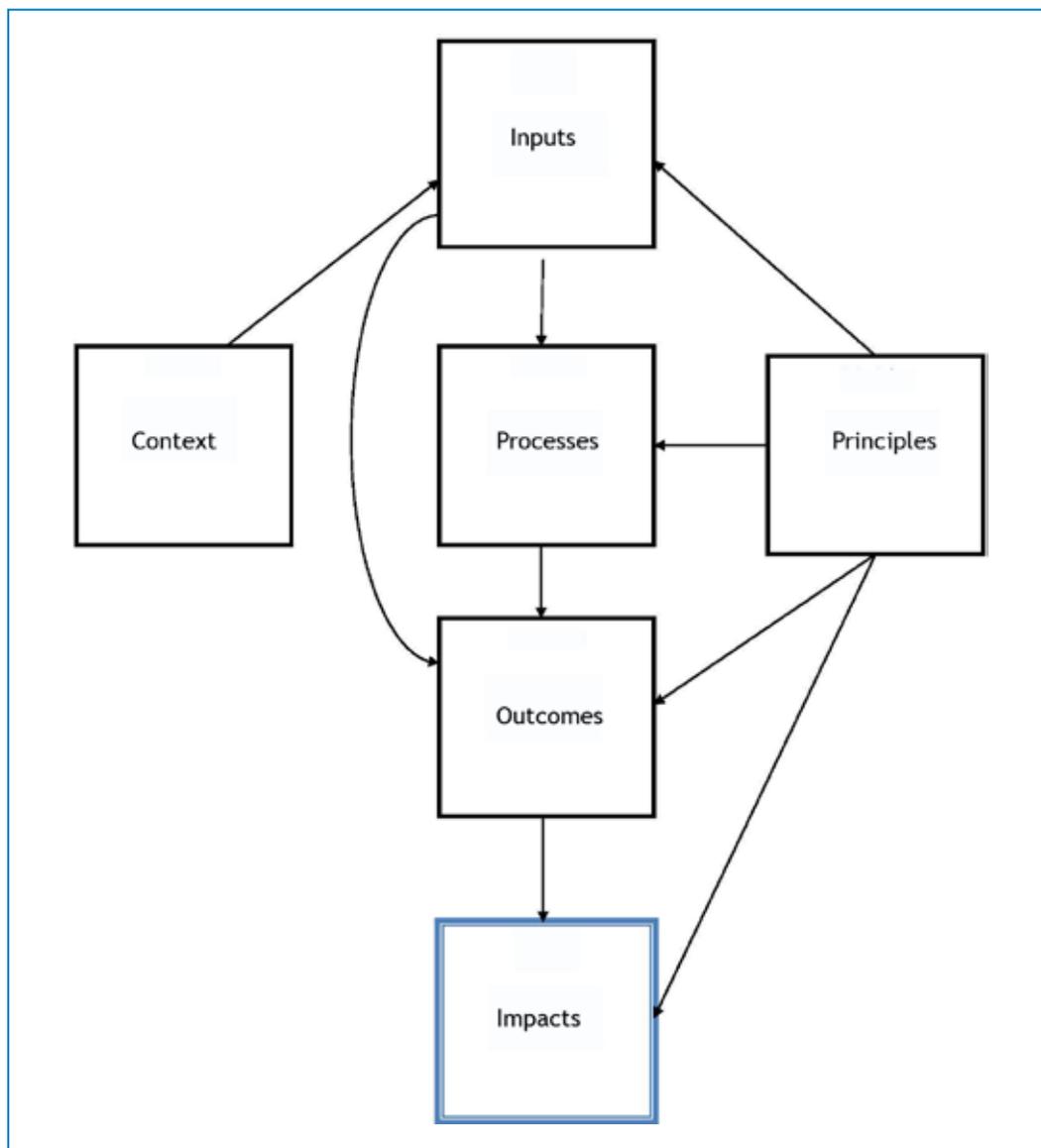
None of the studies had methods and/or reported data suitable for more sophisticated methods of synthesis such as meta-analysis. A narrative synthesis of the factors and impacts of joint commissioning was conducted.

The impacts of joint commissioning were categorised into five groups: service user outcomes, costs, technical efficiency, organisational management outcomes and partnership-related outcomes

The barriers and facilitators to joint commissioning were coded and listed and then a thematic analysis was carried out guided by a framework for examining partnership working.<sup>57</sup> This framework explicitly identifies key components of partnership working mechanisms including inputs, processes, outcomes, and impacts. The context of partnership and interrelationships of stakeholders are also recognised in the framework (see Figure 13).

This produced a list of facilitators and a list of barriers to joint commissioning. These were then grouped into the relevant categories of the partnership working framework. The frequency with which these were mentioned in the studies was taken into account when analysing the themes.

**Figure 13:** A framework for evaluating partnership working  
(Adapted from Asthana and others, 2002)<sup>57</sup>



## CHAPTER FOUR

# In-depth review: results

### 4.1 Characteristics of mapped studies

The map consisted of 597 studies. Of these, 446 were in health, 149 in social care/services and 59 in education (there was some overlap of sectors). As noted in Chapter 3, only a limited automated coding of these studies was undertaken and therefore the number of studies given in each case are estimates only. At least half of the studies were from the UK.

Approximately 105 studies were about fund holding of some type and approximately 39 about PCTs' commissioning. Approximately 17 studies were about commissioning care for older people, 51 about commissioning mental health services and 43 about commissioning children's services.

In terms of the staged process approach to commissioning, approximately 30 studies focused on the analysis stage, 115 on the planning stage, 134 on the implementation or doing stage, and 103 on the review stage.

### 4.2 Characteristics of the joint commissioning studies

Twenty-five studies of joint commissioning were identified (58-82). A descriptive summary of each study is given in Appendix 8. Twenty-four studies were conducted in the UK and one in Sweden. All of the studies investigated joint commissioning at an area/locality level. All of the studies investigated joint commissioning between health and social care (Local Authority) agencies and in

four cases also included education. Table 4 shows the breakdown of the commissioners in the different studies. In the majority of studies, multiple services were being jointly commissioned, although in some studies the focus was on the joint commissioning of a specific service, e.g. home care, or a specific sector of the population, e.g. the elderly.

**Table 4:** Who was/were the commissioners/purchasers of services

Attribute	Number (not mutually exclusive)
Care trusts	1
Children's trusts	3
General practitioners	4
Health authorities	13
Housing authorities	1
Local authorities	22
Mental health care trusts	1
Primary care groups	4
Primary care trusts	12

The studies did not always describe in detail what 'joint commissioning' entailed in the sites they were investigating. Table 5 provides a breakdown based on the information that was provided.

**Table 5:** Types of joint commissioning investigated in the study

Attribute	Number (not mutually exclusive)
Aligned budget	4
Integrated care/services management of care	8
Joint board commissioning/ decision making/development of commissioning framework	17
Joint monitoring and evaluation	1
Joint needs assessment	2
Lead commissioning	4
Pooled budget	2
Structural integration of organisations	11
Working together	4

Studies used either postal surveys, interviews, focus groups or, in a small number of examples, observations (of meetings). The scale of the studies, in terms of examples of joint commissioning investigated, ranged from case studies in one geographical area to fairly large-scale national surveys involving significant numbers of health and local authority agencies. The actual size of the studies in terms of sample also varied from the comparatively small (13 interviews) to comparatively large (several hundred questionnaire responses). With regard to the question of ‘the factors that affect commissioning, the majority of studies were rated as medium quality (n=15) or low (n=8) (with only one study rated as high).

### 4.3 Factors influencing the impacts of joint commissioning

The synthesis develops themes from a list of factors influencing the impacts of commissioning that were recurrently reported in the finding of these 25 studies which are summarised in Table 6. However, in the reporting of these studies these distinctions were not always clear and in practice it would seem likely that these factors overlap and interconnect.

#### 4.3.1 Inputs

##### Staff, leadership and management

Many studies found that efficient management, leadership and staff recruitment and retention were among the most important factors for joint commissioning and partnership working. Among these, the following factors were considered to facilitate joint commissioning:

- Strong and stable leadership that encourages effective implementation of joint commissioning strategies.<sup>76</sup>
- A commitment to partnership working at senior and middle management level.<sup>59,69,70,76,80</sup>
- Retention of key personnel, which results in continuity and effective implementation of joint commissioning strategies.<sup>81</sup> Factors such as the attractiveness of commissioning as a career<sup>82</sup> and the ‘attraction of being in the vanguard of initiatives with national significance’<sup>70</sup> also facilitate the process of joint commissioning.
- Balanced and well-developed management structures that allow professionals to move across management roles.<sup>60,70,79</sup>
- Mechanisms for professional peer support and development of new skills.<sup>64,70,79</sup>

The following were considered to impede successful joint commissioning:

- Lack of stability in the management workforce.<sup>76,81</sup>
- Problems recruiting and retaining staff.<sup>81</sup>
- Union resistance and staff anxiety about change.<sup>69,70,82</sup>
- Dependence and excessive reliance on key personnel. This increases vulnerability of joint commissioning to the effects of reorganisation or staff changes within one of the partner bodies.<sup>60,73</sup> It also increases the risk of making joint commissioning management inaccessible to new groups.<sup>60</sup>
- Lack of equivalent expertise and the lack of a competency framework or training module to guide skills development for joint commissioning.<sup>75,82</sup> This further makes it harder to identify suitable candidates to act as lead commissioners.<sup>82</sup>
- Lack of experience of working with populations rather than individuals and gaps in knowledge regarding adequate capacity of staff for joint working.<sup>74,82</sup>

**Table 6:** Summary of the main facilitators and barriers identified from the primary studies

(a) Input from partners		(b) Relationship with partners	
Facilitators	Barriers	Facilitators	Barriers
<ul style="list-style-type: none"> <li>• Strong and stable leadership</li> <li>• Commitment from management</li> <li>• Retention of key staff</li> <li>• Balanced and well-developed management structures</li> <li>• A prior history of successful commissioning</li> <li>• A prior history of working together</li> <li>• Time required</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of stability in management workforce</li> <li>• Problems recruiting and retaining staff</li> <li>• Dependence and excessive reliance on key personnel</li> <li>• Lack of equivalent expertise and the lack of a competency framework or training module</li> <li>• A small organisation or trust</li> <li>• Lack of experience</li> <li>• Lack of financial resources</li> </ul>	<ul style="list-style-type: none"> <li>• Mutual trust and understanding</li> <li>• Willingness and commitment to work together</li> <li>• Cultural integration</li> <li>• Clarification of roles and responsibility</li> <li>• Shared priorities and objectives</li> <li>• Common understanding of the service to be delivered</li> <li>• Integrated systems</li> <li>• Pooled budgets</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of clarity of roles and responsibility</li> <li>• Difficulties in managing partnership dynamics and organisational differences</li> <li>• Lack of communication</li> <li>• Difficulties in managing the bureaucracy and governance aspects of partnership working</li> <li>• Lack of respect and understanding</li> <li>• Lack of shared goal and destiny</li> <li>• Fear of lost control</li> <li>• Inability to integrate human resource management systems</li> <li>• Fear of competing for the same resources</li> <li>• Concern over the loss of both control over the budget and of flexibility once the money is committed to a ringfenced pooled budget</li> <li>• Deeply engrained patterns of working and widely differing agendas and priorities</li> </ul>

<b>(c) Internal processes</b>		<b>(d) Context of partnership</b>	
<b>Facilitators</b>	<b>Barriers</b>	<b>Facilitators</b>	<b>Barriers</b>
<ul style="list-style-type: none"> <li>• Mechanisms for professional peer support and development of new skills</li> <li>• Effective communication processes</li> <li>• Commitment, credibility and a positive attitude by individuals within the teams</li> <li>• Sustained involvement and integration of key staff</li> <li>• User engagement and wider consultation</li> <li>• Fairness in procedures, manageability, transparency of managing the joint commissioning process</li> <li>• Planning, developing, and facilitating organisational structures in advance</li> <li>• Development and aligning of operating systems and information management systems</li> <li>• Incentives</li> </ul>	<ul style="list-style-type: none"> <li>• Internal reorganisation</li> <li>• Organisation instability</li> <li>• Lack of monitoring, evaluation and audit systems</li> </ul>	<ul style="list-style-type: none"> <li>• Co-location of teams and coterminous geographical boundaries</li> <li>• Political willingness and policy initiatives</li> <li>• Legal arrangements and clear frameworks</li> <li>• Financial deficit for jointly commissioned services in the public sector</li> </ul>	<ul style="list-style-type: none"> <li>• Geographical distance and discrepancies in geographical boundaries</li> <li>• National policy changes</li> <li>• Difference in national measurement systems between health and social care</li> </ul>

**(e) Wider consultation**

- involvement with GPs, carers, and users
- engagement with voluntary sector

## Prior history

A prior history of successful collaboration between local authorities and PCT/health authorities was also one of the most frequently cited facilitators of successful joint commissioning<sup>66,68-70,76,77,81</sup>. A number of authors concluded that having an existing close relationship, continued interaction, pre-existing networks, shared working history and a culture of multi-agency working made joint planning and integration easier and faster.<sup>69,77</sup>

Similarly, the lack of a prior history and in particular a history of a distant relationship between PCTs and councils was identified as resulting in 'misalignment and low levels of trust'<sup>82</sup>. Rummery<sup>74</sup> found that a lack of experience of working with social services at the Primary Care Group board level was an important barrier to joint commissioning. In a case study by SHM,<sup>82</sup> the author reported that successful commissioning was impeded by the local schools refusing to engage in commissioning arrangements due to their prior history of poor relationships with the council.

## Resources

A number of studies found that partnership working demands a long term and genuine commitment to communication and negotiation between partners, which in turn required a large investment in terms of time, finances and human resources<sup>61</sup>.

Financial aspects of partnership working appeared to be a frequently reported barrier to successful joint working. The feeling that both partners were competing for the same resources was frequently reported.<sup>61,70,81</sup> Added to this were concerns about a lack of resources amongst one or both partners.<sup>69,81</sup>

### 4.3.2 Internal processes within organisations

Another category of factors identified in the studies concerns how joint commissioning processes were organised within and between the participating organisations. How the internal process was undertaken in partner organisations played an important role in determining the success of joint commissioning. The specific factors identified in this category were:

- Accountability in the way in which joint commissioning is conducted: fairness in procedures, manageability, transparency.<sup>62</sup>
- The impact of disruptive organisational changes, especially when new networks need to be formed and existing partnerships are disturbed.<sup>69</sup> It was also argued in a number of studies that organisational instability slows down progress and leads to a loss of faith in senior management,<sup>64,82</sup> disorientation, and general anxiety about job losses and about the future.<sup>63,64,82</sup>
- The development and aligning of operating systems and information management systems.<sup>58,64,69,80</sup> Although issues around confidentiality and protocol sharing are viewed as time consuming, these need to be resolved.<sup>73</sup> In addition, the ability to integrate human resource management systems may be considered as a factor in successful joint commissioning.<sup>58,80</sup>
- The presence of effective communication processes that provide informal and formal opportunities for staff to voice concerns and discuss issues around management and professional development.<sup>79,80</sup>

### 4.3.3 Relationship between partners

The development of strong personal- and agency-level relationships across agencies and a mutual and equal commitment to integration at all levels were the most frequently reported factors affecting joint commissioning.<sup>59,61,62,64,66,69,70,74,75,77,79,81</sup>

These studies identified the following characteristics as key to developing integration and in turn to successful joint commissioning:

- mutual trust and common understanding;<sup>62,77</sup>
- willingness and commitment to work together: a belief in the advantages of partnership working;<sup>64,81</sup>
- clarification of roles and responsibilities;<sup>62</sup>
- shared priorities and objectives.<sup>74</sup> This may include recognizing and addressing the cultural gaps between health and social services.<sup>79</sup>

However, difficulties in establishing a positive relationship between partners were also frequently reported as a barrier to joint commissioning. The most frequently reported barriers in this category included:

- lack of clarity and presence of asymmetry in the roles and responsibilities of different agencies;<sup>67,70,72,75,79</sup>
- difficulties in managing partnership dynamics and differences around professional culture, political structure, human resource frameworks, languages and central government targets;<sup>61,64,67-70,72,73,79,82</sup>
- lack of understanding and respect for others' professions and a lack of a sense of a shared destiny;<sup>64,72</sup>
- lack of trust and fear of a loss of control.<sup>68</sup> In addition, reservations over ring-fencing of budgets and resources were also expressed in many studies.<sup>69,80,81</sup> In particular there was concern over the loss of both control over the budget and of flexibility once the money is committed to a ring-fenced pooled budget;<sup>69,80</sup>
- failing to take joint responsibility and an asymmetry in responsibilities.<sup>59,65,67,70,74,80,82</sup>

#### 4.3.4 Context of partnership

##### Geographical distances and boundaries

Both co-location of teams and coterminous geographical boundaries are commonly listed as facilitating factors for joint commissioning.<sup>61,69,72,78,80,81</sup>

Co-location permits regular meetings<sup>66</sup> and provides greater informal contact and the possibility of more joint training, which can in turn lead to better relationships.<sup>78,80</sup> Coterminous boundaries can result in less time and resources spent on resolving border disputes.<sup>61</sup> Geographical distance and discrepancies in geographical boundaries can cause problems and complexities that act as a barrier to joint commissioning.<sup>71,72,74,81</sup>

##### Political and national policy initiatives

Political willingness and policy initiatives at the central government level can act as external levers of change and foster greater collaboration between organisations.<sup>59,67,72,74,75</sup>

Other motivating factors that stem from policy initiatives include seeking improvements in service delivery, increased financial payments for collaboration, and regulatory body performance criteria.<sup>68,70,81</sup> Studies also mentioned issues about measuring the outcomes of joint commissioning and assessing whether it has been successful or not.<sup>64</sup> In particular, dealing with disaggregate performance indicators<sup>75</sup> and with the lack of measurement of service user outcomes appears to be a problem.<sup>80</sup> Disagreements with auditing processes and national measurement systems were also reported.<sup>69,80,82</sup> In particular it was felt that national measurement systems treat social services and health care as separate operations.<sup>69</sup>

##### Legal aspects

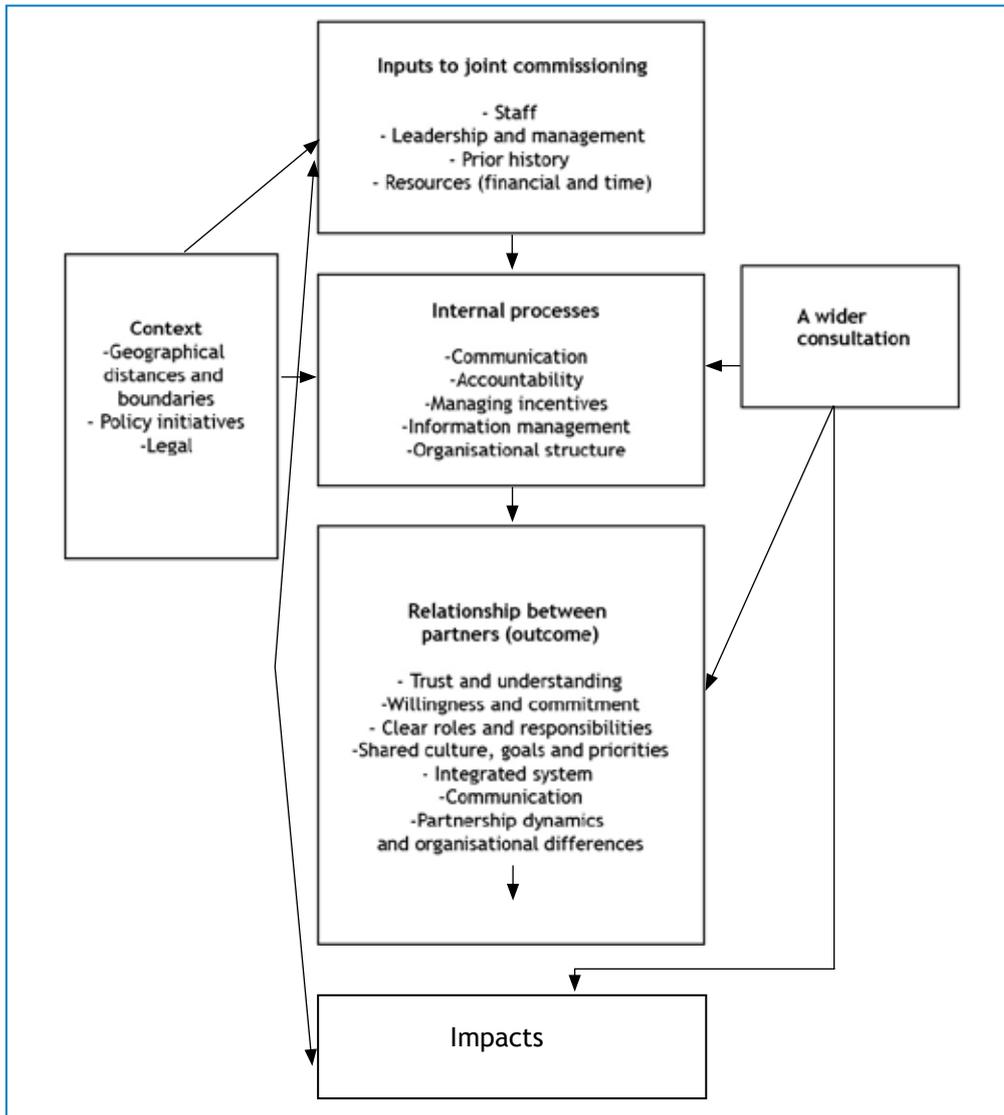
Legal issues were mentioned in only a few studies. Some found that legal arrangements and clear frameworks facilitated joint working.<sup>81</sup> However, the constraints in pooling resources and limiting of control in allocating budgets due to legal frameworks were cited as barriers to joint commissioning in some studies.<sup>64,69</sup> Further, the legal aspects of working out liabilities and accountabilities in joint commissioning also hinder partnership working.<sup>82</sup>

#### 4.3.5 Wider consultation

Another factor that was identified as important to successful joint commissioning was the role that wider stakeholders played in the commissioning process. The involvement of practitioners in particular in the joint commissioning process (for example GPs and social workers) was highlighted as especially important.<sup>58,59,62,65,69,71,72,74</sup>

Engaging with users and carers was also considered an important aspect of successful joint commissioning in some studies.<sup>62,69</sup> However, this was often impeded by a paucity of users who wanted or could be involved.<sup>70</sup> Hudson *et al.*<sup>62</sup> also suggest that commissioners should engage in wider consultation, however, they report that the importance given to the voluntary sector in this regard is considered by some to be a hindrance to effective joint commissioning.

**Figure 14:** Key factors of successful joint commissioning from the synthesis  
(Adapted from Asthana and others, 2002)<sup>57</sup>



#### 4.4 Summary of results

The studies in this review identified a wide range of barriers and facilitators to successful joint commissioning that are summarised in Figure 14. The factors are complex and interrelated. In general the absence of a factor that facilitated joint commissioning became a barrier. For example good leadership and involvement and commitment from senior managers is a factor in successful joint commissioning, and its absence a contributor to a lack of success.

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## CHAPTER FIVE

# Impacts of joint commissioning

### 5.1 Introduction

This chapter gives the results of the synthesis addressing the in-depth review question on the impacts of joint commissioning; all studies identified in the in-depth review explored or provide information on this. The 24 studies from the UK provided data about the views of respondents about the impacts of joint commissioning rather than any comparative outcome data, and therefore confidence in their results was limited.<sup>58-82</sup> One study from Sweden compared the impact between a co-financed site and a control site.<sup>72</sup> This study was rated as of medium quality and therefore we can have some confidence in its results. Further details of all 25 studies are presented in Appendix 8.

### 5.2 Impact of joint commissioning on cost

Six studies (low quality) presented results of the impact of joint commissioning on costs in the context of pooled budgeting.

A number of studies found that cost saving was achieved through reduction in administration and transaction costs.<sup>80,81</sup> For example, a new joint commissioning system was reported to have saved half a million pounds for social care spending within six months, and a youth service and youth training and employment service (Connexions) merger saved about £75,000 by using accommodation better and avoiding duplication of administration.<sup>81</sup> It was also argued that cost savings were achieved through economies of scale.<sup>61,68</sup>

Another study argued that the pooling of budgets as part of the joint commissioning process allowed financial flexibilities which opened up new opportunities to access external sources of finance that would previously only have been available to one partner organisation.<sup>69</sup>

However another study reported problems with dual accounting systems for outcomes and funding, and the unnecessary proliferation of management boards and delivery plans.<sup>81</sup>

### 5.3 Impact of joint commissioning on technical efficiency/outputs

Ten studies (low quality) presented results of the impact of joint commissioning on efficiency or outputs.

These studies claimed that efficiency gains were achieved by avoiding duplication of services, reducing inappropriate referrals and delays in transfer of care. With less overlap and fewer gaps between services provided by different agencies, this reduced waste and improved services using the same amount of resources. It was further argued that improvements in services were generated through the better use of buildings and co-location of staff, and savings from the decommissioning of expensive interventions were reinvested in preventative services.<sup>58,62,69,79,81</sup>

One study reported improved timeliness of chest x-rays, reductions in ultrasound waiting lists and improvements in breast screening services,<sup>63</sup> and another study reported the

development of an efficient and timely system of hospital discharge.<sup>79</sup>

One study found that despite joint provision and commissioning, delays in discharging older people from hospital continued to be common.<sup>71</sup>

#### **5.4 Impact of joint commissioning on service user outcomes**

Thirteen studies (twelve low quality, one medium quality) presented results on the impact of joint commissioning on service user outcomes.

In the medium quality Swedish study of the impact of co-financing, outcomes of patients who attended co-financed centres were compared to outcomes of patients who attended non-co-financed centres. The outcomes measured were pain, number of problems, and health related quality of life. No statistically significant differences between the two groups of patients were identified for any outcomes.<sup>72</sup>

A number of the other low quality studies argued that joint commissioning had led to service improvements and therefore improved outcomes for children, families and staff. For example, in one study, a fall in the number of school-age mothers and a reduction in placements for looked after children was presented as evidence of the success of joint commissioning.<sup>81</sup> Another example of positive impact given was more successful transfer between hospital and community.<sup>59,62,79</sup>

Other studies argued that changes in services and support that resulted from joint commissioning enhanced the quality of life of users, for example, improved mental health and well-being, increased confidence and independence, regaining mobility, staying out of hospital, better use of leisure time, engaging in employment and feeling more secure in general.<sup>60,70,78,80</sup> However some studies reported that joint commissioning led to changes of services that were of concern to service users. Concerns included the introduction of charges, reduced access to services, lack of choice, waiting longer for equipment, the potential isolation of older people and further reductions in the overall quality of home care and residential services.<sup>59,70,76,78</sup>

One study where mental health pooled funds were in place reported that joint financing had little impact on improving learning disability, mental health and older people's outcomes.<sup>58</sup>

#### **5.5 Impact of joint commissioning on team or organisational management for the commissioner or provider**

Twelve studies (low quality) presented results on the impact of joint commissioning on team or organisational management.

In one study a team working through joint commissioning was reported to have created new synergy and 'critical mass', which provided enhanced leverage in relation to local health and social care budgets, making other commissioning arrangements easier. This in turn enhanced morale and improved staff recruitment and retention.<sup>69</sup>

Another study found that joint commissioning groups had improved the morale of GPs. Other studies found that joint commissioning provided stability because of the new capacity to plan ahead, and provided flexibility due to the deployment of a new breed of multi-purpose workers.<sup>59,79</sup> It was felt that the integrated management structure ensured that all professions were afforded respect and equal influence.<sup>79</sup>

There were, however, concerns expressed in some studies about the negative impact of joint commissioning:<sup>59,60,67,70,78,81</sup>

- lack skills or knowledge for new roles;
- additional workloads generated;
- role ambiguity;
- loss of professional identity;
- demotivation and high turnover.

#### **5.6 Impact of joint commissioning on partnership**

Thirteen studies (twelve low quality, one medium) reported results on the impact of joint commissioning on partnership working.

A number of studies suggested that joint commissioning facilitated better partnership working through a number of mechanisms:<sup>58,60,65,66,70-72,74,76,79,80</sup>

- improving communication;
- greater understanding and respect for of different roles and responsibilities approaches;
- fostering greater commitment to joint working;
- providing a ‘framework’ or permission for joint working;
- making accountability clear;
- reducing administration and bureaucracy.

A number of other studies suggested that joint commissioning may have strengthened partnership between some organisations but weakened it between others.<sup>65,74,82</sup> Concerns were also expressed in some studies that joint commissioning had facilitated a ‘takeover’ of one agency by another (usually of social care/welfare by health) rather than development of stronger partnerships.<sup>71</sup>

## 5.7 Summary of results

The perceived positive impacts of joint commissioning identified from studies included in this review can be summarised as:

- reducing duplication of services and cutting out waste;
- saving money;
- providing better services;
- improvements in working relationships and efficiency;
- improvements in staff morale and commitment;
- improvements in patient outcomes.

The perceived negative impacts of joint commissioning identified from studies included in this review can be summarised as:

- increased transaction costs;
- staff demotivation and job insecurity;
- concerns about being taken over by the other partner agency.

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## CHAPTER SIX

# Conclusion and discussion

### 6.1 Discussion

The broad focus of this project was about the models, impact and factors affecting health care commissioning. Identifying what 'commissioning' is or might be on the one hand appears quite straightforward. Most of the UK 'policy' literature appears to refer to a process and would appear by and large to be talking about the same process. However, why this process should be called commissioning instead of planning or continuous quality improvement for example is not immediately obvious from this 'commissioning as process' literature. This is one of the ways in which understanding commissioning is more complex than might at first seem to be the case. Another strand of the policy literature on commissioning appears to focus on the principal-agent relationship, and in particular the purchaser-provider relationship, e.g. GP fundholding. Only a limited subsection of the research literature on commissioning has been investigated in detail in this review (joint commissioning). Based on this literature, it would appear that research either explores or evaluates specific aspects of the commissioning process or some aspect of the principal-agent relationship but not both. It would also appear that little research is conducted in a way that compares different ways of undertaking the process or the outcomes achieved by different types of principal-agent relationship.

The review has proposed that commissioning can be seen as a form of praxis that combines concepts, ideas, and practice from a number of theoretical traditions. It is suggested that the

model proposed by Robinson and others<sup>6</sup> that combines the two dimensions of commissioning referred to above could be applied and developed further as a loose typology for identifying similarities and differences between commissioning approaches. This might sound obvious but it raises important questions about how to characterise different types of commissioning, i.e., what level of granularity is sufficient? Another question addresses the focus and methods of any research that investigates it. For example part of the 'intervention' in Liberating the NHS<sup>83</sup> is GP-led commissioning, i.e., is about changing principal-agent relationships. GPs will have more power and influence in the commissioning process, but the process of commissioning they use is likely to be similar to that used by their predecessor PCTs. It would seem to follow from this that any evaluative effort should focus on comparing outcomes where and when GPs are the 'lead' commissioners with outcomes in situations when they are not.

The review also attempted to map the international research evidence on commissioning in health, social care/ welfare and education. The complexity of commissioning and the different traditions in which the theory/research on commissioning is located mean that the literature on commissioning is very disorganised spread across many fields and difficult to access. The number of potential search sources and search terms is very large. This means that searches were of necessity sensitive, thus generating a lot of off-topic material. This is unusual in

systematic reviews of health interventions as researchers are very specific about what can be included in the review in terms of intervention characteristics and evaluation methods. It is not, however, unusual in social policy reviews. It is therefore important that expectations about what can be achieved by any single review in this area are realistic. This review provides a platform for further systematic interrogation of the existing research literature on commissioning in health because a systematic transparent process has been used to identify the included studies. Further it allows for the expansion of this review to include other sectors and potentially the commissioning of goods (as opposed to just services) in a planned and systematic way.

Only a limited exploration of the identified studies was possible in this review. The identified literature does appear to contain studies from other countries and from sectors other than health. The identified research appears to cover most stages in the commissioning process and quite a large proportion of it appears to focus on the principal-agent relationship aspects of commissioning (e.g. GP commissioning) which are a focus of current policy initiatives.<sup>23</sup>

The in-depth review focused on the impact of joint commissioning of services and the factors that affect this. Given the succession of UK health and social care policy initiatives and the amount of funding that has been allocated to the promotion of joint commissioning, the lack of evidence about impacts and the relatively poor quality of the evidence identified is disappointing. The research evidence identified is mainly from the UK. It is not clear whether this is because the 'problem' of for example health and social care working together is a uniquely UK phenomenon linked to the historical separation of the sectors/services in public policy or whether we just didn't find a way of identifying literature on the same phenomenon in different countries. It could also be the case that in other settings these two 'tribes' are working together within one institutional arrangement and the problems posed by different cultures, histories and perspectives still exist but would be framed as internal organisational performance issues and investigated as such, as business process re-engineering studies for example.

This question also highlights a conceptual or theoretical and linked methodological ambiguity in this literature. Theory was rarely mentioned in the research on joint commissioning reviewed. The research usually takes as its starting point a policy initiative that has been introduced to facilitate commissioners working more closely together. Different stakeholders are then asked whether this led to better outcomes or not and why.

It could be argued that these initiatives are theoretically based on the principal-agent relationship argument, i.e. that 'joint commissioning' is an initiative to change the principal-agent relationship. However as none of the UK studies compared outcomes from 'joint commissioning' with outcomes from single agency commissioning, the question arises as to whether thinking of joint commissioning as part of the general case of joint working might not be a more fruitful approach. How to work effectively together has been widely debated in both health care and social care for several decades.<sup>84</sup> Robust evidence providing indications of good practices and the effectiveness of joint commissioning is scarce. Several systematic reviews of joint working show little reliable evidence of its effectiveness.<sup>4,5,85</sup> The recent review by Weatherly and others<sup>4</sup> indicated that there is a need for robust evidence of effectiveness of financial integration for improved health outcomes or cost saving. Likewise, the review by Snooks and colleagues<sup>85</sup> concluded that the impact of joint working on users' outcomes could not be claimed because the evidence found lacked rigour.

Evidence on the impact of joint commissioning found in this review is limited and inconclusive and thus should be interpreted very cautiously. The synthesis identified a number of claimed impacts of joint commissioning. The term 'claimed impact' is used advisedly. With one exception, all the studies reported outcomes that participants claimed were the results of joint commissioning. There are a number of questions we could ask about these claims but the key question is how those participants 'knew' that the outcomes they reported came about because of joint commissioning and not some other factor. This is a causal claim and in short, the generally accepted scientific approach is that they (and thus we) cannot

be sure of this. This not to say that we could ever be 100 percent certain but rather there are many other possible explanations for these perceived outcomes which are not excluded by the research design and methods used in these studies. It may be significant that the only study that used a design that eliminated at least some of the other potential explanations for any outcomes detected, found no statistically significant differences on any of the patient outcomes measured.<sup>72</sup> The problematic use of research designs that have limited capacity to provide convincing causal explanations is not an uncommon occurrence in the evaluation of social policy. This should not be interpreted necessarily as an absence or omission on the part of the researchers; rather it is linked to the context in which such evaluations are undertaken.

## 6.2 Strengths and limitations of the review

This systematic review was undertaken as part of the NIHR Service Delivery and Organization Programme's themed stream of research work on the practice of health care commissioning. It is, as far as we are aware, the first systematic review to have attempted to be comprehensive, systematic and transparent across such a wide body of literature on the topic of commissioning. As such, both the database and the individual in-depth review provide an important resource for the sectors, not only in their content but also in the development of systematic review methods for future investigation of the questions that remain unanswered in the field.

The careful, detailed and explicit consideration given to the question addressed by each study, the quality of each study, and the quality assurance processes mean that, whilst any reader might not agree with them, the basis for any conclusions reached in the review are clear and open to challenge.

However, this review represents only the first step in an ongoing process of building knowledge and understanding about the impact of commissioning and the factors that affect commissioning. The in-depth review addressed only a very small part of the agenda of interest, but importantly, the systematic and comprehensive approach used means that

it will be possible to utilise the database of studies to begin to address some of the other questions of interest in subsequent reviews.

When conducting systematic reviews in social policy, it is difficult to identify and anticipate all the terminology used to describe or explain the particular phenomenon of interest. When a multidimensional, conceptually complex and ill-defined phenomenon, such as commissioning, is the subject of enquiry, this problem is compounded. Choices have to be made about what 'counts' as an incidence of the phenomenon for the purpose of study selection. This may mean that studies that are relevant but do not apparently fit the definition of the phenomenon used in the review are not identified or are excluded from the review.

It was only possible to conduct a review with such a broad scope in such a comparatively short space of time by using the new technologies of automated text mining. Using an automated approach to selection means that studies are selected for inclusion on the basis of using similar words and/or phrases as studies which are manually identified as being relevant to the review. Therefore, as the technology is dependent on the way that titles and abstracts are written, the automated approach may result in studies being included that are not in fact in scope. In this review, this was minimised by subsequent manual screening of all the studies selected for inclusion in this way. More problematically, the use of text mining might also mean that studies that are within the scope of the review are not recognised as such by the software and are thus missed.

This project has created a publicly available database of research studies on commissioning for the purpose of furthering understanding of past research and to facilitate and guide future inquiry. The database contains approximately 600 empirical studies. Designed to be updatable, the database offers substantial potential for the development of a cumulative knowledge bank in this field. As such, it makes an important contribution to the aim of the NIHR SDO programme to help co-ordinate and share research at national, regional and local levels. However, given the size of the undertaking, only

some limited automated keywording of the database was possible; as a result, some error and/or omission is inevitable and may place some limits on the usage of the database. A further limitation is that included studies were restricted to those published in English.

There were fewer than anticipated high quality studies of the impact of joint commissioning. Given the comprehensive scope of the review and the extensive searching strategy, it seems unlikely that many studies have been missed. The comparatively small number of studies identified is, however, not particularly unusual in social policy systematic reviews. The limitations of the comparatively small number of high quality studies in terms of drawing conclusions about impacts and factors have been discussed above.

## 6.3 Implications

### 6.3.1 The 2010 NHS commissioning reforms

The White Paper of July 2010<sup>23</sup> proposed a significant set of changes affecting the commissioning function in the English NHS. Those that seem particularly relevant to this review include:

- giving several hundred groups of GP practices, to be known as GP commissioning consortia, budgets to commission care for their registered patients by 2013;
- abolishing the 152 Primary Care Trusts and Strategic Health Authorities during 2012/13 plus cutting NHS management costs by 45 percent by the end of 2014;
- establishing a statutory NHS Commissioning Board at national level responsible to the Secretary of State for managing within the overall NHS budget, delivering improvements in key outcome areas (but without use of process targets and top-down performance management) and commissioning highly specialised care, as well as providing guidance and support to GP commissioning consortia, and holding them to account, by April 2012;
- slimming down (30 percent reduction in staff) and refocusing the Department of Health on public health and social care policy, and on

leading a new National Public Health Service to be based in local government;

- extending the role of Monitor, currently the financial regulator of Foundation Trusts, to become the economic regulator of the ‘any willing provider’ market for all services funded by the NHS during 2013/14;
- setting up local ‘HealthWatch’ groups funded by local government to replace Local Involvement Networks to help the public and patients to influence local services, with a national HealthWatch body within the Care Quality Commission (which remains the quality regulator for all health and social care providers), from April 2012;
- transferring funding for health improvement (public health services) to local authorities, which will jointly appoint directors of public health as the local leaders of a new National Public Health Service to be established by 2012.

It is difficult to predict how these changes to commissioning and the rest of the health care system will play out in practice.<sup>86</sup> Furthermore whilst the government itself emphasises certain elements of the plan in its communications (GP-led commissioning for example) commentators highlight others as being of more significance or importance, for example the further extension of market mechanisms signified by opening the NHS market to ‘any willing and competent provider’ and giving Monitor, the former financial regulator of NHS foundation trusts, the far wider role of economic regulator, charged with a duty to promote competition between suppliers.<sup>87</sup>

Arguably the White Paper assumes that ‘commissioning’ requires little definition and as a result does little to clarify its nature and challenges.<sup>88</sup> Some commentators point out that within government itself there appears to be some confusion over whether the vision of commissioning presented represents continuity with previous initiatives such as ‘World Class Commissioning’ or a radical change (e.g. Hunter 2011).<sup>89</sup> The government’s position is that the previous approach to commissioning at local level through PCTs was too remote from the patients it was intended to serve and too little informed by clinicians, and the commissioners

were too constrained by so-called ‘top-down’ targets and managerial control exercised by Ministers and the Department of Health. The idea is that consortia of GP practices will be freer in future to make their own decisions in relation to all but the most specialised services, with the emphasis on holding consortia to account ex post for the outcomes they achieve through the NHS Commissioning Board rather than hedging them around ex ante. The expectation is that this development will, at the same time, push decision making much closer to patients and local communities and ensure that commissioners are also accountable to them as well as to the NHS Commissioning Board. It is further argued that giving GP consortia responsibility for commissioning decisions should improve the quality of decision making since decisions will be more directly underpinned by clinical insight and knowledge of local health care needs. These reforms should also enable consortia to work closely with secondary care, with other health and care professionals, and with community partners to design joined-up services that improve the health and care of patients and the public.

In many respects the plans outlined so far appear to reflect the notion of commissioning as praxis that we outlined in Chapter 2 in that they do not appear to have a clear, articulated conceptual or theoretical underpinning and are being developed in response to feedback and negotiations with key stakeholders (the British Medical Association for example). To the extent that any conceptual or theoretical basis can be identified, using the language of our analytic model of commissioning, the dimension of commissioning emphasised by the government is the principal-agent relationship and specifically the relationship between purchaser and provider, the contract types and the provider types.

The relationship between purchaser and provider relates to the notion of deploying one group of clinicians to act as informed commissioning agents for their patients, thereby enabling them to act as a counterweight to the vested interests of another group of clinicians, namely specialist providers, especially of hospital services, by using their clinical knowledge and experience of local services. This notion underpinned

the previous practice-based commissioning scheme, but more explicitly, the 1990s GP fundholding policy.

Previous initiatives to change the purchaser-provider relationship by strengthening primary care’s position in the relationship include GP commissioning, primary care groups, locality commissioning, Total Purchasing and GP fundholding. This review did not select the question of what these previous models of GP commissioning have been able to achieve as its in-depth review question. Although there have been numerous reviews of variations in these models of commissioning, all have been hampered by the lack of rigorous outcome-based evaluative research on their impacts. These reviews have not been critically analysed as part of our work and therefore we are unable to offer a critical opinion on their findings. It does however seem significant to note that Alan Enthoven, an advocate of the introduction of commissioning and competition into the NHS to improve services, noted that he found little evidence of improved economic performance and a lack of measures of outcomes, service quality and satisfaction on completion of what might be viewed as the first wave of commissioning in 1998(90) (it should be noted that Enthoven attributed this to problematic implementation rather than the policy itself). More recently the House of Commons Health Committee concluded that commissioning (including practice-based commissioning) did not appear on the whole to challenge existing models of care and release savings and appeared to generate increased transaction costs.<sup>91</sup>

Though the evidence from the 1990s on the impact of GP fundholding is relevant to attempting to predict how GP commissioning might perform in the future, consortia will operate in a different NHS environment from that of the GP fundholding era and this may affect their behaviour and likelihood of making a significant contribution to improving the effectiveness, efficiency and responsiveness of services to their patient populations. For example, critics of GP fundholding pointed to high transaction costs as a major weakness of the scheme and the fact that not all practices participated, leading to accusations of a ‘two-tier’ NHS. The subsequent introduction of a standard pricing mechanism for hospital-based

care and national template provider contracts should lead to lower overheads for GP commissioners. All practices will be involved in consortia, removing the risk of a two- or multi-tier system. In addition, the sources of data on the quality and effectiveness of services are now much richer and more readily available, allowing GP consortia to take better informed decisions. Consortia will have far wider budgetary responsibility than fundholders, thereby enabling them to influence a far wider range of services, but they will have to make their own arrangements for managing financial risk since there will be no PCT or health authority at hand to bail them out, during a period of unprecedented financial constraint. It is unclear whether the consortia will be able to mount a more successful challenge to the power of the dominant hospitals than their predecessors and, in particular, whether they will be more effective in shifting care out of hospital, avoiding unscheduled care and providing more efficient models of care for patients with long-term conditions than the PCTs.

There are big questions relating to the willingness and ability of GPs to lead such organisations (their initial reaction has been sceptical,<sup>92</sup> and how well they will be supported (e.g. to assess population needs, handle financial and clinical risk and contract with providers) as management budgets are cut. For example, will consortia have the levers to influence GPs' behaviour to pursue quality improvements and cost savings given that they will not have responsibility for the contracts of their constituent practices? How will the inevitable conflicts of interest between GPs as both commissioners and providers of services be handled, given the strong likelihood that increasing their role in provision will be a strong motivation for GPs to take part in consortia? How will secondary care specialists respond to resources being controlled by groups of primary care generalists? Will GP consortia be better placed to resist pressures to fund high-cost treatments for small numbers of patients at the expense of services able to generate measurable health improvements at a population level? Will consortia be better able to negotiate service reconfigurations with large acute hospitals than their PCT predecessors?

As noted above, commentators and critics of the proposals point to the changes to other aspects of the principal-agent relationship, namely the emphasis on increased competition as a form of contract type, and the greater possibility that private sector institutions will become an active provider type that is signalled in the reforms. According to critics, these changes are not highlighted by government communication precisely because they are the most controversial part of the reforms, and further it is these changes which in the long term will have far more significance for the operation of the NHS than the current proposed changes to the principal-agent relationship.<sup>93</sup> In this respect also, the proposed reforms are consistent with the direction of NHS policy reforms for the last 30 years or so, i.e. that the further introduction of market mechanisms and 'choice' of provider type are necessary to improve the quality of healthcare in the UK. It may or may not be notable that two other countries of the UK, Scotland and Wales, appear to have in recent years rejected this model and returned to a vision of an integrated NHS that predated the introduction of commissioning.<sup>94</sup> This review did not specifically investigate the impact of 'competition' or private companies as providers and therefore it is not possible to offer any comment or prediction on what the possible implications of the introduction of further competition to the NHS may be. Other commentators have however noted that despite the almost universal commitments by the government and its advisers to this model over the last 30 years or so, evidence that supports the claims made for this approach is rather thin on the ground.<sup>95</sup>

### **6.3.2 Implications for proposed reforms of joint commissioning**

Whilst the plans outlined in the White Paper do not appear to emphasise the language of joint commissioning, the theme of partnership and working together is given considerable emphasis, including:

- developing a stronger role for local authorities to help shape commissioning priorities;
- promoting joint approaches to improving health and well-being;

- requiring commissioning consortia to publish their commissioning plans and plans to improve well-being and discuss these with local health boards to ensure that they meet local needs;
- giving local authorities the lead role in promoting the public health of the populations they serve;
- continuing to use and protect capacity for flexible funding arrangements such as pooled budgets where these exist.

This suggests that the issue of relationships between GP commissioning consortia and health and well-being boards will be critical in determining how effective these joint working arrangements are in practice.<sup>86</sup> Given this emphasis, it is useful therefore to reflect on what implications the evidence about joint commissioning identified in this systematic review may have in the newly reconfigured world of commissioning that will emerge in the health and social care sectors over the next few years.

Whilst the strength of the evidence base on the factors affecting the impact of joint commissioning is regarded as weak, nevertheless it may be regarded as providing some insights into issues that may be worth attending to in the process of developing and implementing any new arrangements for health and social care commissioning. What stands out in the evidence is the repeated emphasis on the quality of relationships. The importance of relationships between GP consortia and local authorities is acknowledged in the White Paper but suggests that the changes in structures outlined in the White Paper are needed in order to facilitate good relationships.<sup>83</sup> In this respect, the planned radical changes in structure of the NHS run contrary to the evidence that emphasises the importance of stability and commitment to the success of those relationships and thus joint commissioning. The evidence also suggests that clarity over roles and responsibilities and supportive legal frameworks are important for joint commissioning, particularly in the context of pooling or flexible use of budgets. Given that GP commissioning consortia will be entirely new institutional forms, new legislative

frameworks will be developed to govern their operation. The direction of travel signalled by the proposals suggests a 'deregulated environment in which GP consortia as incorporated bodies will not be directly controlled by the secretary of state for health and will have extraordinary discretionary powers to define entitlement to NHS provision and to charge patients. Similarly direct management and control of NHS providers will cease as foundation trust status becomes mandatory for all trusts.<sup>93</sup>

Whilst the NHS competition board has been given responsibility to make sure that budget flexibilities are used, including existing commitments to pooled budgets, it is not clear how this will be enforced on these independent incorporated bodies. If the lead responsibility for public health is given to local authorities, it is also not clear what the responsibilities of the new GP consortia are in this respect.

The evidence also suggests that coterminosity and co-location are factors that support the development of effective joint commissioning. It is unclear as yet how new GP commissioning organisations will work but the emphasis on the importance of local knowledge given in the arguments for reform suggests that coterminosity and co-location with local authority services, for example, may be more difficult. There are suggestions that GP consortia will vary in size.<sup>96</sup> Furthermore whilst they may commission some services alone, for others, where small population size is a problem, they may commission jointly with other GP consortia. This also suggests that there will be a complex set of relationships for the local authority to develop with multiple consortia and multiple populations. The evidence also suggests that new organisations will need to plan and develop transparent and effective organisational structures and procedures that are perceived by all stakeholders to be fair. As part of this, the evidence suggests that there will be a need to pay particular attention to developing effective means of communication between all stakeholder groups.

The evidence also indicates the importance of established clear structures, operating systems and information systems. Given the

degree of structural change proposed, it seems reasonable to assume that the establishing of new, clear and effective structures, operating and information systems will take some time, and in this respect, the emphasis being placed on speedy implementations of the proposed changes may mitigate against their success.

### **6.3.3 Research**

One of the aims of this review was to highlight potential research directions suggested by the current evidence base in this area. The in-depth review investigated only a small part of the evidence base for the impact of commissioning. Research may wish in the future to explore additional areas of the systematic map, for example, by undertaking a synthesis of the impact of commissioning in mental health services.

#### **Primary research**

This review provides little evidence about 'how to do' joint commissioning. This is because the research evidence in the field is methodologically weak and provides largely superficial descriptions of the processes of joint commissioning investigated. The deficits noted in this literature mean that further and better quality research is required in this field.

Even with the caveat that this review has explored only a small part of the evidence base for the impact of commissioning, it seems likely that the yield of high quality evaluative studies that use quantitative, valid and reliable measures of impact on patients in this area is likely to be small, and those defined as high quality even smaller. Whilst this is not unusual in most areas of social policy, commissioners of research should consider commissioning further rigorous high quality impact studies that compare outcomes achieved by different types or approaches to commissioning.

However, any commissioned research needs to be designed such that it can develop the existing knowledge base. Studies would need to use designs that control adequately for bias and that were of a sufficiently large scale to facilitate 'transfer' into policy and practice. The study by Hulberg and others<sup>72</sup> included in this review provides a useful model for the design of such studies. Furthermore any such research should have a clear theoretical or conceptual framework that provides the basis

for its account/description of commissioning that is investigated. The 'loose typology' suggested here provides a starting point for this but further development and testing through application will be required to verify the validity and utility of this approach. There also appears to be little if any cost-benefit analysis in this area, and this should be a feature of any new evaluation research that is commissioned.

Perhaps one of the main barriers to the conduct of high quality evaluative research is policy makers or politicians. It would appear that most research on commissioning (certainly the research on joint commissioning in this review) is conducted in response to a change in policy on commissioning and is funded by Government (directly or indirectly). The problem with policymaking on commissioning (as with many areas of government policy) is that when a change is made it is done all at once for everybody. This makes the conduct of comparative prospective experimental studies much more difficult. It is important that politicians and policy makers should consider requirements for rigorous prospective evaluation of policy interventions as part of any policy roll out and that the stakeholders in the field continue to remind them of this. Whilst there are many challenges in designing and conducting rigorous studies of this type on social policy initiatives, they are not impossible given sufficient political will and resource. Secondary research, i.e. retrospective analysis of data, could also make a contribution to the evaluation of commissioning. Whilst there appear to be some studies of this type in the commissioning database, there are not as many as would be expected given the focus on impact. The new proposals for reorganising health commissioning present an ideal opportunity to create the conditions necessary for conducting rigorous evaluations of different types of commissioning relationships. A phased introduction of the changes would create the conditions for a natural experiment and possibly even some kind of prospective random allocation to the new system. A rigorous evaluation on a sufficiently large scale would represent an invaluable contribution to knowledge about the impact of different forms of commissioning.

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## CHAPTER SEVEN

# References

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# Appendix 1.1: Authorship of this report

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## Appendix 1.2: Scoping exercise: search sources

### 1.1 Websites and key reports of relevant organisations

Health	Department of Health and world class commissioning ( <a href="http://www.dh.gov.uk/en/managingyourorganisation/commissioning/worldclasscommissioning/index.htm">http://www.dh.gov.uk/en/managingyourorganisation/commissioning/worldclasscommissioning/index.htm</a> )
	Royal College for Nursing ( <a href="http://www.rcn.org.uk/">http://www.rcn.org.uk/</a> )
	King's Fund ( <a href="http://www.kingsfund.org.uk/">http://www.kingsfund.org.uk/</a> )
	Bazian (Evidence-based support for healthcare commissioning) ( <a href="http://www.bazian.com/about_us/index.html">http://www.bazian.com/about_us/index.html</a> )
Local government	Department for Communities and Local Government - National Procurement strategy ( <a href="http://www.communities.gov.uk/localgovernment/">http://www.communities.gov.uk/localgovernment/</a> )
	Department for Communities and Local Government
	The Society of Procurement Officers in Local Government (SOPO) ( <a href="http://www.sopo.org/">http://www.sopo.org/</a> )
Social care	The Social Care Institute for Excellence (SCIE) ( <a href="http://www.scie-socialcareonline.org.uk">www.scie-socialcareonline.org.uk</a> )
Education	Department for Education
	The Commissioning Support Community ( <a href="http://www.commissioningsupport.org.uk/">http://www.commissioningsupport.org.uk/</a> )
Research Centres	Health Services Management Centre, University of Birmingham ( <a href="http://www.hsmc.bham.ac.uk/">http://www.hsmc.bham.ac.uk/</a> )
	Centre for Research in Strategic Purchasing and Supply, University of Bath ( <a href="http://www.bath.ac.uk/crisps/">http://www.bath.ac.uk/crisps/</a> )
	University of Brighton, Institute of Postgraduate Medicine ( <a href="http://www.bsms.ac.uk/school-and-staff/divisions/ipgm/">http://www.bsms.ac.uk/school-and-staff/divisions/ipgm/</a> )
	Centre for Health Economics, University of York ( <a href="http://www.york.ac.uk/inst/che/">www.york.ac.uk/inst/che/</a> )
	School of Health and Human Sciences, University of Essex ( <a href="http://www.essex.ac.uk/hhs/">www.essex.ac.uk/hhs/</a> )
Other websites of relevant organisations	Chartered Institute of Purchasing and Supply ( <a href="http://www.cips.org/">http://www.cips.org/</a> )
	The Nuffield Trust ( <a href="http://www.nuffieldtrust.org.uk/">www.nuffieldtrust.org.uk/</a> )

## 1.2 Key reviews

Boyne G (1998) Competitive tendering in local government: a review of theory and evidence, *Public Administration*, **76**: 695-712.

Chappel D, Miller P, Parkin D, Thomson R (1999) Models of commissioning health services in the British National Health Service: a literature review. *Journal of Public Health Medicine* **21**(2):221-227.

Figueras J, Robinson R, Jakubowski E (2005) *Purchasing to improve health systems performance*, European Observatory on Health Systems and Policies Series. Maidenhead: Open University Press.

LeGrand J, Mays N, Mulligan J (eds) (1998) *Learning from the NHS internal market*. London: Kings Fund.

Office for Public Management (2008) *Literature review: multi-level commissioning*. London: OPM.

Smith J, Mays N, Dixon J, Goodwin N, Lewis R, McClelland S, McLeod H, Wyke S (2004) *A review of the effectiveness of primary care-led commissioning and its place in the NHS*. London: The Health Foundation.

Wade E, Smith J, Peck E, Freeman T (2006) *Commissioning in the reformed NHS: policy into practice*. Birmingham: Health Services Management Centre.

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## Appendix 2: Stakeholder survey

### *Recruitment and data collection*

The following sources were used to identify the relevant stakeholders:

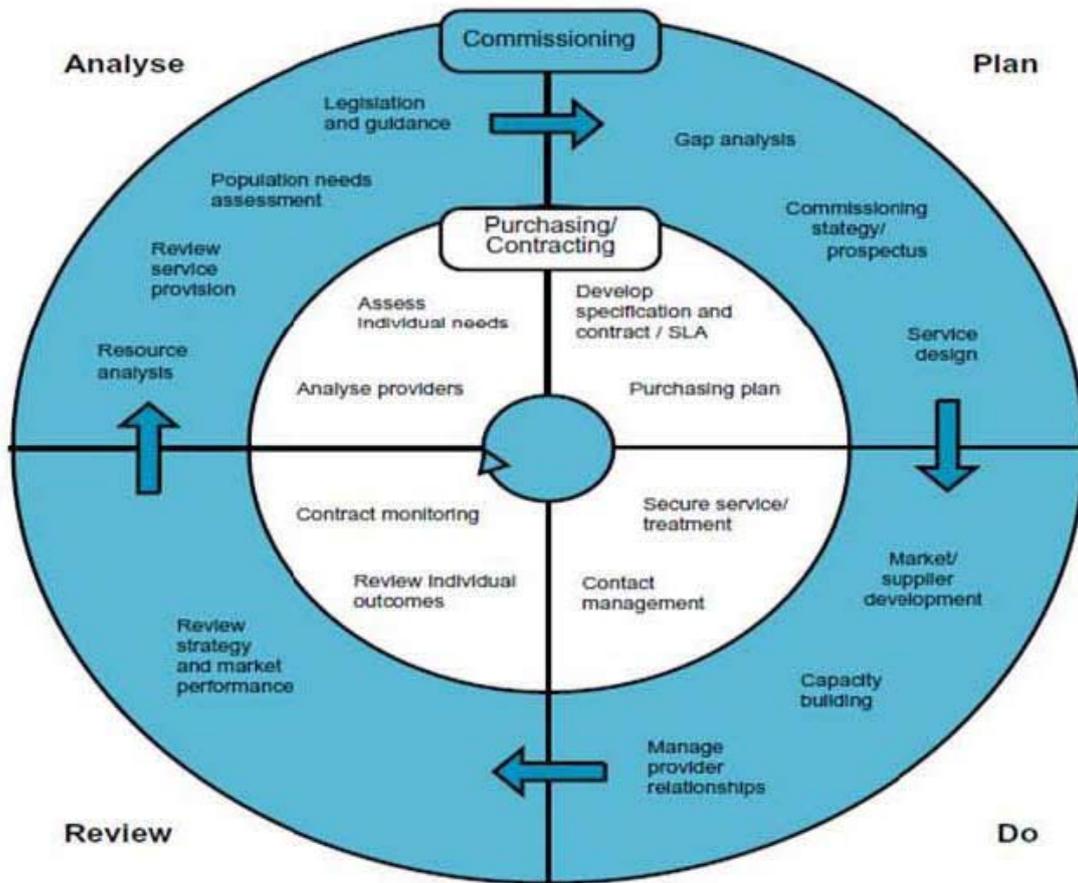
1. The websites of the following organisations were reviewed to identify policy makers and directors/managers involving commissioning in services/programmes:
  - a. Department of Health, commissioning (<http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/index.htm>);
  - b. Department for Children, Schools, and Families ([http://www.commissioningsupport.org.uk/about\\_commissioning.aspx](http://www.commissioningsupport.org.uk/about_commissioning.aspx));
  - c. Department for Communities and Local Government;
  - d. Care and Service Improvement Partnership (<http://www.csip.org.uk/>);
  - e. The Association of Directors of Adult Social Services (ADASS) (<http://www.adass.org.uk/>).
2. Google Scholar was searched to identify relevant reviewed papers, books, or book chapters. The authors of these documents were then included in the sample list.
3. Stakeholders from policy, practice and academia were contacted to obtain their views. Respondents or respondents' organisations were contacted via e-mail with a request to participate in the survey and were free to decline. They were also requested to suggest other potential stakeholders whom we could then contact and ask to participate in this survey.

### **A2.1 Questionnaire**

Department for Communities and Local Government 2008

'Commissioning refers to a series of interlinked processes, based on a robust analysis of needs in a defined area, that enable the purchasing of services that vulnerable people need in a timely, efficient and acceptable manner, at a quality and affordable price that meets stated minimum requirements. It involves developing policy, service models and delivery capability to meet the identified needs in the most appropriate and cost effective way; and then managing performance and seeking service improvement through parallel management of various relationships with providers and commissioning partners.' (p.7)

Department for Communities and Local Government, 2008 (P. 22)



Definition and stages of commissioning:

The model/definition/ scope of ‘commissioning’ presented above is taken from the Dept for Communities and Local Government. However it appears to us to cover all of the different aspects of commissioning that we have identified from a limited initial scoping of academic and policy literature across different public sector areas. (Note: we are not limiting our definition or the model of commissioning to vulnerable people)

- a.) Does this model encompass all the relevant aspects/ dimensions of ‘commissioning’ from the perspective of your role/dept/ field? If not please identify any additional items/ dimensions that we should also consider.
- b.) Is there any other terminology used to describe either the stages in the process of commissioning or the process of commissioning itself that we should include in our search terms for the systematic review?

2. What in your view is/are the conceptual or theoretical underpinnings of ‘commissioning’

3. We plan to identify evidence about the impact of commissioning across the 'public sector'.

a) How would you define the public sector?

b) Given the size and scope of the 'public sector' in addition to 'health' which would you say at the other public sector areas from which we could learn most about the impact of commissioning

4. What outcomes of commissioning do you think should be measured?

5. We would be very grateful for any other relevant information that you think we should engage with as part of the review

6. Demographic information:

Name or respondent and organization

Name:

Organization:

Country:

Email

Address:

7. Are you responding in a personal capacity or on behalf of your organization?

Personal Capacity

Behalf of my organization (If responding on behalf on an organization please specify the total number of individuals in the organization below )

No. of individuals in the organization

8. What is your specialization/ specialization of your organization e.g. health care, mental health, education, social care etc

9. Do you or your organization wish to be named in this report?

Yes

No

Other (please specify)

## A2.2 Letter to stakeholders

Dear Colleague,

We are undertaking a systematic review of the impact of ‘commissioning’ in the public sector, funded by the National Institute for Health Research Service Delivery and Organisation (NIHR SDO) research programme. The initial stage of this process is to identify the practical and conceptual scope of ‘commissioning’. As part of this process we are contacting a range of expert stakeholders to obtain their help with this task. We would be grateful if you could complete this short survey. All responses will be confidential and anonymous and will not be used for any other purpose.

What will you need to do to take part?

The study involves a self-completion questionnaire, which should take no longer than 20-30 minutes to fill in. The questionnaire is available electronically at (ctrl + click to follow link below):

<http://www.surveymonkey.com/s/QXP6LV3>

and the deadline for responses is December 11th, 2009.

Your participation is voluntary but we do very much hope that you will add your views. If you feel there someone in your organization who is more suited to answering this survey, do pass on their details to Dr. Mark Newman on the e-mail address provided below. If you have any questions about the study that you would like to ask before deciding whether to participate, or would like any more information about this review please feel free to contact the project lead Dr Mark Newman [m.newman@ioe.ac.uk](mailto:m.newman@ioe.ac.uk)

## 2.3 List of stakeholders contacted

Stakeholder groups	Sectors	Who
Service users	Health sector	Catton and Platt (2009). Local healthcare commissioning: grassroots involvement.
Policy makers	Health/social care	Claire Whittington, Acting Director of Commissioning, DoH
	Health/private sector	Mark Britnell, former (until Sept 2009) director general of commissioning at the DoH; currently KPMG head of health care
		Barry McConmack, Chief Economist, DoH
		Una O’Brien, Strategy Unit, DoH
		James Kingsley, Commissioning, DoH
		Johnny Marshall, <sup>2</sup> National Association of Primary care
		Ross Gribben, Cabinet Office
	Julie Wood, Director of the NHS Alliance PBC Federation	

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Stakeholder groups	Sectors	Who
Policy makers	Health	Gary Belfield, Director of Commissioning, DoH
	Health	Mike Farrar, Chief Executive, Northwest Strategic Health Authority
	Health/social care	Dr Angela Lennox, Deputy National Director for Primary Care, Department of Health; on the Audit Committee of Turning Point
	Not for-profit/social care	Paul Haigh, Executive Director and Project Manager, East London Integrated Care (ELIC)
	Health/social care	Eamonn Kelly, Director of Commissioning and Performance, NHS West Midlands
	Health	Carole Harder, Director of Primary Care, Darlington PCT
	Health	Stephen Day, Head of Integrated Commissioning, Ealing Council and Ealing Primary Care Trust
	Education	Lorraine O'Reilly, <sup>2</sup> Director of Commissioning Support Programme, DCSF
	Third sector	Tina Holland, Programme Manager for phase two of the National Programme for Third Sector Commissioning and the Theme Consultant for Strategic Commissioning Beacons
	Third sector	Helen Hughes, National Adviser, Voluntary and Community Sector
	Third sector	Judy Weleminsky, Chief Executive, Mental Health Providers Forum
	Third sector	Pauline Kimantas, Commissioning and Procurement Manager, National Association for Voluntary and Community Action
	Third sector	John Dawson, Local Commissioning and Procurement Adviser, National Association for Voluntary and Community Action
	Local government	Sue Hurrell, <sup>2</sup> Government Market Team through the Office of Government Commerce (OGC) Service Desk
	Local government	Peter Fanning, <sup>2</sup> currently Deputy Chief Executive of OGC
	Local government	Local Government Association <sup>2</sup>
	Social care	Sandie Keene, <sup>2</sup> Director in Leeds, Association of Directors Social Services
	Cross-sector	Caroline Watts, Associate Health Director, Audit Commission
	Local government	Communities and Local Government (CLG) <sup>2</sup>
	Health	Elizabeth Wade, NHS Confederation
Health	Rebecca Rosen, Nuffield Trust <sup>2</sup>	
Health	Natasha Curry, Kings Fund	
Private sector	Richard Lewis, <sup>2</sup> Ernst and Young, Kings Fund	
		Clive Bowman, FRCP, Medical Director, BUPA Care Services

Stakeholder groups	Sectors	Who
Managers	Health	Dr Nigel Watson
	Health	Dr Nicholas Hicks, Chief Executive and Director of Public Health, Milton Keynes Primary Care Trust and Director of Public Health, Milton Keynes Council
	Health/ social care	Alex Walker, Associate Director - Commissioning, NHS Central Lancashire
	Health/ social care	Jasbant Mann, Senior Joint Commissioning Manager, NHS Walsall
	Health/ social care	Ayesha Lulat, PBC Development Manager
	Health	Tony Roberts, NHS Middlesbrough (formerly Middlesbrough PCT)
Academic	Health	David Chappel, Newcastle upon Tyne
	Private sector	Barbara Allen, Warwick
	Health care	Helen Dickinson, Birmingham
		Rod Sheaff
	Private sector	Philip Provenzano, Assistant Director IPC, Oxford Brooks University
	Health	David Hunter, Commissioning Research Unit, University of Durham
	Health	Alicia O’Cathain, SchARR, Sheffield
	Health/not for-profit	Martin Roland, Cambridge/RAND
	Health	Chris Ham, University of Birmingham
	Health	Judith Smith, The Nuffield Trust
	Social services	Kirstein Rummery, University of Stirling
	Health and social care	Jon Glasby, Professor of Health and Social Care and Co-Director, Health Services Management Centre, University of Birmingham
	Health	Stephen Peckham, Reader in Health Policy, London School of Hygiene and Tropical Medicine (LSHTM)
	Private sector/health of vulnerable people	Pauline Allen, Senior Lecturer in Organisational Research, LSHTM
	Private sector	Evan Mills, University of California, Berkeley
	Social services	Caroline Glendinning, University of York
	Social services	Dr Kate Baxter, University of York
	Private sector	Patrick Bajari, University of Minnesota
	Private sector	Steven Tadelis, University of California Berkeley
	Health sector	Stephen Smith, Imperial College, London
	Health and social care	Nick Goodwin, LSHTM/Kings Fund
	Mental health	Graham Thornicroft, Kings College, London
	Social care	Colin Slasberg, Community Well-being, Thurrock District Council
Local government	Professor Chris Skelcher, Professor of Public Governance, University of Birmingham	

Stakeholder groups	Sectors	Who
Academic	Private sector	Christine Harland, Professor, in Supply Management and Director of the Centre for Research in Strategic Purchasing and Supply, University of Bath School of Management
	Private sector	Cam Donaldson, Newcastle
	Private/health care	Ruth McDonald, Nottingham
	Private sector	Guy Callender, Foundation Chair and Professor of Strategic Procurement, Curtin University of Technology, Perth, Australia
	Private sector	Jan Telgen, NEVI Professor of Purchasing Management and Professor of Applied Operations Research, the University of Twente
	Private sector	Dr Khi V. Thai, School of Public Administration Florida Atlantic University
	Education	Harry Anthony Patrinos, World Bank/Harvard
	Local authority	Professor Steve Martin, Cardiff Business School, Cardiff University
	Health systems	Joseph Figueras, <sup>2</sup> European Observatory on Health Systems and Policies
	Social services	Julien Forder, London School of Economics
	Health/social services/ economics	Martin Knapp, LSE/Kings College
	Health	Ray Robinson, LSE
	Health	Geoff Boyne, <sup>2</sup> University of Birmingham

1. This report involves a large sample of health care user and public perspectives on the definitions, advantages and disadvantages of local health care commissioning (n=226 groups of which 200 are local groups based across different parts of England). The survey's questions were open-ended. Therefore, since such a report already fulfils our purpose, it may be beneficial to use its findings directly instead of repeating the task.

2. Individuals that could not be contacted directly as no e-mail address for them could be found. Their organisations were contacted requesting them to forward a request to participate in the survey to them or to provide a relevant e-mail address. Therefore, it is not clear if these stakeholders received our request to participate or not.

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## Appendix 3: Exclusion criteria

**EXCLUDE 1** NOT published in English

**EXCLUDE 2** NOT published in or after 1989

**EXCLUDE 3** Is out of topic

*Study has nothing to do with the process of commissioning, assessing, planning, purchasing, evaluation of products/services.*

**EXCLUDE 4** NOT about health/education/social care

*Study is NOT about commissioning of services in three service areas: health (health services, public health services), education, and social care (sickness and disability, old age, family and children, unemployment, housing)*

*In the other word, public or private sector entities that provide, supply and maintain the following services were NOT in the scope of this review.*

- *General public services (executive and legislative organs, financial and fiscal affairs, external affairs, foreign economic aid and general services)*
- *Defence (military and civil defence and defence R&D)*
- *Public order and safety (police services, fire-protection services, law courts, prisons)*
- *Economic affairs (general economic, commercial and labour affairs, agriculture, forestry, fishing and hunting, fuel and energy, mining, manufacturing and construction, transport, communication)*
- *Environmental protection (waste management, waste water management, pollution abatement, protection of biodiversity and landscape)*
- *Housing and community amenities (housing development, community development, water supply, street lighting)*
- *Recreation, culture and religion (Recreational and sporting services, cultural services, broadcasting and publishing services, religious and other community services)*

**EXCLUDE 5** About commissioning of products

*Study is about commissioning of products such as health care insurance, medical products, medical appliances and equipment, school buildings, stationery.*

**EXCLUDE 6** About commissioning of support services

*Study is about commissioning, outsourcing, or contracting of support services. These services include cleaning, catering, maintenance, security, professional or research services, or business functions within the organisations (such as human resources, finance, accounting, information technology, legal services, R & D)*

**EXCLUDE 7** About services bought by individuals

*Study is about services bought by individuals or purchasing of services by individuals.*

**EXCLUDE 8** NOT an empirical primary study

*Study is NOT an empirical primary study and is not a relevant review or overview or country case study description on the topic.*

*Policy documents, editorials, comments, reviews, anecdotes, case descriptions, news reports, government policy and guidance were not included in this review.*

*If a title and abstract does NOT use any terms/words (e.g. investigate, analyse, finding, result, explore, interview, survey, case studies, evaluate etc) that would indicate/imply that the study is empirical, it was excluded.*

**EXCLUDE 9** Systematic reviews on the topic

**EXCLUDE 10** NOT empirical BUT background readings

*Relevant reviews and background reading on topic but not empirical*

**EXCLUDE 11** Monitoring reports, audit reports or country case studies

*Study is an inspection report or monitoring projects/programme report or a country level overview/case description study with no primary analysis of data.*

**EXCLUDE 12** Does NOT report relevant outcomes of commissioning

*For example, a primary study does NOT report/measure an outcome of commissioning included in (but not limited to) the list below:*

- *Quantity of outputs (e.g., numbers of operation performed in hospitals, hours of teaching delivered in schools, numbers of houses built, waiting time)*
- *Quality of output (e.g. reliability of services)*
- *Efficiency*
- *Equity (e.g. fairness of service distribution)*
- *Outcomes (e.g. mortality, morbidity, quality of life, examination results, poverty rate)*
- *Value for money (e.g. cost per unit of outcome)*
- *Customer satisfaction (e.g. customer choices, experiences)*

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# Appendix 4: Search sources and search strategies of systematic review

## 4.1 The bibliographic databases searched

AEI  
Applied Social Science Index (ASSIA)  
BEI  
CINAHL  
Econlit  
ERIC  
Health Business Elite  
Health Management Information Consortium (HMIC)  
Medline  
PsychINFO  
Social Policy and Practice  
Social Science Citation Index (SSCI)  
Social Service Abstract (CSA)  
The Cochrane Central Register of Controlled Trials  
the Health Management Information Service (HELMIS) (OVID)  
The International Bibliography of the Social Sciences (IBSS)

## 4.2 Websites of relevant organisations and research centers

Asian Development Bank (ADB) (<http://www.adb.org/>)  
Bazian (Evidence-based support for healthcare commissioning) ([http://www.bazian.com/about\\_us/index.html](http://www.bazian.com/about_us/index.html))  
Commissioning Support Programme (<http://www.commissioningsupport.org.uk/>)  
Department for Children, Schools and Families (<http://www.dcsf.gov.uk/schoolscommissioner/LA-commission.shtml> - now decommissioned)  
Department for Work and Pensions (<http://www.dwp.gov.uk/>)  
Department of Health and world class commissioning (<http://www.dh.gov.uk/en/managingyourorganisation/commissioning/worldclasscommissioning/index.htm>)

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DH care network (<http://www.dhcarenetworks.org.uk/BetterCommissioning/>)

ELDIS (<http://www.eldis.org/go/topics/dossiers/meeting-the-health-related-needs-of-the-very-poor/health-related-strategies-for-reaching-the-poor/contracting-out-of-health-care-provision>)

Google

Google Scholar

Health Foundation (<http://www.health.org.uk/>)

Health Services Management Centre, University of Birmingham (<http://www.hsmc.bham.ac.uk/>)

Health Systems Evidence, McMaster University (<http://www.healthsystemsevidence.org/>)

Institute of Local Government Studies, University of Birmingham (<http://www.inlogov.bham.ac.uk/>)

Institute of Public Care, Oxford Brooke University (<http://ipc.brookes.ac.uk/>)

Medicare and Medicaid (<http://www.cms.gov/>)

National Audit Office, UK (<http://www.nao.org.uk/>)

National Foundation for Educational Research (<http://www.nfer.ac.uk/index.cfm>)

NHS Evidence - commissioning (<http://www.library.nhs.uk/commissioning/ViewResource.aspx?resID=282415>)

Nuffield Centre for International Health and Development (<http://www.leeds.ac.uk/nuffield/>)

Office for Public Management (<http://www.opm.co.uk/>)

RAND Corporation (<http://www.rand.org/>)

School of Health and Human Sciences, University of Essex (<http://www.essex.ac.uk/hhs/>)

Social Care Institute for Excellence (SCIE) ([www.scie-socialcareonline.org.uk](http://www.scie-socialcareonline.org.uk))

World Bank (<http://www.worldbank.org/>)

World Health Organization (<http://www.who.int/en/>)

### **4.3 Reference lists searched from the following systematic reviews, reviews, reports and peer-reviewed journal articles**

Bifulco L, Vitale T (2006) Contracting for welfare services in Italy. *Journal of Social Policy* 35(3): 495-513.

Bovaird T (2006) Developing new forms of partnership with the 'market' in the procurement of public services. *Public Administration* 84(1): 81-102.

Bovaird T, Halachmi A (2001) Learning from international approaches to Best Value. *Policy and Politics* 29(4): 451-463.

Boyne GA (2003) Sources of public service improvement: a critical review and research agenda. *Journal of Public Administration Research and Theory*, 13(3): 367-394.

Bredgaard T, Larsen F (2008) Quasi-markets in employment policy: do they deliver on promises? *Social Policy and Society* 7(3): 341-352.

Cameron AM, Lart RA (2003) Factors promoting and obstacles hindering joint working: a systematic review of the research evidence. *Journal of Integrated Care* 11(2): 9-17.

Chappel D, Miller P, Parkin D, Thomson R (1999) Models of commissioning health services in the British Health Service: a literature review. *Journal of Public Health Medicine* 21(2): 221-227.

Donaldson C, Currie G (2000) *The public purchase of private surgical services: a systematic review of the evidence on efficiency and equity*. Working paper 00-9. Edmonton: Institute of Health Economics.

Dudley RA, Frolich A, Robinowitz DL, Talavera JA, Broadhead P, Luft HS (2004) *Strategies to support quality-based purchasing: a review of the evidence*. Rockville, MD: Agency for Healthcare Research and Quality.

England R (2004) *Experiences of contracting with the private sector: a selective review*. London: DFID Health Systems Resource Centre.

Finn D (2007) *Contracting out welfare to work in the USA*. Research report No 466. London: Department for Work and Pensions.

Finn D (2008) *The British Welfare Market: lessons from contracting out welfare to work programmes in Australia and the Netherlands*. York: Joseph Rowntree Foundation.

Finn D (2009) *Differential pricing of contracted out employment programmes: review of international evidence*. London: Department for Work and Pensions

Glendinning C (2003) Breaking down barriers: integrating health and care services for older people in England. *Health Policy*. **65**: 139-151.

Gosden T, Torgerson DJ (1997) The effect of fundholding on prescribing and referral costs: a review of evidence. *Health Policy* **40**: 103-114.

Greig R, Poxton R (2001) Nice process: but did joint commissioning change anyone's life? *Journal of Integrated Care* **9**(2): 16-21.

Ham C (2008) World class commissioning: a health policy chimera? *Journal of Health Service Research Policy* **13**(2): 116-121.

Hirsch, WZ (1995) Contracting out by urban governments: a review. *Urban Affairs Review* **30**(3): 458-472.

Hodge G (1998) Contracting public sector services: a meta-analytic perspective of the international evidence. *Australian Journal of Public Administration* **57**(4): 98-110.

Hultberg E-L, Glendinning C, Allebeck P, Lonnroth K (2005) Using pooled budgets to integrate health and welfare services: a comparison of experiments in England and Sweden. *Health and Social Care in the Community*, **13**(6): 531-531.

Lagarde M, Palmer N (2009) The impact of contracting out on health outcomes and use of health services in low and middle-income countries. *Cochrane Database of Systematic Reviews*, Issue 4. Art. No.: CD008133

Liu X, Hotchkiss DR, Bose S (2007) The impact of contracting-out on health system performance: a conceptual framework. *Health Policy* **82**(2):200-211.

Liu X, Hotchkiss, DR, Bose S (2008) The effectiveness of contracting-out primary health care services in developing countries: a review of the evidence. *Health Policy and Planning*, **23**(1): 1-13.

Livesey H (1998) Fundholding and contracting for community nursing services: a selective review of the literature. *Journal of Advanced Nursing* **28**(3): 483-490.

McClelland S, Rogers D, Davies R, Griffiths L, Hughes H, Jones M, Phillips, C (2001) *Effective models of commissioning: the evidence*. Pontyclun: The Centre for Health Leadership Wales.

Mills, A, and Broomberg, J (1998) *Experiences of contracting health services: an overview of literature*. London: Health Economics and Financing programme, WHO.

Office for Public Management (2008) *Literature review: multi-level commissioning*. London: OPM.

Peterson L, Woodard L, Urech T, Daw C, Sookanan S (2006) Does pay-for-performance improve the quality of health care? *Annals of Internal Medicine* 14(4): 265-272.

Smith J, Mays N, Dixon J, Goodwin N, Lewis R, McClelland S, McLeod H, Wyke S (2004) *A review of the effectiveness of primary care-led commissioning and its place in the NHS*. London: The Health Foundation.

Smith J, Dixon J, Mays N, McLeod H, Goodwin N, McClelland, S, Lewis R, Wyke, S (2005) Practice based commissioning: applying the research evidence. *British Medical Journal* 331: 1397-1399.

Weatherly H, Mason A, Goddard M, Wright K (2010) *Financial integration across health and social care: evidence review*. Edinburgh: Scottish Government Social Research.

West PA (1998) Market - what market? A review of health authority purchasing in the NHS internal market. *Health Policy* 44: 197-183.

Winston P, Burwick A, McConnell S, Roper R (2002) *Privatization of welfare service: a review of the literature*. Washington DC: Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

Yeh SS (2007) The cost-effectiveness of five policies for improving student achievement. *American Journal of Evaluation* 28(4): 416-436.

#### **4.4 Relevant peer reviewed journals**

Journal of Integrated Care

International Journal of Integrated Care

#### **4.5 Commissioning terms**

Commissioning

Competitive tendering

Contracting

Fund-holding

Internal market

Outsourcing

Pay for performance

Privatisation

Procurement

Purchaser-provider split

Purchasing

Quasi market

Sickness fund

More specific terms (used when it was not possible to use the terms above)

Assessment of service quality and cost

Budgets

Collaborative commissioning

Contracting out

Contracting-out/ contracting out

GP purchasing

Integrated commissioning

Joint commissioning

Locality commissioning/purchasing/contracting

Locality planning

Macro commissioning

Micro commissioning

Multi-level commissioning

Needs analysis

Needs assessment

Outcome-based purchasing/contracting

Output-based contract

Pay for performance

Performance-based commissioning/contracting/purchasing

Primary care-led commissioning

Priority-setting

Programme budgeting and marginal analysis

Public-private partnership

Regional commissioning

Specialist commissioning

Strategic commissioning/purchasing/contracting

Sub-regional commissioning

Value-based purchasing

## **4.6 Search strategies**

Searches were carried out between 19 January 2010 and 15 February 2010

### ***Social policy and practice***

#### *Search 1*

1 (multi level commissioning or multi-level commissioning or integrated commissioning or strategic commissioning or joint commissioning or regional commissioning or micro commissioning or macro commissioning or locality commissioning or (value-based commissioning or value based commissioning) or (outcome based commissioning or outcome-based commissioning) or performance-based commissioning or performance based commissioning or collaborative commissioning or primary care led commissioning or primary care-led commissioning).af.

2 (contracting out or strategic contracting or locality contracting or (value-based contracting

or value based contracting) or (outcome based contracting or outcome-based contracting) or (performance-based contracting or performance based contracting)).af.

3 (strategic purchasing or locality purchasing or specialist commissioning or GP purchasing or (value-based purchasing or value based purchasing) or (outcome based purchasing or outcome-based purchasing) or (performance-based purchasing or performance based purchasing)).af.

4 (purchasing adj10 service\*).mp. [mp=abstract, title, publication type, heading word, accession number]

5 (procurement adj10 service\*).mp. [mp=abstract, title, publication type, heading word, accession number]

6 (privatisation and social care).af.

7 (privatisation and education).af.

8 (privatization and service\*).af.

9 (privatization and education).af.

10 (privatization and social care).af.

11 (privatisation adj10 service\*).mp. [mp=abstract, title, publication type, heading word, accession number]

12 (outsourcing adj10 service\*).mp. [mp=abstract, title, publication type, heading word, accession number]

13 (fundhold\* or fund holding or fund-holding).af.

14 (internal market or quasi market or quasi-market).af.

15 sickness fund.af

16 competitive bidding.af.

17 (competitive tendering adj10 service\*).mp. [mp=abstract, title, publication type, heading word, accession number]

18 purchaser-provider split.ti,ab.

19 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18

20 limit 19 to yr='1989 -Current' (2073)

## *Search 2*

1 priority setting.mp. [mp=abstract, title, publication type, heading word, accession number]

2 ('best value' adj5 'local authorit\*').mp. [mp=abstract, title, publication type, heading word, accession number]

3 marginal analysis.mp. [mp=abstract, title, publication type, heading word, accession number]

4 budget holding.mp. [mp=abstract, title, publication type, heading word, accession number]

5 (budget\* adj3 service\*).ti,ab.

6 5 or 6 or 7 or 8 or 9 or 10

7 limit 11 to (yr='1989 -Current)

## ***Social Service Abstracts***

### *Search 1*

DE=('contracts' or ('public sector private sector relations') or 'purchasing') or AB=((('contracting out') or 'commissioning' or 'procurement') or AB=('prepayment' or 'pre-payment' or ('competitive tendering'))) or AB=((('internal market') or ('quasi market') or ('sickness fund')) or AB=((('sick fund')

or 'outsourcing' or ('pay for performance'))

Date Range: 1985 to 2010

Limited to: English Only

### *Search 2*

(DE='resource allocation') or(DE='budgets') or(KW=(best value) and KW=(local authorit\*)) or(KW=assessment and KW=(service quality)) or(KW=assessment and KW=(service cost)) or(KW=priority-setting) or(KW=(programme budget) and KW=(marginal analysis))

## ***Health Management Information Consortium (HMIC)***

### *Search 1*

1 (procurement adj10 service\*).mp. [mp=title, other title, abstract, heading words]

2 outsourcing.mp.

3 PRIVATISATION/

4 privatization.mp. [mp=title, other title, abstract, heading words]

5 quasi market.mp.

6 quasi-market.mp.

7 sickness fund.mp.

8 COMPETITIVE TENDERING/

9 competitive bidding.mp.

10 (multi level commissioning or multi-level commissioning).af.

11 integrated commissioning.af.

12 strategic commissioning.af.

13 (commissioning adj3 service\*).mp. [mp=title, other title, abstract, heading words]

14 joint commissioning.af.

15 regional commissioning.af.

16 specialist commissioning.af.

17 (micro commissioning or macro commissioning).af.

18 locality commissioning.af.

19 (value based commissioning or value-based commissioning).af.

20 (outcome based commissioning or outcome-based commissioning).af.

21 (performance-based commissioning or performance based commissioning).af.

22 (primary care led commissioning or primary care-led commissioning).af.

23 TOTAL PURCHASING/ or exp SERVICE PURCHASING/ (107)

24 (purchasing adj3 service\*).mp. [mp=title, other title, abstract, heading words]

25 strategic purchasing.mp.

26 joint purchasing.mp. [mp=title, other title, abstract, heading words]

27 locality purchasing.mp. [mp=title, other title, abstract, heading words]

28 (value based purchasing or value-based purchasing).af.

29 (outcome-based purchasing or outcome based purchasing).af.

30 (performance based purchasing or performance-based purchasing).af.

31 exp SOCIAL SERVICES PURCHASING/

32 exp CONTRACTING OUT/

33 exp SELECTIVE CONTRACTING/

34 exp GENERAL PRACTICE FUNDHOLDING/

35 public private partnership.mp. [mp=title, other title, abstract, heading words]

36 internal market.ti.

37 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30 or 31 or 32 or 33 or 34 or 35 or 36

38 limit 37 to (yr='1989 -Current')

### *Search 2*

1. exp GENERAL PRACTITIONER FUNDHOLDERS/

2 GENERAL PRACTICE FUNDHOLDING/

3 fundhold\*.mp. [mp=title, other title, abstract, heading words]

4 1 or 2 or 3

5 limit 4 to (yr='1989 -Current')

### *Search 3*

1 ('best value' adj5 'local authorit\*').mp. [mp=title, other title, abstract, heading words]

2 marginal analysis.mp. [mp=title, other title, abstract, heading words]

3 budget holding.mp. [mp=title, other title, abstract, heading words] (54)

4 BUDGETS/

5 exp GENERAL PRACTICE BUDGETS/

6 exp POOLED BUDGETS/

7 pooled budget\*.mp. [mp=title, other title, abstract, heading words]

8 general practice budget\*.mp. [mp=title, other title, abstract, heading words]

9 PRIORITY SETTING/

10 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9

11 limit 12 to (abstracts and yr='1989 -Current')

## ***Econlit***

### *Search 1*

1. commissioning.mp. [mp=heading words, abstract, title, country as subject]

2. contracting out.tw.

3. (purchasing and (health or service\*)).tw.

4. (purchasing adj health service\*).mp. [mp=heading words, abstract, title, country as subject]

5. strategic purchasing.mp. [mp=heading words, abstract, title, country as subject]

6. locality purchasing.mp. [mp=heading words, abstract, title, country as subject]

7. GP purchasing.mp. [mp=heading words, abstract, title, country as subject]

8. general practice purchasing.mp. [mp=heading words, abstract, title, country as subject]

9. value-based purchasing.mp. [mp=heading words, abstract, title, country as subject]
10. outcome-based purchasing.mp. [mp=heading words, abstract, title, country as subject]
11. performance-based purchasing.mp. [mp=heading words, abstract, title, country as subject]
12. performance-based contracting.mp. [mp=heading words, abstract, title, country as subject]
13. performance-based buying.mp. [mp=heading words, abstract, title, country as subject]
14. value-based contracting.mp. [mp=heading words, abstract, title, country as subject]
15. outcome-based contracting.mp. [mp=heading words, abstract, title, country as subject]
16. purchaser-provider split.mp. [mp=heading words, abstract, title, country as subject]
17. output-based contract\*.mp. [mp=heading words, abstract, title, country as subject]
18. (procurement adj service\*).mp. [mp=heading words, abstract, title, country as subject]
19. (privatisation and service\*).tw.
20. (privatisation and health).tw.
21. (privatization and public service\*).tw.
22. (privatization and health).tw.
23. (outsourcing and service\*).tw.
24. (outsourcing and health).tw.
25. (fund-holding or fundholding).tw.
26. (internal market and health).tw.
27. (internal market and service\*).tw.
28. (quasi-market or quasi market).tw.
29. competitive tendering.tw.
30. competitive contract\*.tw.
31. 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30
32. limit 31 to (yr='1989 -Current' and English)

## *Search 2*

1. (public service\* adj5 budget\*).mp. [mp=heading words, abstract, title, country as subject]
2. (health service\* adj5 budget\*).mp. [mp=heading words, abstract, title, country as subject]
3. (assessment adj5 service cost).mp. [mp=heading words, abstract, title, country as subject]
4. (assessment adj5 service quality).mp. [mp=heading words, abstract, title, country as subject]
5. (programme budgeting and marginal analysis).mp. [mp=heading words, abstract, title, country as subject]
6. priority-setting.mp. [mp=heading words, abstract, title, country as subject]
7. 1 or 2 or 3 or 4 or 5 or 6
8. limit 7 to (abstracts and yr='1989 -Current')

## ***The Cochrane Central Register of Controlled Trials***

### *Search 1*

- #1 MeSH descriptor Contract Services explode all trees
- #2 'SR-EPOC' and (commission OR commissioning OR commissioned OR purchasing OR

purchased OR purchaser):ti,ab,kw or (procurement OR 'contracting-in' OR 'contracting-out' OR 'contracting in' OR 'contracting out' OR contract NEXT services):ti,ab,kw or 'sick fund' OR 'sick-fund' OR 'sickness fund' OR 'sickness funds' OR 'community-based insurance' OR 'social insurance' OR 'competitive tendering' OR privatization NEXT services OR privatisation NEXT services OR outsourcing:ti,ab,kw or (prepayment OR pre-payment OR 'pay for performance' OR 'pay-for-performance' OR 'internal market' OR 'quasi-market' OR 'quasi market'):ti,ab,kw, from 1989 to 2010

#3 (#1 OR #2), from 1989 to 2010

### *Search 2*

#1 (assessment adj service cost):ti,ab,kw or (assessment adj service quality):ti,ab,kw or (priority setting):ti,ab,kw or (budget\* adj service\*):ti,ab,kw or (programme budgeting and marginal analysis):ti,ab,kw

#2 (best value adj5 local authorit\*):ti,ab,kw 0 edit delete

#3 'SR-EPOC'

#4 MeSH descriptor Budgets, this term only

#5 (#1 OR #2 OR #3 OR #4)

### *Search 3*

'SR-EPOC' and 'fund\* hold\*' in Title, Abstract or Keywords or fund-hold\* in Title, Abstract or Keywords or fundhold\* in Title, Abstract or Keywords, from 1989 to 2010 in Cochrane Central Register of Controlled Trials and economic evaluations

## **PsychINFO**

### *Search 1*

KW ( commissioning OR purchasing OR purchaser OR purchased ) or KW ( procurement OR 'contracting-in' OR 'contracting-out' OR 'contracting in' OR 'contracting out' ) or KW ( 'sick fund' OR 'sick-fund' OR 'sickness fund' OR 'sickness funds' OR 'competitive tendering' OR privatization W2 services OR privatisation W2 services OR outsourcing OR 'community-based insurance' OR 'social insurance' ) or KW ( prepayment OR pre-payment OR 'pay for performance' OR 'pay-for-performance' OR 'internal market' OR 'quasi-market' OR 'quasi market' )

Publication Year from: 1989-2010; Published Date from: 1989 0101-20100131; Language: English

Search modes - Boolean/Phrase

### *Search 2*

1 (best value adj5 local authorit\*).mp. [mp=title, abstract, heading word, table of contents, key concepts]

2 (programme budgeting and marginal analysis).mp. [mp=title, abstract, heading word, table of contents, key concepts]

3 priority-setting.mp.

4 (need assessment adj5 health).mp. [mp=title, abstract, heading word, table of contents, key concepts]

5 (assessment adj service cost).mp. [mp=title, abstract, heading word, table of contents, key concepts]

6 (assessment adj5 service quality).mp. [mp=title, abstract, heading word, table of contents, key concepts]

7 (budget\* adj5 service\*).mp. [mp=title, abstract, heading word, table of contents, key concepts]

1 or 2 or 3 or 4 or 5 or 6 or 7

### *Search 3*

Fund-hold\* (ti, ab, kw) OR Fund\* hold (ti, kw, ab) OR Fundhold\*(ti, kw, ab)

## **Medline**

### *Search 1*

1. strategic purchasing.mp. [mp=title, original title, abstract, name of substance word, subject heading word, unique identifier]
2. strategic contracting.mp. [mp=title, original title, abstract, name of substance word, subject heading word, unique identifier]
3. strategic buying.mp. [mp=title, original title, abstract, name of substance word, subject heading word, unique identifier]
4. (fundholding or fund-holding).mp. [mp=title, original title, abstract, name of substance word, subject heading word, unique identifier]
5. locality purchasing.mp. [mp=title, original title, abstract, name of substance word, subject heading word, unique identifier]
6. central\* purchasing.mp. [mp=title, original title, abstract, name of substance word, subject heading word, unique identifier]
7. GP purchasing.mp. [mp=title, original title, abstract, name of substance word, subject heading word, unique identifier]
8. performance-based purchasing.mp. [mp=title, original title, abstract, name of substance word, subject heading word, unique identifier]
9. performance-based contracting.mp. [mp=title, original title, abstract, name of substance word, subject heading word, unique identifier]
10. (contracting adj out).mp. [mp=title, original title, abstract, name of substance word, subject heading word, unique identifier]
11. (purchasing adj service\*).mp. [mp=title, original title, abstract, name of substance word, subject heading word, unique identifier]
12. outcome-based contracting.mp. [mp=title, original title, abstract, name of substance word, subject heading word, unique identifier]
13. outcome-based purchasing.mp. [mp=title, original title, abstract, name of substance word, subject heading word, unique identifier]
14. (purchasing adj health care).mp. [mp=title, original title, abstract, name of substance word, subject heading word, unique identifier]
15. (purchasing adj social care).mp. [mp=title, original title, abstract, name of substance word, subject heading word, unique identifier]
16. (procurement adj service\*).mp. [mp=title, original title, abstract, name of substance word, subject heading word, unique identifier]
17. value-based purchasing.mp. [mp=title, original title, abstract, name of substance word, subject heading word, unique identifier]
18. commissioning.mp. [mp=title, original title, abstract, name of substance word, subject heading word, unique identifier]

19. exp competitive bidding/ or exp outsourced services/
20. competitive tendering.mp.
21. competitive bidding.mp. [mp=title, original title, abstract, name of substance word, subject heading word, unique identifier]
22. outsourcing.mp. [mp=title, original title, abstract, name of substance word, subject heading word, unique identifier]
23. (outsourcing adj service\*).mp. [mp=title, original title, abstract, name of substance word, subject heading word, unique identifier]
24. (outsourcing adj health care).mp. [mp=title, original title, abstract, name of substance word, subject heading word, unique identifier]
25. privatization.mp. or \*Privatization/
26. public.mp. [mp=title, original title, abstract, name of substance word, subject heading word, unique identifier]
27. 25 and 26
28. (health adj service\*).mp. [mp=title, original title, abstract, name of substance word, subject heading word, unique identifier]
29. 25 and 28
30. 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 23 or 24 or 27 or 29
31. limit 30 to (abstracts and English language and yr='1989 -Current')

## Search 2

1. (assessment adj5 service quality).mp. [mp=title, original title, abstract, name of substance word, subject heading word, unique identifier]
2. service cost.mp.
3. (programme budgeting and marginal analysis).mp. [mp=title, original title, abstract, name of substance word, subject heading word, unique identifier]
4. priority-setting.mp.
5. (best value adj5 local authorit\*).mp. [mp=title, original title, abstract, name of substance word, subject heading word, unique identifier]
6. (budget\* adj5 service\*).mp. [mp=title, original title, abstract, name of substance word, subject heading word, unique identifier]
7. 1 or 2 or 3 or 4 or 5 or 6
8. limit 7 to (English language and yr='1989 -Current')
9. from 8 keep 1-1130

## ASSIA

### Search 1

DE=('commissioning' or ('joint commissioning') or ('local commissioning')) or DE=('purchasing' or ('evidence based purchasing') or ('locality purchasing')) or DE=('contracting' or ('contracting out') or ('performance based contracting')) or DE=('procurement' or ('internal market') or ('social insurance')) or DE=('prepayment schemes') or ('Public-Private partnerships')) (Copy Query)

Date Range: 1985 to 2010

Limited to: English Only

*Search 2*

('basic needs budget' or 'programme budgets')) or(KW=(best value) and KW=(local authorit\*))  
 or(KW=assessment and KW=(service quality)) or(KW=assessment and KW=(service cost))  
 or(KW=priority-setting) or(programme budget and marginal analysis) (Copy Query)

**Social Science Citation Index***Search 1*

# 1 Topic=(Strategic SAME commissioning) OR Topic=(commissioning SAME services) OR  
 Topic=('Joint commissioning') OR Topic=('Locality commissioning') OR Topic=('Integrated  
 commissioning') OR Topic=('Regional SAME commissioning') OR Topic=('Micro commissioning') OR  
 Topic=('Macro commissioning') OR Topic=('Specialist commissioning') OR Topic=('Performance-  
 based commissioning') OR Topic=('Collaborative commissioning') OR Topic=('primary care-  
 led commissioning') OR Topic=('Community based insurance') OR Topic=('Community-based  
 insurance')

Databases=SSCI Time span=1989-2010

#2 Topic=(Strategic SAME contracting) OR Topic=(strategic SAME purchasing)  
 OR Topic=(procurement SAME services) OR Topic=('outcome based contracting') OR  
 Topic=('prepayment') OR Topic=('pre-payment') OR Topic=('pay for performance') OR Topic=('pay-  
 for-performance') OR Topic=('sick fund') OR Topic=('sickness fund') OR Topic=('internal  
 market' SAME services) OR Topic=('quasi market') OR Topic=('competitive tendering') OR  
 Topic=(commissioning SAME processes) OR Topic=(contracting SAME services)

Databases=SSCI Time span=1989-2010

3 #1 OR #2

Databases=SSCI Time span=1989-2010

*Search 2*

#7 OR #6 OR #5 OR #4 OR #3 OR #2 OR #1

# 7 Topic=('need assessment' SAME service\*)

# 6 Topic=('need analysis' SAME service\*)

# 5 Topic=('programme budgeting and marginal analysis')

# 4 Topic=('assessment of service costs')

# 3 Topic=('assessment of service cost')

# 2 Topic=('assessment of service quality')

# 1 Title=(priority-setting)

*Search 3*

Purchase\* SAME Services (title) OR Contract\* SAME service\* (title)

**IBSS***Search 1*

S22 S1 or S2 or S3 or S4 or S5 or S6 or S7 or S8 or S9 or S10 or S11 or S12 or S13 or S14 or S15 or  
 S16 or S17 or S18 or S19 or S20 or S21

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S21	'conditional cash transfers'
S20	'competitive tendering'
S19	'community-based insurance'
S18	'social insurance'
S17	'pre-payment'
S16	'prepayment'
S15	'Needs analysis'
S14	'quasi market'
S13	'internal market'
S12	'performance based'
S11	'pay for performance'
S10	'sick fund'
S9	'sickness fund'
S8	'strategic purchasing'
S7	'Strategic Procurement'
S6	'contracting services'
S5	'outcome-based contracting'
S4	'strategic contracting'
S3	'contracting out'
S2	'contracting in'
S1	commissioning

*Search 2*

S8 (S1 or S2 or S3 or S4 or S5 or S6) Limiters - English Only

S7 (S1 or S2 or S3 or S4 or S5 or S6)

S6 TX programme budgeting and TX marginal analysis Search modes

S5 TX priority-setting

S4 TX assessment N3 'service cost'

S3 TX assessment N3 'service quality'

S2 TX 'best value' N3 local authority\*

S1 TX budget\* N3 service\*

***British Education Index***

'( ( COMMISSIONING OR CONTRACTING OR PURCHASING OR PRIVATISATION OR PRIVATIZATION OR COMPETITIVE ADJ 'ADJ' ADJ TENDERING OR QUASI ADJ 'ADJ' ADJ MARKET ADJ OR SICKNESS ADJ 'ADJ' ADJ FUND OR SICK ADJ 'ADJ' ADJ FUND OR INTERNAL ADJ 'ADJ' ADJ MARKET ) .TI,AB. OR ( PRIVATISATION OR PURCHASING OR CONTRACTS ) .DE. OR PERFORMANCE-CONTRACTS.DE. ) AND LG=ENGLISH

***Australian Education Index***

1. commissioning
2. purchasing.TI,AB.

3. contracting
4. procurement
5. privatization
6. PRIVATISATION.W..MJ.
7. privatization
8. outsourcing
9. fundholding
10. internal ADJ market
11. quasi ADJ market
12. sickness ADJ fund
13. competitive ADJ tendering
14. provider ADJ purchaser ADJ split
15. public ADJ private ADJ partnership
16. 1 OR 2 OR 3 OR 4 OR 5 OR 6 ADJ OR 7 OR 8 OR 9 OR 10 OR 11 OR 12 OR 13 OR 14 OR 15
17. limit set 16 DATE > 1988

### **ERIC**

(KW=commissioning) or(DE='bids') or(KW=(strategic purchasing)) or(KW=(locality purchasing)) or(KW=(GP purchasing)) or(KW=(general practice purchasing)) or(KW=(value-based purchasing)) or(KW=(outcome-based purchasing)) or(KW=(performance-based purchasing)) or(TI=purchasing and TI=service\*) or(KW=(contracting out)) or(KW=procurement and AB=service\*) or(DE='privatization') or(KW=outsourcing and AB=service\*) or(KW=(fund-holding or (fund holding))) or(KW=(internal market)) or(KW=((quasi market) or quasi-market)) or(KW=(sickness fund)) or(KW=(competitive tendering)) or(KW=(education\* voucher\*)) or(KW=(Educational Management Organizations)) or(KW=(purchaser-provider split)) or(KW=(public private partnership)) or(DE=('contracts' or 'performance contracts')) or(KW=(pay for performance))

### **CINAHL**

#### *Search 1*

KW ( commissioning OR purchasing OR purchaser OR purchased ) or KW ( procurement OR 'contracting-in' OR 'contracting-out' OR 'contracting in' OR 'contracting out' ) or KW ( 'sick fund' OR 'sick-fund' OR 'sickness fund' OR 'sickness funds' OR 'competitive tendering' OR privatization W2 services OR privatisation W2 services OR outsourcing OR 'community-based insurance' OR 'social insurance' ) or KW ( prepayment OR pre-payment OR 'pay for performance' OR 'pay-for-performance' OR 'internal market' OR 'quasi-market' OR 'quasi market' )

#### *Search 2*

- 1) TX- priority setting
- 2) TX-marginal analysis
- 3) best value AND local authorit\*
- 4) TX -budget hold\*
- 5) TI -budget\* AND TI service\*
- 6) 1 or 2 or 3 or 4 or 5

---

# Appendix 5: Coding tool

## *Section A: General details of the study*

### A.1 Country

A.1.1 Australia
A.1.2 Austria
A.1.3 Belgium
A.1.4 Brazil
A.1.5 Cambodia
A.1.6 Canada
A.1.7 China
A.1.8 Denmark
A.1.9 Finland
A.1.10 France
A.1.11 Germany
A.1.12 Greece
A.1.13 Hungary
A.1.14 Iceland
A.1.15 India
A.1.16 Ireland
A.1.17 Israel
A.1.18 Italy
A.1.19 Japan
A.1.20 Korea
A.1.21 Mexico
A.1.22 Netherlands
A.1.23 New Zealand
A.1.24 Norway
A.1.25 Pakistan
A.1.26 Poland
A.1.27 Portugal
A.1.28 Russia

A.1 Country	A.1.29 Spain
	A.1.30 Sweden
	A.1.31 Switzerland
	A.1.32 Thailand
	A.1.33 Turkey
	A.1.34 UK (please specify)
	A.1.35 USA
	A.1.36 Others
	A.1.37 Please select this item if this study compared more than one country
	A.1.38 Unclear (please specify)
A.1.39 Not specified	
A.2 Sectors of study <i>please tick more than one, if relevant</i>	A.2.1 Health
	A.2.2 Social care/social services
	A.2.3 Education
A.3 Aim of the study <i>please tick more than one if relevant</i>	A.3.1 Impact study with a quantitative measure of outcome
	A.3.2 Impact with a non quantitative (view/observational) measure of the outcomes
	A.3.3 Views study on the process/barriers and facilitators to commissioning

### **Section B: Commissioning details reported in the study**

B.1 Who was/were the commissioners/ purchasers of services <i>as indicated in the study. Please select more than one, if relevant</i>	B.1.1 General practitioners
	B.1.2 Health authorities
	B.1.3 Medicare/Medicaid
	<i>Medicaid is available only to certain low-income individuals and families who fit into an eligibility group that is recognized by federal and state law. Medicaid does not pay money to you; instead, it sends payments directly to your health care providers. Depending on your state's rules, you may also be asked to pay a small part of the cost (co-payment) for some medical services. ('Medicaid At-A-Glance 2005' may be downloaded from the bottom of the page.)</i>
	<i>Medicaid is a state administered program and each state sets its own guidelines regarding eligibility and services.</i>
	B.1.4 Health management organisations
	B.1.5 Local authorities (select this for UK social service departments or other LA departments)
B.1.6 State governments (Select this for the U.S. or other federal systems)	

	B.1.7 Educational Management Organisations
	B.1.8 Employers' funds
	B.1.9 Health plans
	B.1.10 Primary care trusts
	B.1.11 Primary care groups
	B.1.12 Foundation Trusts
	B.1.13 Insurance plans
	B.1.14 Sickness fund
	B.1.15 Hospitals
	B.1.16 Schools
	B.1.17 Care managers
	B.1.18 Child's Trusts
	B.1.19 Mental health care trusts
	B.1.20 Housing Authorities
	B.1.21 International organisations (WHO, World Bank, IMF etc)
	B.1.22 Care trusts
	B.1.23 Integrated Organization (Please specify)
	B.1.24 Other (please specify)
	B.1.25 Unclear (please specify)
	B.1.26 Not specified
B.2 What types of service(s) were investigated in this study? (select more than one if applicable)	B.2.1 Mental health services
	B.2.2 Social care (e.g. home care)
	B.2.3 Primary physician care (e.g. general practitioners, family doctors, ambulatory care)
	B.2.4 Dentistry
	B.2.5 Maternity
	B.2.6 Emergency medical services
	B.2.7 School health/prison health
	B.2.8 Secondary care/hospital health services (specialist services e.g. psychiatrists, cardiologists)
	B.2.9 Pharmacy
	B.2.10 Drug and alcohol treatment services
	B.2.11 Sexual health services (e.g. HIV services)
	B.2.12 Vision care
	B.2.13 Welfare/benefit programmes (e.g. employment provisions)
	B.2.14 Human services (in USA)
	B.2.15 Homelessness services/housing
	B.2.16 Primary education
	B.2.17 Secondary education
	B.2.18 Higher education

	B.2.19 Special need education
	B.2.20 Integrated services/care
	B.2.21 Health promotion
	B.2.22 Health visitor
	B.2.23 Family services
	B.2.24 Disability services
	B.2.25 Intermediate care
	B.2.26 Cant differentiate as there are multiple services
	B.2.27 Other (please specify)
	B.2.28 Unclear (please specify)
	B.2.29 Not specified
B.3 Age group(s) of population commissioned for? (please select more than one if relevant)	B.3.1 Children and young people (0-25 years)
<i>not a sample of the study but population for which the service(s) was commissioned: as stated in the report</i>	B.3.2 Adults (26-59)
	B.3.3 Elderly (60 and over)
	B.3.4 Whole population (please select this item if not specify age groups)
	B.3.5 Not specified
B.4 Characteristics of population commissioned	B.4.1 Unemployed
<i>not a sample of the study but population for which the service was commissioned</i>	B.4.2 People with a particular health conditions
	B.4.3 People with disability
	B.4.4 People on state/benefit or welfare programmes (e.g. on Medicaid)
	B.4.5 Ethnic minority
	B.4.6 Women/girls
	B.4.7 Homeless
	B.4.8 Whole population
	B.4.9 Other (please specify)
	B.4.10 Unclear (please specify)
	B.4.11 Not specified
B.5 Characteristics of the service providers: Ownership of providers	B.5.1 Non governmental: not for-profit
<i>(if reported in the study)</i>	B.5.2 Private ownership
	B.5.3 State owned
	B.5.4 Other (please specify)
	B.5.5 Unclear (please specify)
	B.5.6 Not specified
B.6 Commissioning model	B.6.1 Fund holding/budget holding
<i>(if reported in the study)</i>	B.6.2 Care management/managed care
	B.6.3 Practice-based commissioning
	B.6.4 Commissioning/contracting out/ purchasing <i>Not specific</i>
	B.6.5 Privatisation
	B.6.6 Public-private partnership

	B.6.7 Private finance initiative
	B.6.8 Joint commissioning
	B.6.9 Locality commissioning
	B.6.10 Total purchasing
	B.6.11 Charter school
	B.6.12 Other (please specify)
	B.6.13 Unclear (please specify)
	B.6.14 Not specified
B.7 Commissioning stages  <i>if they are a focus of the study</i>	B.7.1 Need assessment
	B.7.2 Priority setting/resource allocation
	B.7.3 Contracting
	B.7.4 Data management <i>e.g. Bench marking</i>
	B.7.5 Negotiation
	B.7.6 Monitoring and evaluation
	B.7.7 Whole process of commissioning
	B.7.8 Other (please specify)
	B.7.9 Unclear (please specify)
	B.7.10 Not specified
B.8 Context of commissioning  <i>(if reported in the study, this can be reported in background or introduction, method section- described commissioning contexts, or a focus of the study)</i>	B.8.1 Nature of market and degree of competition
	B.8.2 Institutional and organisational environment surrounding the commissioning <i>(e.g. structure of organizations; management styles; direction of management; effective leadership; network or systems that supports to an individual to work effectively; organizational values or attitudes towards commissioning; organizational culture; attitudes to change; attitudes towards competitiveness; rewarding systems designed for commissioning; risk taking)</i>
	B.8.3 Relationship between purchasers and providers or between partners <i>(e.g. building or agreeing shared values; being clear about organizational roles in terms of responsibilities between commissioning, purchasing, and providing; identified agreed resources)</i>
	B.8.4 Regulations and policy <i>(for example, The Health Act flexibilities, policy framework)</i>
	B.8.5 Health care/benefit systems
	B.8.6 Financial mechanisms
	B.8.7 Other (please specify)
	B.8.8 Unclear (please specify)
	B.8.9 Not specified

# Appendix 6: Joint commissioning data extraction and quality assessment framework

## Section A: Joint commissioning details

A.1 Level of joint commissioning	A.1.1 Area-based/locality commissioning (please specify) <i>Primary care and social care staff are involved in planning and commissioning a range of services for people in a given geographical area</i>
	A.1.2 Practice-based commissioning (please specify) <i>takes place at that level of organizational activity where teams of professionals routinely interact and will normally involve in smaller population than in the case of are-based population, general practices joint commissioning with social workers</i>
	A.1.3 Individual based (please specify) <i>focused on services for individual clients or patient. The team includes different professionals</i>
	A.1.4 Other (please specify)
	A.1.5 Unclear (please specify)
	A.1.6 Not specified
A.2 What is the extent of the study i.e. the number of partnerships investigated in this study and areas covered?	A.2.1 Please specify
	A.2.2 Not specified
A.3 What was the sample size of the study i.e. No. of individuals investigated?	A.3.1 Not Specified
	A.3.2 Please specify
A.4 What are aspects of joint commissioning that the authors investigate?  <i>please select more than one if relevant</i>	A.4.1 Identify barriers/concerns and facilitators/opportunities relating to joint commissioning (please specify)
	A.4.2 Measure the impact of undertaking a joint commissioning approach (please specify)  <i>(both quantitative and qualitative measure like modelling or survey or qualitatively exploring people's perceptions about the impact)</i>
	A.4.3 Other (please specify)

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A.5 Types of Joint commissioning investigated in the study

*Very important question, please provide further details as well as ticking an item response*

A.5.1 Integrated care/services management of care (please specify)

*e.g. integrated staff, equipment*

A.5.2 Pooled budget (please specify)

*Each partner makes contributions to a common fund to be spent on pooled functions or agreed NHS or health-related council services under the management of a host partner organisation*

A.5.3 Aligned budget (please specify)

*partners align resources (identifying their own contributions) to meet agreed aims for a particular service, with jointly monitored spending and performance but separate management of, and accountability for, NHS and council funding streams*

A.5.4 Lead commissioning (please specify)

*One partner takes the lead and acts as the host in commissioning services on behalf of another to achieve a jointly agreed aims*

A.5.5 Structural integration organisations (please specify)

*wholly integrated health and social care organizations that provide and sometimes commission services*

A.5.6 Joint board commissioning/ decision making/development of commissioning framework (please specify)

A.5.7 Joint monitoring and evaluation (please specify)

A.5.8 Joint need assessment

A.5.9 Working together

*select this item when type of joint commissioning was loosely defined or not explicitly stated*

A.5.10 Other (please specify)

**Section B: Quality assessment**

<p>B.1 Can the participants in the study considered to be sufficiently representative of all the relevant stakeholders in the study (sampling frame)</p> <p><i>(where applicable consider: sampling strategy was appropriate to the question posed in the study, attempt to obtain a diverse sample of the population in question, characteristics of the sample included that critical to the understanding of the study context and findings were presented)</i></p>	<p>B.1.1 A lot (please specify)</p> <hr/> <p>B.1.2 To some extent (please specify)</p> <hr/> <p>B.1.3 Not at all (please specify)</p>
<p>B.2 Do the data collection/measurement approaches used provide a trustworthy indicator of the phenomenon investigated?</p> <p><i>(Consider: who collected the data?; if its a quantitative outcome do the authors' describe any ways they addressed the repeatability or reliability of their data collection tools/methods e.g. test-retest, standardized instruments etc?; and do the authors describe any ways they have addressed the validity or trustworthiness of their data collection tools/methods? e.g. mention previous piloting or validation of tools, published version of tools, involvement of target population in development of tools)</i></p>	<p>B.2.1 A lot (please specify)</p> <hr/> <p>B.2.2 To some extent (please specify)</p> <hr/> <p>B.2.3 Not at all (please specify)</p>
<p>B.3 Has the data analysis been conducted rigorously such that you trust the results of the analysis?</p> <p><i>(Consider: what rationale do the authors give for the methods of analysis for the study?; For quantitative studies also consider which statistical methods, if any, were used in the analysis?; For views studies also consider, how well has diversity of perspective and content been explored?, did the authors triangulate their findings?)</i></p>	<p>B.3.1 A lot (please specify)</p> <hr/> <p>B.3.2 To some extent (please specify)</p> <hr/> <p>B.3.3 Not at all (please specify)</p>

**Section C: Weight of Evidence (WoE)**

<p>C.1 Weight of Evidence A: Does the execution of the study lead to confidence in the results of the study?</p>	<p>C.1.1 A lot <i>(if ‘a lot’ was answered for 2 or more in questions B.1,B.2,B.3)</i></p>
<p><i>Taking account of all quality assessment issues, can the study findings be trusted in answering the study question(s)?</i></p> <p><i>(Please refer to B.1,B.2 and B.3)</i></p>	<p>C.1.2 To some extent <i>(if ‘to some extent’ answered for 2 or more in questions B.1,B.2,B.3)</i></p>
	<p>C.1.3 A little <i>(If ‘not at all’ was answered for 2 or more in question B.1, B.2, B.3)</i></p>
<p>C.2 Weight of Evidence B for IMPACT STUDY: Does the design of the study lead to confidence in the results of the Impact study?</p> <p><i>(Appropriateness of research design and analysis for addressing the question, or sub-questions, of this specific systematic review)</i></p>	<p>C.2.1 A lot <i>(RCTs and well matched control group before and after and across design e.g. matching through controlling for intervening variables and by Propensity Score Matching)</i></p>
	<p>C.2.2 To some extent <i>(Unmatched comparison group study with pre and post i.e. Comparison group present without demonstrated comparability to intervention group. Must also be a pre-post design)</i></p>
	<p>C.2.3 A little (comparison group post test, single pre-post) <i>(comparison group post test, single pre-post)</i></p>
	<p>C.2.4 A little (Single group at one point in time) <i>for example, perceptions of impact at one point in time</i></p>
<p>C.3 Weight of Evidence B for BARRIERS: Does the design of the study lead to confidence the results an authentic representation of participant views i.e. its ability to capture barriers and facilitators in the process of commissioning?</p>	<p>C.3.1 A lot <i>in-depth interviews/view studies</i></p>
	<p>C.3.2 To some extent <i>surveys, descriptive case studies</i></p>
	<p>C.3.3 Not applicable <i>only about impact of commissioning</i></p>

<p>C.4 Weight of Evidence C: Does the study provide sufficient information OR have a particular focus of joint commissioning?</p> <p><i>(Consider: Relevance of particular focus of the study, including conceptual focus, context, sample and measures) for addressing the question, or sub-questions, of this specific systematic review</i></p> <p><i>Consider if the aim of the study is to explore some aspect of joint commissioning and if the study describes the context of joint commissioning</i></p>	C.4.1 A lot (please specify)
	C.4.2 To some extent (please specify)
	C.4.3 A little (please specify)
<p>C.5 For IMPACT study: How trustworthy are the results of this study in measuring the impact?</p> <p><i>Average of A, B and C and cannot be higher than WoE A and WOE B</i></p>	C.5.1 A lot
	C.5.2 To some extent
	C.5.3 A little
<p>C.6 For BARRIERS study: How trustworthy are the results of this study in assessing barriers or facilitators to the Joint commissioning process?</p> <p><i>Average of A, B and C and cannot be higher than WoE A or WoE B</i></p>	C.6.1 A lot
	C.6.2 To some extent
	C.6.3 A little
	C.6.4 Not applicable <i>only about impact of commissioning</i>

## Appendix 7: Details of the studies in the in depth review

Studies	General details of study	Details of joint commissioning
<p>Bachmann M (2009) Integrating children's services in England: national evaluation of children's trusts</p>	<p><i>Reviewers' interpretation of the aims of the study</i> To assess the perceived impact of and views on the process of, barriers to and facilitators of commissioning</p> <p><i>Types of outcomes investigated</i> Quantitative and non-quantitative measures of outcomes</p> <p><i>Reviewers' summary of study</i> An examination of</p> <ul style="list-style-type: none"> <li>• the experience of integrating children's services</li> <li>• the changing interfaces between health services and local authorities which are intended to improve quality of care</li> <li>• the perceived barriers and facilitators of joint working in the trust pathfinders</li> </ul> <p><i>Country</i> UK: nationwide</p>	<p><i>Commissioning context</i> New regulations and policy</p> <p><i>Level of joint commissioning</i> Area-based commissioning: trusts selected to represent spread of geographical location</p> <p><i>Sectors of study</i> Health, social care/social services and education</p> <p><i>Commissioners/purchasers of services</i> Children's trusts</p>
<p><i>Overall weight of evidence (trustworthiness)</i> For IMPACT study: A little For BARRIERS study: To some extent</p> <p><i>Sample size of the study i.e. no. of individuals investigated</i> Over 3 years</p> <ul style="list-style-type: none"> <li>• 35 managers of the trust pathfinders were sent 2 questionnaire surveys (response rate: 88 percent)</li> <li>• 147 managers and professionals working in the children's trusts were interviewed, including 172 semi-structured interviews</li> <li>• documents examined: trust documents, Census and performance indicators</li> </ul>	<p><i>Commissioning stages</i> Whole process of commissioning</p> <p><i>Characteristics and ownership of the service providers</i> Not specified</p> <p><i>Types of service(s) investigated in this study</i> Multiple services</p> <p><i>Characteristics of population commissioned</i> Whole population</p> <p><i>Age group(s) of population commissioned for</i> Children and young people (0-25 years)</p> <p><i>Extent of the study i.e. the number of partnerships investigated in this study and areas covered</i></p> <ul style="list-style-type: none"> <li>• 35 children's trust pathfinders, covering 20 percent of children in England</li> <li>• case studies in 8 children's trusts and in 3 non-pathfinder areas</li> </ul>	

Studies	General details of study	Details of joint commissioning
<p>Banks P (2005a) Commissioning care services for older people: achievements and challenges in London</p>	<p><i>Reviewers' interpretation of the aims of the study</i></p> <ul style="list-style-type: none"> <li>to investigate how local authorities and their primary care trust (PCT) partners were commissioning care services for older people in London</li> <li>to assess users' views on the process, barriers and facilitators to commissioning</li> </ul> <p><i>Types of outcomes investigated</i></p> <p>Quantitative and non-quantitative measures of outcomes</p> <p><i>Reviewers' summary of study</i></p> <p>An examination of</p> <ul style="list-style-type: none"> <li>the impact of the commissioning processes/stages on the commissioning team, stakeholders and end users</li> <li>the factors which hindered progress of developing a high quality service</li> </ul> <p><i>Country</i></p> <p>UK: London</p>	<p><i>Commissioning context</i></p> <p>Concerns about the quality, appropriateness and adequacy of care services for older people in London</p> <p><i>Level of joint commissioning</i></p> <p>Area-based commissioning: 6 local authorities with their PCT partners</p> <p><i>Sectors of study</i></p> <p>Health and social care/social services</p> <p><i>Commissioners/purchasers of services</i></p> <p>Local authorities and primary care trusts</p> <p><i>Commissioning stages</i></p> <p>Whole process of commissioning</p> <p><i>Characteristics and ownership of the service providers</i></p> <p>State owned</p> <p><i>Types of service(s) investigated in this study</i></p> <p>Mental health services, social care and home care</p> <p><i>Characteristics of population commissioned</i></p> <p>Whole population and people with a particular health condition</p> <p><i>Age group(s) of population commissioned for</i></p> <p>Elderly (60 and over)</p> <p><i>Extent of the study i.e. the number of partnerships investigated in this study and areas covered</i></p> <p>6 boroughs in London with their PCT partners</p>

Studies	General details of study	Details of joint commissioning
<p>Carpenter G, Syrett P (1997) Commissioning social care: 'if it looks like a duck -': report of a survey of good practice in commissioning in local authority social services departments in England and Wales</p>	<p><i>Reviewers' interpretation of the aims of the study</i></p> <ul style="list-style-type: none"> <li>to examine the experiences of joint commissioning</li> <li>to assess views on the process, barriers and facilitators to commissioning</li> </ul> <p><i>Types of outcomes investigated</i></p> <p>Non-quantitative measure of the outcomes</p> <p><i>Reviewers' summary of study</i></p> <p>An examination of current practice in commissioning social care through contracting, particularly on the nature and extent of joint commissioning taking place in authorities</p>	<p><i>Commissioning context</i></p> <ul style="list-style-type: none"> <li>nature of market and degree of competition</li> <li>relationship between purchasers and providers or between partners</li> </ul> <p><i>Level of joint commissioning</i></p> <p>Area-based/locality commissioning: local authority</p> <p><i>Sectors of study</i></p> <p>Health, social care/services and education</p> <p><i>Commissioners/purchasers of services</i></p> <ul style="list-style-type: none"> <li>General practitioners</li> <li>Health authorities</li> <li>Local authorities</li> <li>Others: education organisations, health commissions, housing authorities, probation services and health trusts</li> </ul>
<p><i>Country</i></p> <p>UK: exact locations not specified</p>		<p><i>Commissioning stages</i></p> <p>Contracting, and monitoring and evaluation</p>
<p><i>Overall weight of evidence (trustworthiness)</i></p> <p>For IMPACT study: a little</p> <p>For BARRIERS study: a little</p>		<p><i>Characteristics and ownership of the service providers</i></p> <p>Not specified</p>
<p><i>Sample size of the study i.e. no. of individuals investigated</i></p> <p>Not specified</p>		<p><i>Types of service(s) investigated in this study</i></p> <ul style="list-style-type: none"> <li>Mental health services</li> <li>Drug and alcohol treatment services</li> <li>Special needs education</li> <li>Disability services</li> <li>Multiple services: HIV/AIDS, nursing care and residential care</li> </ul>
		<p><i>Age group(s) of population commissioned for</i></p> <p>Whole population</p> <p><i>Extent of the study i.e. the number of partnerships investigated in this study and areas covered</i></p> <p>140 local authority social service departments</p>

Studies	General details of study	Details of joint commissioning
Davey V, Henwood M, Knapp M (2004) Integrated commissioning for older people	<p><i>Reviewers' interpretation of the aims of the study</i> To examine how the planning, prioritising and commissioning of non-acute health and social care for older people are evolving between local authorities and PCTs</p> <p><i>Types of outcomes investigated</i> Quantitative and non-quantitative measure of the outcomes</p> <p><i>Reviewers' summary of study</i> An examination of</p> <ul style="list-style-type: none"> <li>• the evolution of planning, prioritising and commissioning of non-acute health and social care services for older people between local authorities and PCTs</li> <li>• the readiness and capacity to integrate commissioning</li> <li>• the strengths and weaknesses, latent threats and opportunities within the context of integrated commissioning</li> </ul> <p><i>Country</i> UK: London, central and southern England</p> <p><i>Overall weight of evidence (trustworthiness)</i> For IMPACT study: a little For BARRIERS study: To some extent</p> <p><i>Sample size of the study i.e. no. of individuals investigated</i> Not specified</p>	<p><i>Commissioning context</i> Regulations and policy: The Health Act</p> <p><i>Level of joint commissioning</i> Area-based/locality commissioning: PCTs and social services within local authority</p> <p><i>Sectors of study</i> Health and social care/social services</p> <p><i>Commissioners/purchasers of services</i> Local authorities and PCTs</p> <p><i>Commissioning stages</i> Not specified</p> <p><i>Characteristics and ownership of the service providers</i> Not specified</p> <p><i>Types of service(s) investigated in this study</i> Intermediate care</p> <p><i>Characteristics of population commissioned</i> Whole population</p> <p><i>Age group(s) of population commissioned for</i> Whole population</p> <p><i>Extent of the study i.e. the number of partnerships investigated in this study and areas covered</i> 6 localities: 2 county councils, 2 unitary authorities and 2 London boroughs in central and southern England</p>

Studies	General details of study	Details of joint commissioning
<p>ECOTEC (2006) Connexions moving towards children's trusts</p>	<p><i>Reviewers' interpretation of the aims of the study</i> To assess the impact of and views on the process of, barriers to and facilitators of commissioning</p> <p><i>Types of outcomes investigated</i> Quantitative and non-quantitative measure of the outcomes</p> <p><i>Reviewers' summary of study</i> An examination of</p> <ul style="list-style-type: none"> <li>• the integration and delivery of front-line services through joint planning and commissioning</li> <li>• good practice and the lessons learnt around the alignment of services and pooling of resources of 12 Connexions partnerships including the difficulties, barriers and risks, and how they were overcome</li> <li>• how the Connexions partnerships were preserving and promoting the positive elements of youth provision</li> </ul> <p><i>Country</i> UK: exact locations not specified</p>	<p><i>Commissioning context</i> Relationship between purchasers and providers or between partners</p> <p><i>Level of joint commissioning</i> Area-based/locality commissioning: PCTs, social services and local authority</p> <p><i>Sectors of study</i> Health, social care/social services and education</p> <p><i>Commissioners/purchasers of services</i></p> <ul style="list-style-type: none"> <li>• Local authorities</li> <li>• Primary care trusts</li> <li>• Children's trusts</li> <li>• Adult social care</li> <li>• Children's portfolio</li> </ul>
<p><i>Overall weight of evidence (trustworthiness)</i> For IMPACT study: a little For BARRIERS study: a little</p>	<p><i>Sample size of the study i.e. no. of individuals investigated</i></p> <ul style="list-style-type: none"> <li>• 60 stakeholder interviews across the 12 case studies</li> <li>• additional interviews with young people and new stakeholders</li> <li>• 2 workshops with key stakeholders</li> </ul>	<p><i>Commissioning stages</i> Whole process of commissioning</p> <p><i>Characteristics and ownership of the service providers</i> Not specified</p>
<p><i>Types of service(s) investigated in this study</i></p>	<p><i>Multiple services (providing information, advice, guidance and other support for young people)</i></p>	<p><i>Characteristics of population commissioned</i> Whole population</p>
<p><i>Age group(s) of population commissioned for</i></p>	<p><i>Young people aged 13-19 (up to aged 25 for individuals with learning difficulty and/or disability)</i></p>	<p><i>Extent of the study i.e. the number of partnerships investigated in this study and areas covered</i> 12 Connexions partnerships</p>

Studies	General details of study	Details of joint commissioning
<p>Freeman T, Peck E (2006) Evaluating partnerships: a case study of integrated specialist mental health services</p>	<p><i>Reviewers' interpretation of the aims of the study</i> To assess the impact of and views on the process of, barriers to and facilitators of commissioning</p> <p><i>Types of outcomes investigated</i> Quantitative and non-quantitative measures of outcomes</p> <p><i>Reviewers' summary of study</i> An examination of</p> <ul style="list-style-type: none"> <li>• the investigation of partnership working between social services and NHS organisations</li> <li>• the perceptions of a wide range of stakeholders</li> <li>• the impact of partnership working</li> </ul> <p><i>Country</i> UK: Hertfordshire</p> <p><i>Overall weight of evidence (trustworthiness)</i> For IMPACT study: a little For BARRIERS study: To some extent</p> <p><i>Sample size of the study i.e. no. of individuals investigated</i></p> <ul style="list-style-type: none"> <li>• a census of 600 staff in specialist and generic teams (response rate 53.8 percent) in 2002</li> <li>• a census of 660 (response rate 37.6 percent) in 2004</li> <li>• 235 (35.6 percent) respondents in the study</li> </ul>	<p><i>Commissioning context</i></p> <ul style="list-style-type: none"> <li>• Institutional and organisational environment surrounding the commissioning</li> <li>• Regulations and policy</li> </ul> <p><i>Level of joint commissioning</i> Area-based/locality commissioning: Hertfordshire county council and its NHS partners</p> <p><i>Sectors of study</i> Health and social care/social services</p> <p><i>Commissioners/purchasers of services</i> LAs and PCTs</p> <p><i>Commissioning stages</i> Whole process of commissioning</p> <p><i>Characteristics and ownership of the service providers</i> Not specified</p> <p><i>Types of service(s) investigated in this study</i> Mental health services</p> <p><i>Characteristics of population commissioned</i> Whole population</p> <p><i>Age group(s) of population commissioned for</i> Whole population</p> <p><i>Extent of the study i.e. the number of partnerships investigated in this study and areas covered</i> 10 districts within 8 PCTs across Hertfordshire</p>

Studies	General details of study	Details of joint commissioning
<p>Glendinning C, Hudson B, Hardy B, Young R (2002) National evaluation of notifications for use of the Section 31 partnership flexibilities in the Health Act 1999</p>	<p><i>Reviewers' interpretation of the aims of the study</i> To assess the impact of and views on the process of, barriers to and facilitators of commissioning</p> <p><i>Types of outcomes investigated</i> Quantitative and non-quantitative measures of outcomes</p> <p><i>Reviewers' summary of study</i> An examination of the 3 new flexibilities of the Health Act: flexibilities on pooled budget, lead commissioning and integrated provision</p> <p><i>Country</i> UK: nationwide</p> <p><i>Overall weight of evidence (trustworthiness)</i> For IMPACT study: a little For BARRIERS study: To some extent</p> <p><i>Sample size of the study i.e. no. of individuals investigated</i></p> <ul style="list-style-type: none"> <li>• a baseline survey received from 22 of the 32 sites (response rate 73 percent)</li> <li>• a follow-up survey at 18 months, 23 completed questionnaires (response rate 72 percent)</li> <li>• in-depth case studies undertaken of 10 partnerships; and further follow-up studies conducted in 3 of these sites</li> </ul>	<p><i>Commissioning context</i></p> <ul style="list-style-type: none"> <li>• Nature of market and degree of competition</li> <li>• Regulations and policy</li> </ul> <p><i>Level of joint commissioning</i> Not specified</p> <p><i>Sectors of study</i> Health and social care/social services</p> <p><i>Commissioners/purchasers of services</i></p> <ul style="list-style-type: none"> <li>• Health authorities</li> <li>• Local authorities</li> <li>• Primary care trusts</li> <li>• Primary care groups</li> </ul> <p><i>Commissioning stages</i> Whole process of commissioning</p> <p><i>Characteristics and ownership of the service providers</i> Not specified</p> <p><i>Types of service(s) investigated in this study</i> Multiple services</p> <p><i>Characteristics of population commissioned</i> People with disability</p> <p><i>Age group(s) of population commissioned for</i> Whole population</p> <p><i>Extent of the study i.e. the number of partnerships investigated in this study and areas covered</i> 10 partnerships and 32 sites</p>

Studies	General details of study	Details of joint commissioning
Goldman C (2010) Joint financing across health and social care: money matters, but outcomes matter more	<p><i>Reviewers' interpretation of the aims of the study</i> To assess the impact of and views on the process of, barriers to and facilitators of commissioning</p> <p><i>Types of outcomes investigated</i> Quantitative and non-quantitative measures of outcomes</p> <p><i>Reviewers' summary of study</i> An examination of the impact of pooled budgeting between social services agencies and PCTs on expenditure and user outcomes</p> <p><i>Country</i> UK: exact location not specified</p> <p><i>Overall weight of evidence (trustworthiness)</i> For IMPACT study: a little For BARRIERS study: To some extent</p> <p><i>Sample size of the study i.e. no. of individuals investigated</i></p> <ul style="list-style-type: none"> <li>• survey of Audit Commission's appointed auditors for all PCTs, metropolitan and London borough councils, county councils and unitary authorities in England (responses covered 69 percent of organisation)</li> <li>• 8 workshops held with 12 PCTs, 13 councils, 3 mental health trusts and 3 care trusts. Each workshop involved between 2 and 8 organisations</li> <li>• interviews carried out with 2 councils, 1 PCT and 1 mental health trust</li> <li>• findings were shared through a seminar with 16 organisations previously not involved in the research</li> </ul>	<p><i>Commissioning context</i> Relationship between purchasers and providers or between partners</p> <p><i>Level of joint commissioning</i> Area-based/locality commissioning: at borough and county level</p> <p><i>Sectors of study</i> Health and social care/social services</p> <p><i>Commissioners/purchasers of services</i></p> <ul style="list-style-type: none"> <li>• Local authorities</li> <li>• Primary care trusts</li> <li>• Mental health care trusts</li> <li>• Others: London borough, metropolitan and county councils</li> </ul> <p><i>Commissioning stages</i> Pooled budgets</p> <p><i>Characteristics and ownership of the service providers</i> Not specified</p> <p><i>Types of service(s) investigated in this study</i></p> <ul style="list-style-type: none"> <li>• Mental health services</li> <li>• Special needs education</li> <li>• Learning disability services</li> </ul> <p><i>Characteristics of population commissioned</i> Whole population</p> <p><i>Age group(s) of population commissioned for</i> Whole population</p> <p><i>Extent of the study i.e. the number of partnerships investigated in this study and areas covered</i> 12 PCTs, 13 councils, 3 mental health trusts and 3 care trusts</p>

Studies	General details of study	Details of joint commissioning
<p>Heenan D, Birrell D (2006) The integration of health and social care: the lessons from Northern Ireland</p>	<p><b>Reviewers' interpretation of the aims of the study</b> To assess the impact of and views on the process of, barriers to and facilitators of commissioning</p> <p><b>Types of outcomes investigated</b> Non-quantitative measures of outcomes</p> <p><b>Reviewers' summary of study</b> An examination of the service providers' views on the impact of integrated purchasing and provision by health and social services in Northern Ireland</p> <p><b>Country</b> UK: Northern Ireland</p> <p><b>Overall weight of evidence (trustworthiness)</b> For IMPACT study: A little For BARRIERS study: To some extent</p> <p><b>Sample size of the study i.e. no. of individuals investigated</b></p> <ul style="list-style-type: none"> <li>• 24 people were interviewed (4 directors of social services from the boards, 3 chief executives from the trusts, and 17 directors and assistant directors from the trusts)</li> <li>• 22 users and carers were contacted and 16 participated in the focus-group sessions</li> <li>• focus groups were organised in separate locations throughout Northern Ireland (number not specified)</li> </ul>	<p><b>Commissioning context</b> Not specified</p> <p><b>Level of joint commissioning</b> Area-based/locality commissioning: Community trusts Practice-based commissioning: programme of care</p> <p><b>Sectors of study</b> Health and social care/social services <i>Commissioners/purchasers of services</i> Health and social services boards under the Department of Health and Social Services and Public Safety</p> <p><b>Commissioning stages</b> Whole process of commissioning</p> <p><b>Characteristics and ownership of the service providers</b> State owned</p> <p><b>Types of service(s) investigated in this study</b></p> <ul style="list-style-type: none"> <li>• Mental health services</li> <li>• Special needs education</li> <li>• Learning disability</li> <li>• Health promotion</li> <li>• Family services (child and family care)</li> <li>• Disability services</li> <li>• Others: elderly care, acute services, primary and adult community health</li> </ul> <p><b>Characteristics of population commissioned</b> Whole population</p> <p><b>Age group(s) of population commissioned for</b> Whole population</p> <p><b>Extent of the study i.e. the number of partnerships investigated in this study and areas covered</b></p> <ul style="list-style-type: none"> <li>• 4 health and social services boards</li> <li>• 11 community health and social services trusts</li> <li>• separate locations throughout Northern Ireland (number not specified)</li> </ul>

Studies	General details of study	Details of joint commissioning
Hudson B, Hardy B, Henwood M, Wistow G (1997) Inter-agency collaboration: joint commissioning sub-study (final report)	<p><i>Reviewers' interpretation of the aims of the study</i> To assess the impact of and views on the process of, barriers to and facilitators of commissioning</p> <p><i>Types of outcomes investigated</i> Non-quantitative measures of outcomes</p> <p><i>Reviewers' summary of study</i> An examination of</p> <ul style="list-style-type: none"> <li>• the impact and factors which impede or promote collaboration in the context of joint commissioning</li> <li>• interviewees' perceptions of 'collaborative world'</li> <li>• the concern with the macro features of policy making and the micro features of policy implementation</li> </ul> <p><i>Country</i> UK: London, Midlands, North England</p> <p><i>Overall weight of evidence (trustworthiness)</i> For IMPACT study: A little For BARRIERS study: A little</p> <p><i>Sample size of the study i.e. no. of individuals investigated</i></p> <ul style="list-style-type: none"> <li>• 62 separate semi-structured interviews were conducted with senior and middle managers, supplemented by visits to a number of joint commissioning projects (number not specified)</li> <li>• supplemented by local documentation (number and nature not specified)</li> </ul>	<p><i>Commissioning context</i> Institutional and organisational environment surrounding the commissioning</p> <p><i>Level of joint commissioning</i> Area-based/locality commissioning: county and local borough</p> <p><i>Sectors of study</i> Health and social care /services</p> <p><i>Commissioners/purchasers of services</i></p> <ul style="list-style-type: none"> <li>• Health authorities</li> <li>• Local authorities</li> <li>• Housing authorities</li> <li>• Education authorities</li> </ul> <p><i>Commissioning stages</i> Whole process of commissioning</p> <p><i>Characteristics and ownership of the service providers</i> Not specified</p> <p><i>Types of service(s) investigated in this study</i> Multiple services</p> <p><i>Characteristics of population commissioned</i> Whole population</p> <p><i>Age group(s) of population commissioned for</i> Whole population</p> <p><i>Extent of the study i.e. the number of partnerships investigated in this study and areas covered</i> 5 anonymous localities in the UK (a London borough, a northern county, a Midlands Borough, a southern county and a northern borough)</p>

Studies	General details of study	Details of joint commissioning
<p>Hudson B, Willis J (1996) Analysis of joint commissioning developments in the northern region stage 2</p>	<p><i>Reviewers' interpretation of the aims of the study</i> To assess the impact of and views on the process of, barriers to and facilitators of commissioning</p> <p><i>Types of outcomes investigated</i> Non-quantitative measures of outcomes</p> <p><i>Reviewers' summary of study</i> An examination of the general attitude of and approaches used in joint commissioning</p> <p><i>Country</i> UK: South Tyneside, Sunderland, North Yorkshire and Northumberland</p> <p><i>Overall weight of evidence (trustworthiness)</i> For IMPACT study: A little For BARRIERS study: A little</p> <p><i>Sample size of the study i.e. no. of individuals investigated</i> Project managers, front line staff and users and carers were interviewed (number not specified)</p>	<p><i>Commissioning context</i> Not specified</p> <p><i>Level of joint commissioning</i> Area-based/locality commissioning: local authorities and district health authorities Practice-based commissioning</p> <p><i>Sectors of study</i> Health and social care /services</p> <p><i>Commissioners/purchasers of services</i> Health authorities Local authorities</p> <p><i>Commissioning stages</i> Whole process of commissioning</p> <p><i>Characteristics and ownership of the service providers</i> Not specified Provider an outside agency in the first case study</p> <p><i>Types of service(s) investigated in this study</i></p> <ul style="list-style-type: none"> <li>• Mental health services</li> <li>• Drug and alcohol treatment services</li> <li>• Multiple services (respite care, learning disability, equipment for physical disability, personal care at home, child protection)</li> </ul> <p><i>Characteristics of population commissioned</i> Whole population</p> <p><i>Age group(s) of population commissioned for</i> Whole population</p> <p><i>Extent of the study i.e. the number of partnerships investigated in this study and areas covered</i> 4 different localities within the northern and Yorkshire regions: South Tyneside, Sunderland, North Yorkshire and Northumberland</p>

Studies	General details of study	Details of joint commissioning
<p>Hultberg E-L, Lonnroth K, Allebeck P (2003) Co-financing as a means to improve collaboration between primary health care, social insurance, and social service in Sweden: a qualitative study of collaboration experiences among rehabilitation partners</p>	<p><i>Reviewers' interpretation of the aims of the study</i> To assess the impact of and views on the process of, barriers to and facilitators of commissioning</p> <p><i>Types of outcomes investigated</i> Quantitative and non-quantitative measures of outcomes</p> <p><i>Reviewers' summary of study</i> An examination of</p> <ul style="list-style-type: none"> <li>• the differences in the character and process of interdisciplinary collaboration between the DELTA health centres and control health centres</li> <li>• the comparison of health outcomes</li> <li>• the extent to which co-financing contributed to differences in process and outcome</li> </ul> <p><i>Country</i> Sweden</p> <p><i>Overall weight of evidence (trustworthiness)</i> For IMPACT study: To some extent For BARRIERS study: A lot</p> <p><i>Sample size of the study i.e. no. of individuals investigated</i></p> <ul style="list-style-type: none"> <li>• 167 patients were interviewed (128 from the intervention centres and 39 from the control) at baseline</li> <li>• second interviews were completed with 142 patients (109 from the intervention centres and 33 from control) at 6 months</li> <li>• third interviews were completed with 138 patients (107 from intervention centres and 31 from control) at 12 months</li> <li>• 224 patients interviewed (75 percent response rate) at 14 months</li> <li>• 9 focus groups with 2-8 respondents including physicians, nurses, occupational therapists, physiotherapists, social workers, social insurance staff and secretaries (number not specified)</li> </ul>	<p><i>Commissioning context</i></p> <ul style="list-style-type: none"> <li>• Relationship between purchasers and providers or between partners: joint collaboration in funding and decision making between organisations</li> <li>• Regulations and policy</li> </ul> <p><i>Level of joint commissioning</i> Area-based/locality commissioning: health centres within an area Practice-based commissioning</p> <p><i>Sectors of study</i> Health and social care/social services</p> <p><i>Commissioners/purchasers of services</i></p> <ul style="list-style-type: none"> <li>• The social insurance</li> <li>• County council and municipality</li> </ul> <p><i>Commissioning stages</i> Whole process of commissioning</p> <p><i>Characteristics and ownership of the service providers</i> Not specified</p> <p><i>Types of service(s) investigated in this study</i> Care and rehabilitation of patients with musculoskeletal diseases</p> <p><i>Characteristics of population commissioned</i> People with musculoskeletal diseases</p> <p><i>Age group(s) of population commissioned for</i> 16-64 years</p> <p><i>Extent of the study i.e. the number of partnerships investigated in this study and areas covered</i> 107 DELTA health centres and 31 control health centres</p>

Studies	General details of study	Details of joint commissioning
Kurunmaki L, Miller P, Keen J (2001) Health Act flexibilities: first steps	<p><i>Reviewers' interpretation of the aims of the study</i> To assess the impact of and views on the process of, barriers to and facilitators of commissioning</p> <p><i>Types of outcomes investigated</i> Non-quantitative measures of outcomes</p> <p><i>Reviewers' summary of study</i> An examination of</p> <ul style="list-style-type: none"> <li>• the key stakeholders' incentives to enter a formal partnership</li> <li>• the choice of which client groups to work with</li> <li>• the form of partnership to select</li> </ul> <p><i>Country</i> UK: location not specified</p> <p><i>Overall weight of evidence (trustworthiness)</i> For IMPACT study: A little For BARRIERS study: A little</p> <p><i>Sample size of the study i.e. no. of individuals investigated</i></p> <ul style="list-style-type: none"> <li>• 13 semi-structured interviews with a number of different stakeholders involved in financing and delivery of services</li> <li>• observation of 3 meetings in two research sites</li> </ul>	<p><i>Commissioning context</i></p> <ul style="list-style-type: none"> <li>• Nature of market and degree of competition: role of the independent sector and managing the market</li> <li>• Relationship between purchasers and providers or between partners</li> </ul> <p><i>Level of joint commissioning</i> Area-based/locality commissioning: health authority and local authority level</p> <p><i>Sectors of study</i> Health and social care/social services</p> <p><i>Commissioners/purchasers of services</i></p> <ul style="list-style-type: none"> <li>• Health authorities</li> <li>• Local authorities</li> <li>• Learning disability services</li> <li>• Primary care groups</li> </ul> <p><i>Commissioning stages</i> Needs assessment, monitoring and evaluation and the whole process of commissioning</p> <p><i>Characteristics and ownership of the service providers</i> Not specified</p> <p><i>Types of service(s) investigated in this study</i> Multiple services (secondary care/hospital health services; hospital discharge related services; special needs education; learning disability)</p> <p><i>Characteristics of population commissioned</i> Whole population</p> <p><i>Age group(s) of population commissioned for</i> Whole population</p> <p><i>Extent of the study i.e. the number of partnerships investigated in this study and areas covered</i> 5 regions of a reasonable geographical spread</p>

Studies	General details of study	Details of joint commissioning
<p>Peck E, Gulliver P, Towell D (2002) Modernising partnerships: an evaluation of Somerset's innovations in the commissioning and organisation of mental health services: final report</p>	<p><b>Reviewers' interpretation of the aims of the study</b> To assess the impact of and views on the process of, barriers to and facilitators of commissioning</p> <p><b>Types of outcomes investigated</b> Quantitative and non-quantitative measures of outcomes</p> <p><b>Reviewers' summary of study</b> An examination of the impact of joint commissioning on users, carers, staff, and the joint commissioning board</p> <p><b>Country</b> UK: Somerset</p>	<p><b>Commissioning context</b></p> <ul style="list-style-type: none"> <li>• Relationship between purchasers and providers or between partners</li> <li>• Regulations and policy</li> <li>• Financial mechanisms</li> </ul> <p><b>Level of joint commissioning</b> Area-based/locality commissioning: 4 localities in Somerset</p> <p><b>Sectors of study</b> Health and social care /social services</p> <p><b>Commissioners/purchasers of services</b></p> <ul style="list-style-type: none"> <li>• Health authorities</li> <li>• Local authorities</li> <li>• County council</li> </ul> <p><b>Commissioning stages</b> Needs assessment and whole process of commissioning</p>
<p><b>Overall weight of evidence (trustworthiness)</b> For IMPACT study: A little For BARRIERS study: To some extent</p> <p><b>Sample size of the study i.e. no. of individuals investigated</b></p> <ul style="list-style-type: none"> <li>• structured interviews with 96 service users</li> <li>• a survey of all staff members at 3 time points: At time 1: 207 responded (response rate 44 percent) At time 2: 124 (response rate 34 percent) At time 3: 151 (response rate 37 percent)</li> <li>• focus group with self-selected service users and their carers (number not specified)</li> <li>• exploratory workshops with self-selected staff members (number not specified)</li> <li>• semi-structured interviews with senior managers of health and social services, members and non-executive directors (number not specified)</li> <li>• non-participant observation of 10 out of 12 Joint Commissioning Board meetings</li> </ul>	<p><b>Characteristics and ownership of the service providers</b> Not specified</p> <p><b>Types of service(s) investigated in this study</b> Mental health services</p> <p><b>Characteristics of population commissioned</b> Whole population</p> <p><b>Age group(s) of population commissioned for</b> Whole population</p> <p><b>Extent of the study i.e. the number of partnerships investigated in this study and areas covered</b> The Somerset Partnership NHS and Social Care Trust based in 4 localities</p>	<p><b>Characteristics and ownership of the service providers</b> Not specified</p> <p><b>Types of service(s) investigated in this study</b> Mental health services</p> <p><b>Characteristics of population commissioned</b> Whole population</p> <p><b>Age group(s) of population commissioned for</b> Whole population</p> <p><b>Extent of the study i.e. the number of partnerships investigated in this study and areas covered</b> The Somerset Partnership NHS and Social Care Trust based in 4 localities</p>

Studies	General details of study	Details of joint commissioning
<p>Phelps K, Regen E (2008) To what extent does the use of Health Act flexibilities promote effective partnership working and positive outcomes for older people?</p>	<p><i>Reviewers' interpretation of the aims of the study</i> To assess the impact of and views on the process of, barriers to and facilitators of commissioning</p> <p><i>Types of outcomes investigated</i> Quantitative and non-quantitative measures of outcomes</p> <p><i>Reviewers' summary of study</i> An examination of</p> <ul style="list-style-type: none"> <li>• how Health Act flexibilities (HAF) promote effective partnership working and positive outcomes for frail older people</li> <li>• the relationship between context, process and outcomes in relation to the use of HAF</li> <li>• the complex relationships between context and outcomes by teasing out the mechanisms via which the HAF are producing effects</li> </ul> <p><i>Country</i> UK: 3 anonymous sites (2 rural, 1 urban)</p>	<p><i>Commissioning context</i> Regulations and policy: The Health Act flexibilities, introduced in Section 31 (s31) of the 1999 Health Act</p> <p><i>Level of joint commissioning</i> Area-based/locality commissioning: 3 HAF sites in rural and urban areas</p> <p><i>Sectors of study</i> Health and social care/social services</p> <p><i>Commissioners/purchasers of services</i></p> <ul style="list-style-type: none"> <li>• Health authorities</li> <li>• Local authorities</li> </ul>
<p><i>Overall weight of evidence (trustworthiness)</i> For IMPACT study: A little For BARRIERS study: To some extent</p> <p><i>Sample size of the study i.e. no. of individuals investigated</i></p> <ul style="list-style-type: none"> <li>• 66 surveys (response rate 30 percent)</li> <li>• 36 one-to one interviews and 3 focus groups</li> </ul> <p>directors and assistant directors of social services, chief executives and department heads in PCTs, finance officers, service managers, therapists, nurses, social workers, social care staff and voluntary sector workers</p> <ul style="list-style-type: none"> <li>• 22 interviews and focus groups with service users and carers</li> </ul> <p>National data (CSCI data; 2001 Census databases; Countryside Agency; DOH Community Care Statistics)</p>	<p><i>Characteristics and ownership of the service providers</i> State owned</p> <p><i>Types of service(s) investigated in this study</i></p> <ul style="list-style-type: none"> <li>• Social care (e.g. home care)</li> <li>• Intermediate care</li> </ul> <p><i>Characteristics of population commissioned</i> Whole population and carers of the elderly</p> <p><i>Age group(s) of population commissioned for</i> Elderly (60 and over)</p> <p><i>Extent of the study i.e. the number of partnerships investigated in this study and areas covered</i></p> <ul style="list-style-type: none"> <li>• 47 partnerships which were using HAFs</li> <li>• 11 local authorities which had not indicated use of HAFs</li> <li>• 3 case-study sites</li> </ul>	<p><i>Commissioning stages</i> Monitoring and evaluation</p>

Studies	General details of study	Details of joint commissioning
Powell J, Jones M, Kimberlee R (2003) Commissioning drug services for vulnerable young people	<p><i>Reviewers' interpretation of the aims of the study</i> To assess the impact of and views on the process of, barriers to and facilitators of commissioning</p> <p><i>Types of outcomes investigated</i> Non-quantitative measures of outcomes</p> <p><i>Reviewers' summary of study</i> An examination of how government guidance on commissioning interacted with decision-making at the local level commissioning processes for drug services for vulnerable young people</p> <p><i>Country</i> UK: location not specified</p> <p><i>Overall weight of evidence (trustworthiness)</i> For IMPACT study: A little For BARRIERS study: To some extent</p> <p><i>Sample size of the study i.e. no. of individuals investigated</i></p> <ul style="list-style-type: none"> <li>• 20 unstructured interviews with personnel from all agencies connected with young people</li> <li>• 3 participant observations at formal committee meetings documentary evidence in the form of strategy documents</li> </ul>	<p><i>Commissioning context</i> New requirements for agencies to plan and create strategies to help vulnerable young people</p> <p><i>Level of joint commissioning</i> Area-based/locality commissioning</p> <p><i>Sectors of study</i> Health, social care/social services and education</p> <p><i>Commissioners/purchasers of services</i></p> <ul style="list-style-type: none"> <li>• Health authorities</li> <li>• Local authorities</li> <li>• Primary care trusts</li> </ul> <p><i>Commissioning stages</i> Whole process of commissioning</p> <p><i>Characteristics and ownership of the service providers</i> State owned</p> <p><i>Types of service(s) investigated in this study</i></p> <ul style="list-style-type: none"> <li>• Drug and alcohol treatment services</li> <li>• Secondary education</li> <li>• Higher education</li> <li>• Health promotion</li> <li>• Others: youth community service, LA, police and the voluntary sectors</li> </ul> <p><i>Characteristics of population commissioned</i> Vulnerable young people under age 19</p> <p><i>Age group(s) of population commissioned for</i> Children and young people (0-25 years)</p> <p><i>Extent of the study i.e. the number of partnerships investigated in this study and areas covered</i> 7 Drug Action Teams</p>

Studies	General details of study	Details of joint commissioning
<p>Rummary K (1999) The way forward for joint working? Involving primary care in the commissioning of social care services</p>	<p><i>Reviewers' interpretation of the aims of the study</i> To assess the impact of and views on the process of, barriers to and facilitators of commissioning</p> <p><i>Types of outcomes investigated</i> Non-quantitative measures of outcomes</p> <p><i>Reviewers' summary of study</i> An examination of the benefits and challenges of working together to commission services</p>	<p><i>Commissioning context</i> Nature of market and degree of competition Regulations and policy</p> <p><i>Level of joint commissioning</i></p> <ul style="list-style-type: none"> <li>• Area-based/locality commissioning: Easington and North Down</li> <li>• Practice-based commissioning: Bromsgrove and Arley</li> <li>• Individual-based commissioning</li> </ul> <p><i>Sectors of study</i> Health and social care/social services</p> <p><i>Commissioners/purchasers of services</i></p> <ul style="list-style-type: none"> <li>• Health authorities</li> <li>• Local authorities</li> <li>• Primary care trusts</li> <li>• Others: community health council, district council, joint commissioning management group</li> </ul>
<p><i>Country</i> UK: Easington, North Down, Bromsgrove, Arley, Malmesbury, Lyme and Castlefields</p> <p><i>Overall weight of evidence (trustworthiness)</i> For IMPACT study: A little For BARRIERS study: To some extent</p> <p><i>Sample size of the study i.e. no. of individuals investigated</i> Interviews were carried out with key stakeholders from each of the purchasing agencies (number not specified)</p>	<p><i>Commissioning stages</i> Whole process of commissioning</p> <p><i>Characteristics and ownership of the service providers</i> Not specified</p> <p><i>Types of service(s) investigated in this study</i> Social care (e.g. home care)</p> <p><i>Characteristics of population commissioned</i> Whole population</p> <p><i>Age group(s) of population commissioned for</i> Elderly (60 and over)</p> <p><i>Extent of the study i.e. the number of partnerships investigated in this study and areas covered</i> 7 sites</p>	<p><i>Commissioning context</i> Nature of market and degree of competition Regulations and policy</p> <p><i>Level of joint commissioning</i></p> <ul style="list-style-type: none"> <li>• Area-based/locality commissioning: Easington and North Down</li> <li>• Practice-based commissioning: Bromsgrove and Arley</li> <li>• Individual-based commissioning</li> </ul> <p><i>Sectors of study</i> Health and social care/social services</p> <p><i>Commissioners/purchasers of services</i></p> <ul style="list-style-type: none"> <li>• Health authorities</li> <li>• Local authorities</li> <li>• Primary care trusts</li> <li>• Others: community health council, district council, joint commissioning management group</li> </ul> <p><i>Commissioning stages</i> Whole process of commissioning</p> <p><i>Characteristics and ownership of the service providers</i> Not specified</p> <p><i>Types of service(s) investigated in this study</i> Social care (e.g. home care)</p> <p><i>Characteristics of population commissioned</i> Whole population</p> <p><i>Age group(s) of population commissioned for</i> Elderly (60 and over)</p> <p><i>Extent of the study i.e. the number of partnerships investigated in this study and areas covered</i> 7 sites</p>

Studies	General details of study	Details of joint commissioning
<p>Rummary K (2004) Progress towards partnership? The development of relations between primary care organisations and social services concerning older people's services in the UK</p>	<p><i>Reviewers' interpretation of the aims of the study</i> To assess the impact of and views on the process of, barriers to and facilitators of commissioning</p> <p><i>Types of outcomes investigated</i> Quantitative and non-quantitative measures of outcomes</p> <p><i>Reviewers' summary of study</i> An examination of</p> <ul style="list-style-type: none"> <li>• partnership working at the strategic, managerial and operational levels</li> <li>• the desirability and feasibility of integrating services into one organisation for partnership working in health and social care generally</li> </ul> <p><i>Country</i> UK: location not specified</p> <p><i>Overall weight of evidence (trustworthiness)</i> For IMPACT study: A little For BARRIERS study: To some extent</p> <p><i>Sample size of the study i.e. no. of individuals investigated</i> Surveys/interviews were carried out with key stakeholders in the PCG/T Board, the wider NHS and relevant social services departments (number not specified)</p>	<p><i>Commissioning context</i></p> <ul style="list-style-type: none"> <li>• Regulations and policy</li> <li>• Health care/benefit systems</li> </ul> <p><i>Level of joint commissioning</i> Area-based/locality commissioning</p> <p><i>Sectors of study</i> Health and social care /social services</p> <p><i>Commissioners/purchasers of services</i></p> <ul style="list-style-type: none"> <li>• Local authorities</li> <li>• Primary care trusts</li> <li>• Primary care groups</li> </ul> <p><i>Commissioning stages</i> Not specified</p> <p><i>Characteristics and ownership of the service providers</i> Not specified</p> <p><i>Types of service(s) investigated in this study</i> Not specified</p> <p><i>Characteristics of population commissioned</i> Whole population</p> <p><i>Age group(s) of population commissioned for</i> Elderly (60 and over)</p> <p><i>Extent of the study i.e. the number of partnerships investigated in this study and areas covered</i> 4 sites</p>

Studies	General details of study	Details of joint commissioning
<p>Secker J, Davies P, Howell V (2000) Joint commissioning for mental health services between primary health care and social care in Wales</p>	<p><i>Reviewers' interpretation of the aims of the study</i> To assess the impact of and views on the process of, barriers to and facilitators of commissioning</p> <p><i>Types of outcomes investigated</i> Non-quantitative measures of outcomes</p> <p><i>Reviewers' summary of study</i> An examination of</p> <ul style="list-style-type: none"> <li>• the current extent of joint commissioning</li> <li>• the issues involved in joint commissioning</li> </ul> <p><i>Country</i> UK: Wales</p> <p><i>Overall weight of evidence (trustworthiness)</i> For IMPACT study: A little For BARRIERS study: To some extent</p> <p><i>Sample size of the study i.e. no. of individuals investigated</i></p> <ul style="list-style-type: none"> <li>• 17 health authority commissioners for mental health</li> <li>• 22 social services commissioners for mental health</li> <li>• 5 GPs</li> </ul>	<p><i>Commissioning context</i> Regulations and policy</p> <p><i>Level of joint commissioning</i> Area-based/locality commissioning: the health authority area Practice-based commissioning: between GPs and social service</p> <p><i>Sectors of study</i> Health and social care/social services</p> <p><i>Commissioners/purchasers of services</i></p> <ul style="list-style-type: none"> <li>• Health authorities</li> <li>• Local authorities</li> </ul> <p><i>Commissioning stages</i> Whole process of commissioning</p> <p><i>Characteristics and ownership of the service providers</i> Not specified</p> <p><i>Types of service(s) investigated in this study</i> Mental health services</p> <p><i>Characteristics of population commissioned</i> Whole population</p> <p><i>Age group(s) of population commissioned for</i> Whole population</p> <p><i>Extent of the study i.e. the number of partnerships investigated in this study and areas covered</i> 3 commissioning groups</p>

Studies	General details of study	Details of joint commissioning
SHM (2009) Commissioning Services for children, young people and families: a study of the dynamics in six local authority areas	<p><i>Reviewers' interpretation of the aims of the study</i> To assess the impact of and views on the process of, barriers to and facilitators of commissioning</p> <p><i>Types of outcomes investigated</i> Non-quantitative measures of outcomes</p> <p><i>Reviewers' summary of study</i> An examination of the dynamics around commissioning and in particular in relation to questions of leadership, partnership, and locality working</p> <p><i>Country</i> UK: exact locations not specified</p> <p><i>Overall weight of evidence (trustworthiness)</i> For IMPACT study: A little For BARRIERS study: To some extent</p> <p><i>Sample size of the study i.e. no. of individuals investigated</i> Not clear: Within each selected case study area the authors worked with a local champion, usually the director of children's services, who helped them to identify a sample of 8 or more stakeholders in a range of different roles to interview for the case study (exact numbers not specified)</p>	<p><i>Commissioning context</i> Not specified</p> <p><i>Level of joint commissioning</i></p> <ul style="list-style-type: none"> <li>• Area-based/locality commissioning: local authority area</li> <li>• Practice-based commissioning</li> </ul> <p><i>Sectors of study</i> Health and social care/social services</p> <p><i>Commissioners/purchasers of services</i></p> <ul style="list-style-type: none"> <li>• Local authorities</li> <li>• Primary care trusts</li> <li>• Children's trusts</li> </ul> <p><i>Commissioning stages</i> Whole process of commissioning</p> <p><i>Characteristics and ownership of the service providers</i> Not specified</p> <p><i>Types of service(s) investigated in this study</i> Multiple services: children and young people's services</p> <p><i>Characteristics of population commissioned</i> Whole population</p> <p><i>Age group(s) of population commissioned for</i> Children and young people (0-25 years) Adults (26-59)</p> <p><i>Extent of the study i.e. the number of partnerships investigated in this study and areas covered</i> 6 case studies in 6 different local authority areas</p>

Studies	General details of study	Details of joint commissioning
<p>Smith J, Bamford M, Ham C, Scrivens E, Shapiro J (1997) Beyond fundholding: a mosaic of innovation in the West Midlands</p>	<p><i>Reviewers' interpretation of the aims of the study</i> To assess the impact of and views on the process of, barriers to and facilitators of commissioning</p> <p><i>Types of outcomes investigated</i> Non-quantitative measures of outcomes</p> <p><i>Reviewers' summary of study</i> An examination of</p> <ul style="list-style-type: none"> <li>• what was emerging as the health authority and GPs moved 'beyond fundholding' and in the provision of care by new primary care organisations and alliances</li> <li>• the different mosaic of diversity of innovations in the West Midlands</li> </ul> <p><i>Country</i> UK: West Midlands</p> <p><i>Overall weight of evidence (trustworthiness)</i> For IMPACT study: A little For BARRIERS study: To some extent</p> <p><i>Sample size of the study i.e. no. of individuals investigated</i></p> <ul style="list-style-type: none"> <li>• interviews were carried out with a range of key local stakeholders (number not specified)</li> <li>• field work visits included multi-funds, locality commissioning groups, health authority/GP, co-operatives and whole district approaches (number not specified)</li> </ul>	<p><i>Commissioning context</i> To examine what was emerging as HA and GPs moved 'beyond fundholding'</p> <p><i>Level of joint commissioning</i> Area-based/locality commissioning: Sandwell HA, Shropshire HA, South Staffordshire HA</p> <p><i>Sectors of study</i> Health and social care/social services</p> <p><i>Commissioners/purchasers of services</i></p> <ul style="list-style-type: none"> <li>• General practitioners</li> <li>• Local authorities</li> <li>• NHS trusts</li> </ul> <p><i>Commissioning stages</i> Monitoring and evaluation</p> <p><i>Characteristics and ownership of the service providers</i> Not specified</p> <p><i>Types of service(s) investigated in this study</i></p> <ul style="list-style-type: none"> <li>• Primary physician care: Sandwell HA: Tripartite alliance of health</li> <li>• Social services and local authority: Shropshire HA: include community services; South Staffordshire HA: a range of services</li> </ul> <p><i>Characteristics of population commissioned</i> Whole population</p> <p><i>Age group(s) of population commissioned for</i> Whole population</p> <p><i>Extent of the study i.e. the number of partnerships investigated in this study and areas covered</i> 6 case studies in West Midlands</p>

Studies	General details of study	Details of joint commissioning
Smith J, Shapiro J (1996) Evaluation of the Easington Joint Commissioning Board: 'Some real wins for Easington': report to the Joint Commissioning Board	<p><i>Reviewers' interpretation of the aims of the study</i> To assess the impact of and views on the process of, barriers to and facilitators of commissioning</p> <p><i>Types of outcomes investigated</i> Non-quantitative measures of outcomes</p> <p><i>Reviewers' summary of study</i> An examination of the achievement of the JCB in Easington relating to what it sets out to do</p> <p><i>Country</i> UK: County Durham</p> <p><i>Overall weight of evidence (trustworthiness)</i> For IMPACT study: A little For BARRIERS study: A little</p> <p><i>Sample size of the study i.e. no. of individuals investigated</i> 25 semi-structured interviews with a sample of Joint Commissioning Board members, Local Advisory Groups members and other providers and commissioners</p>	<p><i>Commissioning context</i> Concerns about the extent of ill-health in Easington, the fragmentation of services provision and the inherent complexities of working across the boundaries of health and social services</p> <p><i>Level of joint commissioning</i> Area-based/locality commissioning: locality of Easington, County Durham</p> <p><i>Sectors of study</i> Health and social care/social services</p> <p><i>Commissioners/purchasers of services</i></p> <ul style="list-style-type: none"> <li>• Health authorities</li> <li>• Local authorities</li> </ul> <p><i>Commissioning stages</i> Whole process of commissioning</p> <p><i>Characteristics and ownership of the service providers</i> State owned</p> <p><i>Types of service(s) investigated in this study</i> Social care (e.g. home care) Primary physician care</p> <p><i>Characteristics of population commissioned</i> Whole population</p> <p><i>Age group(s) of population commissioned for</i> Whole population</p> <p><i>Extent of the study i.e. the number of partnerships investigated in this study and areas covered</i> 1 county (Easington, County Durham)</p>

Studies	General details of study	Details of joint commissioning
<p>Thistlethwaite P (1997) Finding common cause? impressions of links between G.P. fundholders and five social services departments in England</p>	<p><i>Reviewers' interpretation of the aims of the study</i> To assess the impact of and views on the process of, barriers to and facilitators of commissioning</p> <p><i>Types of outcomes investigated</i> Non-quantitative measures of outcomes</p> <p><i>Reviewers' summary of study</i> An examination of  <ul style="list-style-type: none"> <li>• collaborative working of primary health care teams and social services departments</li> <li>• the determinants of good practice and outcomes of joint collaboration</li> </ul> </p> <p><i>Country</i> UK : Northern County, Northern city, North West Borough, North west County, South West county</p> <p><i>Overall weight of evidence (trustworthiness)</i> For IMPACT study: A little For BARRIERS study: A little</p> <p><i>Sample size of the study i.e. no. of individuals investigated</i>  <ul style="list-style-type: none"> <li>• interviews with a small sample -in each practice, 1 or more partners were interviewed, sometimes with the practice manager (not specified)</li> <li>• in the south west county, the social services department interviewees were the locally based managers linking with the 5 practices (number not specified)</li> <li>• in the north west county those interviewed were senior operational managers and the relevant local team manager (number not specified)</li> </ul> </p>	<p><i>Commissioning context</i> Relationship between purchasers and providers or between partners</p> <p><i>Level of joint commissioning</i> Area-based/locality commissioning: in different localities</p> <p><i>Sectors of study</i> Health and social care/social services</p> <p><i>Commissioners/purchasers of services</i>  <ul style="list-style-type: none"> <li>• General practitioners</li> <li>• Health authorities</li> <li>• Local authorities</li> <li>• Primary care trusts</li> <li>• NHS trusts and district councils</li> </ul> </p> <p><i>Commissioning stages</i> Whole process of commissioning</p> <p><i>Characteristics and ownership of the service providers</i> Not specified</p> <p><i>Types of service(s) investigated in this study</i> Multiple services: residential home for rehabilitation</p> <p><i>Characteristics of population commissioned</i> Whole population</p> <p><i>Age group(s) of population commissioned for</i> Whole population</p> <p><i>Extent of the study i.e. the number of partnerships investigated in this study and areas covered</i> Interviews with  <ul style="list-style-type: none"> <li>• 2 practices in northern county</li> <li>• 2 practices in northern city</li> <li>• 2 practices in north west borough</li> <li>• 2 practices in north west county</li> <li>• 5 practices in southwest county</li> <li>• 5 local social services authorities</li> </ul> </p>

Studies	General details of study	Details of joint commissioning
Wilkin D, Coleman A, Dowling B, Smith K (2002) National Tracker Survey of Primary Care Groups and Trusts, 2001/2002: taking responsibility	<p><i>Reviewers' interpretation of the aims of the study</i> To assess the impact of and views on the process of, barriers to and facilitators of commissioning</p> <p><i>Types of outcomes investigated</i> Quantitative measures of outcomes</p> <p><i>Reviewers' summary of study</i> An examination of</p> <ul style="list-style-type: none"> <li>• the different aspects of PCGs' working including commissioning</li> <li>• the progress of joint commissioning activities implemented by PCGs/Trusts</li> <li>• the barriers/obstacles to commissioning</li> </ul> <p><i>Country</i> UK: nationwide</p> <p><i>Overall weight of evidence (trustworthiness)</i> For IMPACT study: A little For BARRIERS study: To some extent</p> <p><i>Sample size of the study i.e. no. of individuals investigated</i> 66 chief executives and 61 chairs were interviewed</p>	<p><i>Commissioning context</i> Regulations and policy</p> <p><i>Level of joint commissioning</i> Area-based/locality commissioning: PCTs</p> <p><i>Sectors of study</i> Health and social care/social services</p> <p><i>Commissioners/purchasers of services</i></p> <ul style="list-style-type: none"> <li>• Local authorities</li> <li>• Primary care trusts</li> <li>• Primary care groups</li> </ul> <p><i>Commissioning stages</i> Whole process of commissioning</p> <p><i>Characteristics and ownership of the service providers</i> Not specified</p> <p><i>Types of service(s) investigated in this study</i> Multiple services (community based and domiciliary services)</p> <p><i>Characteristics of population commissioned</i> Whole population</p> <p><i>Age group(s) of population commissioned for</i> Whole population</p> <p><i>Extent of the study i.e. the number of partnerships investigated in this study and areas covered</i> 65 PCGs and 6 PCTs</p>

Studies	General details of study	Details of joint commissioning
<p>Wyke S, Myles S, Popay J, Scott J, Cambell A (1999) Total purchasing, community and continuing care: lessons for future policy departments in the NHS</p>	<p><i>Reviewers' interpretation of the aims of the study</i> To assess the impact of and views on the process of, barriers to and facilitators of commissioning</p> <p><i>Types of outcomes investigated</i> Non-quantitative measures of outcomes</p> <p><i>Reviewers' summary of study</i> An examination of integrated purchasing with social service departments and continuing care</p> <p><i>Country</i> UK: south, Midlands and north England and Scotland</p> <p><i>Overall weight of evidence (trustworthiness)</i> For IMPACT study: A little For BARRIERS study: To some extent</p> <p><i>Sample size of the study i.e. no. of individuals investigated</i> 48 interviews with key Total Purchasing Pilots (TPP), health authorities and social service providers</p>	<p><i>Commissioning context</i> Institutional and organisational environment surrounding the commissioning</p> <p><i>Level of joint commissioning</i> Area-based/locality commissioning: health authority area Practice-based commissioning</p> <p><i>Sectors of study</i> Health and social care/social services</p> <p><i>Commissioners/purchasers of services</i></p> <ul style="list-style-type: none"> <li>• General practitioners</li> <li>• Total Purchasing Pilots</li> <li>• Health authorities</li> <li>• Local authorities</li> </ul> <p><i>Commissioning stages</i></p> <ul style="list-style-type: none"> <li>• Needs assessment</li> <li>• Contracting and budget setting</li> <li>• Integrated provision of services</li> </ul> <p><i>Characteristics and ownership of the service providers</i> Unclear: statutory and voluntary organisations but not specified</p>
		<p><i>Types of service(s) investigated in this study</i> Multiple services (community and continuing care services)</p> <p><i>Characteristics of population commissioned</i> Whole population</p> <p><i>Age group(s) of population commissioned for</i> Whole population</p> <p><i>Extent of the study i.e. the number of partnerships investigated in this study and areas covered</i> 5 Total Purchasing Pilots</p>



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