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The Chiltern Forum Commissioning Project – a model for primary care groups?

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Aim: To describe a general practice commissioning project including 19 nonfundholding practices in Buckinghamshire: its structure, aims, representativeness, outcomes, costs and sustainability, and lessons learned from the process over the first 18 months.

Method: Examination of project documentation; postal questionnaire to all 73 participating GPs and to eight key players in the Health Authority (response rate 72%); and in-depth interviews with six Health Authority staff and 15 general practitioners (GPs).

Results: A representative structure and process were established for GP involvement in commissioning. 75% of GPs were involved. Mutual understanding improved between the GPs and the Health Authority. Service improvements identified included developments in orthopaedics, community psychiatric nursing, physiotherapy and ophthalmology. Lessons were learned about the importance of open and continued communication; clarity about expectations, accountability, power and responsibility; development of relationships and understanding in joint working; the time required to achieve tangible results; and the need to develop GPs' commissioning skills.

The project cost about £10000 in cash and £32500 in staff time in the first year. Participants perceived their input as sustainable.

Conclusion: The results of the study suggest that the success of Primary Care Groups will depend on ensuring engagement of all parties in the process, clarifying roles, responsibilities and expectations, identifying shared agendas, developing explicit and achievable goals, and a commitment among all parties to implement recommendations. The work and time involved in developing mutual respect and shared understanding, and in developing commissioning skills need to be acknowledged.

Key words: Commissioning; evaluation; primary care groups

Introduction

Primary Care Groups (PCGs) are being set up across the country in response to the White Paper 'The New NHS' (Secretary of State for Health, 1997). New commissioning groups have been shown to need time to become established, both to do things that need to be done, and also to allow the new relationships and approaches to grow. Quite a lot of the necessary learning has to be 'learning by doing', as the people and situations are unique to every location (Woolley *et al*., 1995). The development of these new groups may be assisted if they can learn from the experience gained by previous types of commissioning groups, tackling similar issues and problems.

Engagement of GPs in local purchasing initiatives has been identified as one of the key issues in a variety of studies of different models of commissioning (Balogh and Thomasson, 1995; Brittan, 1994; Ham, 1992; Klein and Redmayne, 1992; Office for Public Management, 1994; Shapiro, 1994).

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As for the development of the variety of commissioning organizations in the past, developing PCGs requires managing change both within and between organizations. Other key aspects of a proactive approach to implementation of change in the NHS (Appleby *et al*., 1994) include clarification (understanding and gaining agreement between parties); communication (well thought out communication strategies and working hard to defuse anxieties and misunderstandings); and corporate commitment (clear leadership roles).

This paper describes the first 18 months of an early general practice based locality commissioning project, the Chiltern Forum, launched in April 1995, comprising all 19 nonfundholding practices in South Buckinghamshire, covering a population of about 130 000 (about 20% of the county).

The key issues addressed by our evaluation were whether the Chiltern Forum genuinely represented the GP constituency, whether GPs were involved, whether there was mutual understanding and communication between those involved, and whether there was clear leadership. We also aimed to document the service changes which occurred, the outcomes and costs of the project, and what was learned by the participants.

Methods

Three methods of data collection were used. Firstly, papers describing the project's framework, minutes of meetings, letters, interim reports and the Health Authority's Purchasing Plan were examined to obtain objective evidence about the project's development, aims, processes, costs and outcomes.

Secondly, postal questionnaires were sent to all 73 participating GPs and to eight key players in the Health Authority. These identified respondents' involvement and participation in the project; their expectations and whether these had been met; their perceptions of outcomes; and the costs in terms of paperwork and meetings. 51 GPs and seven Health Authority staff responded (response rate: GPs 70%, Health Authority 88%; overall 72%.)

Thirdly, interviews lasting about one hour were undertaken with 15 GPs and six Health Authority staff. The GP sample covered the range of participants in terms of age, sex, all practices in the project, involvement in the project and also attitudes towards its outcomes, ascertained from the questionnaires. Interviews covered the extent to which GPs felt represented in the Forum, its processes and outcomes, and lessons learned. The six Health Authority staff were selected on the basis of their involvement in the project. Transcripts were available from all 21 interviews, which were taped with respondents' permission. These interviews were carried out by Patterson, Fletcher and Wright who jointly developed the topic guides and coding schedule. Analysis of transcripts was carried out by Patterson for all interviews using a grounded theory method (Glaser and Strauss, 1967), and checked with Fletcher and Wright for reliability. Each transcript was analysed and each segment of text coded into themes. New concepts were related to those already gathered in an emerging framework of related themes. Quotations are included (*in italics*) where they illustrate important or recurring themes most concisely.

Results

In 1992, nonfundholders in Buckinghamshire began to consider the problems and opportunities of the purchaser-provider split, and to suggest closer working with the Health Authority. By 1994, the group realized that to influence purchasing they would need a formal structure and recognition from the Health Authority. They formed the 'Chiltern Forum commissioning project' comprising all the nonfundholders in South Buckinghamshire, which was launched in April 1995. Their main aim was to develop more cost-effective and responsive heath services locally by undertaking service reviews to influence the commissioning decisions of the Health Authority.

Structure

The project Core Group consisted of six GPs elected from the whole Forum, plus a project manager and a senior registrar in Public Health seconded from the Health Authority. Information was exchanged between the Health Authority and Forum GPs, via the Core Group. Practice staff validated Contract Minimum Data Sets, while the senior registrar and GPs gathered evidence about effectiveness of interventions and reviewed local services. Recommendations were ratified by the

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Forum and incorporated into the Health Authority's Purchasing Plan.

Representativeness

All Forum GPs were eligible for election as Core Group members. From the questionnaires, 75% of GPs acknowledged some involvement in the project, ranging from being a Core Group member to simply keeping abreast of issues. All GPs had a mechanism for exchanging information and engaging with the Core Group in debates at Forum meetings. Although attendance at these meetings was sometimes low, Core Group GPs and the project manager developed an outreach mechanism to communicate with nonattenders. Interviews with GPs suggested that this process had worked, since all those interviewed were satisfied with the group's ability to represent their opinions.

The effectiveness of the mechanisms for representation and participation was demonstrated when, a year into the project, three Core Group members proposed that the Forum should enter Community Fundholding to increase budgetary power. This debate produced the highest turnout of any Forum meeting, since it was perceived as a relevant issue directly affecting GPs who were otherwise not involved in the project. The GPs had such a strong commitment against fundholding that this suggestion was vetoed.

In contrast, interviews with Health Authority staff revealed that while they saw the Forum as a legitimate voice of nonfundholders, they were still concerned about the extent to which the Core Group spoke on the authority of the other GPs. This meant that they were not confident that the other GPs would implement the Core Group's recommendations, particularly when these would require the GPs to change their clinical (referral) practice.

Outcomes of service reviews

The first service reviews undertaken examined orthopaedics, counselling, ophthalmology, community psychiatric nursing, and physiotherapy. These reviews recommended (respectively):

- Contracts should be shifted between providers to reduce waiting times in orthopaedics;
- Counselling services for women undergoing terminations of pregnancy should be increased;
- Preschool vision screening should be undertaken by orthoptists rather than health visitors;
- Community psychiatric nurses should increase their communication with Chiltern Forum doctors in line with their service to fundholders;
- Physiotherapy should be increased in primary care and reduced in secondary care settings.

These developments were perceived by the GPs, both as having occurred, and also as being due to the Chiltern Forum. Other changes also identified were: having a route to influence service delivery, improved understanding of commissioning issues and Health Authority constraints, and improved relationships between participants.

Lessons learned from the process

The review of orthopaedic waiting times illustrates some difficulties faced by GP commissioning groups, and lessons learned by the Chiltern Forum.

The service review concluded that waiting times were 'unacceptably long' (Wadd, 1996). The Forum recommended that 15% of contracted activity should be removed from the local provider and a contract established with a neighbouring provider. This proposal was included in the 1996/7 Purchasing Plan. Following publication of the Plan, a meeting took place between representatives of the Forum and the orthopaedic department at the existing provider, who pledged to meet twelve-month waits for admissions.

As a result, the Health Authority considered the issue resolved. They did not implement the shift of activity since they feared that funds released from the current contract would only be at marginal rates, giving insufficient funds to purchase the required level of activity at the alternative provider (Wood, 1995). Because the Health Authority was not confident that all Forum GPs would comply with the proposed change in referral patterns, they were also unwilling to take the risk of shifting contracts. If GPs did not change their referrals, the contract at the original provider would overperform, with money committed to the new provider also.

Thus the Forum was constrained by the Health Authority's risk management strategies, leading to disappointment among some GPs, with one Health Authority respondent commenting:

> *The GPs knew that fundholders can make small changes because they buy on a cost per case basis, so they thought they [the Forum] could too. But we [the Health Authority] buy*

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in large volume, so there was a total misunderstanding about the volume of work which Chiltern Forum would have to move for us to recoup fixed as well as marginal costs. The GPs felt disenchanted – they didn't feel an opportunity had been taken forward; equally the Health Authority were confused as to what the outcome of the discussion with the Trust had been. We had clearly failed to communicate.

In this process, GPs learned about the budgetary constraints of the Health Authority and the wider implications of their recommendations. The Health Authority learned to value GP input into contract negotiations, with Chiltern Forum GPs being 'welcome to join the Health Authority contract meetings' in future (Chiltern Forum, 1995).

One hundred per cent of Health Authority staff and 33% of GPs perceived mutual relationships as improved during the project; 65% of GPs thought relationships had stayed the same, with only 1 GP (2%) suggesting that relationships had actually worsened.

One Health Authority respondent commented:

We've had a great opportunity for getting to know one another, establishing communications, getting a handle on how things work – now we need to move to the next stage which is putting these things into practice, and allow Chiltern Forum to be bold and engage in achieving things.

A GP commented that the Health Authority now '*pays heed to general practitioners in a way that they were very bad at before.*' Another felt '*a loss of the feeling of isolation which used to occur for nonfundholders.*'

The timing of the project was difficult because it coincided with major reorganizations within the Health Authority. Responsibilities within the Health Authority were redefined, leading to lack of clarity in structures and roles and this flagged up the need for the Forum to continually make new relationships and engage different personnel in the project.

Outcomes – did the project meet expectations?

The questionnaire included questions covering both positive and negative expectations of the project. Responses suggested that GPs and the Health Authority had some differences in their implicit expectations which had not been shared initially and were only made apparent by the evaluation (Table 1). In particular, two thirds of the Health Authority staff anticipated that the project would improve liaison with social services, an expectation which was held by less than a fifth of the GPs. The Health Authority (HA) appeared overall to have higher expectations of the project than GPs. Higher proportions of Health Authority staff than GPs anticipated more effective services, better relationships between the participants and improved patient satisfaction from the project. However, the differences in proportions holding these expectations was not statistically significant except for social services (possibly due to small numbers in the HA group), and the rank order of importance of these expectations, judged by the proportion of respondents holding each, was similar between the two groups.

Twenty of the 47 people who responded to the question on negative anticipations (43%) had none of these. The main negative anticipation held by the remainder was of spending too much time in meetings (held by 16, 34%).

The interviews also demonstrated different interpretations of some expectations. For example, GPs interpreted the term 'greater GP input into decision-making' to mean automatic Health Authority ratification of their recommendations:

Why does the Health Authority ask us if they are not prepared to act on it?

Conversely, some Health Authority staff who were less involved in the project perceived the GPs as having only an advisory role, and not being experienced enough to take responsibility:

GPs think they should be in the driving seat, and there's a gap between that expectation and reality because Chiltern Forum is still heavily dependent on the Health Authority to support the GPs' development of expertise.

This highlighted the need to be clear about expectations relating to accountability, power and responsibility.

Another lesson learned was that both sides recognised GPs' need to develop their commissioning skills, supported by the Health Authority. One GP described the Forum as '*still at the*

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Table 1 The expectations of the project

Expectation	Held by Health Authority	Held by GPs	P value for difference in proportions
Greater GP input to resource decisions	6 (100%)	42 (82%)	NS
More effective services	6 (100%)	26 (51%)	NS
Better relationships between the Health Authority and the Chiltern Forum GPs	5 (83%)	25 (49%)	NS
Improved patient satisfaction	5 (83%)	18 (35%)	NS
Faster access to community services	2 (33%)	17 (33%)	NS
Faster access to acute services	2 (33%)	16 (31%)	NS
Greater choice of services available	2 (33%)	14 (27%)	NS
Better liaison with social services	4 (67%)	9 (17%)	$0.01 < p < 0.05$

toddler stage – playing at shops with Monopoly money' while a Health Authority interviewee saw Health Authorities as having '*an enabling role. It's a case of GPs taking on more responsibility, but in a planned way, in a structured way, involving training and a step-wise approach which builds up their capacity and that is fully supported by the Health Authority.*'

There was an almost universal feeling that important issues were being addressed (92% respondents), but less certainty about the effectiveness of the project to achieve changes in commissioning (53%) or whether the investment of time and effort was justified (43%) (Table 2).

Some participants, both GPs and Health Authority, reported disillusionment about the lack of tangible results from the project. Both unrealistic expectations of the extent and rate of change possible, and underestimation of the importance of what had been achieved seemed from the interviews to have contributed to this. One GP commented:

> *One gets an impression that what started off with great beginnings and enthusiasm seems now more like banging your head against the wall. While one has all the best intentions and puts all the effort in, if nothing substantial comes out of it, it is frustrating – it seems very difficult to change the system.*

Thus another lesson is the importance of developing structures, engagement and relationships as precursors to service changes, and also the length of time required to achieve more 'tangible' results.

Costs of the Chiltern Forum Project

The project was allocated a budget of £30 000 from the Regional Health Authority's Purchaser Development monies to cover:

Table 2 Effectiveness of the Chiltern Forum as described by general practitioners and the Health Authority

	Yes		No		Don't know	
	GPs	HA	GPs	HA	GPs	HA
Do you think the Chiltern Forum has tackled important issues?	39 (91%)	6 (100%)	4 (9%)	0 (0%)	0 (0%)	0 (0%)
Do you think the group has been effective in commissioning?	26 (53%)	3 (50%)	6 (12%)	1 (17%)	17 (35%)	2 (33%)
Do you think the results justify the time and effort that have been put in?	19 (40%)	4 (66%)	6 (12%)	0 (0%)	23 (48%)	2 (33%)

(There were no significant differences between GPs and Health Authority in responses to these questions.)

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- Core Group GP time at £60 for an evening meeting per GP × six GPs = £360 per meeting, held approximately every six weeks;
- Practice staff time for survey work (£6.50 per hour for data collection);
- The running costs of a project office (building maintenance, service charges; printing, stationery, furniture, phone rental and calls);
- Attendance at conferences.

In the first year (1995/6), the budget was underspent by £21 000, so this money was carried over to 1996/7.

The Health Authority contributed ≅£12 500 in staff time:

- a commissioning manager as project manager (1.5 days per week; £5000 approximately);
- a Senior Registrar in Public Health (1.5 days per week; £5000 approximately);
- support from Information and Finance (£1500 approximately), and
- secretarial support and office space (£1000 approximately).

General practitioners contributed ≅£20 000:

- A 'token of commitment' of £50 per practice in the first year for running expenses: use of a surgery for Forum meetings (£50), books (£75) and membership of the National Society of Commissioning General Practitioners (£50);
- Time to attend meetings (usually out of hours) totalling four days per week (shared among the participants);
- Extra paperwork totalled 25 hours per week (costed at ≅£1000 per practice).

Overall, the total cost was approximately £10 000 in cash and £32 500 in kind in the first year. The majority of questionnaire respondents perceived their input to the project as sustainable (84% GPs and 83% Health Authority). Fears about excessive time spent in meetings as a result of the project did not seem to have been realized.

Conclusion

This evaluation demonstrated that it was possible to establish a nonfundholding commissioning group which represented GPs in participating practices, addressed important issues, enabled closer joint working between GPs and the Health Authority, was relatively inexpensive and even in the formative stages had a demonstrable impact on services, through implementation of the service review recommendations.

The majority of GPs and Health Authority participants were supportive and actively involved, although reorganizations meant that some people within the Health Authority were less engaged than would have been ideal. Concerns have been raised in the literature about engagement of GPs in various models of Primary Care led commissioning elsewhere. Attendances at meetings are frequently low, and those GPs who do attend may be the vocal, involved practitioners whose views are already known (Shapiro, 1994). For example in locality commissioning, one conclusion was that 'ways needed to be found of engaging these doctors in the locality' (Smith and Shapiro, 1997b).

In terms of roles, accountability and implementation, uncertainty existed around the extent to which the Health Authority was prepared to delegate responsibility and power, its commitment to acting on the Forum's recommendations, and its capability to implement recommendations within the constraints of resources, policy and the financial cycle. The Health Authority still had concerns about the GPs' commitment to implementation of recommendations which would have serious consequences for the Health Authority. This finding echoes results of the national evaluation of commissioning pilots (Smith *et al*., 2000).

This project supports the findings from studies of other approaches to commissioning, often based around GPs who preferred not to be fundholders (Shapiro, Smith and Walsh, 1996), where the nature and style of GP involvement varied from an advisory to an executive role. Primary care led commissioning was intended to marry the strategic skills of the Health Authority with the operational knowledge of GPs; in some areas partners stated the terms of the relationship clearly, in others, it was allowed to evolve as the partnership developed. Some Health Authorities were 'parent-like' and GPs were eager to share power more evenly. In other areas, there has been ambiguity in the extent to which the Health Authority has been able to 'let go' control and responsibility to GP groups. The most effective approach appeared to be when expectations on both sides were clear, and where there was gradual assumption of responsi-

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bility as the GPs recognized the constraints on the Health Authority from NHS bureaucracy, Health Authorities began to feel more comfortable in letting go control (Smith and Shapiro, 1997a) and where Health Authorities backed the demands of GP commissioners and were prepared to move custom if quality was not improved (Glennerster, 1998). The need for two way accountability between GPs and Health Authorities was also demonstrated (Smith and Shapiro, 1997b).

There was also evidence of a maturing of alliances with both parties understanding and respecting each other's culture. Evaluations of Total Purchasing Pilots (Mays *et al*., 1997) have shown few incentives for Health Authorities to cooperate with new primary care input into commissioning. Similarly, evaluations of GP commissioning groups (Mays and Dixon, 1996) state that the biggest concern is whether the GP commissioners will be able to bring about the changes they desire since they are reliant on the Health Authority to purchase services on their behalf. This ability depends on the relationships which have been built up between the GPs and the Health Authority.

The main gains during the course of the project were better communication and understanding between GPs and the Health Authority. The disparity in views of the two sides about the improvements in the relationship may be due to the fact that the HA participants were chosen specifically for their involvement in the project, while the GPs represented the full range of involvement or otherwise. The development of trust between groups of people who have not worked closely together before can only develop gradually, but openness at the outset of a project such as this is likely to increase the rate at which it develops. It might have been helpful for the implicit expectations and concerns of the participants to have been made explicit at the outset. Realistic expectations about what outcomes are feasible in defined timescales are necessary to avoid disillusionment, but it may be difficult to avoid some over expectation in the first stages of new projects. In addition, some developments had not been recognized by participants, so perhaps changes that had occurred could have been more widely publicized.

For locality commissioning, reported achievements were more commonly those relating to cultural change and the establishment of new ways of working rather than concrete changes to patient services (Smith and Shapiro, 1997b). Evaluations of Total Purchasing Pilots have also reported a perceived lack of progress, stated to be due to due to conflicts with the Health Authority, or Health Authority inertia (Mays *et al*., 1997). It may be that there were just different expectations between the parties, and a lack of definition of what constitutes a reasonable rate of progress. Cultural change is certainly a necessary prerequisite, and the opportunity for mutual learning between Health Authority staff and Primary Care professionals may be one of the most significant achievements of any new commissioning process.

Other researchers have pointed out since this project was undertaken that it takes considerable time to alter provider behaviour, whatever model of purchasing or commissioning is in place (Le Grand *et al*., 1997). This may mean that expectations will be more realistic about the pace of change in the future.

Similarly, there is now a greater realization of the need to strengthen management capacity and invest in organizational development in primary care (Smith *et al*., 1997, Goodwin *et al*., 1998).

The Chiltern Forum provides a possible model for the development of first level Primary Care Groups, with a number of similarities between the two types of organizations including a specific geographical area covered, the inclusion of doctors from several practices, having enthusiastic local leaders, developing partnerships with the HA, and building dialogue with trusts. Our results give confidence that PCGs could have an impact on NHS commissioning. The results imply that successful implementation of the White Paper will require the development of both skills and also trusting relationships between Primary Care and Health Authorities. These are likely to develop more quickly if:

- The time and energy required to ensure engagement and participation, communication and mutual understanding, are recognized;
- Roles, responsibilities, expectations and constraints are debated explicitly;
- Skills and strengths of all participants are acknowledged and developed;
- Realistic goals are set acknowledging time required for change, and changes which do occur are publicized;

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- The mechanism of implementation of the PCGs' recommendations is clear.

These aims may be facilitated by the dissimilarities between PCGs and commissioning groups. The involvement of all practices and both medical and nonmedical personnel will mean a larger pool of human resources is available from which to provide the required expertise.

The design of PCGs puts accountability at the top of the agenda, with issues of clinical quality rather than financial accountability at the fore (Wilson, 1999). The fact that the PCGs' remit is much wider than that of commissioning groups in terms of clinical governance and primary care development should mean that there is more emphasis on investing in developing the necessary skills. PCGs will need to continue to provide an environment of learning, to enable PCGs to work effectively with new partners, in new ways.

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References

Appleby, J., Smith, P., Ranade, W., Little, V. and **Robinson, R.** 1994: Monitoring managed competition. In Robinson, R. and Le Grand, J., editors. *Evaluating the NHS Reforms*. London: King's Fund.

Balogh, R. and **Thomasson, G.** 1995: The persuaders. *Health Services Journal* 104, 26.

Brittan, Y. 1994: *Working through localities in Berkshire, Buckinghamshire, Northamptonshire and Oxfordshire*. Anglia and Oxford: RHA/NHSE Anglia and Oxford.

Chiltern Forum 1995: *Minutes of the Chiltern Forum meeting* 25 September. Courtesy of Viki Wadd, Project Manager.

Glaser, B. and **Strauss, A.L.** 1967: *The discovery of grounded theory*. Howthorne, NY: Aldine de Gruyter.

Glennerster, H. 1998: Competition and quality in health care: the UK experience. *International Journal for Quality in Health Care* 10, 403–410.

Goodwin, N., Mays, N., McLeod, H., Malbon, G. and **Raftery, J.** 1998: Evaluation of total purchasing pilots in England and Scotland and implications for primary care groups in England: Personal interviews and analysis of routine data. *British Medical Journal* 317, 256–259.

Ham, C. 1992: Local heroes. *Health Services Journal* 102, 20–21.

Klein, R. and **Redmayne, S.** 1992: *Patterns of Priorities*. Birmingham: National Association of Health Authorities and Trusts.

Le Grand, J., Mays, N., Mulligan, J., Goodwin, N., Dixon, J. and **Glennerster, H.** 1997: *Models of Purchasing and Commissioning: Review of the Research Evidence*. London: Kings Fund.

Mays, N. and **Dixon, J.** 1996: *Purchaser Plurality in UK Health Care: Is a Consensus Emerging and is it the Right One?* London: King's Fund.

Mays, N., Goodwin, N., Bevan, G. and **Wyke, S.** 1997: *Total Purchasing: A Profile of National Pilot Projects*. London: King's Fund.

Office for Public Management 1994: *The North East Westminster Locality Purchasing Project*. London: Kensington Chelsea and Westminster Commissioning Agency.

Secretary of State for Health 1997: *White Paper: The New NHS*. London: HMSO.

Shapiro, J. 1994: *Shared Purchasing and Collaborative Commissioning Within the NHS*. University of Birmingham: Health Services Management Centre.

Shapiro, J., Smith, J. and **Walsh, N.** 1996: *Approaches to Commissioning: The Dynamics of Diversity. NAHAT Research Paper No 22*. University of Birmingham: Health Services Management Centre.

Smith, J., Bamford, M., Ham, C., Scrivens, E. and **Shapiro J.** 1997: *Beyond Fundholding: A Mosaic of Primary Care Led Commissioning and Provision in the West Midlands*. University of Birmingham: Health Services Management Centre.

Smith, J. and **Shapiro, J.** 1997a: Local call. *Health Services Journal*, 26–27.

Smith, J. and **Shapiro, J.** 1997b: *Holding On While Letting Go: Evaluation of Locality Commissioning in County Durham and Newcastle/North Tyneside*. University of Birmingham: Health Services Management Centre.

Smith, J., Regen E., Shapiro, J. and **Baines D.** 2000: National evaluation of general practitioner commissionning pilots: Lessons for primary care. *British Journal of General Practice* 50, 469–472.

Wadd, V. 1996: Chiltern Forum Project Manager 1996 *Interim Chiltern Forum Report to the Joint Executive,* 31 January.

Wilson, T. editor 1999: *The PCG Development Guide.* Oxford: Radcliffe Medical Press.

Wood, M. 1995: Assistant Director of Commissioning, Buckinghamshire Health Authority *1995 Letter to Chiltern Forum,* 21 September.

Woolley, M., Ham, C., Harwood, A. and **Patchett, S.** 1995: *The Route to Total Care: Joint Commissioning of Community Care*. London: Health Services Management Centre, Institute of Health Services Management.

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