King's Fund

What were the achievements of Total Purchasing Pilots in their first year and how can they be explained?

National Evaluation of Total Purchasing Pilot Projects Working Paper

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'Total purchasing' was introduced in 1995 as a pilot extension for volunteer fundholders of the controversial general practitioner (GP) fundholding scheme. It was widely seen at the time as heralding a potential shift of all health services' purchasing to GP-led bodies and away from health authorities. The total purchasing pilots (TPPs) have been, in key respects, forerunners of the *Primary Care Groups (PCGs)* announced in the December 1997 English White Paper, *The New NHS.* As a result, the lessons learned from the performance of the TPPs have an important bearing on the future organisation of the National Health Service.

This working paper is the first report from the national evaluation of total purchasing pilot projects to provide evidence on the achievements of all 53 'first wave' pilots in England and Scotland. It also looks at the range of factors associated with more and less successful total purchasing in 1996–97 and considers their implications for the establishment of PCGs in England in the future.

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The Total Purchasing National Evaluation Team (TP-NET)

The national evaluation of total purchasing pilots in England and Scotland is a collective effort by a large consortium of health services researchers. The study is led by the King's Fund, but also involves the National Primary Care R&D Centre; Universities of Edinburgh, Bristol, Southampton, York and Birmingham; the London School of Hygiene and Tropical Medicine; and the London School of Economics and Political Science. More information about the evaluation as a whole is available from: Nicholas Mays, King's Fund, 11–13 Cavendish Square, London W1M 0AN.

For further information on this part of the national evaluation contact Nick Goodwin at the King's Fund.

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Preface

Total purchasing pilot projects (TPPs) allow for the purchasing of potentially all hospital and community health services by fundholding general practices. They began their preparations for contracting in April 1995 in England and Scotland. Since 'total purchasing' (TP) represented an important extension of the already controversial fundholding scheme, the Department of Health decided to commission an assessment of the costs and benefits of this NHS Executive initiative. This working paper represents part of the interim reporting of the evaluation (further details are given opposite) which began data collection in October 1995 (mid-way through the TPPs' preparatory year) and which is due to produce final reports in Autumn 1998, by which time the TPPs will have completed two full purchasing years.

The evaluation amounts to a programme of inter-linked studies and is being undertaken by a large consortium of researchers from different universities led from the King's Fund. Full details of the participants are given on the back cover of this report. All 53 of the 'first wave' TPPs and the 35 'second wave' pilots which began a year later are being studied. Figure 1 on page 2 summarises the main elements of the research on the 'first wave' which has at its core an analysis of how TP was implemented at all projects and with what consequences in terms of hospital activity changes. This element is linked to a series of studies at sub-samples of TPPs which attempt to compare the costs and benefits of TP with conventional health authority purchasing for specific services (emergency admissions, community care, maternity and mental health). In this part of the evaluation, comparisons are also made between extended fundholding (EFH), where practices take on a new responsibility for purchasing in a single service area (e.g. maternity or mental health) and TP, where practices may be purchasing more widely.

Further details about the evaluation design and methods are given in a leaflet available from the King's Fund and in the preliminary report of the evaluation which was published by the King's Fund early in 1997 and entitled *Total purchasing: a profile of national pilot projects*.

The evaluation would not have been possible without the co-operation and interest shown by all the staff involved in the TPPs. We are very grateful, principally for the time people have given up to be interviewed, whether in practices, health authorities, trusts, social services departments or elsewhere in the health and social care system.

The national evaluation was commissioned and funded by the Department of Health and the Scottish Office Health Department. However, the views expressed in this paper do not necessarily represent the policy of the Departments.

This report has been produced to disseminate research findings and promote good practice in health and social care. It has not been professionally copy-edited or proof-read.

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Total Purchasing National Evaluation Team
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King's Fund, London
January 1998

Boxes, tables and figures

Abbreviations

CHC	Community Health Council
CMHT	Community Mental Health Team
CPN	Community Psychiatric Nurse
DH	Department of Health
DVT	Deep Vein Thrombosis
EA	Emergency Admission
ECR	Extra Contractual Referral
EFH	Extended Fundholding
EL	Executive Letter
FCE	Finished Consultant Episode
FHSA	Family Health Services Authority
GP	General Practitioner
GMS	General Medical Services
HA	Health Authority
HCHS	Hospital and Community Health Services
HES	Hospital Episode Statistics
HRG	Healthcare Resource Group
LOS	Length of Stay
NHS	National Health Service
NHSE	National Health Service Executive
PH	Public Health
PCG	Primary Care Group
SFH	Standard Fundholding
TP	Total Purchasing
TPP	Total Purchasing Pilot

Summary

Under Total Purchasing (TP), individual fundholding general practices or groups of such practices have been delegated budgets from their local health authority or health board on a pilot basis to purchase potentially all hospital and community health services (HCHS) for their patients.

This working paper from the national evaluation of the total purchasing pilots (TPPs) analyses the achievements reported by the 'first wave' TPPs in England and Scotland in their first purchasing year, 1996–97, and begins the process of explaining the relative success of each pilot project in terms of its characteristics.

Given the marked similarity between the TPPs and the Primary Care Groups (PCGs) proposed by the Labour Government in its December 1997 White Paper in England entitled *The New NHS*, the implications of TP for the future development of PCGs involving all general practitioners (GPs) are also discussed.

The main source of data used in this part of the national evaluation was face-to-face, semi-structured interviews carried out with lead GPs, project managers and health authority representatives involved with each TPP at the end of their first 'live' year of purchasing (1996–97).

All the projects were engaged in *selective* rather than *total* purchasing in 1996–97.

The broadly defined concept of TP as first announced by the NHS Executive late in 1994 had been interpreted in a number of distinct ways. Thus 44% of the pilots were directly purchasing at least some services beyond the scope of the standard fundholding scheme and controlled their own, delegated budgets. Twenty-one per cent were still preparing for active purchasing in 1996–97 and 15% were either 'co-purchasing' with their local health authority or focusing predominantly on developing primary care services rather than purchasing secondary care.

There was wide variation between the TPPs both in the contents of their purchasing objectives and their level of ambition and also in the extent to which they reported being able to achieve their own purchasing objectives in 1996–97. Overall, pilots reported achieving about half of their four main purchasing objectives for 1996–97.

TPPs were far more likely to report achievements which related to developments in primary care than, for example, in more specialised service areas delivered by secondary care providers such as inpatient care of people with mental health problems.

The vast majority of the TPPs, including those which had been the most successful in 1996–97, reported a higher level of ambition for the following purchasing year, 1997–98.

Among the potentially very wide range of influences on the level of achievements of the pilots in the first purchasing year, the findings tended to show that:

- smaller TPPs (with five or fewer practices) tended to do better in attaining their own purchasing objectives in the first purchasing year, particularly those with fewer GPs and smaller populations. In contrast, none of the larger, multi-practice projects (with more than five practices) were high achievers as assessed in relative terms by the researchers;
- smaller TPPs, particularly single practices, were able to achieve their own objectives with relatively little need for organisational development (they tended to have 'simple' structures), whilst the larger TPPs had to establish new, more complex forms of organisation before they could make progress;
- those TPPs with higher direct management costs per capita tended to achieve more in the first 'live' year;
- pilots with their own independent contracts were more likely to bring about achievements than those which did not contract independently;

- higher achieving TPPs were more likely to report that their local health authority was providing 'fair or good' support to the project than lower achieving projects;
- there was no association between a higher level of achievement in the first year and whether the practices involved in the TPP had had previous experience of working together;
- higher achieving projects were more likely to report future ambitions to 'do more and in TP-related service areas' than lower achieving TPPs.

One of the main implications of these findings is that larger, more complex projects involving more practices and/or GPs require a considerably longer and more intensive period of organisational development before they are in a position to bring about major achievements and service changes. Since all the TPPs were engaged in *selective* rather than 'total' purchasing in the first 'live' year, projects with smaller populations were not handicapped by an inability to manage their financial risks. Single practice TPPs had to do less to produce the necessary organisation and decision making system to manage TP whereas multi-practice projects were required to design a new form of organisation linking previously separate practices in order to achieve a consensus on their purchasing priorities.

The interim findings further suggest that having a devolved budget and developing independent contracts (or service agreements as they will be known in future) is associated with more effective purchasing, at least in the short term.

Since the White Paper, *The New NHS*, proposes PCGs in all areas of England, involving all practices irrespective of their previous fundholding or commissioning experience and with populations of around 100,000 (which is far larger than the TPPs), this strongly indicates the scale and duration of the development task to create effective commissioning bodies. This is particularly likely to be the case in inner cities where general practice has generally had far less experience of managing budgets and purchasing services. In these circumstances, it is hard to envisage that successful PCGs can be developed without substantial managerial expenditure, yet the White Paper indicates that the government plans to reduce overall management spending on the Health Service over the next five years.

1. Introduction

Total Purchasing (TP) was introduced as an extension of the general practitioner (GP) fundholding concept, in which general practices are delegated a budget to purchase potentially all of the hospital and community health services (HCHS) not included in standard fundholding (SFH) for their practice populations. It was seen officially as a development of GP-led purchasing *in collaboration* with the health authority and viewed as a potential source of innovation in which GPs would devise new ways of meeting patients' needs (NHS Executive, 1995). Thus a working definition of TP is as follows:

> *'Where either one GP practice, or a consortium of practices, is delegated money by the relevant health authority to purchase potentially all the community, secondary and tertiary health care not included in standard fundholding for patients on their lists'*. (Mays *et al.* on behalf of Total Purchasing National Evaluation Team, 1997)

TP was announced by the National Health Service Executive (NHSE) in October 1994. Volunteer pilots were selected to start their preparations in April 1995 with a view to purchasing initially in 1996–97 and again in 1997–98. The scheme was to be experimental, ending in March 1998 after three years. However, TP was implemented without a central blue print and with minimal guidance, in part because of a strong conviction within the NHSE that GPs had great potential to improve the efficiency of services through their purchasing and that they should be allowed to get on with the task as unfettered as possible. This led to considerable variation between the TPPs in the way in which they approached the scheme (for example, in the level of management spending and level of ambition). In particular, TPPs were free to choose which service areas they wished to work in and most appeared to undertake 'selective purchasing', selecting those services within TP that they wished to purchase or influence whilst not using their delegated budget to purchase in other areas.

The highly decentralised approach to implementing TP revealed the high level of trust which the NHSE placed in the leading fundholders in 1994.

As the paper which was published alongside the Executive Letter (EL) which established TP stated:

> *'The experience of the past four years has shown that purchasing delivers more appropriate services for patients when GPs are involved and particularly where they are involved by taking on the direct control of resources used by their patients'*. (NHS Executive, 1994, p2)

There were four, so called 'pioneer' TPPs already in existence when the national TP pilots were first announced and they were already regarded as 'successful' (NHS Executive, 1995) at an early stage.

Unlike SFH, the NHSE's total purchasing pilot projects (TPPs) are the subject of a multi-faceted three-year national evaluation in England and Scotland (1995–98). The study is the first Government-funded evaluation of a major initiative resulting from the NHS and Community Care Act, 1990. This paper presents the first analysis of the TPPs' achievements. This is of interest because of the earlier controversy about the merits of SFH and the Labour Government's determination to build on the best of the internal market and to develop fairer and less costly forms of devolved purchasing involving groups of GP practices in the form of so called Primary Care Groups (PCGs) (Secretary of State for Health, 1997). The experience of the TPPs will be particularly relevant initially to the direction of the 42 GP commissioning pilots announced by the new Government in the summer of 1997 ahead of the December 1997 White Paper (NHS Executive, 1997). These are due to start in April 1998 before the PCGs and will have much in common with the existing TPPs.

The TPP evaluation aims to look at a range of costs and benefits which could potentially flow from TP and was informed by an assessment of the potential pros and cons of the new model of purchasing as set out in Table 1.

The 'hands-off' approach from the centre has presented considerable difficulties for developing criteria by which to assess whether the projects have

Table 1: Potential strengths and weaknesses of general practitioner total purchasing of hospital and community health services identified to inform the design of the evaluation

Potential strengths

- Combination of best of 'top-down' (health authority) and 'bottom-up' (SFH) models of purchasing (i.e. needs vs demand focus; individual vs population focus; 'leverage' vs 'bite')
- Scope for service innovation and substitution leading to improvements in cost-effectiveness
- Sites act as 'vanguard' to secure service improvements and/or cost reductions in specific services which other purchasers can build on
- Sensitivity to local needs
- Clinician-to-clinician negotiations on service improvement

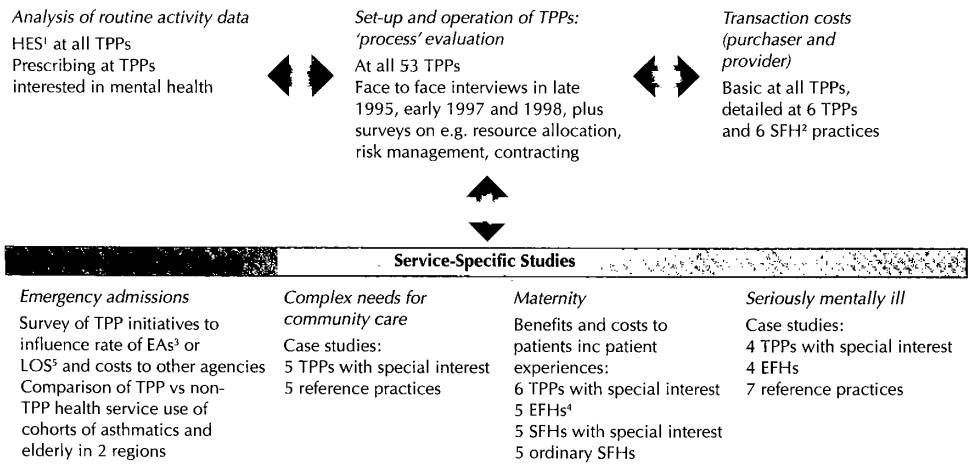
Potential weaknesses

- Fragmentation of NHS priority-setting and purchasing decisions and accountability for decisions
- Higher transaction costs (especially for providers) generated by larger numbers of smaller purchasing agencies
- Difficulty in managing unpredictable demand and associated costs (e.g. medical emergencies)
- Difficulty in finding a fair means of setting budgets for projects
- Deepening existing inequity between general practices
- Excessive reliance on expertise of a few 'lead' general practitioners, threatening sustainability
- No clear incentives at outset for practices to take part and for health authorities to co-operate

been successful. A considerable part of the early fieldwork of the evaluation was spent trying to improve understanding of what exactly TP was (Mays *et al.* on behalf of Total Purchasing National Evaluation Team, 1997) and what success criteria the projects themselves could identify (Mahon, Leese, Baxter, Goodwin and Scott, 1998). TP is a complex and not closely defined initiative making it difficult to rely on a small number of simple outcome indicators. The Department of Health also required that *all* the 53 'first wave' TPPs should be evaluated. In the event, the design of the study (see Figure 1) reflects a balance between external evaluation criteria (e.g. equity, efficiency, etc.), criteria related to the TPPs' progress in relation to national policy goals and internal project-specific criteria of success. The design further has to balance a reliance on quantitative data (which may be relatively insensitive to changes) with qualitative data from participants' own accounts (where there may be problems of bias and verification of reports).

The study as a whole is due for completion at the end of 1998. The data in this paper came from the so called 'process evaluation' component in Figure 1 which has been conducted at all the first wave TPPs.

Figure 1: Main components of the national evaluation of first wave TPPs



Notes: 1. HES = hospital episode statistics; 2. SFH = standard fundholding; 3. EAs = emergency admissions; 4. EFH = extended fundholding pilot; 5. LOS = length of stay

2. Objectives

The objectives of the analysis reported in this part of the national evaluation are as follows:

- to assess the progress of the first wave TPPs against six basic developmental criteria;
- to assess the extent to which TPPs achieved their principal purchasing priorities in 1996–97;
- to assess the extent to which they achieved other objectives which had not been identified during their preparatory year (1995–96);
- to assess the extent to which their achievements were in service areas included in TP (i.e. new to GP-led purchasing as a result of the TP initiative) rather than in service areas already included in SFH;
- to assess their level of ambition for purchasing in 1997–98;
- and, to begin to explain the extent to which TPPs reached their objectives in terms of features of the pilots and their external relationships.

3. Methods

The stages in data collection and analysis are summarised in Figure 2.

Data collection

Face-to-face, semi-structured interviews were held with the principal participants: lead GPs; project managers; and HA lead managers at all 53 'first-wave' TPPs mid-way through their 'preparatory year' (1995–96) and again at the end of their first year of TP in March/April 1997. The latter set of interviews included questions on their experience of TP in 1996–97, their overall perceptions of how successful their projects had been, their specific achievements against their main objectives and the enabling factors and obstacles which they had encountered. Data were also collected at interview on the amount spent on managing the project, whether the project held a budget, whether the project stayed within budget and the project's plans for 1997–98.

Analysis

Stage 1: interview synopses

The first round of interviews covered themes predicted as being important to assessing the TPPs. Subsequent rounds of interviews included questions on new themes as their importance became apparent to the researchers.

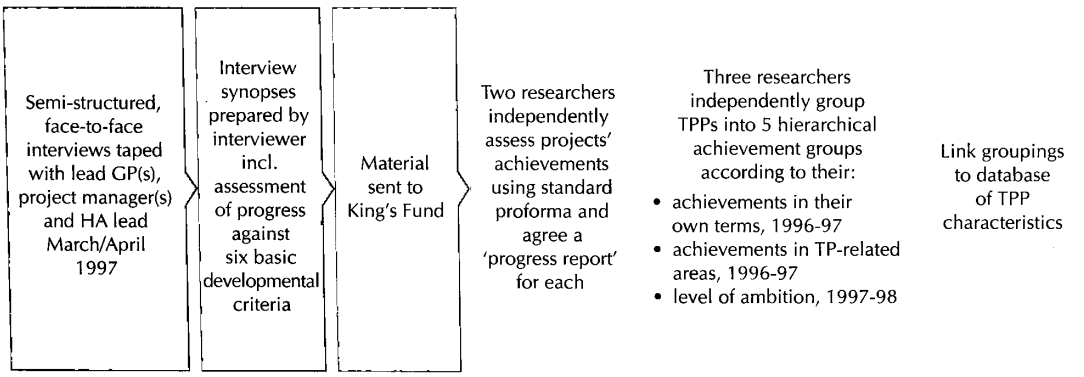
As well as preparing an extensive synopsis of the discussion in each interview, the interviewers also prepared a summary analysis of the progress made by the TPP in the previous year in relation to six basic developmental criteria determined by the research team which were as follows:

- have the practices stayed together (where multi-practice project);
- has the TPP purchased any services directly;
- has the TPP brought about any service changes;
- has the TPP brought about a shift in the location of care;
- has the TPP made effective external links; and
- has it stayed within budget?

These basic criteria were not intended to capture fully the progress, potential and achievements of each TPP, but to provide a simple, at-a-glance indication of the extent to which the project had pursued TP in a manner which appeared to be close to the intentions underlying the original EL which had first announced the scheme (NHS Executive, 1994). The 'basic criteria' were deliberately minimal such that a TPP which did not achieve at least half of them could scarcely be said to have fulfilled any of the pre-conditions for effective TP in the longer term.

The summary analysis of each TPP also included a record of the key problems faced by the TPP, key enabling factors, comments on the organisation and management arrangements at the TPP, the main lessons learned by the respondents in the previous year and the main differences of view between the respondents.

Figure 2: Stages in data collection and analysis



Stage 2: agreeing a summary of progress of projects

In order to generate the analysis of achievements in 1996–97 which is the focus of this paper, the summary interviews were collated at the King's Fund and further reduced using a standard data extraction proforma which attempted to capture the performance of the TPP against its four main stated purchasing objectives for 1996–97 as they were stated at interview mid-way through 1995–96. It also recorded other achievements reported by the TPP which were not contained in its four main objectives; the main enabling factors and obstacles encountered by the TPP; and the management costs incurred in implementing and running the project. The number of basic developmental criteria (see above) met by the TPP was also recorded alongside how many of the four main purchasing objectives had been fulfilled. Finally, a series of subjective judgements were made on the achievements of the TPP in relation to its level of ambition relative to its local context (supportive or resistant) and compared with the direct costs of managing the project. The site-by-site summaries of achievements using a standard proforma were prepared separately by two of the research team at the King's Fund who then met to discuss each other's summaries, resolve any ambiguities in the interview data and in their accounts and agree a summary of progress for each TPP.

Stage 3: grouping the projects

Finally, each of the summaries of achievements in 1996–97 was used by three researchers at the King's Fund independently to place each TPP in one of five performance groups as follows:

- firstly, in terms of its achievement in its own terms (i.e. irrespective of the project's level of ambition or where it started from);
- secondly, in terms of its achievements in relation to service areas within TP (i.e. did the TPP focus on any one of, services for the seriously mentally ill, care of the frail elderly in the community, altering use of A&E, avoidance of emergency admissions, reducing length of stay and maternity services?);
- thirdly, in terms of the *future level of ambition* of each TPP for 1997–98, irrespective of its achievements in 1996–97.

The groupings were then discussed by the three researchers wherever there was disagreement to arrive at an agreed set of groupings. The procedure for reaching a consensus was, firstly, to accept all cases in which there was 100% agreement between the three raters without discussion; secondly, to discuss all cases where at least one of the three judges had placed the TPP in either group 5 (the best) or group 1 (the worst); thirdly, to discuss all remaining cases where there was a two-group or more disparity between any two of the three judges' assessments; and, fourthly, to discuss all the remaining cases where the disparity was of one grouping overall. In this way, the process of consensus development attempted to confirm the nature of the fixed upper and lower groups while at the same time resolving cases where there were major differences of assessment between the three judges.

Stage 4: relating achievements to project characteristics

The characteristics of each of the TPPs in each of the performance groups based on its achievements in its own terms were then explored using a database comprising features of the projects hypothesised to be important for successful TP, derived from analysis of the first set of interviews, carried out at the end of 1995. These included: population size; number of practices in the project; wave of fundholding of practices; previous experience of working together; organisational complexity; spending on management/ administration; level of HA support; and market context (e.g. availability of alternative providers, access to nursing homes, etc.).

Thus the notions of success, failure and achievements used in this analysis are relative and based on the interpretation of the participants and the researchers. It should not be assumed that any of the achievements automatically improved either the effectiveness, cost-effectiveness, acceptability or otherwise of local health services, simply that the TPP appeared to have been able to achieve/or not what it set out to do and, in the case of the TPPs bringing about changes in TP service areas, that the changes brought about were likely to have a significant impact on local health services as far as three researchers could judge.

4. Results

Basic features of TPPs

Table 2 gives the basic features of the first wave of national TPPs in England and Scotland which were studied. It underlines their diversity in terms of features such as size. Although the first wave TPPs are in all 8 English Regions and in five Scottish Health Boards, they are predominantly not in major towns and cities.

Table 2: Characteristics of first wave TPPs in England and Scotland, April 1996

Number of projects	53
Number of single practice projects	20
Median (mean) practices per site	3.0 (3.4)
Median population	28,200
Range of population	8,100–84,700
Percentage of total population	3.3
Range of direct management budget per head, 1996–97 (£)	0.02–7.08

TP has attracted practices from all six waves of fundholding from April 1991 to April 1996. While the majority of practices involved were either first or second wave fundholders (98/191, 51%), there were 23 practices with no experience of fundholding before becoming involved in TP; that is, they joined the sixth wave of fundholding at the same time as TP. Interviews undertaken in the preparatory year, 1995–96, had shown that TP was likely *not* to be total but selective, that it was *not* always about purchasing using a budget but could also be about co-purchasing (see below for definition) and that it appeared to be dependent on a finely balanced relationship between the practices involved and the HA.

TPPs which withdrew from the scheme

Perhaps the most basic assessment of the success of the national TP initiative includes an account of those TPPs which are still in existence and those which have dropped out. Table 3 summarises the features and explanations for the four TPPs that dropped out of the scheme before and at the beginning of the first year of TP proper. Although the precise circumstances at each TPP differed, common features were the time and management pressures on the lead GP, which it was not possible to accommodate in the practices concerned, and difficulties in agreeing a budget with the HA. All TPPs have been under similar pressures, but some were unable to sustain themselves, perhaps because of a lack of external support.

Table 3: Features of TPPs which dropped out or postponed TP and main reasons given, 1995–97

Single practice, rural area

- Insufficient management capacity – needed more management input/resources
- Insufficient information on past spend to assess if budget adequate
- Difficulty in setting budget for a single practice
- Impact of TP on lead GP's clinical contribution to practice
- Wanted to join a larger TPP

Single practice, large country town

- Workload/time commitment, especially of lead GP
- Practice and HA preference to devote efforts to wider locality commissioning group with own budget (like a multi-practice TPP)

Multi-practice (n=4), rural/suburban

- Inability to agree budget setting method with HA
- Concern at financial risk associated with reduced population after one practice withdrew

Multi-practice (n=7), suburban

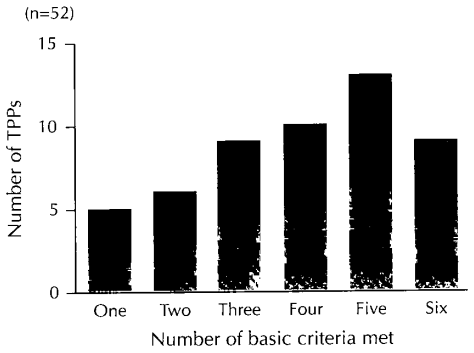
- Lack of GP input to management leading to inability to maintain support of all practices
- Weak communication between practices, especially between GPs
- Unwillingness of practices to manage a single budget
- Workload involved for size of early benefits
- 3 practices had withdrawn Dec. 95 – Mar. 96

Of the remaining first wave TPPs, one project subsequently split into four separate projects each with its own budget and purchasing strategy. Since the practices had become independent of each other, with no central coordination, they have been treated as four separate TPPs and this is reflected in the presentation of the analyses. As a result, the achievements of 52 surviving TPPs are considered.

Progress of TPPs against six basic developmental criteria

The progress made by each project in setting up and operating as a total purchaser is presented against the six basic criteria discussed above. Figure 3 shows the extent to which TPPs succeeded in meeting the six criteria. Thirty-eight per cent of the projects (20/52) only exhibited half of the basic criteria by the end of their first 'live' year and only 9/52 (17%) were reported as having reached all the basic criteria.

Figure 3: Number of basic developmental criteria met by first wave TPPs, 1996–97



Achievements of TPPs in the first purchasing year

The palest bars in Figure 4 represent each of the TPPs distributed into five groups by their level of reported achievement in 1996–97. This distribution of achievement is rated entirely in the TPPs' own terms; i.e. irrespective of the scale of their objectives, where they started from or, indeed, whether the objectives could have been met within SFH or by ordinary general practice developments. The assessment includes *all* their achievements irrespective of whether these were originally included in the project's four main objectives reported to the research team mid-way through the preparatory year, 1995–96. The range of achievement is also an assessment of each TPP *in its context* since the overall achievements of each project are likely to reflect the interaction of internal project characteristics with the external environment including the level and nature of HA support and the extent to which local providers were willing to accede to the wishes of the practices.

The resulting distribution shows the wide range of achievements in their own terms reported by the projects and their HAs, reflecting the fact that most projects had over-estimated the time and effort required to bring about change in the first purchasing year.

Figure 4: TPPs in five groups according to their level of achievement in their own terms, their level of achievement in TP service areas and their future ambitions, 1996–97

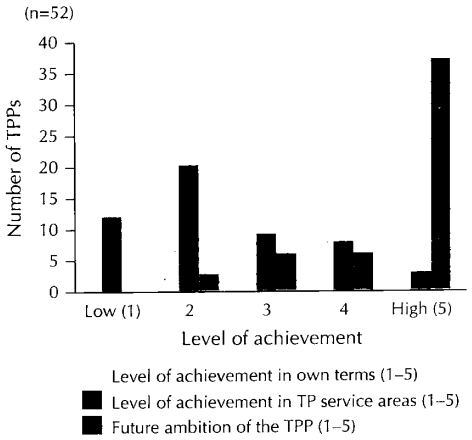


Figure 5: Number of objectives met (0-4) by level of achievement in TPPs' own terms, 1996–97

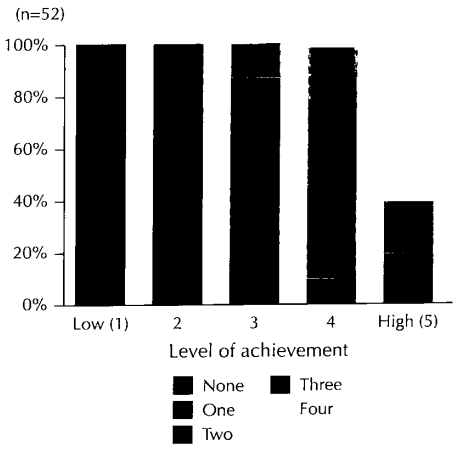


Figure 5 gives an indication of this by showing that only three of the 52 TPP purchasing sites (6%) reported that they had been able to achieve all four of the objectives which they had previously stated to be their principal goals for 1996–97. At the other end of the distribution, two-thirds of the projects in Group 1 (the lowest achieving group) achieved none of their stated objectives and a third only attained one of their aims.

The darkest bars in Figure 4 provide a grouping of the TPPs in terms of their achievements in TP service areas (i.e. their identifiable achievements in relation to any of the following service areas new to GP-led purchasing: maternity; services for the seriously mentally ill; care of the frail elderly in the community; A&E services; emergency admissions; inpatient length of stay; and alternatives to acute hospital inpatient services). TPPs making changes in these service areas are more likely than others to be influencing local health services in a major way. It can be seen that this assessment of the first year's purchasing tends to push the TPPs leftwards in the distribution, indicating that a noticeable proportion of their achievements in their own terms were not in TP service areas as defined here.

In order to illustrate the differences between the projects in each of the achievement groups, Boxes 1, 2 and 3 comprise three case studies of a TPP from each of Group 1, Group 3 and Group 5 in Figure 4. Each TPP fell into the bottom, middle and top achievement Group irrespective of whether the assessment was made in its own terms or exclusively in terms of its actions in relation to TP services (see Figure 4). The case studies reinforce the point that the TPPs are an integral part of the local NHS and depend for their success on the support of the local HA and the willingness of local providers to respond in 1996–97 to the initiatives which they proposed.

The Group 1 (low achieving) TPP in Box 1 also demonstrates the fact that for a number of TPPs its main achievements were in terms of improving relations between practices, with the HA and local providers, or in terms of developing the SFH capacity of the practices. Box 1 shows that, like so many TPPs, this project had more ambitious plans for the future (see below). The Group 3 TPP in Box 2, which represents a TPP in the middle of the range of achievement reported in the first year, was crucially handicapped in two of its purchasing objectives by the local re-organisation of A&E services which was outside its control, again emphasising the extent to which TPPs have to be assessed in their context.

The Group 5 (high achieving) TPP (Box 3) was actively engaged in making service changes all of which were in TP service areas (i.e. services new to the GPs as purchasers), but even this project was not able to change the currency of its main acute contract in the first year of TP. It is worth noting that one of the elements in the TPP's plans for 1997–98 was to attempt to re-organise its management in order to reduce its management costs.

Content of reported achievements in the first purchasing year

Having identified the wide range of levels of achievement of the TPPs, it is helpful to look at the content of their main achievements. Table 4 summarises the extent to which the TPPs were able to achieve their four main purchasing objectives as stated in the preparatory year (1995–96) in each of the main service areas. The first five service areas in Table 4 represent the main new areas of purchasing introduced when the practices moved from SFH to TP status. They are also the service areas where it would be reasonable to expect that TPP action would have a major impact on local health services. Overall, just over half the main purchasing objectives were reported to have been met, but this varied from 39% in mental health to 87% of objectives which were related to developing services through the primary health care team. The lower proportion of achievements in mental health is scarcely surprising given the complexity of purchasing and service development in this field. It represents a severe test of GP-led purchasing (see Gask, Lee, Donnan and Roland, 1998, in this series of working papers, for more on mental health).

Box 1: An example of a Group 1 TPP

45,000 population
8 practices
Locality

Progress against basic developmental criteria

Criterion	*Yes/No?*	*Details*
Stayed together?	✓	
Purchased directly?	✗	No interest in purchasing secondary care
Changed service provision?	✗	
Shift in location of care?	✗	The TPP wants to have some influence on local service provision but no progress as yet
Effective external links?	✗	The TPP is not pro-active; rather, it is 'respectful'. Links to HA and trusts, but no direct link with social services
Stayed within budget?	N/A	No budget held so far

Extent of achievement of four main purchasing objectives

Stated objectives	*Achieved*	*How achievements were met*
To explore the option of employing a community midwife, in line with Changing Childbirth recommendations	✗	Not met. The scheme was dropped due to opposition from the trust and fears from the midwives over job security
To shift the community care contract to the community hospital	✗	Not met
To work more closely with the Social Services Department, particularly in community care	✗	Not met
To enhance the local hospital by looking at the option of providing GP beds and exploring the possibility of freeing the hospital from the trust and running it independently	✗	Not met

Additional achievements

- Total purchasing has acted as a catalyst for co-operation between the eight practices in terms of fundholding – they now contract as a single unit in the locality.
- A Community Mental Health Team (CMHT) has been established in which the TPP has been involved on a consultative basis. The TPP has had an input into the new CMHT to which GPs can refer patients and access hospital care if needed. The project is funded by HA
- Cardiovascular Disease – The TPP is putting forward a locality strategy to tackle diet, exercise and smoking as well as reviewing use of medication. The TPP is exploring a scheme for 'exercise on prescription' which offers subsidised access to the local leisure centre to promote exercise. Neither has yet been implemented

Box 2: An example of a Group 3 TPP

70,000 population
8 practices
Non-locality

Progress against basic developmental criteria

Criterion	*Yes/No?*	*Details*
Stayed together?	✓	Solid commitment to TP in practices which had not varied – only about 20% anti-TP and 18 of the 36 GPs involved in one or other sub-group of the project
Purchased directly?	✓	HA operates on the presumption that TPP should not 'cherry-pick' but should, as far as possible purchase everything it reasonably can. This resulted in the TPP having 4 acute contracts,1 community contract and responsibility for its entire ECR budget
Changed service provision?	✓	See management of ECRs, drug and alcohol services, below
Shift in location of care?	✗	Wary about offering in-house services previously provided by Trusts because of conflicts of interest
Effective external links?	✗	Good links with HA, community trusts and social services but local acute trust was very resistant to change, partly because of financial position of the trust. This relationship was improving
Stayed within budget?	Almost!	1% over-spent

Extent of achievement of four main purchasing objectives

Stated objectives	*Achieved*	*How achievements were met*
Maintaining care of the elderly at the local hospital rather than having to send patients to another hospital further away	✓	Not stated
To employ a specialist nurse (CPN) to improve the drug and alcohol services available at the practice	✓	A CPN was employed and she manages patients in the community rather than admitting them to the hospital
To reduce waiting time in A & E	✗	No changes were due to the possible relocation of the A & E department
To introduce a telephone triage out of hours system which would prevent unnecessary admissions	✗	The TPP spent a considerable amount of time developing a sophisticated '888' software system, however no changes were made due to the relocation of the A & E department and the trust was unwilling to redeploy resources
To establish a dedicated midwifery team for TPP patients	✗	The funding was not made available because it was too difficult to extract resources from the local block contract for maternity

Additional achievements

- The TPP also undertook research into the type and volume of emergency admissions with a view to reducing them in the elderly and children
- The TPP has also produced a set of guidelines for Deep Venous Thrombosis (DVT) treatment and some cardiac problems, with a view to reducing admissions
- Promoting evidence based practice
- Managing the ECR budget effectively
- TP has stimulated much greater contact between GPs and hospital clinicians, public health and other parts of the HA and better relations with social services.

Box 3: An example of a Group 5 TPP

58,000 population
5 practices
Non-locality

Progress against basic developmental criteria

Criterion	*Yes/No?*	*Details*
Stayed together?	✓	Good relations between practices have been crucial to the development of the TPP. This trust developed through fundholding and has been enhanced through TP
Purchased directly?	✓	The TPP has developed innovative contracts that differ significantly from HA contracts, particularly in terms of clinical specifications
Changed service provision?	✓	See below
Shift in location of care?	✓	Greater use of GP unit and nursing homes. The TPP wants to increase its provider role in the future
Effective external links?	Mostly	Good links forged with the health authority and local providers. The lack of provider will to concede to some TPP demands is not a result of poor communications. Links with social services remain ad hoc and underdeveloped
Stayed within budget?	✗	The TPP was heading for an overspend in 1996–97

Extent of achievement of four main purchasing objectives

Stated objectives	*Achieved*	*How achievements were met*
Improving documentation at the A & E department	✓	The TPP introduced a financial penalty into its local contract with the main providers when a discharge letter is not issued. This has led to letters being produced in 90% of cases, compared with 70% previously
Changing the contract currency with the acute provider from FCEs to HRGs	✗	
Developing the CMHT and appointing a practice-based CPN with a view to avoiding unnecessary admissions	✓	The TPP appointed a practice-based CPN and developed the CMHT (including psychologists and counsellors). This has helped prevent a number of emergency admissions
Improving bed utilisation at the local acute trust in order to promote early discharge, reduce length of stay and enhance continuity of care	✓	The TPP established a Discharge Liaison Team (DLT). Practice nurses track patients and assist in transferring patients from the acute hospital to the community hospital and then to the GP unit (where appropriate). This has been particularly successful for elderly patients who appear to have gained more and better rehabilitation at the GP unit than at the acute hospital
Co-purchasing maternity with the HA	✓	Agreement with the HA over the contract

Additional achievements

As indicated above, the TPP succeeded in achieving all but one of the above stated objectives, in addition it achieved the following:

- The TPP managed its ECRs for mental heath and acute services in 1996–97 and intends to manage all ECRs in 1997–98
- The TPP has been successful with the community trust in getting them to agree to contract by occupied bed days, instead of FCEs
- The appointment of a part time public health physician in primary care who researches into the TPP's specific population needs and is developing a population profile for the TPP

Table 4: Achievements and non-achievements by service area, 1996–97

Service area of four main purchasing objectives	*Total no. of main objectives*	*% achieved*
Early discharge	22	64
Community and continuing care	19	53
Maternity services	27	52
Managing emergency services	32	44
Mental health services	28	39
Developing primary health care team	15	87
Information/needs assessment	12	83
Other*	35	59
TOTAL	*190*	*54*

* wide variety including oncology, cardiology, school health, palliative care etc.

Table 5: Achievements and non-achievements in mental health, 1996–97

Main objective	*Number of achievements*	*Number of non-achievements*
Enhanced community mental health team (including CPNs, counsellors, psychologists etc.)	6	9
Practice-based CPNs only	3	2
Change of provider	1	1
Change of contract currency	1	0
Local mental health unit to be set up by provider	0	1
Common service specification between providers	0	1
Freedom of referral to preferred consultant to improve quality	0	1
Contracting for emergencies	0	2
TOTALS	*11*	*17*

More detailed analysis of the achievements and non-achievements *within* each service area showed that achievements were more often service developments within primary care. The non-achievements (for whatever reason, bearing in mind that these could have been due to obstructive providers as much as deficiencies in the project team) tended to be spread across a range of primary and secondary care objectives. TPPs attempting to influence mental health care (and by no means all were), for example, found making changes in services controlled by mental health trusts more difficult than extending existing primary care services in mental health (Table 5). They may also have chosen to bring about service change in this way, bypassing the specialist providers.

Table 6 presents reported achievements and non-achievements in another difficult area for NHS purchasers, reducing emergency admissions and changing the use of A&E services. It can be seen that the TPPs, not surprisingly, found it much easier to implement their objectives in relation to early discharge and reducing lengths of stay in the acute sector than to reduce emergency admissions or change the way in which A&E services were used, underlining the general point from the previous Table.

None of the six TPPs which planned, perhaps ambitiously, to set up minor injuries units managed to do so in the first year. Achievements were concentrated in the area of information gathering (presumably to inform changes *in the future*) and in developments in primary care aimed at reducing emergency admissions.

Future ambitions of the TPPs

Although the TPPs were only able to achieve about half of their most important objectives in 1996–97,

Table 6: Achievements and non-achievements in managing emergency services, 1996–97

Main objective	*Number of achievements*	*Number of non-achievements*
Information gathering	3	0
Increased primary care to reduce emergency admissions	3	1
Intermediate care facility	2	0
24-hour primary care	2	1
A&E protocols for emergency admissions	2	2
Agreement with ambulance service on medical emergencies	1	0
A&E triage system	1	2
Research to assess ways of reducing emergency admissions	0	1
Change in contract currency	0	1
Increased prescribing to reduce emergency admissions	0	1
Rapid-response out-of-hours team to reduce emergency admissions	0	1
Intermediate care facility	0	1
Pre-operative assessment scheme	0	1
Minor injuries unit	0	6
TOTALS	*14*	*18*

data were collected on their plans for 1997–98. The final set of columns in Figure 4 presents an assessment of the level of future ambition of each TPP for 1997–98, derived from interviews undertaken at the end of 1996–97. The vast majority of TPPs appeared in Group 5 which was defined in this analysis as 'TPPs which planned to do more than they had previously and in TP-related service areas'. This suggests that many of the projects had used 1996–97 as a developmental or further preparatory year. However, it is worthy of note that a *higher* proportion of the two groups which had achieved the most *in their own terms* also had greater ambitions in *TP* service areas than those TPPs in the two lowest achieving groups. This suggests that the more successful TPPs in the first year were also the more ambitious for year two of TP.

Characteristics of high and low achieving TPPs in the first year

There are potentially a very wide range of influences at work acting to separate the more and less successful TPPs in their first year of operation. In some of the projects, the explanation for difficulties in achieving objectives in the first year was not hard to grasp from the accounts given in the interviews. For example, in a small number of cases, practices had been accepted into the TP scheme, but without having a clear vision of what they wanted to achieve through becoming a TPP. In other cases, the TPP was handicapped during 1996–97 by the loss of key personnel such as a lead GP or project manager who could not easily be replaced in the context of a time-limited pilot project. However, these are the exceptions. For the rest, it is likely that explanations will involve subtle interactions between a range of complex factors. Some of the important variables may relate to things such as the quality of the relationships between the parties involved in the TPP and in the local health system which are difficult to capture in the depth of field work possible at 52 projects.

Attempting to produce convincing explanations for the variation between the performance of the TPPs is still at an early stage. It has not been possible so far to include data on the level of resources in the TPPs' budgets for hospital and community health services. This was due to the unreliability of the information provided by the HAs which was associated with the difficulty experienced in estimating the historic expenditure share of each TPP, particularly when their patients were drawn from more than one HA and the difficulty of separating SFH from TP expenditure. Other possible factors such as the receptivity of local providers have not yet been able to be brought to bear on the analysis. In addition, there may be factors associated with the detail of the types of changes which the TPPs wished to bring about which have influenced their ability to do so, but which the current analysis cannot capture.

Table 7: Comparison of selected characteristics of TPPs which were high or low achievers in their own terms, 1996–97

Characteristics	*Low achiever in own terms (n=19)*	*High achiever in own terms (n=16)*	*Significant/ Not (95% level)*
Size			
Median number of GPs per TPP	21	12	Significant
Median number of practices per TPP	4	2	Not significant
Median population size	35,800	24,000	Significant
Proportion of single practice TPPs	16%	38%	Not significant
Proportion of small multi-practice TPPs (2–5 practices)	53%	63%	Not significant
Proportion of large multi-practice TPPs (>5 practices)	32%	0%	Significant
Organisation and structure			
Proportion of TPPs who had a dedicated site manager (either employed by the TPP or HA)	84%	62%	Not significant
Proportion of site managers employed by the HA	16%	6%	Not significant
Proportion of TPPs with a 'simple' organisational structure	5%	38%	Significant
Proportion of TPPs with a 'complex' organisational structure	58%	38%	Not significant
Experience and level of support			
Proportion of TPPs with either first, second or third wave fundholders in their pilot	89%	94%	Not significant
Proportion of TPPs who had prior experience of working together (excl. single practice TPPs)	40%	40%	Not significant
Proportion of TPPs who said the HA was providing 'fair or good' support	26%	44%	Not significant
Independent contracting and management costs			
Proportion of TPPs who had purchased directly	33%	94%	Significant
Proportion of TPPs with their own independent contracts, 1996–97	44%	82%	Significant
Median amount of management costs per TPPs, 1996–97	£95,000	£52,000	Not significant
Median amount of management costs per capita per TPP, 1996–97	£2.86	£3.45	Not significant
Future ambition			
Proportion of TPPs whose future ambitions were 'to do more, and in areas of strategic significance'	53%	88%	Significant

Nonetheless, a wide range of the more straightforward features of the TPPs and their local settings such as their structure, size, level of spending on management, perceived quality of HA support, previous experience of working together, level of fundholding experience, future level of ambition and so on, have been explored in simple univariate analyses. Table 7 summarises the results to date by comparing the two lowest and the two highest achieving groups as assessed in their own terms (i.e. Groups 1 and 2, and 4 and 5 from Figure 4).

The findings tend to show that single practice and small multi-practice TPPs; those with fewer GPs; those with smaller populations (which is associated with single practice status and number of GPs); and those with higher per capita spending on direct management costs appeared to have brought about more achievements in the first year of TP than the remainder. Although there is a wide range of per capita management costs within each achievement group, higher achieving TPPs were, on average, more costly to run than lower achieving TPPs in the first live year (see working paper by Posnett, Goodwin, Killoran, Malbon, Mays, Place and Street (1998) for more on this). The data on management arrangements do not currently include the *quality* of management, but there is evidence to suggest that higher spending TPPs were able to invest in more experienced project managers and more elaborate data systems. The cause and effect between achievement and level of direct management costs is

harder to interpret since the level of management spending was a matter of negotiation between each TPP and its parent HA. It is, therefore, possible that the level allocated by the HA is an indication of either the confidence which the HA placed in the abilities of the practices to bring about beneficial change, or a reflection of the TPP's level of ambition as expressed during the early stages of preparation in 1995–96. Table 7 shows, for example, that the higher achieving TPPs were also more likely to report future ambitions to 'do more and in TP service areas' than the lower achieving TPPs suggesting that the HA may have felt obliged to invest more in the support of these projects, both directly and indirectly in terms of both the time of staff specifically allocated to work on the TPP and others. Finally, the TPPs with the most ambition for the future appear to have the highest direct management costs.

Table 7 also shows that the higher achieving TPPs were more likely to report that their local HA was 'providing fair or good support' to the project than the lower achieving projects. This is consistent with the observation at the beginning of this paper that, in comparison to SFH, TP appeared from an early stage to be very much more a *collaboration* between the practices and the HA, particularly since the TPP's budget remained technically the responsibility of the HA.

Figure 6: Comparison of TPPs with independent contracts and those without by level of achievement in their own terms, 1996–97

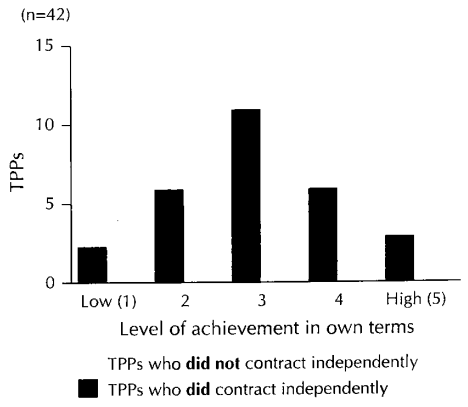


Table 7 further shows that TPPs with at least some of their own independent contracts (which meant that they had also received their own budgets) seemed to be more commonly found in the higher performing group than in the lower. Figure 6 shows the distribution of all the TPPs by achievement group separating those which had some independent contracts from those without. It appears to show clearly the advantage, at least in the first year, of having independent contracts, although not all TPPs with independent contracts were automatically high achievers. Just over 60% of the TPPs had independent contracts in the first year (Robinson, Robison and Raftery, 1998). Many of the same variables associated with higher reported achievements were found to be associated with a greater likelihood of having at least some independent contracts. For example, TPPs with at least one first wave fundholder and with good HA support were more likely to have such contracts than the rest. Large, 'complex' projects, however, appeared to inhibit contracting innovation and restrict reported achievement levels in the first year of live purchasing. Whether or not having independent contracts had a genuinely causal link with a higher level of reported achievements is impossible to say at this stage. However, 76% of the TPP managers whose TPPs had contracted independently judged that independent contracts were either very or quite important in achieving change. Sixty-two percent reported that they had used their contracts to bring about service changes such as earlier discharge arrangements (Robinson, Robison and Raftery, 1998).

One variable which one might have expected to find associated with a higher level of early achievement was whether the practices involved in the TPP had had previous experience of working together. However, there appeared to be no association with previous collaborative experience in the multi-practice TPPs.

The final approach to looking at factors which may be associated with the level of achievement of the TPPs is to look at the number and type of enabling factors and obstacles to the implementation of TP identified by the lead GP and the project manager at each TPP. Tables 8 and 9 set out the obstacles and enabling factors. The most commonly reported problems were a lack of GP time to contribute to

Table 8: Obstacles to TP implementation identified by lead GPs and project managers, 1996–97

Obstacles	*Number of responses*	*Per cent of responses*	*Per cent of TPPs*
Lack of GP time/input	21	13	47
Problems with the HA in setting budget	20	12	44
Poor relations with the main acute Trust	18	11	40
Inadequate IT system	17	10	38
Poor relations with the HA/lack of support	15	9	33
External factors	14	8	31
Too much HA input (lack of independence)	11	7	24
Poor relations with local social services	10	6	22
Lack of enthusiasm from GPs	8	5	18
Poor relations between the practices	6	4	13
Other obstacles*	25	15	56
*TOTAL***	*165*	*100*	

* Including poor TPP organisation (7), inadequate project manager skills (6), lack of central guidance (6), size of the TPP (6), etc.

** 11 TPPs not reporting any obstacles

Table 9: Enabling factors in the implementation of TP identified by lead GPs and project managers, 1996–97

Enabling factors	*Number of responses*	*Per cent of responses*	*Per cent of TPPs*
Good relationship with the HA	20	19	50
Committed TPP staff (including lead GP)	20	19	50
Enthusiastic lead GP	14	13	35
Good working relationships between/within the practices	13	12	33
Effective organisation	12	11	30
Good relationships with local providers	9	8	23
Helpful size of the TPP (both large and small)	4	4	10
Generous management allowance	3	3	8
Successful IT system	3	3	8
Possession of a budget	2	2	5
Good relations with the local social services	1	1	3
Other	7	6	18
*TOTAL**	*108*	*100.0*	

* 16 TPPs not reporting any enabling factors

the project, problems in setting the budget, poor relations with the main acute Trust (all over 40% of projects), an inadequate IT system and lack of support from the health authority (over 30%). Enabling factors were less frequently reported (108 versus 165 times), but those most commonly mentioned were a good relationship with the HA, committed TPP staff, an enthusiastic lead GP and good working relationships between the practices, where relevant. However, there does not appear to be any association between TPP achievement group and the number of obstacles or facilitating factors reported.

Towards a typology of TPPs

Taken together, the data covering the different purchasing objectives and achievements of the TPPs and the information on the different ways in which projects were operating in the first 'live' year suggest that the broadly defined concept of TP was interpreted in a number of distinct ways. With this in mind, the three researchers who had undertaken the task of placing TPPs in achievement groups based on a summary of progress in 1996–97, went on to place each project in one of the following types related to its level of development:

- *Under-performing* – projects not achieving or not intending to achieve any changes in TP-related service areas;

- *Developmental* – projects at a preparatory stage with the emphasis on developing the infrastructure and undertaking population needs assessment before active purchasing;

- *Co-purchasing* – projects not holding a budget and/or undertaking no direct purchasing, but attempting to change HA purchasing activities;

- *Primary care developer* – projects which were developing primary care services in TP-related areas, particularly through an emphasis on primary care substituting for secondary care. In this type, TPPs could either co-purchase with the HA or have independent contracts;

- *Commissioning* – projects directly purchasing in TP-related service areas with their own budgets and independent contracts to achieve changes in secondary care;

- *Integrated* – TPPs taking a strategic role, directly purchasing and influencing both secondary and primary care. In this type, TPPs manage an integrated budget spanning SFH, TP and General Medical Services expenditure.

Table 10: Different types of TPPs, 1996–97

Types of TPPs	*Number*	*Per cent*
Under performing TPP	2	4
Developmental TPP	11	21
Co-purchasing TPP	8	15
Primary care developer TPP	8	15
Commissioning TPP	23	44
Fully integrated TPP	0	0
TOTAL	*52*	*100*

In order to categorise each project relatively simply, given that some projects, inevitably, demonstrated some features of more than one approach to TP, each project was categorised under the most 'developed' type reflected in some aspect of its work. Thus if a TPP was mainly involved in developmental activities, but had at least some independent contracts and intended to change secondary care, it would have been placed in the '*commissioning*' type. The results of this analysis are given in Table 10 which shows that 23/52 (44%) of projects were of the '*commissioning*' type, followed by 11/52(21%) '*developmental*' and 15% in each of '*co-purchasing*' and '*primary care developer*' categories. Only two out of 52 appeared to be neither achieving nor wishing to achieve in TP-related areas.

No TPP has yet become 'integrated', as the pilot status of TP means that, technically, projects are unable to integrate their different budgets. However, a small number of projects are well advanced in preparing to become 'integrated'.

5. Discussion

Methodological issues in interpreting the findings

The most important point to make about the findings is to stress their provisional nature and to caution against over-interpreting them. There are at least seven reasons for caution.

- Firstly, the achievements are from participants' accounts and may be influenced by the degree to which they are prepared to be honestly self-critical.

- Secondly, the data do not yet include a view from the local providers on the first year. It may be that providers will report a lower level of achievement than participants in the TPPs themselves.

- Thirdly, the amount and quality of the data from each TPP was dependent on the willingness of the interviewees to provide full accounts and the ability of the interviewers to draw them out. The interviews had to be semi-structured because of high variation on most aspects between the TPPs.

- Fourthly, it is possible that the range of variables available on each project which has been used to begin to explore possible reasons for the different levels of achievement is incomplete in areas crucial to explaining TPP performance. For example, in a large scale study of 52 projects it was simply not possible to collect data on subtleties of local relationships between participants or of past experience. The results in Table 7 are from bivariate analyses of the relation between level of achievement and a range of factors which may be hypothesised to have a bearing on the level of achievement. The relative importance of different factors in influencing the level of achievement is unclear, but it was not judged appropriate with the type of data available to attempt a multi-variate analysis of the determinants of different levels of achievement.

- Fifthly, it has to be stressed that assessing the achievements of the TPPs from participants' accounts (which are all that are likely to be available for some time given the lag before activity data and other information on the effects of TPPs becomes available) is not straightforward and involved a series of individual and group judgements by the researchers which were essentially subjective. Another problem is the fact that the aims of TP were never clearly set out by the NHSE so it is not possible to decide, firstly, that a particular TPP was or was not implementing TP in the manner intended and, secondly, that a particular type and level of achievement was adequate or inadequate for the first live year. It depends on what one expects devolved GP-led purchasing organisations to be able to achieve. On the other hand, the data are from three separate interviews with three of the main participants repeated twelve months apart and each was lengthy and wide-ranging with opportunities throughout for corroboration and exploration of discrepancies between participants' accounts.

- Finally, there is the inevitable limitation with data of the type presented, of how to know whether to attribute the achievements reported to the effects of TP and TPP status or whether they might have occurred at the sites without the existence of TP. This issue is being tackled more directly in some of the other parts of the national evaluation (e.g. sub-study on TP and maternity services). A related point concerns avoiding the facile assumption that the TPPs have been able to bring about a higher level of beneficial change than the HA would have been able to achieve in the absence of TPPs. There is no way of knowing this from the evidence in this component of the national evaluation.

Interpreting the level of achievement in the first year

Not only was 1996–97 only the first year of 'live' purchasing for most sites – they may do far more in 1997–98 as long as they do not suffer too much from the uncertainty which comes with the final year of a 'pilot' – but it was also a difficult year financially for the NHS as a whole. This may help explain why the level of achievement was lower than the goals of most projects. Very few TPPs were able to achieve all of their four main objectives in

the first year; many decided subsequently to do other things as well or instead. In addition, the achievements tended to be relatively small scale or close to primary care. Only a minority tackled issues of wider significance successfully. It appeared that the TPPs found achieving change in secondary care more difficult than developing services within a primary care context. As a result, and not surprisingly, many of the commonly reported achievements concerned better information, better understanding of issues and improved relationships, for example with providers. This pattern of attainment is in line with the only other published evaluation of a TPP, namely, that of the Berkshire Integrated Purchasing Project (BIPP) which was one of the four 'pioneer' TPPs set up in 1994 ahead of the national initiative (Walsh, Shapiro, Davidge and Raftery, 1997). This suggests that TP represents a stiffer challenge to GP purchasers than SFH.

Of course, interpreting the achievements of the TPPs other than in relation to their own objectives for the first year is problematic since such a judgement depends largely on what one would have expected the projects to have been able to attain. Given that the projects were pilots and the TP concept is still experimental, it is not surprising that few TPPs could be regarded as having 'changed the world' locally in 1996–97. It is also worth reflecting on the fact that pilot schemes almost invariably produce their benefits more slowly than their architects expect.

Variation and commonality between the projects

Given the absence of a detailed prescription of the ingredients or objectives of TP when it was launched, it is not surprising that there is considerable diversity between the projects in the contents of their purchasing objectives, whether strategic or service-specific, their level of ambition, whether they were allocated a budget or not, whether they contracted independently of the health authority or not and, finally, in their reported level of attainment. Boxes 1 to 3 and the typology in Table 10 indicate this clearly. Although the largest group of TPPs was, indeed, '*commissioning*', they were still a minority (44%) and remained *selective* in the scope of their purchasing. A considerable proportion of the pilots were interpreting TP as a primary care development tool or were still involved in preparing for active purchasing.

There was also inevitable diversity in objectives and methods of working *within* each of the achievement groups, 1–5, in the current analysis, suggesting that the explanation for the level of achievement is likely to be complex.

On the other hand, the TPPs appeared to have a number of aspects in common in the first year. They were all involved in *selective* rather than genuinely *total* purchasing. They all had, to varying degrees, collaborative relations with, and a degree of dependence on, the local HA. Finally, the purchasing goals of the organisation were very much those of the GPs rather than other health care professionals although there is some evidence from the interviews with participants that providers have a big influence on shaping service developments pursued by TPPs. However, these data have yet to be examined in detail to see to what extent this is so in all projects. Evidence from other studies of purchaser-provider relationships suggests that providers are frequently dominant (Rosen and Mays, 1998)

The range of achievement

As in the Audit Commission evaluation of SFH (Audit Commission, 1996), the findings to date suggest that there is a wide variation in the ability of TPPs to take advantage of their status. At present, it is not possible to be clear exactly why this is the case, but it is highly likely to be due to a mixture of extrinsic (e.g. resistant providers) and intrinsic factors (e.g. weak project management or the difficulty of establishing an effective organisation in multi-practice TPPs). Nonetheless, it is interesting to note that some TPPs appeared to cope better than others despite the uniformly adverse financial climate.

Beginning to explain the differences between projects in their level of achievement

The finding that single practice and smaller multi-practice TPPs appeared to have made more progress with their purchasing objectives in the first year than larger multi-practice TPPs (Table 7) is, at first

sight, surprising, particularly given a legitimate concern on *a priori* grounds that TPPs with smaller populations would find it problematic to manage the financial risks to which they would be exposed. However, given that all the TPPs were engaged in *selective* purchasing in 1996–97, the likelihood of this becoming a problem was greatly reduced. In future, if the scope of purchasing by TPPs widens, small projects may find this aspect more difficult to manage. Another concern about the size of the smaller TPPs was the possibility that providers would be relatively unresponsive because the TPPs would not account for a large proportion of their workload. Irrespective of whether this was a genuine concern, it was mitigated by the fact that many of the purchasing objectives of the TPPs related to extending services close to the practice level and did not necessarily involve negotiations to alter secondary care providers' services. It seems more likely that smaller projects were better able to achieve a consensus and decide their purchasing priorities. Single practice TPPs, in particular, did not have to work so hard to design a new form of organisation linking previously independent practices. In this way, they could manage TP as an extension of their existing SFH activity rather than having to invest in an overarching management infrastructure. By contrast, the multi-practice projects faced a major task in bringing together a larger number of GPs and from different practices. It is not surprising, therefore, that in the first 'live' year of TP, smaller organisations achieved more, whilst the larger projects needed more time to develop more complex and mature organisations before proceeding. The extent to which the larger projects are able to 'catch up' will be an important aspect of the next stage of the evaluation covering the 1997–98 purchasing year. At the same time, it is possible that some of the smaller TPPs with simpler organisational structures could find sustaining TP more difficult since typically they rely on a small number of people to manage the project. In this context, it is worth noting that three of the four pilots which had withdrawn from the scheme by the end of 1996–97 had operated without a dedicated project manager, relying instead on GPs and the existing fundholding managers.

The single practice and small multi-practice projects were also more likely than the rest to have their own contracts for at least some of their services, indicating that they had been allocated their own budgets. Care should be taken in interpreting this finding since those TPPs which either did not receive a budget or chose not to receive a budget in 1996–97 were not necessarily typical of TPPs in general. It seems likely that budgetary control and having independent contracts are normally a necessary but not sufficient requirement for effective GP-led purchasing. However, much else is needed including an able manager, strong GP involvement, good information, a supportive health authority and so on. Faced with a resistant provider, having a budget is essential if any kind of change is to be negotiated, but it may not always be sufficient.

Knowledge and motivation may be as important as controlling a budget. There is a sense, for example, in reviewing the objectives and achievements of some of the lowest achieving TPPs that they did not know what they wished to do with their TPP status and had low ambitions. TP was simply the next way for the practices to show that they were at the leading edge of NHS developments. In looking at some TPPs which were put forward and accepted into the scheme, there are questions about the selection criteria used by health authorities and the NHSE at each stage. By contrast, the highest achieving projects were also those with major ambitions for the future. In addition, independent contracting in 1996–97 was significantly associated with a higher level of future ambition.

On experience, there was no evidence that TPPs which did include any early wave fundholders performed better in the first year than those which did not. Moreover, there was no association in multi-practice TPPs between level of achievement and a previous history of working together. It is important to have shown that the extent of previous experience was not associated with reported achievements since it suggests that the requirements to be a successful TPP are very different from those for SFH.

The apparent association between higher direct management costs at project level and better reported performance in the first year is highly relevant to the debate about one of the most obvious weaknesses of devolving purchasing responsibility below HA level, namely, the higher transaction costs of having a larger number of smaller purchasers. More detailed analysis of the direct management costs and the full transaction costs of

TP from the current evaluation which is presented elsewhere (Posnett, Goodwin, Killoran, Malbon, Mays, Place and Street, 1998), provides a warning to policy makers that effective TP may not be achieved while attempting to reduce the costs of local purchasing of services. The recent government White Paper aims to reduce overall NHS management costs while, at the same time, devolving the vast majority of purchasing responsibilities to groups of practices very similar to TPPs to be called Primary Care Groups (PCGs) (Secretary of State for Health, 1997). Other work on the costs and functions of HAs and GP purchasers, including SFHs and selected TPPs, suggests that GP purchasers generate on average 50% to 90% of the costs of HA purchasers for half the number of functions (Millar, 1997). Many TPPs appear to be higher spenders on management in relation to their range of functions than many HAs, although there is a wide range of costs in both TPPs and HAs.

In practice, the policy choice is not simply between HA or GP-led purchasing. It is apparent thus far that the current TPPs and, by implication other forms of GP commissioning in the future, cannot function without the support of their parent HAs. Thus HAs (albeit somewhat slimmed down) will be required to continue to provide management services in areas such as information, finance, contracting and public health to TPPs and to the new PCGs. In these circumstances, it seems unlikely that major reductions in the total costs of managing purchasing in the NHS will be possible.

Implications of the analysis of TPP achievements for the 1997 White Paper proposals for Primary Care Groups

The December 1997 White Paper envisages that, over time, large groups of former fundholding and non-fundholding practices with populations of around 100,000 will take budgets for up to 85% of the total NHS expenditure in order to secure most health services for their patients (Secretary of State for Health, 1997). The evaluation of TPPs has three main implications for this model of devolved purchasing.

The first implication is that effective GP-led purchasing organisations cannot be developed and maintained without substantial expenditure. Higher spending TPPs have, by and large, been the more successful. Given that the proposed PCGs will involve many practices which have little or no experience of direct purchasing or budgetary management of HCHS, the likelihood is that these bodies will require considerable management investment, especially in the early stages.

The second implication is that it will take considerable time for PCGs to construct robust organisations capable of bringing about important changes in local health services. Large multi-practice TPPs took considerably longer than single practice and small multi-practice TPPs to reach the point of bringing about service changes. Since the PCGs will be much larger than most of the TPPs (an average population of 100,000 versus 30,000), the likelihood is that even more time will be required to decide on purchasing priorities and implement them. The White Paper wisely refrains from specifying the period over which the Government expects the PCGs to develop to their fullest form.

The third implication of the analysis of the achievements of the TPPs in their first 'live' year is that having a budget and developing independent contracts or service agreements is associated with more effective purchasing, at least in the short term. The recent White Paper makes it clear that the PCGs will be expected to develop fairly quickly to the point at which they receive a genuine delegated budget from their local HA.

6. Conclusions

The findings reported in this working paper offer the first indication of the consequences of the establishment of the TPPs in April 1995 and their ability to achieve their own objectives. The findings so far show a wide variation between projects in their achievements in the first year of 'live' TP. On the other hand, about half the TPPs' main purchasing objectives were reported as attained, although it was plain that different service areas presented a different degree of challenge. Whether these achievements are seen as disappointing or encouraging depends largely on the observer's expectations. Supporters and critics of GP-led purchasing can each take some comfort from the findings so far. For example, for critics, there is evidence that developing purchasing organisations across general practices is a slow process, particularly as the number of participating practices rises (for example, 11/52 were still at the '*developmental*' stage at the end of 1996–97). For supporters, there is evidence, for example, that TPPs with their own budgets and their own contracts were able to make greater progress than those which relied on working via the HA, at least in the first year of TP. There was also evidence of TPPs reporting achievements in the first 'live' year in relation to strategically important aspects of the health system such as the management of emergency services.

The findings further show that the reality of TP was in some ways at variance with what one might have expected given that it was introduced by the NHSE as an extension of fundholding and as a *purchasing* initiative. For example, only 64% of the pilots had any independent contracts in 1996–97, by no means all the TPPs (only 44%) chose to emphasise the role of the TPP as a purchaser of secondary care and many emphasised the development of primary care and their own provision, thereby using TPP status to work further on services which were largely within the scope of the previous SFH scheme. Thus TPPs may have been a catalyst as much for change in primary care provision as in secondary care purchasing. This observation raises the question for the future development of PCGs as to whether they should be seen predominantly as primary care developers or purchasers of services provided by others.

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