King's Fund

The Dynamics of Primary Care Commissioning: a close up of Total Purchasing Pilots

Analysis and Implications of Eleven Case Studies

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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 Research and Development Centre at Manchester, Salford and York Universities, together with researchers from the 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: Gill Malbon, King's Fund, 11-13 Cavendish Square, London W1M 0AN.

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The authors are very grateful to all respondents at TPPs throughout the country who generously devoted time and energy to the National Evaluation.

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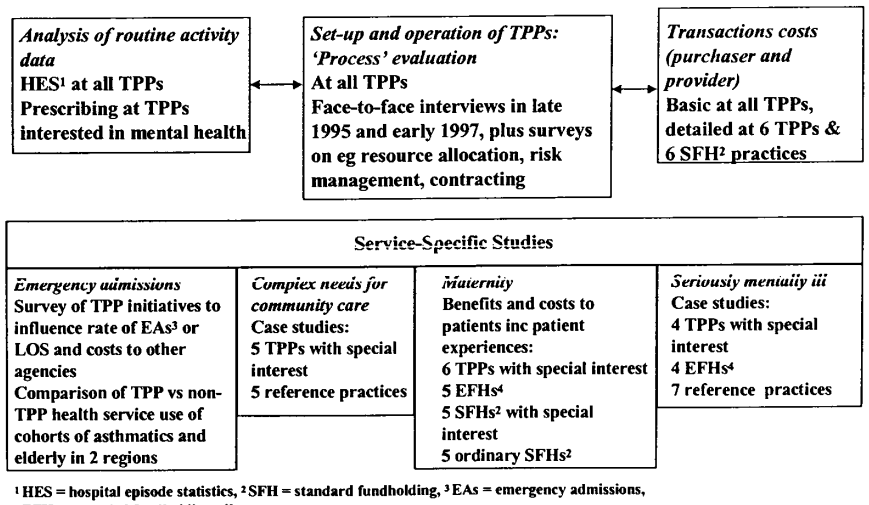
Preface: The National Evaluation of Total Purchasing Pilot Projects

Total Purchasing Pilot Projects allow for the purchasing of potentially all hospital and community health services by fundholding general practices which began their preparations for contracting in April 1995. 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 which began data collection in October 1995 (mid-way through the total purchasing pilots' (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. Other titles in this series of working papers are listed below.

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. The diagram below summarises the main elements of the research which has at its core an analysis of how TP was implemented at all projects and with what consequences, for example, in terms of hospital activity changes. These elements are 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 these parts 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 purchase more widely.

Main components of National Evaluation of First Wave Total Purchasing Pilot Projects



[1] HES = hospital episode statistics, [2] SFH = standard fundholding, [3] EAs = emergency admissions, [4] EFH = extended fundholding pilot

Further details about the evaluation design and methods are available 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.

Nicholas Mays
Co-ordinator, Total Purchasing National Evaluation Team (TP-NET)
January 2000

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Forthcoming reports from the final year of the national evaluation

Wyke S et al (1999) *National evaluation of general practice-based purchasing of maternity care: Final report.* 1-85717-295-7

Forthcoming book from the national evaluation of TPPs

Nicholas Mays, Sally Wyke, Nick Goodwin, Gill Malbon (eds) 2000 *Can General Practitioners purchase health care? The total purchasing experiment in Britain.*

1 INTRODUCTION

General practitioner (GP) fundholding was introduced into the National Health Service (NHS) as part of the 1991 reforms. The main rationale was a belief that GPs, clinically informed and with the added incentive of being able to keep any 'savings' made, would negotiate better contracts with providers for elective hospital and community services than their health authority (HA) counterparts. They would thus be able to improve the responsiveness of services to patients' needs as well as to increase efficiency. In the event, the performance of GP fundholders varied widely (Audit Commission, 1996).

A similar pattern has been observed for the GP total purchasing pilots (TPPs). These were practices which volunteered to take an additional, delegated budget from their local health authority with which to commission potentially all hospital and community health services for their registered populations (Mays, Goodwin, Bevan and Wyke, 1997). The TPPs are of continuing relevance to the Labour Government's reforms (Secretary of State, 1997) since they had a great deal in common with the new Primary Care Groups (PCGs) which began commissioning (or advising HAs on commissioning) hospital and community health services in April 1999. However, PCGs are considerably larger than the average TPP (50,000-150,000 patients versus an average of 30,000) and are compulsory for all practices (Mays and Goodwin, 1998).

In their first 'live' year of TPPs (1996/97), the progress of all 53 projects was followed in detail by the national evaluation team. TPPs began to purchase selectively in areas outside the scope of fundholding such as maternity and care of the seriously mentally ill, although most of their achievements were incremental, small scale, locally generated and focused on developing services in or closely related to primary care settings. TPPs were also shown to vary widely in their ability to achieve their main purchasing objectives (Goodwin, Mays, Malbon, McLeod and Raftery, 1998). Broadly, the progress made by each TPP was a reflection of the interaction between its local context (for example, the quality of the relationship of the practices with the local health providers), the process by which total purchasing (TP) was implemented (for example, whether the pilot received its own budget at an early stage or not) and the content of the changes which the pilot wished to bring about (Mays, Goodwin, Killoran and Malbon, 1998).

TPPs operating in seemingly unhelpful contexts were, nonetheless, able to make progress when the process of change management was well crafted.

More specifically, the main factors associated with achievement in 1996/97 across the 53 first wave TPPs were:

- TPPs with smaller populations, fewer GPs and with no more than five practices achieved more than larger pilots;
- smaller projects, particularly single practices, needed relatively little additional organisational development, whereas larger TPPs had to establish more complex organisational arrangements which were less likely to be complete in the first 'live' year;
- TPPs with higher direct management costs achieved more than the remainder;
- higher achieving TPPs were more likely to report a 'fair' to 'high' level of support from the local HA than lower achieving projects;
- TPPs with at least some of their own independent contracts were more commonly found in the higher performing groups than in the lower; and
- higher achieving projects were also more likely to have greater ambitions for the future (Mays, Goodwin, Malbon, Leese and Mahon, 1998).

There appeared to be a strong link between the degree of TPPs' organisational maturity (for example, their ability to forge a corporate identity between previously separate practices) and their ability to realise their commissioning goals. Larger TPPs with more practices to co-ordinate had found it more time-consuming to develop an effective organisation capable of determining priorities, negotiating contracts, monitoring services and managing expenditure. This finding has significant implications for the development of PCGs in England which are discussed elsewhere (Killoran, Mays, Wyke and Malbon, 1998).

Given what had already been learned about the factors influencing the development and achievements of the TPPs in the first 'live' year, it was decided to adopt a different evaluative strategy in the second year, 1997/98. Rather than attempting to follow all the TPPs in some detail, it was decided to monitor all sites in outline while looking at how a small number of pilots

brought about service changes and developments. In the second 'live' year, it would also be possible to investigate whether the larger TPPs 'caught up' with and, perhaps, overtook their smaller counterparts.

2 AIMS AND OBJECTIVES

2.1 Overview

The overall aim of the third year of the national evaluation of TPPs, spanning October 1997 to September 1998, was to identify the ingredients of successful devolved purchasing based in primary care by in-depth study of twelve first wave TPPs. It was clear that an adequate understanding of the complex mix of contexts and processes that influenced the development of TPPs required a more intensive scrutiny than had been possible to date. One of these case study sites covered a whole district, and was thought worthy of separate consideration (Killoran et al, 1999). The analysis presented here, therefore, considers the eleven other case studies, and links findings with other sources of information on the TPPs, in particular, the collection of monitoring data undertaken at all the first and second wave TPPs by postal survey and telephone interviews in 1997/8.

2.2 Objectives

The case study analysis can be arranged into five groups as follows:

TPPs as organisations

Objectives: to identify the organisational functions and features that are central to effective total purchasing, and to identify the key tasks involved in developing these organisations. To achieve these objectives, the following issues were examined:

- management and administration arrangements and structures;
- database creation and information management;
- mechanisms for intra-practice communication and working, including ways of involving all members of the Primary Health Care Team (PHCT);
- mechanisms for developing and managing relationships with key stakeholders (health authorities, provider managers/clinicians, social services) and involvement of patients and the wider public;
- approaches to planning, needs assessment, selecting priorities and applying evidence of effectiveness;
- contracting and performance monitoring, including budgetary management.

Tools and levers for achieving change

Objective: to identify the roles of different tools and levers used in total purchasing to bring about changes. The following issues were investigated:

- the role of budgets and contracting contrasted with co-purchasing with the health authority;
- the importance of intra- and inter-practice relationships within the TPP and of relationships with external organisations (HA, provider managers and clinicians, and social services).

The scope and nature of benefits/outcomes for patients and populations

Objective: to define the scope and nature of benefits for patients and populations at each site, examining changes in patterns of services and/or health outcomes. The following were investigated:

- the development and extension of primary care provision, particularly through substitution for and shifts from secondary care;
- improvements to secondary care provision (in terms of quality, access, efficiency and effectiveness) exerted primarily through selective purchasing;
- the development beyond selective purchasing towards a more strategic commissioning role concerned with community health needs.

In addition, particular attention was paid to one initiative at each site which was considered to have been successfully implemented. Examination of such initiatives was also used to explore in depth tools and levers for change.

The position of TPPs within local commissioning systems

Objective: to identify the position of total purchasers within the district-wide commissioning framework. Specifically, the case studies examined the following issues:

- the respective roles and responsibilities of the HA and the TPP and the extent to which these are complementary;
- the relationships of the TPPs to other devolved purchasing/commissioning initiatives in the district (e.g. locality commissioning) and the differences and similarities between TPPs and such initiatives;

- the role and impact of the TPP with respect to equity issues, especially whether and how benefits achieved by projects were 'rolled-out' district-wide;
- how national and district policies and priorities relate to those of the TPP;
- the mechanisms of accountability employed by the HA in relation to the TPP;
- how the role of the TPP may be affected by the reorganisation of the NHS, and the implications for the respective roles and responsibilities of TPPs and their HA.

Management capability, costs and issues of sustainability

Objective: to describe and assess management capability and costs, and to explore whether TPPs were sustainable as organisations. The following issues were explored:

- the role of GPs, the role of the lead GP, and the impact on GP staffing, activity and workload;
- the importance of the background experience and training received by GPs, future training requirements and consideration of succession planning (the identification of other GPs to become involved, or take the lead, in the TPP);
- how GPs are motivated to take part in total purchasing and the extent to which they are paid to take part;
- the impact on the role of other primary care team members in Total Purchasing, including workload and training implications;
- the role and effectiveness of project management, including the importance of a TP-specific project manager role and what it requires;
- the role of the HA in supporting TPPs, and future support requirements;
- analysis of management costs and sources of funding;
- sustaining the required level of management investment, and development requirements.

3 METHODS

3.1 Selection of case studies

Of the 52 total purchasing pilots that were functioning at the end of their first 'live' year in 1997, 12 were selected for case study investigation. The choice of twelve reflected a balance between the optimum utilisation of research resources and the need to include a range of different types of TPPs. From the outset, Wakefield TPP was included as one of the twelve studies since this was a project which had expanded to a district-wide, multi-locality project (reported in Killoran et al, 1999).

The following TPPs were excluded from the sampling frame:

- those not expected to continue throughout 1997/8;
- TPPs which were likely to be terminated in April 1998 as a result of fundholding being abolished
- single-practice TPPs, which were not likely to attract support from their HAs to continue beyond April 1998, and whose experience would be less relevant to PCG development;
- those unlikely to attempt service changes in TP-related areas during 1997/98;
- Scottish sites, since funding for their evaluation was not available.

In total 31/52 TPPs were excluded from potential case study selection using the above criteria. The selection of the remaining sites sought to include TPPs which varied in a number of respects as follows:

Locality and non-locality TPPs

As it was already known that PCGs would be locality-based, it was thought important to compare how locality and non-locality TPPs operated. TPPs were subdivided into locality projects and non-locality projects using the definition shown in Box 3.1.

Box 3.1: Definition of a locality total purchasing pilot

A locality TPP is defined as a pilot which displays all of the following characteristics:

- all the practices of the TPP are located in the same city, town or village with a contiguous population (i.e. they serve a specific locality);
- the practices of the TPP share a common strategy and purchase/commission as a group;
- the practices in the TPP share the same main provider(s).

Size

Both large TPPs (five or more practices) and small (two to four practices) were included, to enable further exploration of previous findings from the national evaluation that smaller multi-practice TPPs appeared to be higher achievers, with higher management costs per capita, than their larger counterparts (Wyke, Mays, Abbott et al, 1999).

Proximity to providers

Because it was possible that TPPs which contracted with local providers were more able to do so successfully than those negotiating with more distant trusts, the case study sites were chosen to reflect a mixture of the two. Five sites had main providers based in the same town or city; six did not. It was also thought that such a classification might be an approximate way of distinguishing between urban and rural TPPs, and might therefore reflect differences in rural and urban populations. In fact, it turned out to distinguish between TPPs based in cities and those based in towns (large or small) (see Table 3.1).

Level of deprivation

Not least because the new government had signalled an intention to address health inequalities across the country, sites were chosen to reflect a range of socio-economic environments. However, only one TPP in the sampling frame attracted a positive Jarman score of more than 20%, so less prosperous areas were under-represented.

The TPPs selected (Table 3.1) reflect the range of characteristics desired with 6 locality and 5 non-locality TPPs, and 7 large and 4 small TPPs. In addition, those TPPs which registered a positive Jarman score of more than 20% have been included

Table 3.1: Characteristics of the 11 case study TPPs

Name of TPP	Locality/ Non-locality	Urban/non-urban	Large (>4 practices) or small (2 to 4)	Jarman score of >20% in 1995/96
TPP A	Locality	City	Large	Yes
TPP B	Locality	City	Large	No
TPP C	Locality	Town	Small	No
TPP D	Locality	Town	Small	No
TPP E	Locality	Town	Large	No
TPP F	Locality	Town	Large	No
TPP G	Non-locality	City	Small	No
TPP H	Non-locality	City	Large	No
TPP I	Non-locality	City	Large	No
TPP J	Non-locality	City	Large	No
TPP K	Locality	Town	Small	No

3.2 A Phased Approach to Case Study Investigation

From the outset, an iterative approach was adopted: members of the case study team met regularly, approximately every six weeks, to share findings, to consider the developing policy agenda as PCG guidance was published, and to identify key themes and questions for the next stages of the research. The case study approach was undertaken in two main phases.

Phase 1

The purpose of the first phase was to provide a detailed profile of each case study, specifically defining the 'type' of TPP it represented, and to provide the basis for more selective and in-depth investigation of particular themes in the second phase.

The main objectives of phase 1 were as follows:

1. to produce a working checklist of key management and organisational functions for TP (i.e. indicators of good practice);

2. to define the total budget of each case study and its pattern of purchasing; and to map its key internal and external contacts and relationships;
3. to provide a working definition of the different types of TPPs as expressed by their ambitions and achievements;
4. to demonstrate how each TPP sat within and contributed to the local commissioning arrangements, particularly in the light of the NHS White Paper;
5. to define the management costs of each TPP and the proportion of HA management costs this represented.

The first phase involved first, the examination (in December 1997) of data already collected from both the 'process' evaluation and the tracer studies during 1996/97; and second, generic fieldwork across all the sites exploring the five themes set out in the research objectives.

This fieldwork comprised semi-structured, face-to-face interviews with lead GPs and project managers in the TPPs and a representative from the host HA, and was carried out in January and February 1998. Documentary evidence was also gathered and assessed, including TPP purchasing intentions and plans, current/updated policies, HA purchasing intentions and documents on local commissioning arrangements.

Following the completion of the fieldwork, the case study research team undertook content analysis of the interviews and documentary data on a team basis. Two key areas for further investigation were established: first, defining the scope and nature of benefits for patients and populations through an examination of selected service developments of TPPs in 1997/98; and second, examining the progress and issues surrounding the transition from TPP to PCGs.

Phase 2

The second phase employed similar research methods to phase 1. In the evaluation of selected service developments, a wide range of methods were employed including face-to-face and telephone interviews with individual stakeholders and, where appropriate, focus groups and workshops with particular interest groups. Respondents included lead GPs, non-lead GPs, PHCT

members, trust clinicians, personnel from social services and other local government departments, and the HA. Relevant documentary material was also collected and analysed.

The examination of the TPPs' transition to PCGs was undertaken chiefly through interviews with lead GPs, project managers and HA representatives. A framework of research topics and questions was used by each researcher as a guide to the key generic issues that had to be investigated.

Work for this phase of the research was carried out from April to June 1998.

4 PROFILE OF CASE STUDY TPPS

This section gives a profile of the case study TPPs, and is itself divided into three parts. The first provides a summary of the case study TPPs, including the size of TPP, the complexity of the organisation, and direct management costs. The second gives details of the TPPs' budgets and their pattern of purchasing, plus the TPPs' own interpretations of their involvement in key commissioning and providing functions. The third categorises the TPPs by their geographical location and by type of TPP, concluding with a summary table.

4.1 Basic Characteristics

Tables 4.1 and 4.2 give summaries of the case study TPPs' basic characteristics. All case study TPPs are multi-practice projects, varying in size from three to ten practices. The range in terms of patient population is wide (from 20 000 to 81 000). Per capita direct management costs also vary widely (£1.43 to £7.08). Most projects have at least one first or second wave standard fundholder in the group, and almost half have a simple organisational structure. Organisational structure is defined by the number of management groups and sub-groups (Mays et al, 1997).

Table 4.1 Basic characteristics of case study TPPs in 1997/8

	Mean	Median	Range
Number of practices per project	6	5	3-10
Number of GPs per project	24	22	10-59
Patient population per project	43 000	36 000	20 000-81 000
Per capita direct management costs in 1997/8	£3.26	£2.94	£1.43-£7.08

Table 4.2 Basic organisational details of case study TPPs

	Number (n=11)	%
Number (%) with 'complex' organisational structure	2	18%
Number (%) with 'simple' organisational structure	5	45%
Number (%) with 1st/2nd wave FHs	9	82%

Table 4.3 gives further details of the direct management costs as reported by the TPPs. Expenditure is shown as non-recurrent (e.g. equipment) and recurrent (e.g. staff costs).

The majority of the case study TPPs paid 'lead GPs' on a sessional basis, usually between one and three sessions a week. Other methods of payment were fixed sums: annually to practices as a whole, or based on completed projects or attendance at meetings. One TPP planned to merge the management costs for TPP and SFH. Non-recurrent management costs were generally a low proportion of the overall total with most projects having spent nothing in 1997/98 - only a few had incurred one-off costs, either for IT hardware or project office equipment.

Table 4.3 Total direct management costs 1997/8

(£000's)	Mean	Median	Range
TPP direct management costs	£118 519	£95 000	£51 413-£277 000
- non-recurrent	£7 089	£0	£0-£42 000
- recurrent	£111 430	£95 000	£51 413-£277 000

Table 4.4 shows direct management costs per capita. The range is wide but the most common cost per capita is about £3.00. This figure can be compared with the median per capita direct management cost for all first wave TPPs in their first live year (1996/7) of £2.78 (Mays, Goodwin, Killoran et al, 1998). The inter-quartile range for all first wave TPPs was £1.79 to £3.80. This inter-quartile range is used to code the case study TPPs as having high (greater than £3.80) or low (less than £1.79) direct management costs.

Table 4.4 Per capita direct management costs 1997/8

	Mean	Median	Range
TPP direct management costs per capita	£3.26	£2.94	£1.43-£7.08
- non-recurrent per capita	£0.25	£0.00	£0.00-£1.70
- recurrent per capita	£2.98	£2.34	£1.43-£5.38

Seven of the eleven TPPs are locality based (a locality project is defined as one where all the practices are located in the same city, town or village, the practices share a common strategy, and

they share the same main provider). All case study TPPs were multi-practice projects, three comprise four or fewer practices.

Six types of TPP had already been devised from information about the stage of development of projects, and the focus of their objectives, achievements and future ambitions (see Box 5.1 below) (Mays, Goodwin, Killoran et al, 1998). Each case study TPP, in conjunction with a researcher, placed themselves in the categories shown in Table 4.5. Two TPPs were 'co-purchasing' and 'commissioning' TPPs respectively, but also emphasised their commitment to developing primary care, they are therefore also placed in the 'primary care developer' category. None of the case study TPPs were in the 'under-performing' or 'developing' categories.

Table 4.5 Typology of case study TPPs

Type of TPP	TPPs	
0-under-performing	-	
1-developmental	-	
2-co-purchasing	TPP G	TPP B
3-primary care developer	(TPP G)	(TPP A)
4-commissioning	TPP C TPP E TPP H TPP I	TPP K TPP D TPP A TPP F
5-integrated	TPP J	

4.2 TP Budget Commissioning and Providing Roles

This section gives details of the TPPs' budgets and their pattern of purchasing, and the TPPs' own interpretations of their involvement in key commissioning and providing functions. Tables 4.6 and 4.7 give details of the size of the TPPs' budgets and how these were used, as a whole and per capita respectively. The figures in the tables vary threefold, a result of the proportion of budgets that were delegated to the TPPs and the different ways of defining budgets, not necessarily as a result of different formulae. For example, some HAs allocated TPPs budgets to cover all services and responsibilities but then 'top sliced' these budgets, holding a certain amount back for HA-wide financing, for example, for clinical negligence. Others allocated their

TPPs a budget only for the services to which they wished to make changes. From the figures supplied by the TPPs, on average, more than half the TPPs' budget per capita was used to purchase services directly.

Table 4.6 Total TPP budget with method of purchasing 1997/8

	Mean	Median	Range
TPP budget	£12 215 000	£10 028 000	£3 898 000 – £22 621 000
- top sliced	£1 556 000	£390 000	£0 – £8 223 000
- blocked back	£1 070 000	£4 400	£0 – £6 880 000
- co-purchased	£675 000	£17 650	£0 – £2 390 000
- directly purchased	£8 914 000	£10 006 000	£34 000 – £15 741 000

Table 4.7 Per capita TPP budget with method of purchasing 1997/8

	Mean	Median	Range
TPP budget per capita	£269.28	£262.11	£158.07-£430.00
- top sliced per capita	£34.40	£12.21	£0.00-£141.78
- blocked back per capita	£18.56	£0.10	£0.00-£84.94
- co-purchased per capita	£23.94	£0.39	£0.00-£118.68
- directly purchased per capita	£192.38	£207.31	£1.69-£319.79

Table 4.8 shows the extent to which the TPPs rated themselves as having been involved in key commissioning and providing responsibilities. A score of zero indicates no involvement, of one, minimum involvement, two means modest involvement and three implies a significant level of involvement. There is some variation in the way the questions have been interpreted and scores decided; scores are briefly discussed below. Scores are available for nine TPPs.

Strategy development

In terms of health needs assessment (HNA) for the local population, three TPPs reported very limited involvement in HNA, most often for just one service area. A further three TPPs reported at level two revealing that more systematic needs assessment had been undertaken in conjunction with their HAs. Three other TPPs reported at level 3. Each of these had an attached HNA officer or team of some sort. For example, one TPP had a HA public health medicine doctor attached for two days a week with a remit to develop profiles on which a health strategy could be based.

In terms of service planning (e.g. reviews, overall acute services strategy/reconfiguration, planning with Social Services), most TPPs (six) believed that they had had a significant involvement in planning issues, but, in the main, this was on their own (TPP) issues. There was little involvement by any of the TPPs in the wider HA issues such as service reconfiguration or planning with social services. From the descriptions that the TPPs gave about their involvement, all TPPs should have scored 1 for involvement in HA issues and 3 for involvement in the own TPP planning. Table 4.8 reflects the latter score.

The question of resource prioritisation was answered by the TPPs in a number of different ways. Each TPP appeared to have addressed prioritisation issues in relation to their own resources but had little involvement with health authority decisions on prioritisation.

Table 4.8 Responsibilities and Functions: TPPs' own views of their level of involvement

Responsibilities/ Functions	Level of involvement of TPP			
	0	1	2	3
Strategy development				
Health needs assessment for local population	0	3	3	3
Service planning (e.g. reviews, overall acute services strategy/reconfiguration, planning with Social Services)	0	1	2	6
Prioritisation of resources	0	1	6	2
Involvement of the public (CHC, public relations, patient involvement)	0	2	4	3
Implementation				
Specification of range & activity levels to be commissioned (including ECRs)	1	0	3	5
Specification of contract quality	1	0	3	5
Negotiation and monitoring of contracts	0	1	1	7

Primary care development	0	1	4	4
Health Promotion	1	2	2	4
Monitoring and Performance Management	0	2	1	6
Core functions	1	0	4	4

* for nine TPPs

Each TPP claimed some involvement of the public with their organisation (e.g. CHC, public relations, patient involvement). Four TPPs scoring two had a representative from the community health council either on the Board or invited to attend the Board meetings. Three had patient participation groups, and others had obtained feedback through practice-based or service-specific surveys.

Implementation

The involvement of the case studies in specifying the range and activity levels to be commissioned varied. The TPP with a zero score did not hold a budget and all contracts were sub-contracts with the HA. TPPs scoring three were involved in ECR management plus service specific and GPFH service specification, usually through the project manager working with trusts.

A similar and related distribution of scores was associated with specification of contract quality. The TPP with a zero score had no independent contracts whilst TPPs scoring two were working to agreed standards or had developed quality specifications. A score of three implied more work in this area; for example, one TPP has a quality alert system and also has held a GP forum on day cases.

In terms of negotiation and monitoring of contracts, the TPP with no independent contracts had been to a few meetings and hoped to increase involvement in the future. One project was monitoring contracts for FH services, the others were all monitoring their TPP contracts, usually this was done by the lead GP and the project manager.

Primary care development

Some TPPs seem to have judged themselves more harshly than others on this criterion. Those for whom primary care development was a main issue scored themselves lower than those TPPs who were not planning any developments in primary care. This may be because practice-based improvements gave a greater sense of satisfaction than more ambitious strategies which were only partially realised. TPPs had increased peer review and joint decision making, and most had developed new services or ways of working within the primary health care team. There has been little provision of secondary care services by primary care.

Health Promotion

Some TPPs had worked regularly with the HA public health medicine department. Others had taken a more pro-active role: liaison with health visitors and social services; work on family planning; move towards direct patient advice rather than practice based leaflets; an information centre about illnesses at the local library; development of a health improvement team; and health promotion undertaken by the GPs and nurses.

Monitoring and Performance Management

Most had regular monitoring meetings both for themselves and with the HA. They analysed and reported on their own data for services, finance and activity.

Core functions

Two employed and managed dedicated TPP staff as well as a project manager, while others delegated TPP tasks to practice, fundholding and/or HA staff. Most fulfilled their own information needs.

4.3 Summary of Basic Characteristics of Case Study TPPs

Table 4.9 summarises the main characteristics described in this section, for each individual TPP. None of the three small (<=4 practices) TPPs had low management costs or a simple organisational structure. All the five TPPs with a simple organisational structure were large, and four of these five were also of urban context. There are no other obvious similarities between the TPPs.

Table 4.9 Summary of TPPs' basic characteristics and settings

	1	2	3	4	5	6	7	8	9	10	11
*Large TPP (>4 practices)	✓	✓	✓		✓	✓		✓	✓	✓	
*Urban context	✓						✓	✓	✓	✓	
*Locality based	✓	✓	✓		✓	✓					✓
*1st/2nd wave SFHs	✓	✓		✓	✓		✓	✓	✓	✓	✓
High management costs (>£3.80)		✓		-	✓			✓	✓		✓
Low management costs (<£1.79)			✓	-							
Complex organisation	✓					✓		✓	✓	✓	
Simple organisation			✓				✓				
Commissioning/integrated TPP	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓

* indicates geographical/pre-determined characteristics

- indicates missing data

5 THE ACHIEVEMENTS OF CASE STUDY TPPS

In this chapter, the achievements of the case study TPPs are examined. The first part examines the extent to which case study TPPs attained their main purchasing priorities in 1997/98, and relates this to progress made in 1996/97, the content and scope of objectives, project typology, project size, locality or non-locality nature, and level of deprivation.

The next section looks at what was achieved in terms of specific themes: primary care focus of innovations; controlling demand and shifting resources; equity; creating new models of primary care organisation; better collaboration between health and social services.

Finally, eleven specific service changes are described, not only to provide an in-depth understanding of mechanisms and processes, but also to illustrate the potential that primary care-based purchasing has for the development of health care. Explanations for the achievements of the case study TPPs are then explored in chapter six.

5.1 The Extent to which Purchasing Priorities were met

Achievement of main objectives, 1997/98

In order to assess the reported achievements of each case study TPP in relation to its purchasing and other main objectives in 1997/98, each TPP was placed into one of five hierarchical groups according to, firstly, the project's ability to achieve its objectives in it's own terms and, secondly, focusing exclusively on achievements in TP-related areas. The method for assessing the TPPs' progress and achievements is that used previously in the national evaluation and which is explained in detail elsewhere (see Mays, Goodwin, Killoran and Malbon, 1998).

Table 5.1 shows the rating of each of the eleven case study projects by hierarchical groups of achievement for 1997/98 both in the projects' own terms and in TP-related areas. The tables show a wide range of achievement amongst the case study TPPs which matches, broadly, the range shown for the first-wave TPPs as a whole. There were also varying levels of progress between the two 'live' purchasing years, 1996/97 and 1997/98. In the project's own terms, three projects improved their achievement grouping, four stayed the same whilst a further four fell back

to lower achievement group. Again, the situation was similar for TP-related achievements with four projects improving their grouping, four remaining the same, and three regressing.

Table 5.1 Progress of the eleven case study TPPs, 1996/97 to 1997/98

Achievement in TPP's own terms			**Achievement in TP-related service areas**		
Name of TPP	**1998 grouping**	*1997 grouping*	Name of TPP	**1998 grouping**	*1997 grouping*
Case study TPPs in lower achievement groupings in 1998					
TPP G	**2**	*3*			
TPP K	**2**	*3*	TPP K	**2**	*3*
TPP D	**3**	*5*	TPP D	**4**	*5*
TPP I	**4**	*5*	TPP I	**3**	*5*
Case study TPPs in the same achievement grouping in 1998					
TPP B	**2**	*2*	TPP B	**1**	*1*
TPP H	**4**	*4*	TPP H	**4**	*4*
TPP A	**4**	*4*	TPP A	**2**	*2*
TPP C	**4**	*4*			
			TPP G	**2**	*2*
Case study TPPs in a higher achievement grouping in 1998					
TPP E	**3**	*2*	TPP E	**3**	*2*
TPP F	**3**	*1*	TPP F	**2**	*1*
TPP J	**4**	*2*	TPP J	**5**	*3*
			TPP C	**4**	*3*

The case study TPPs show considerable variation in their level of achievement during 1997/98 and the next section examines potential reasons for this variation in performance through the following five key characteristics:

- Size of project
- Locality versus non-locality TPPs
- Level of deprivation
- Typology of project: co-purchasing, commissioning and integrated
- Management resource

Achievement and size of project

During the first live year of the TP scheme it was found that small TPPs were more likely to achieve objectives than their larger counterparts (Mays, Wyke, Goodwin et al, 1998). One

possible reason for this was the requirement for larger TPPs to invest greater time and resources into establishing organisational development arrangements. A key question was whether larger projects had managed to 'catch up' in 1997/8 in terms of ability to achieve purchasing objectives.

From the experience of the case study TPPs in 1997/98 it appears that three of the four smallest projects (two to four practices) had regressed in terms of achievement against objectives (Table 5.2). The larger TPPs had either remained in the same achievement grouping or advanced. The two projects which had improved the most over the period were the largest and third-largest TPPs in the case study sample. Some of the largest TPPs, therefore, appear to have been able to 'catch up' and larger multi-practice projects have perhaps been more successful than smaller ones, a reversal in the trend observed in the first year. The case study findings are somewhat reinforced by the monitoring of all TPPs (Malbon, Mays, Killoran et al, 1999)

Table 5.2 Number of case study TPPs in achievement groups 1 to 5 in the projects' own terms by size of project for the years 1996/97 and 1997/98

TPP size	*Number of TPPs by achievement grouping*				
	1 (LOW)	*2 (LOW)*	*3 (MEDIUM)*	*4 (HIGH)*	*5 (HIGH)*
2 -4 practices					
1996/97	-	-	2	1	1
1997/98	-	2	1	1	-
>4 practices					
1996/97	1	3	-	2	1
1997/98	-	1	2	4	-

The apparent increase in success in large TPPs may be understood in a number of ways. The second year may have provided time for the development of effective organisations, or for the achievement of objectives of larger scope than those attempted by smaller TPPs, or perhaps because larger TPPs had more leverage and power over providers than small TPPs. However, the announcement of PCGs had a negative impact on small case study TPPs. For example, it became clear that each of the practices in one TPP would become part of a different PCG, a prospect which severely curtailed TPP activity.

Locality versus non-locality TPPs

Given the recent policy shift towards PCGs based on distinct geographical localities, one might have assumed that locality projects would have a contextual advantage. However, as Table 5.3

reveals, there appears to be no obvious association between level of reported achievement and locality/non-locality status.

Table 5.3 Number of case study TPPs in achievement groups 1 to 5 in the projects' own terms by locality and non-locality for the years 1996/97 and 1997/98

TPP type	*Number of TPPs by achievement grouping*				
	1 (LOW)	*2 (LOW)*	*3 (MEDIUM)*	*4 (HIGH}*	*5 (HIGH)*
Locality					
1996/97	1	2	-	2	1
1997/98	-	1	3	2	-
Non-locality					
1996/97	-	1	2	1	1
1997/98	-	2	-	3	-

However, the move towards PCGs favoured the largest projects' ability to make progress. Table 5.4 shows that large locality TPPs, which in 1996/97 had tended to be low achieving projects, had improved over the year whilst the smaller localities had dropped back: larger locality TPPs appear to have made the best progress as a cohort. No association appeared between achievement and location relative to main providers.

Table 5.4 Number of case study TPPs in achievement groups 1 to 5 in the projects' own terms by size and locality/non-locality for the years 1996/97 and 1997/98

TPP type	*Number of TPPs by achievement grouping*				
	1 (LOW)	*2 (LOW)*	*3 (MEDIUM)*	*4 (HIGH}*	*5 (HIGH)*
Large locality					
1996/97	1	2	-	1	-
1997/98	-	1	2	1	-
Small locality					
1996/97	-	-	-	1	1
1997/98	-	-	1	1	-
Large non-locality					
1996/97	-	1	-	1	1
1997/98	-	-	-	3	-
Small non-locality					
1996/97	-	-	2	-	-
1997/98	-	2	-	-	-

Achievements by level of deprivation

The percentage of patients attracting Jarman deprivation payments within the practices of the TPPs was used as a proxy measure of deprivation. However, only one of the case study projects attracted payments for more than 20%, and was recorded as a medium/low achiever in the first two live years of total purchasing. One cannot conclude anything from the case studies about the impact of deprived populations on the ability of TPPs to achieve objectives.

Achievements by project typology

In the first year of 'live' total purchasing, 1996/97, the evaluation identified a number of project types (Box 5.1). An important finding of the evaluation of first wave TPPs in 1996/97 was that commissioning projects were the more likely to achieve objectives than co-purchasers whilst integrated projects had yet to develop.

Box 5.1 Typology of TPPs

Under-performing TPPs - projects not achieving or intending to achieve in TP-related service areas (these were omitted from case study selection)

Developmental TPPs - projects in a preparatory stage, placing emphasis on needs assessment and infrastructural investment, with the intention of making changes in TP-related areas in the future

Co-purchasing TPPs - projects influencing local provision in TP-related areas through partnership with the HA and/or collaboration with Trusts. These projects did not hold a budget and have independent contracts

Primary care developer TPPs - projects focusing exclusively on developments of primary care in TP-related areas. These projects could achieve changes through co-purchasing or through commissioning

Commissioning TPPs - projects which directly purchase in TP-related service areas to achieve changes in secondary care as well as primary care. Such projects hold budgets and have independent contracts

Integrated TPPs - TPPs which directly purchase and influence both secondary and primary care provision. These TPPs adopt an integrated approach to the use of TP and SFH budgets and are moving towards fully integrated planning and management structures

In line with the experience of 1996/97, all of the co-purchasing case studies remained low achievers in 1997/98 whilst there was a range of achievement amongst the commissioning group. One TPP which moved from a co-purchaser to a commissioner was a project that particularly improved its achievement grouping between the two years. Similarly, the one TPP that was regarded to have progressed to an integrated project improved its rating dramatically to become the highest achiever amongst the case studies (group 5). Importantly, the more successful commissioning case study projects had been developing an increasingly integrated approach, suggesting that successful future primary care organisations may need to do the same.

Achievement by direct management costs

Malbon et al (1999) show that the ability to achieve objectives within total purchasing in 1997/98 is significantly related to the level of direct management costs per capita. Within the case studies direct management costs per capita ranged from £1.43 to £7.08 with the higher achievers being the more costly projects to administer. This relationship is clearly shown in table 5.5 where the lowest achieving projects (groups 1 and 2) consistently spent about half as much on management than the others. The relationship between direct management costs and ability to achieve objectives is examined in more detail in chapter six.

Table 5.5 Level of achievement in the case study projects' own terms and in TP-related objectives in relation to direct management costs per capita, 1997/98

Achievement in own terms Achievement grouping	Number of TPPs	Mean cost per capita
1 and 2 (low)	3	£1.91
3 (medium)	3	£2.80
4 and 5 (high)	5	£3.71
Achievement in TP-related areas		
1 and 2 (low)	6	£2.19
3 (medium)	2	£4.63
4 and 5 (high)	3	£3.56

5.2 The Achievements of Case Study TPPs Considered Thematically

This section examines recurrent themes emerging from case study data. These are:

- primary care focus of innovations

- controlling demand and shifting resources
- equity
- creating new models of primary care organisation
- better collaboration between health and social services

Some of these have similarities to those identified by the national evaluation team from the first live year of total purchasing (Mays, Goodwin, Killoran and Malbon, 1998). In particular, TPPs' have continued to retain emphasis on primary care innovations rather than changes to secondary care directly. For example, a recurrent theme amongst the case studies has been the shifting of resources from trusts to fund primary care alternatives that also reduce demand for hospital services.

Key differences in the emergent themes between the two 'live' years also emerge. Perhaps most importantly, the objectives of the case study TPPs appeared to have moved beyond a purely local focus, characterised by a lack of strategic planning, to the evolution of a more collective approach aspiring to greater integration of care with other health and social care stakeholders and a greater emphasis on service planning, needs assessment and equity.

Primary care focus of innovations

The case study TPPs reported a number of service changes achieved which had the effect of moving the provision of services closer to the TPP itself. These can be divided into two groups:

- changes in services provided by PHCTs, including GPs;
- commissioning more local services.

Six TPPs claimed that the scope of their PHCT had been strengthened by attaching community health staff to practices and/or by linking with a named worker based elsewhere (e.g. community nurses, midwives, mental health workers and counsellors). In other TPPs, parts of existing PHCTs were re-organised. For example, one TPP integrated nursing teams with team midwifery whilst another integrated self-managed nursing teams. The skills of existing PHCT members have also been enhanced, e.g. in relation to chest and heart conditions, breast cancer, substance misuse. In one case, a community nurse was trained to administer social care budgets. Attempts have also

been made in three cases to increase the cost-effectiveness of GP prescribing by using pharmaceutical advisers.

The perceived benefits of these developments were:

- a greater sense of TPP ownership of services;
- improved communications between services and/or within the PHCT;
- more appropriate matching of patient needs to professional expertise;
- enhanced awareness and knowledge or particularly health care issues across the team as a whole.

Case study respondents commonly spoke of initiatives which had the effect of bringing into the local community services which were previously provided at a distance. In some cases, the motivations were predominantly financial, but the effect was nevertheless to enhance local access to services (e.g. an acute back pain clinic, and a child and adolescent mental health service).

Controlling demand and shifting resources

Many of the TPP case studies sought to manage demand for hospital care by avoiding inappropriate admissions and enabling early discharge, commissioning and/or providing new forms of intermediate and community-based care. Examples included:

- a hospital discharge team/co-ordinator to promote the early discharge of patients into the community and to secure appropriate community-based treatment
- nursing home beds for respite care
- GP beds in community hospitals
- hospital at home beds and hospital at home nursing teams.

However, changes were sometimes only marginal, because trusts refused to release resources. In one case, for example, the small size of the TPP, its lack of a delegated budget, and an effective HA veto on resource-shifting (so as not to destabilise the trust) meant that the TPP had very little leverage.

However, others did succeed: for example, one TPP introduced a number of related services that resulted in significantly reduced admissions (including a discharge planning team, intermediate care beds and a discharge alert register), and funded the project by capping the acute trust's contract and diverting the money into the scheme.

Two projects attempted demand management on a longer time scale by means of health promotion initiatives (on-line health information in the practices; involving patients in making a health promotion video).

Equity

A recurrent theme within the case studies was the problem of finding an equitable method of resource allocation. While the majority was seeking to apply capitation-based budgets there was some way to go before TPPs would actually achieve their 'fair share' allocation. For example one case study TPP in a deprived area agreed a budget which was shown to be substantially below a form of capitation-based budget which took particular account of its level of deprivation.

There was little direct evidence that changes brought about by TPPs were increasing inequalities in service provision. However, the case studies provide a number of examples of TPPs achieving some marginal changes in hospital provision, reducing their costs, for example through contract currencies linked to length of stay, only to see trusts increase costs to other purchasers as a consequence.

There are also examples where benefits have been secured for TPP populations, which were not available across the district, as is common in primary care in general. Conversely, there are examples where the changes brought about by TPPs were pushing up standards across the district. For example, new service specifications developed by a TPP for maternity based on Changing Childbirth have subsequently been applied district wide, and models for the prevention of emergency medical admissions have been more widely applied in recent Winter Pressures initiatives.

Creating new models of primary care organisation

A striking feature of the TPPs in this study, and of successful TPPs in general, is the degree to which they developed new models of primary care organisation. Historically, primary care in the UK has been based on the small business model of the independent general practice. Although GPs have increasingly worked in group partnerships employing practice managers, nurses, and other directly employed staff, and attached community health staff, the basic organisational form of 'the practice' has not significantly altered. Inter-practice co-operation (e.g. within multi-funds) has been relatively rare, and GP practices have only occasionally joined broader health partnerships or alliances with social services, other local authority departments, voluntary, community and user groups. By contrast, a recurring theme amongst the case studies examined was that TP acted as a catalyst for both inter-practice and inter-agency collaboration.

TP has contributed to such developments in three main ways: first, by facilitating the development of new primary care leadership roles within primary care; second, in developing new structures and processes for inter-practice communication; and third, by developing new structures and processes for inter-agency partnerships.

Within each TPP, lead GPs were reported to be playing a greater role in developing strategic thinking and managing colleagues than in the past. Many project managers had also extended their management role, some developing into the equivalent of an executive manager (in two cases called chief executive). Such developments required the willingness of non-lead practitioners to delegate responsibilities to such leaders. Such willingness represents a major innovation in primary care, which has important lessons for PCGs since they require similar arrangements.

Case study TPPs were also characterised by new structures of inter-practice communication. TPPs have generally operated through a structure in which each practice was represented on the health authority sub-committee/TPP project board and a TPP-based executive group. This 'democratic' structure was often based on the desire by non-lead practitioners for effective representation, facilitated regular communication between the enthusiasts and the larger group of (often ambivalent) GPs. Another common mechanism was the sub-group, focused on clinical or

managerial tasks. Other mechanisms included regular meetings of all TPP GPs, practice/fundholding manager meetings and the integration of fundholding and TPP management. Often the cumulative effect of such developments was that the majority of GPs shared in some aspect of TPP work.

A feature of successful case study TPPs was the continued move towards joint working. For example, partnerships with social service departments addressed common continuing care and mental health issues. A number also reported improving relationships with community health councils. Several TPPs became involved in multi-agency locality-based needs assessment projects, and one was planning a Healthy Living Centre in partnership with the HA, the borough council (education, leisure and social services), trusts and the Health Promotion service.

However, there is also evidence of limitations to these developments. Several respondents pointed out that a consensus approach to decisions within the TPP meant moving only as fast as the 'slowest' practice would allow. Moreover, despite evidence of the greater involvement of social services, CHCs and community nurses within the executive management group, GPs were generally very careful to ensure that they retained overall control of decision-making. Overall, the range and role of other agencies regularly involved in TPPs remained relatively narrow.

Better collaboration between health and social services

A final underlying theme was the move towards greater integration of care with social services. The extent of the case study TPPs' strategic and operational involvement with social services can be seen in table 5.6. Joint-working with social services has been identified at three levels: first, a good relationship manifest in regular dialogue and information exchange; second, a strategic link, e.g. the presence of a social services representative on the TPP project board; and third, an operational link, e.g. co-operation over and above the standard referral procedures between primary care and social services. Eight of the eleven TPPs had developed, or were in the process of developing, some form of operational link with social services, examples including:

- the development of an attached social worker post;
- aligning a social worker to a TPP to facilitate hospital discharge;
- practice-based district nurses acting as care managers, deploying social services budgets;

- the development of a joint budget;
- the joint commissioning of services (relating to hospital admission and discharge, or to rehabilitation and respite services).

In other cases, TPPs participated in joint working initiated elsewhere, for example, a HA/SSD-funded care project to examine care packages for the mentally ill.

Table 5.6 Summary of Case Study TPPs' joint-working with Social Services

TPP	*Locality based*	*Large TPP >4 pracs*	*Urban context*	*1st level: Good Relations*	*2nd level: Strategic link*	*Final level: Operational link*
TPP F	✓	✓		✓		✓ HA/SSD led
TPP B	✓	✓	✓	✓	✓ since April 1998	developing/ TPP led
TPP A	✓	✓	✓			developing/TPP led
TPP E	✓	✓				developing/HA led
TPP C	✓	✓			✓	
TPP D	✓			✓		✓
TPP H		✓	✓			
TPP J		✓	✓			developing/ SSD led
TPP I		✓	✓		✓	
TPP G			✓		✓	✓ HA led
TPP K				✓		✓

Shading indicates TPP/Social Service operational links or joint service developments.

The experience of organisational development within the TPP appears to have helped pilots understand the need for and means of improving joint working. However, it is clear that attempts to breach the divide between health and social care were limited: for example, there was little evidence of the joint funding of new services.

5.3 The Potential for Primary Care-based Purchasing: an examination of eleven specific service changes

The examination of selected service developments sought to explore in more detail the mechanisms and processes that lead to service changes, and to provide examples of what can be achieved through primary care commissioning. Service developments detailed below were examined in terms of their objectives and scale, the mechanisms used for achieving change, and the nature and scope of benefits to patients which resulted.

Each account begins with a summary of objectives, mechanisms and outcomes, and which is followed by supplementary information of particular interest.

Service development 1 - Developing a low back pain clinic

Summary	
Objectives	• Easier access and reduced waiting times to services for acute back pain sufferers • More appropriate treatment - reduced repeat referrals
Mechanisms	• Tendering exercise for delivery of local back pain clinic • Use of TPP savings and development money to initialise service followed by resource shifting from orthopaedic contract with acute trust to back pain clinic provided by community trust • Creation of specialist physiotherapist post holding regular clinics at local TPP practice
Outcome	• Much reduced waiting times for acute back pain sufferers • Greater GP awareness of treatments for acute back pain sufferers • Closer relationship between GPs and physiotherapists

The TPP's aim in prioritising this service was to avoid an 18 months waiting list for orthopaedic appointments and a high level of repeat referrals, which suggested that treatment was ineffective. The service is physiotherapist-led, and includes both the assessment and treatment of patients in regular clinics, and the provision of advice to GPs on the need for further investigations. The service has been extended to provide a group session for chronic back pain sufferers (back

education and exercise sessions), and a small shop has been set up for the sale of books and distribution of advice leaflets and back care equipment such as lumbar rolls.

The service was initially funded out TPP budget savings and a proportion of the HA's development fund. Later, the TPP transferred money from its orthopaedic budget into the Community Trust budget, since the new clinic allowed orthopaedic referrals to be reduced.

Service development 2: Developing cost effective prescribing and a joint formulary

The project arose out of an offer by the Regional Office of the NHS Executive to joint-fund projects which could strengthen the role of community pharmacists. The local HA supported this aim, and joint-funded the pharmacy project with the TPP.

Summary

Objective	• encourage GPs to prescribe more cost-effectively • compile a joint formulary with local acute provider • involve community pharmacists in delivery of primary care
Mechanism	• employment of pharmacy advisor, jointly funded by TPP and HA • encourage high degree of GP interest through representation on prescribing board • joint working with hospital pharmacist to develop joint formulary
Outcome	• some containment of prescribing costs • greater shared understanding between GPs and hospital consultants about prescribing-related issues; • a joint formulary, making cost-effective and evidence-based prescribing more consistent across the town; • a strengthening of the cohesiveness of the TPP as a whole; • lack of interest in involvement from community pharmacists

A pharmacy advisor held monthly meetings with the TPP's prescribing group, producing monthly reports on prescribing costs, practice by practice. As 'profligate' prescribing became transparent, some GPs formed a sub-group to discuss how to change their own prescribing behaviour.

An example of how costs were reduced is provided by work around ulcer-healing drugs. The TPP's prescribing group audited prescribing in the light of evidence of effectiveness; nurses (funded by a drugs company) ran special clinics, reviewed individual prescribing and made recommendations to GPs about unnecessary prescribing; and the group agreed to use the cheaper of the two main drugs available.

The pharmacy advisor worked with pharmacists at the acute trust to devise a joint formulary of drugs for use across the borough, based on evidence of cost-effectiveness and approved by GPs and hospital doctors. It is believed that this has changed the prescribing behaviour of both GPs and consultants, although no objective data were available.

In the first year of the project (1996/97), prescribing costs were contained, with particular impact in practices where prescribing had been increasing most quickly. This was not sustained in the second year to the same degree, mainly because the larger practices had already been more cost-effective prescribers, and so there was limited scope for identifying overspends which could be trimmed.

An important sub-agenda was the encouragement of GP involvement in the TPP, particularly those who had not hitherto shown much interest in the project. Each of the 10 practices supplied a representative to the pharmacy group, which meant that the group had credibility among all the GPs.

The final objective of involving community pharmacists had not been achieved. This was particularly disappointing since the original TPP vision was that all primary care agencies should work together to improve the health of the local population. The pharmacists did not show commitment to the idea of enhancing their role within the TPP and were perceived to be still functioning primarily as small businesses.

Service development 3: Reducing emergency geriatric admissions

Summary	
Objective	• shift the pattern and volume of geriatric admissions from the acute to the GP unit • improve patient choice and quality of care through more local and appropriate GP-led service • save the TPP £1200 per patient
Mechanism	• GP financial incentive scheme (£1600 per GP) to manage emergency geriatric admissions at GP unit • Cost and volume contract with trust to cover both acute and GP beds
Outcome	• acute geriatric admissions reduced by 6.1% with potential saving of £106,000 • perceived quality of care unchanged and patient choice and access enhanced

Both acute and GP beds were provided by one trust. The TPP re-negotiated its cost and volume contract in order to make savings to fund extra admissions to GP beds. Before the scheme commenced, GPs in the TPP had already received payments for patients in GP beds (approximately £58 per GP). This was regarded as an insufficient incentive, so the TPP provided approximately £1600 per GP for the management of emergency geriatric admissions (although some GPs were heavier users and thus would receive more). There was no significant resistance from the trust to the new contract, despite a few concerns expressed by geriatricians about potential problems with quality of care; the trust management did not perceive this shift as representing a potentially significant loss of income to them. The savings to the TPP may not be as significant as intended, as the trust managers reported that under and over performance on different cost and volume contracts tended to be cancelled out in the end of year 'mop up'.

In terms of quality of care, all stakeholders interviewed (GPs, TPP manager, trust managers, HA, social services) perceived quality of care to be equal in the GP beds, and patient choice and access enhanced. However, there has been no systematic audit of quality. The lead GP proposed an independent audit but encountered marked resistance from other GP board members. The TPP's data show the number of acute admissions fell by 6.1%. However, GP admissions also fell

during the same period by 18.2%, so that the scheme does not appear to be the cause of the reduced acute sector admissions. In summary, there is little firm evidence on the value of this scheme.

Service development 4: Developing a rehabilitation team for the elderly

Summary	
Objective	• improve the quality and extent of rehabilitation services to elderly people • shorten length of stay in acute sector through early transfer to outreach community rehabilitation
Mechanism	• ability of TPP to invest growth money to provide rehabilitation service • joint funding made available from the community trust • length of stay sensitive contract with acute trust
Outcome	• despite failure to negotiate new contract with acute trust, early discharge to community rehabilitation team has occurred • user and TPP perception that patient choice, satisfaction, quality and continuity of care has improved

The initiative was based on a perception by TPP GPs that current rehabilitation services did not provide comprehensive high quality care, although no systematic needs assessment was undertaken by the TPP to validate this perception.

Planning for the service was led by the TPP, but a sub-group was established with representation from the community trust (who managed the local hospital), the acute trust and social services. Initially, enthusiasm from other stakeholders was low (the GPs reported that discussions about a rehabilitation team had taken place over many years with no action resulting). By using growth money within its budget, however, the TPP was able to invest in the new service. The community trust became more supportive of the scheme and agreed to half fund it in its first year (1996/97) with the TPP funding it in full in subsequent years.

Although the TPP wished to negotiate a length of stay-sensitive contract with the acute trust, this was plagued by difficulties. The acute trust charged one price for treatment and rehabilitation

regardless of length of stay; if the patient was transferred early to the local community hospital for rehabilitation, the trust paid a rebate much lower than the charge made by the community trust. This double charging was a major barrier to developing the scheme; resolving it would have required both trusts to revise their whole pricing structures to make them sensitive to length of stay, which they were not willing to do.

A range of informants perceived the rehabilitation team to be highly successful, and there were strongly expressed perceptions that patient choice, satisfaction, quality and continuity of care had all been significantly improved but no systematic audit had been undertaken. No data were available on the length of stay, disability or independence of patients to enable comparison between the existing service and the TPP's initiative.

Service development 5: Promoting continuity of mental health services

Summary

Objectives	• Change catchment provider to improve continuity of the mental health service and to eliminate ECR costs; • Develop a CMHT at the local community hospital • Co-examine with the HA and social services intensive care packages for people in the community who are seriously mentally ill.
Mechanisms	• Change of contract with non-catchment trust for non-mental health care plus disengagement arrangements from mental health provision; • Change of contract with catchment provider involving risk-sharing arrangements, trigger and tolerance arrangements and new contract currency. Growth monies used to help fund financial shortfall
Outcome	• Change of mental health catchment provider has been negotiated and is being phased in during 1998; • Far fewer ECRs expected but impact on quality of care questioned; • Provider change has moved TPP agenda forward to development of locality CMHT

When the TPP's plans for a joint local service failed to interest its two main providers, it sought to move the contract to one provider only. Because of trusts' perceptions of financial threats to themselves in this arrangement, the plan was only implemented with the support of the HA, and, at a crucial stage, the backing of the HA's chief executive. The Trust and the GPs thereafter agreed to jointly monitor changes in admission/discharge, length of stay and after-care arrangements.

The TPP also wanted to examine intensive care packages for the seriously mentally ill, and has been involved in a HA-led initiative funded jointly by the NHS Executive Regional Office and Social Services. The change in provider has prompted the TPP to discussed the creation of a CMHT, but this has not yet been achieved.

Service development 6: Developing a child and adolescent mental health service

Summary	
Objectives	• Improved access to mental health services through provision of local service including named consultant • Shorter waiting times • Development of outreach services
Mechanisms	• Employment of full-time consultant psychiatrist, part-time psychologist and two CPNs • Change of provider through competitive tendering exercise • Easy access to service provided by direct telephone line to consultant
Outcome	• Patients treated more quickly and closer to home; • Easier access to consultant advice for GPs, social services and school nurses

Before this development, no local services were available, and waiting times were perceived to be too long. Four Trusts were invited to tender. The most local Trust won the contract since it was already providing a similar service for the rest of the county, was joint-working with social services and education (the Trust's catchment area was coterminous with local authority boundaries), and also provided adult mental health services for the TPP, thus ensuring continuity

of care as adolescents grew older. The Trust also agreed to give regular feedback on the referral patterns of each TPP practice for review by the TPP project manager and consultant psychiatrist.

The TPP had difficulties in negotiating the transition from the existing provider, particularly over responsibility for patients on the waiting list. It was believed that holding a budget was the crucial lever for the eventual success of negotiations.

Respondents agreed that patients were being seen closer to home and more quickly.

Service development 7: Reducing length of stay and the number of emergency admissions

Summary	
Objectives	• Reduce length of stay of emergency admissions; • Improve discharge planning; • Avoid emergency admissions where possible.
Mechanisms	• Increased use of existing fast response service to avoid admissions; • Appointment of case manager to review TP patients admitted to hospital in an emergency; • Close collaboration with social workers and district nurses; • Project nurse employed to facilitate the scheme.
Outcome	• Shorter lengths of stay; • Improved co-ordination of care.

This scheme took a two-pronged approach to address the problem of increasing numbers and lengths of stay of emergency hospital admissions. First, GPs were to try to avoid admissions by more proactive management themselves, and by using more often the fast response service, which provided up to 72 hours of health and social care to those who would otherwise be admitted to hospital. Second, a case manager was appointed, who followed the progress of patients admitted to hospital as emergencies, ensuring that the stay in hospital was no longer than necessary and that preparation for discharge was timely and comprehensive. This post was funded by development money.

GP commitment to the first strategy was rather variable, and in any event, the case manager thought that most admissions were probably necessary. The case manager function was regarded as much more successful in ensuring that discharge was timely and that pre-and post-discharge care was co-ordinated. Factors enabling the role to work well included: a positive attitude in the acute trust, which regarded the scheme as an opportunity to improve discharge planning rather than as a threat to activity levels; the case manager's wide experience and substantial local networks; regular meetings with district nurses in each practice, and relevant social workers. Links with GPs were less satisfactory both for district nurses and for the case manager, and there was a lack of awareness at senior management levels in the community trust.

No 'hard' outcome data were available, but the scheme was generally regarded very positively. In the face of major upheaval in the TPP at the end of 1996/7 (several practices left and others joined), the decision to continue the TPP in altered form rather than to disband it was due to the perceived benefit of continuing to explore the potential of this service development.

Service development 8 - Reducing length of stay for acute in-patients

Summary	
Objectives	• Reduce length of acute stay in main providers, especially for elderly patients; • Improve discharge planning to reduce bed-blocking; • Develop admission avoidance techniques
Mechanisms	• Investment in community hospital beds for patients no longer requiring intensive treatment; • GPs paid from TP budget for additional clinical care of community patients at local hospital and at home; • Development of Community Discharge Team (CDT) in co-operation with the Community Trust to help primary care staff manage patients at home who would otherwise be admitted, or remain, in hospital; • Project nurse employed to facilitate the scheme.
Outcome	• Reduction in lost bed days

A locally recognised problem in this TPP was the high degree of 'bed-blocking' occurring in its main acute hospitals and the inability to secure more appropriate care places in the community. During 1996/97, the TPP established GP-beds at the local community hospital to help facilitate discharge. However, since this was not allied to any significant strategy to develop care alternatives, bed-blocking simply shifted from the acute unit to the community hospital.

The 1997/8 objectives were similar: reduce length of acute stay in main providers for elderly patients; improve discharge planning to reduce bed-blocking; and develop admission avoidance techniques. A more comprehensive strategy was established to meet the TPP's aims involving the following:

- The employment of a dedicated project nurse to facilitate the scheme;
- Continued investment in community hospital beds for patients no longer requiring intensive treatment at the acute unit;
- Financial incentives for general practitioners, paid from the TPP's service budget, to provide additional clinical care at the local community hospital and at home;
- The development of community discharge team (CDT), led by the project nurse, to act in co-operation with the Community Trust to help primary care staff manage patients at home who would otherwise be admitted, or remain, in hospital;

Initially, the TPP's initiatives appeared to force a rise in lost bed days because of 'glitches in the system' that needed to be addressed. However, as the program matured, reduction in lost bed days were achieved that significantly outpaced those for the health authority as a whole.

The ability of the TPP to reduce 'bed-blocking' needed to be addressed in a comprehensive manner that involved a range of factors: the increase in availability of alternative care facilities; a proactive discharge policy; better care and support for patients in the community and at home; and some effort to promote admission avoidance. The interaction of all elements in a 'team' approach appears to have had a significant impact on lost bed days in the case study. Political backing from the local council and the HA was also important in enabling an environment in which solutions were actively encouraged - the ability of the TPP to engender intensive local action being the important force behind these global views.

Service development 9: Enhancing the primary care-based mental health team to reduce hospital use

A mental health working group was set up, which included a non-lead GP, the CPN manager, a further CPN representative, an HA representative and the TPP's project manager. Practice population profiles and activity were reviewed to gain an assessment of need beyond that already recognised by GPs. One practice within the TPP had previously used practice attached CPNs and the perceived effectiveness was regarded as something that could be rolled out to the TPP as a whole. The scheme did reflect government priorities for mental health care services in moving the focus of mental health care to primary and community care. However, the TPP did not attempt to gain the views of mental health care users.

The level of CPN involvement was doubled, and CPNs became increasingly involved in the PHCT, often taking referrals directly from its members as well as monitoring and working with the seriously mentally ill, anticipating crises, preventing admissions and facilitating safe discharges.

Summary

Objective	• to improve mental health care for the practices' patients; • to reduce pressure on acute mental health beds; • to develop primary care based mental health care teams
Mechanism	• needs assessment exercise • creation of multi-disciplinary working group • employment of practice-based CPNs funded by reduced contract pricing with trust based on estimated reductions in admissions • contract currency changed from FCEs to occupied bed days
Outcome	• the enhanced availability of and access to mental health professionals for patients • improved discharge liaison in mental health • reduced lengths of stay in hospital and prevention of admissions • positive improvement in the workload of general practitioners dealing with the mentally ill.

The scheme was funded from savings made from the in-patient mental health contract with the main trust. The TPP negotiated a reduced contract pricing based on estimated reductions of acute mental health admissions as a result of the practice-based CMHT. The TPP also negotiated a change in contract currency from FCEs to occupied bed days, which meant that the TPP could realise savings from reduced lengths of stay immediately. However, the TPP experienced difficulties in negotiating the release of funds from the Trust on an ongoing basis (the Trust re-priced its services in order to combat the potential loss of funds).

Occupied bed days for acute mental health admissions of the under 65s have been reduced by 42.5% over three years. Although occupied bed days have increased for the over 65s, the change in contract currency means that the TPP has nonetheless paid less.

The TCP has undertaken evaluations to examine the quality and the effectiveness of its service, which are ongoing, although the following benefits were stressed by those interviewed: the enhanced availability of and access to mental health professionals for TCP patients; improved discharge liaison in mental health; reduced lengths of stay in hospital and prevention of admissions; and a reduction in the workload of GPs.

Service development 10: Integrated care project to reduce inappropriate admissions and promote early discharge

Summary	
Objectives	• Improve the quality of care for patients by the provision of community based intermediate care facilities • Offer a choice of community based intermediate care facilities. • Ease pressure on acute beds by reducing the number of emergency admissions to secondary care and by facilitating the early discharge of appropriate patients. • Prevent delay in discharge from hospital by anticipating, identifying and addressing the issues which lead to delayed discharge and/or frequent hospital admission.
Mechanisms	• Acute trust contract capped and money diverted to the TPP for use on the intermediate care scheme • Employment of hospital discharge co-ordinator and creation of discharge planning team • Co-ordination with Community Trust's hospital at home scheme
Outcome	• Acute hospital admissions reduced by 10-14% • Greater treatment of illnesses in intermediate care settings • Length of stay reduced • The project overspent on budget

The project was developed by a multi-agency interest group involving managers and clinicians from the TPP, social services, housing, acute and community trusts, and the HA. It arose out of an initial needs assessment, including a literature review and an audit of A&E admissions which suggested that up to 15% of these could be avoided.

To fund the scheme, the TPP capped the acute trust contract by the anticipated value of savings from the avoidance of admissions. A hospital discharge co-ordinator was appointed to develop and implement plans, which were initially implemented on a small scale. Over time, the scope of the project progressively broadened to encompass early discharge arrangements, and to cover all practices and both local hospitals.

TPP data suggested that acute hospital admissions were reduced by 10-14%. Hospital activity analysis also provides corroboration that the project was meeting its objectives (Raftery and McLeod, 1998). The majority of intermediate care activity was delivered, as planned, by a hospital at home scheme (61%). Referrals were mainly from GPs (there was a gradual increase in use of the scheme by GPs), other members of the primary care team, and the two main providers' A&E Departments. Social Services regarded the project very positively, and were planning to align a social worker to the TPP, possibly funded by the TPP.

Service development 11: - Developing shared standards for breast cancer care

Summary	
Objective	• develop a standard for breast cancer care in primary care
Mechanism	• use of health needs assessment to identify needs • use of available evidence about clinical effectiveness • nurse training in breast cancer care screening techniques • creation of cancer care standard
Outcome	• greater GP ownership of TPP as a whole • PHCT members better informed about breast cancer and cancer care techniques • GP's less likely to refer inappropriately • greater use of skills of practice nurses

This required no contract changes and was inexpensive to develop. However, it was an unusual scheme in comparison with other TPP initiatives (Mahon et al, 1998) because of its origin in detailed local health needs assessment, the public health agenda of the Health of the Nation, and available evidence about clinical effectiveness, and its importance as a health promotion intervention.

The TPP had at its inception decided to appoint a health needs assessment officer (HNAO) and had also compiled a list of a number or priorities for work, but there was no strategy for using health needs assessment to set priorities for commissioning and provision. The HNAO facilitated discussions about such a strategy, and breast cancer was chosen as the "closest fit" between locally assessed need, available evidence of effectiveness, national priorities and achievable

objectives. Theoretically, the successful development of this project did not require TP. However, informants were in no doubt that, without TPP, the HNAO would not have been appointed, and that without a HNAO, the standard would not have been developed. Other PHCT members would not have had the time and range of skills to lead and co-ordinate the project as the HNAO had done.

The standard begins with a summary of the evidence on the epidemiology, pathology, treatment and management of breast cancer, and describes in detail agreed procedures for both the services offered within the practices and for appropriate referrals to secondary care. The implementation of these standards required some additional skills. Practice nurses undertook training in taking family histories from patients and aide-memoirs were produced to remind practitioners of procedures (e.g. the use of the national breast screening program, what constitutes a significant family history, conditions requiring referral etc.). Once developed, the standard was launched at a special event, a major purpose of which was to create a sense of ownership within the TPP as a whole.

Whilst no audit data is yet available to illustrate the standard's impact, it is believed that care had improved: GPs are now less likely to refer inappropriately and are more likely to use the skills of the practice nurses (for example, to discuss breast self-examination with patients, or to accept a nurse's opinion that a referral is necessary). The TPP felt better informed and more able to contribute to local discussions acute trusts about new local services, and consultants were pleased to be asked to endorse the launch of the standard.

5.4 Conclusions: factors associated with achievement

Case study TPPs show a range of achievement in 1997/98 that broadly mirrors the pattern for all TPPs. Approximately one third remained in the same achievement grouping in 1997/8 as in 1996/7, one third improved and one third regressed.

A number of key characteristics were seen to be associated with those case study TPPs that achieved most. First, co-purchasing TPPs remained low achievers whilst commissioning TPPs continued to develop. Second, all case study TPPs with four practices or fewer lost momentum

whilst there was a range of development in the larger case study TPPs. Importantly, whilst there appeared to be no pattern between achievement grouping and locality/non-locality projects, the larger locality projects did tend to improve most quickly over the year. TPPs that had developed the most integrated approach appeared to have made the best progress. Finally, the more successful case study projects were significantly better resourced in terms of direct management costs per capita.

This analysis of the case study TPPs, therefore, suggests that well-resourced, large, locality projects employing an integrated approach were able to achieve more, and make the best progress, during 1997/98. Such projects also tended to place a greater emphasis on strategic/non-commissioning objectives. This is reflected in the fact that, although all the TPPs continued a policy of selective purchasing, the scope of objectives achieved had generally increased.

Case study TPPs tended to have concentrated on service developments with a primary care focus: expanding the role and scope of the primary health care team, of commissioning more local services. Specifically, a number of TPPs attempted to provide cheaper and sometimes more local alternatives to acute hospital care (avoiding admissions and/or reducing length of hospital stay), and by providing instead care at home, in residential care or nursing homes or in community hospitals. Successful TPPs had learnt how, both structurally and culturally, to create the conditions for inter-practice co-operation and leadership within TPPs, and for collaborations with other local agencies, particularly social services departments.

The service-specific case studies highlighted a range of mechanisms that were used successfully to bring about service changes:

- financial incentives to GPs;
- encouragement of non-lead GPs to take an active role in service developments;
- encouraging TPP GPs to subscribe to a collective approach (e.g. the promotion of shared cancer care standards and prescribing formulary);
- using joint/external funding in partnership with a range of agencies including the host HA, trusts, social services and the voluntary sector;
- access to professional support (e.g. pharmaceutical advisors; public health input);

- increased joint working (e.g. the creation of multi-disciplinary and multi-agency working groups);
- using contracting powers to change contract currencies and/or shift resources from trusts;
- developing a more strategic focus (e.g. through the use of health needs assessment and evidence of clinical effectiveness)

It was often difficult to establish the true impact and value of innovations for patients. There was a general lack of reliable data from which to monitor the quality and effectiveness of care following service change. Most TPPs, however, believed that there was benefit either in terms of reduced costs of services or in the beneficial impact on the development of the TPP as a whole (e.g. a greater sense of GP ownership; better relationships with other agencies; the development of more strategic thinking).

6 EXPLAINING PROGRESS AND ACHIEVEMENTS OF CASE STUDY TPPs

6.1 Theoretical approach

In explaining the progress of TPPs after their first live year, 1996/97, it was apparent that whilst a number of key variables could be identified which were associated with achieving change, there was a range of wider and more complex factors which influenced TP development in individual cases (Mays, Goodwin, Killoran et al, 1998). One objective of the case study approach was to examine the mechanisms and processes through which changes were brought about within their local context.

This approach reflects an increasingly important emphasis on the importance of understanding context in social enquiry. The strength of such an approach lies in its attempts to take into account how a range of contextual factors (cultural, geographical, financial) influence the implementation of strategy. The contextual approach, therefore, links action and structure.

As an analytical tool, the contextual approach has been successfully transformed into a framework for understanding a number of health related issues. Pettigrew, Ferlie and McKee (1992), for example, developed a contextual framework to examine how strategic change was achieved in the NHS. Similar frameworks and analyses were also used by Goodwin and Pinch (1995) in relation to the privatisation of NHS ancillary services and by Mays, Goodwin, Killoran et al (1998) in the analysis of the achievements of first wave TPPs in 1996/97. The analysis that follows draws on the experience of these approaches but more directly on a recent contextual approach devised by Pawson and Tilley (1997).

Pawson and Tilley's analytical framework can simplistically be expressed by the following equation: *Outcomes = Contexts + Mechanisms*

As Pawson and Tilley explain,

'outcomes are not inspected simply in order to see if programs work, but are analysed to discover if the conjectured mechanism/context theories are confirmed'.

This means that outcomes (the 'what' of change) require examination in terms of both the mechanisms by which outcomes are obtained (the 'how' of change) and the context within which

they are obtained (the 'why' of change). Thus, outcomes are the product of a specific mix of contexts and mechanisms. The following analysis attempts to address this equation by examining first, the impact of different contexts; second, important causal mechanisms; and last, the interplay between different mechanisms and contexts over time.

6.2 The Impact of Context on the Achievements of TPPs

Contexts, both national and local, determined the circumstances in which TPPs achieved or failed to achieve intended outcomes. Pawson and Tilley (1997) explain that *'context refers to the spatial and institutional locations of social situations together, crucially, with the norms, values, and interrelationships found in them.'*

In the first 'live' year of the evaluation a number of key 'receptive' and 'non-receptive' contextual variables were discovered that influenced the ability of TPPs to achieve their objectives (Table 6.1: Mays et al, 1998, p.90).

The case study analysis re-emphasises the importance of all these contextual factors. In addition, the case study analysis reveals a further range of local contextual factors influencing progress in 1997/98:

- cultural acceptance of new models of primary care organisation;
- the changing health care policy environment - the impact of the New NHS White Paper;
- the geographical context;
- the financial context and the ability to resource innovations.

Cultural acceptance of new models of primary care organisation

'Culture' refers to deep-rooted assumptions and values, both of individuals and organisations, that have an impact on individual action and behaviour. During the first year of total purchasing progress was often greatly influenced by the extent to which TPPs had been able to 'bridge the cultural divide' with other stakeholders, particularly the host HA (Mays, Goodwin, Killoran and Malbon, 1998).

The case study TPPs similarly showed the importance of cultural differences. TP meant for many GPs the emergence of new assumptions, values and languages. Working with community health councils, local authorities and the voluntary sector exposed GPs to different concepts of public participation and accountability. Though 'visionary' lead GPs readily adopted such concepts, others resisted. For example, in one case study where the TPP had developed a close working relationship with its CHC, there was strong GP resistance to CHC interest in an audit of practice in a clinical area where GPs had financial interests. Moreover, GPs take for granted medical knowledge and language which is often inaccessible to other professionals and managers, who sometimes felt excluded as a result.

Table 6.1 Key 'receptive' and 'non-receptive' contextual variables influencing the ability of TPPs to achieve their objectives

Aspect of context	Receptive	Non-receptive
Cultural	Supportive organisational culture	Opposing organisational culture
	Innovation - ability to challenge established practice	Inertia - reliance on established values and working practices
	Openness and trust	Secrecy and mistrust
	Commonality - shared values	Incoherence - incompatible values
	Positive self-image and sense of achievement	Lack of clear purpose and no sense of achievement
Political	Macro-political environment favourable to development of total purchasing	Macro-political environment unfavourable to development of total purchasing
	National policy backing for service changes (e.g. Changing Childbirth)	National/local opposition to service changes proposed
	Coherence of national policy objectives	Incoherent/conflicting policy agenda
	Favourable local political agenda	Obstructive local political agenda
Historical	History of working together	No history of working together
	Advanced and integrated IT system with history of information exchange on activity and costs	Under-development and incompatible IT systems with little previous exchange of information on activity and costs
	TPP established through practice/GP-led initiative	HA developed TPP without grass-roots support
	Local historical issues supporting TP innovations	Lack of purpose behind TP innovations - no local historical issues to act as a basis
Geographical	TPP patient population entirely within one health authority	TPP population spread across more than one health authority
	Provider/social service catchment area congruent with TPP population	TPP population divided between catchment areas
	Potential for provider competition	Monopoly provider only
Financial	National and local fiscal environment favourable	National and local fiscal environment unfavourable
	Availability of adequate direct management resources	Management resources inadequate to establish effective TP organisation
	Flexibility/integration of budgets	Inflexible/ring-fenced budgets

More generally, GPs often emphasised their strong desire to remain as clinicians, and the limits this placed on the time available for intra- or inter-organisational working. Such an emphasis sometimes reflected an implicit negative value judgement about such working.

The strong desire by most GPs for a GP majority on primary care group boards also illustrated the limits to their trust in and desire for partnership with colleagues from other agencies. Most GPs did not apparently feel able to entrust a majority of colleagues from other disciplines with the power to determine aspects of practice, strategy or indeed their own GP contracts and therefore income. The elaborate procedures for 'democratic' elections of GP board members for PCGs illustrated a continuing cultural gap between GPs and other stakeholders who were often more concerned with ensuring a wider democratic accountability for PCGs as a whole.

In that most stakeholders have been defensive of existing working practices, culture has tended to act as a barrier to change. But the case studies also show that an approach based on a locality focus and common agreed goals could enable the barriers of cultural difference to be overcome.

The changing health care policy environment - the impact of the New NHS White Paper

In previous analyses it was shown that policy shifts had a fundamental impact on the ability of the pilots to make progress (Mays, Goodwin, Killoran, Malbon, 1998). In 1997/98 it was announced that fundholding and TP would give way to PCGs in April 1999. Depending on the size and characteristics of the case study TPPs, this context was either a positive or negative influence.

Larger, locality-based, TPPs were placed at a contextual advantage since they came nearer to meeting the basic requirements for a PCG. In these cases, the continuity of the existing TPP as a commissioning organisation was often confirmed by the host HA (though usually with the addition of other neighbouring practices), enabling the TPP to continue pursuing specific objectives whilst planning for the future. For example, in one case study, both the TPP and HA respondents felt that, as a PCG, the TPP would have greater scope to invest in mental health services which had previously been under-resourced, and that there would be greater scope, as a larger group, to achieve one of the original objectives of the TPP, a more integrated local health

service. The development of the PCG, therefore, appeared a logical extension of the TPP and was welcomed by all parties.

However, in other cases, PCG policy had negative impacts on TPPs. The pursuit of TPP priorities often fell away as the agenda became dominated by the future composition of local PCGs. Non-locality TPPs became highly defensive of their existing organisation where it was threatened with a split or with a merger with practices perceived to be less well-developed: progress would be halted as new partners were brought 'up to speed'. Some fundholding practices within TPPs also became pre-occupied with the dissolution of fundholding. Some TPPs reported that staff morale plummeted due to the uncertainty of future job opportunities associated with the end of fundholding and TP: in three cases, project managers resigned their posts, leaving managerial deficits which were difficult to fill for the brief remaining life of the pilot

'The new NHS' probably represents the biggest single contextual influence on the ability of case study TPPs to achieve objectives and make progress in 1997/98. However, other national policies were important both in influencing the choice of objectives of TPPs and their ability to achieve these. For example, one TPP was keen to identify objectives which reflected national priorities and chose cancer services as a priority following the Calman-Hine report, which helped the TPP to enlist the co-operation of trusts. Similarly, case study TPPs developing initiatives in the field of maternity care did so because it was an objective receiving national emphasis (Changing Childbirth). However, as Wyke et al show (1998), projects eventually lost momentum as national support for Changing Childbirth waned.

The geographical context

As noted above, the move to PCGs based on local communities has favoured the locality projects, at least those with larger populations. Such TPPs continued to progress, and reported better relationships with other agencies serving the same communities.

Non-locality case study TPPs appeared to have been less active in working with non-NHS agencies, which are usually locality based. Some attempts at integrating care, for example

through the addition of a care co-ordinator or a social worker to the TPP's PHCT, foundered because of the differences in service area covered.

The financial context and the ability to resource innovations

The financial context was a significant factor in the ability of the case study TPPs to bring about change. Larger TPPs with a delegated budget and/or growth monies appeared able to exert sufficient leverage to conduct strong negotiations, to gain acceptance for changes, and/or to use competitive tendering processes (e.g. studies 3, 6). However, provider reluctance to release funds to TPPs has been widespread.

TPPs operating in districts with a significant financial deficit faced additional challenges. For example, one case study TPP was required to contribute to the district's financial recovery plan and therefore received a reduced budget. In response, the practices within this TPP agreed to pool their resources to increase the flexibility for reallocating within budgets and increasing negotiating power with providers.

Successful case studies tended to be innovative in finding additional funding to help finance proposed changes, e.g. joint and/or external funding with or from HA, trusts, social services and the voluntary sector. The ability to hold budgets was strengthened by the ability to draw on alternative sources of money to bridge resource shifts.

6.3 Causal Mechanisms

Pawson and Tilley (1997) argue that evaluators need to focus on causal mechanisms to understand 'why' change occurs. A key analytical task in the analysis of TP, therefore, has been examination of the diversity of mechanisms involved in enabling (and preventing) TPPs to achieve objectives. The findings from the case study TPPs found three central and recurring themes:

- key leaders and willing followers
- inter-agency co-operation
- budget-holding and contracting.

Key leaders and willing followers

Previous TP-NET reports have noted that TPPs were usually run by a few key players, often by one enthusiastic lead GP and a competent project manager (Mays et al, 1998). Whilst the presence of key leaders was important to the ability of projects to achieve objectives, the reliance on a limited number of key leaders was regarded as a sign of the overall weakness and fragility of TPPs since the removal of one key individual often had profound negative effects on the ability of projects to develop further.

The more successful TPPs developed an inclusive style of project leadership and management, and the greater sharing of roles and responsibilities between practices and individuals has helped projects to survive better when key players left the organisation. For example, a few case study TPPs lost their project manager during 1997/98 following uncertainty as to their potential future employment once the TPP pilot had run its course. In one case, project management was taken over by the full-time data manager for the project, supported by a cohesive GP team and a high level of partnership and information exchange between the member practices. In another, over 75% of the GPs, involving at least two from each participant practice, were involved in developing the TPP's approach to a range of clinical areas. Engendering GP interest in clinical areas has proved to be an important mechanism for increasing project sustainability and legitimacy. The case studies suggest that the most productive scenario has been the combination of strong dynamic leadership with the inclusion of a range of other key TPP players willing to play an active part in the organisation whilst at the same time being willing to respect leadership.

Individuals from outside TPPs also played a key role in enabling progress. For example, in service development 5, in which the TPP wanted to change its provider for mental health care, the backing of the HA Chief Executive was crucial in providing legitimacy for this change.

Inter-agency co-operation

Inter-agency co-operation was stressed by most respondents in TPPs as a key enabling factor to achieving objectives. This is particularly true of the TPP-HA relationship, but is also true of TP relations with providers, social services and voluntary agencies. The service development case

studies provide numerous examples, particularly in the case of mental health (5,6,9) and intermediate care (3,7,8,10).

Budget-holding and contracting

Mays, Goodwin and Malbon et al (1998) suggested that holding a budget was an important prerequisite for TPPs to make progress in the first 'live' year of total purchasing. However, it appeared that it may have been the potential to contract for services which was the key lever in facilitating change (Mays, Goodwin, Killoran et al, 1998).

Table 6.2 examines the service developments of the case study TPPs already described in terms of budgets, contracts and alternative sources of funding. Two of the service developments (2 and 11) did not involve contracting. Of the remaining nine, two attempted to reduce emergency admissions, two to reduce inappropriate admissions/ bed blocking, and three planned to change their mental health services. The others attempted to develop a rehabilitation service, and to begin a back pain clinic. All except one of these nine case studies held a budget (i.e. were commissioning TPPs) and all were successful in implementing their planned change. Three used their ability to contract to shift services from one trust to another. Another three used their contracts to reconfigure services within a trust. Two TPPs used only development or growth money to fund schemes. One gave no details.

An initial interpretation of table 6.2 suggests that contracting was an important mechanism for change, and was often regarded as the most important factor in enabling funds to be available to finance new services. However, the importance of contracting per se may be overstated. The aim of changing contracts and contract currencies was to free up resources from existing services in order to invest in alternatives. However, TPPs were often disappointed with the level of savings they were able to extract from trusts.

Of the three case study TPPs which attempted to reduce admissions and length of stay by amending contracts with existing providers, only one (service development 10) actually managed to acquire and re-invest savings. Of the three which shifted contracts between competing trusts (service developments 1,5 and 6), two managed to release savings for re-invested, although

contracting alone was insufficient in two cases: service development 1 needed development funds at the start, although once the community trust service was established and referrals to the acute trust were reduced, unspent money was extracted from the latter and given to the former. The TPP tackling service development 5 successfully changed providers for its mental health services, but needed additional investment by the HA to overcome a shortfall in the amount offered to the new provider, in order to ensure an acceptable standard of care. In this case, relations with the Trust were deemed by respondents as more important than holding a budget since the TP itself was not large enough to force through such a strategic change initiative through contracting alone.

Table 6.2: Service developments, in terms of budgets, contracts and funding

Service development	TPP held a budget	TPP changed contracts (either provider or contract currency)	TPP used other funding (e.g. development/growth money)
1. Developing a low back pain clinic	Yes	No Money transferred from acute orthopaedics to community back pain clinic through reduction in referrals	Yes Funded initially from development money and TPP savings.
2. Developing cost effective prescribing and a joint formulary	No	N/A	N/A
3. Reducing emergency geriatric admissions	Yes	Yes Contracted on cost & volume basis.	No
4. Developing rehabilitation team for the elderly.	Yes	No No change to acute contract. Community trust half funded scheme in year 1.	Yes Investment from TPP growth money.
5. Promoting continuity of mental health services	Yes	Yes Shifted contract from one trust to another.	Yes HA invested substantial amount of growth money
6. Developing a child and adolescent mental health service	Yes	Yes Removed all existing contracts (cost per case) and began block contract with single provider.	No SFH money only, not TPP budget.
7. Reducing length of stay and the number of emergency admissions	No	No	Yes Development money used to fund case manager.
8. Reducing length of stay for acute in-patients	Yes	No details	No TPP budget paid GPs to provide local care.
9. Enhancing the primary care-based mental health team to reduce hospital use	Yes	Yes Changed currency from FCE to OBD.	No
10. Integrated care project to reduce inappropriate admissions and promote early discharge	Yes	Yes Capped acute trusts contract.	No But pooled SFH & TP money
11. Developing shared standards for breast cancer care	Yes	N/A	N/A

Three of the six TPPs described in the previous paragraph used development or growth money, in addition to changing contracts, to support the service changes they made, and two others used

development monies to fund new schemes in which contracting played little or no role in these changes. Indeed, one of these had no budget.

6.4 The Interplay between Context and Mechanism

The fact that case study TPPs have progressed, or regressed, to varying degrees can be most fully explained by the interplay between context and mechanism over time. In other words, the ability of the TPPs to achieve their objectives should be regarded as the product of a specific mix of variables which either act as barriers or catalysts to change.

The likelihood of a particular TPP to reach a desired outcome is dependent on the abilities of those involved in the mechanics, or the process of change, to overcome contextual barriers or capitalise on contextual advantages. This means that it is possible for desired outcomes to be achieved in an adverse context (such as a local financial crisis) if the mechanisms used, abilities of individuals, and their inter-relationships can overcome these barriers. Similarly, desired outcomes will not necessarily be achieved when the context is favourable if key aspects of mechanism are missing.

The range of achievements in the case study TPPs reflects a complex mix of mechanisms and contexts with some TPPs being better able than others to achieve outcomes of similar ambition in comparable contexts. A further factor, that of time, should also be recognised as an important influence on the ability of projects to achieve objectives since neither mechanisms nor contexts are static. For example, the quality of relationships between TPPs, trusts and health authorities was sometimes poor at the genesis of the pilots. The more able TPPs invested time in developing better relationships, thus improving the context within which they operated. This can be illustrated through TPPs which developed better relationships with their host health authority with the beneficial outcome of greater willingness on behalf of the HA to 'let go' manifest in devolving budgets, generosity and flexibility with resources such as the use of development funds, and greater willingness to provide the TPP with other management support functions.

Figure 6.1 attempts to show the interplay between context and mechanism over time diagrammatically. The vertical axis represents the context in which TPPs operate and the

horizontal axis the mechanisms, or the way in which TPPs went about their business. Where context is termed 'receptive', this equates to an advantageous situation where the ability to achieve objectives is high (or the barriers are low) whilst the opposite is true for 'non-receptive' contexts. Where mechanisms are characterised by 'high ability' this has the effect of making achievements more likely, the opposite being true for a process characterised by 'low ability'.

The cells in figure 6.1 represent the likely consequences for a TPP. Thus, where context is 'receptive' and mechanisms 'appropriate', the more likely it is for achievements to be made. TPPs that have moved closest to this optimal scenario are those that have achieved more.

Figure 6.1 Achieving objectives in total purchasing - the interplay between context and mechanism

CONTEXT	Inappropriate	Appropriate
Receptive	**UNDER-ACHIEVEMENT** Individuals and groups running TP unable to make changes despite receptive context for change *Mechanism Issue*	**OPTIMAL ACHIEVEMENT** Receptive context and appropriate mechanisms lead to change
Non-receptive	**LOW/NO ACHIEVEMENT** *Mechanism and Context Issue*	**STIFLED ACHIEVEMENT** Individuals and groups running TP able but non-receptive context for change hinders potential progress *Context Issue*

MECHANISM

Box 6.1 provides an example of the optimal scenario - that is a TPP which has established a mechanism for achieving change within a receptive context. Taken from service development 10, this case study TPP in the example aimed and succeeded in providing a more integrated community and practice nurse service (see also Wyke, Mays, Abbott et al, 1999)

Most case studies have struggled to reach the optimal scenario since a mix of contextual and mechanistic problems have restricted progress. The top-left cell in Figure 6.1 describes a situation in which the context for change is 'receptive' but where 'inappropriate' mechanisms have been employed. In such circumstances, some aspects of mechanism have blocked progress. Examples would include:

- lack of key leaders and willing partners;
- poor inter-organisational relationships;
- not contracting independently.

Box 6.1: An example of a receptive context and appropriate mechanisms

Service development 10: integrated care project to reduce inappropriate admissions and promote early discharge

Aim
To provide a more integrated community and practice-based nurse service; to set up an intermediate care scheme to prevent delay in discharge and reduce emergency admissions

Context
- Large non-locality TPP in an urban area
- Good cultural context: good HA support and positive self-image
- Good political context: TPP strengthened when policy changes on fundholding and PCGs announced
- Good historical context: history of working together
- Mixed geographical context: TPP practices widespread with pockets of deprivation
- Poor financial context: large financial deficit in HA

Mechanisms
- Tendered for new contract with community trust
- Evidence-based approach through literature review and audit of A&E
- Sophisticated contracting: acute contract capped to divert 4% to fund scheme
- Employment of hospital discharge co-ordinator
- Developed database of vulnerable patients' social and health details

Outcomes
- Change in provider
- Intermediate care scheme operational since 1997
- Increase in use of scheme by general practitioners (86%)
- 10% of acute admissions diverted to spot purchase beds helping to reduce the rate of emergency admissions
- Increased admission rate to intermediate care by almost 100%

Any achievements made in these circumstances are likely to be sub-optimal even though the context within which the project was operating was favourable. For example, one of the case studies (service development 4) set up a multi-disciplinary rehabilitation team based in a local community hospital with the aim of promoting independent living amongst older people. The TPP established the rehabilitation team, but the innovation did not reach its full potential since the acute trust was resistant, being particularly unwilling to alter contract currency (see also Wyke, Mays, Abbott et al, 1999).

The scenario presented in the bottom-right cell in Figure 6.1 describes the situation in which contextual barriers have proved problematic to overcome despite the existence of mechanisms which in other circumstances would have been catalysts for change. Examples of contextual barriers include opposing organisational cultures, national/local opposition to service changes proposed, under-developed management structures and IT systems, and an unfavourable local financial environment (see Table 6.1 for a fuller range of key 'non-receptive' contextual variables). Any achievements by TPPs in these circumstances are likely to be despite the contextual difficulties faced.

Many TPPs have managed to achieve objectives in negative contextual conditions which would suggest that they 'over-achieved' relative to context and that more could have been achieved if some of the contextual barriers had been taken away. More pertinently, it has been easier for projects to improve the appropriateness of mechanisms employed than changing wider contextual constraints. An example of 'stifled achievement' is shown in Box 6.2 which relates to a TPP wishing to work with other agencies to provide integrated management of primary care for the development of more accessible local services. In this case, key contextual barriers to progress were a poor cultural context manifest in secrecy and mistrust between key agencies, and a poor financial context which inhibited the ability to agree a basis for funding the service innovation.

The final cell in figure 6.1 describes the worst scenario - a 'non-receptive' context and 'inappropriate' mechanisms. None of the case study TPPs were wholly in this group, many investing time on developing appropriate mechanisms - such as organisational arrangements, information systems, relationships with external agencies - which in turn helped mitigate

contextual barriers. It should be noted that investment in mechanisms ultimately helps TPPs to develop since contextual barriers can only be overcome when the appropriate mechanisms are in place.

Box 6.2: An example of stifled achievement

Aim
To work with other agencies to provide integrated, primary managed care to enable the provision of accessible services in primary care and in the local community hospital.

Context
- Small, two-practice, TPP in rural area
- Poor cultural context: poor HA support (unwilling to delegate budget); atmosphere of secrecy and mistrust between key individuals in TPP, HA and Trust - inter-agency co-operation at operational but not at strategic level
- HA concern over destabilisation of acute monopoly provider
- Good historical context: history of working with voluntary sector and history of service developments in community care
- Poor financial context: notional budget only, no agreement on basis of funding reached

Mechanisms
- Sophisticated contracting: preferred provider and referral matrix; financial incentives; monitoring
- Information from Trust - but could not resource developments through transfer from acute trusts

Outcomes
Initial progress radical:
- TPP ran community hospital
- Joint working with voluntary sector
- Integrated approach to mental illness services across primary, community, social and secondary care boundaries
- Intermediate care for chronic illness
- Innovative approach to care for older vulnerable people

Reversal in progress over time:
- negotiations on budget halted and became bitter
- project halted prematurely - independent enquiry blamed poor clarity of aims from HA

6.5 Conclusions: explaining progress and achievement

This section has revealed that a key feature of the progress of case study TPPs has been the context within which they operated and the effectiveness of the mechanisms used to achieve objectives within these contexts. Explaining progress and achievements is thus a complex process, not least because some contexts appear to have had a more significant impact than others.

National policy and political change has been particularly important in the ability and motivation of the TPPs to achieve progress since most were faced with the prospect of developing larger organisations, involving other local practices, or splitting to be part of several new organisations. The ability of the smaller case study pilots to progress their TPP goals was adversely affected by the PCG agenda. On the other hand, a few of the larger pilots felt empowered to continue their current set-up. The greater progress made by larger TPPs as opposed to smaller TPPs certainly reflected the national political context.

Explaining progress and achievement for each individual case study TPP, however, revealed a far wider combination of contextual factors. Moreover, the types of mechanisms used to achieve change also had an important impact on the ability to make progress. A crucial point to make is that different contexts require different mechanisms in order to achieve similar objectives. Policy makers should bear this in mind since the implication of this finding is that the top-down imposition of overly-tight organisational or management frameworks will most probably be insensitive to the necessary variations in approaches that are needed in different contexts. Therefore, if one considers the development of PCGs and other new forms of primary care organisation, certain flexibilities and freedoms will be required in their development to cope with local circumstance.

Policy makers will need to face up to the possibility that new primary care organisations will want substantially to alter the shape, size, and structure of their organisations as well as the structure of the providing networks around them (e.g. acute trust workloads). Consequently, if national initiatives are not sympathetic to such flexibilities, primary care-led commissioning is unlikely to reach the optimum scenario. Taking this argument to its logical conclusion, it would

suggest that the key role of policy makers should be to set the strategic direction of primary care-led purchasing (the 'direction of travel'), outline the mechanisms which primary care organisations might use and support and facilitate the process of development. Policy makers, however, should also embrace the need for local flexibilities and should not dictate the mechanisms employed. If this analysis proves correct, it casts some doubts on the efficacy of the increasingly centralist approach of Government to the organisation and functions of PCGs and of new primary care organisations in general.

7 CONCLUSIONS: IMPLICATIONS FOR FUTURE PRIMARY CARE-BASED PURCHASING ORGANISATIONS

What has really mattered in the ability of the case study TPPs to make progress? One might conclude from the context/mechanism debate (chapter six) that the essential mechanisms for success vary by pilot and thus generalisations to TP as a whole become meaningless. However, whilst this is true in part, it is possible to tease out from the case studies a number of generic success factors for TP. In operational terms, the following characteristics were associated with achievement:

- the ability to hold and use budgets;
- the availability of adequate management resources;
- good relationships with external agencies, particularly the health authority;
- effective management systems inclusive of a skilled project manager, a professional support team, and appropriate IT systems;
- the presence of product champions both within the TPP but also in HAs and Trusts;
- a strong dynamic executive management team;
- the inclusivity of stakeholders to provide project sustainability and cohesiveness;
- the engendering of a collective responsibility and corporacy within the TPP manifest in shared vision and trust;
- a positive national and local context, particularly the national political context.

In practice, few case study TPPs exhibited all of the above characteristics. Nevertheless, as new primary care organisations are established, their success will be dependent on their ability to succeed in all these areas since the inability to foster any one of these characteristics can, and has, acted as a barrier to progress.

In terms of developing specific services, the case study investigations also shed light on the more appropriate methods. For example, developing services in which there is vested local interest or enthusiasm were usually more successful than more strategic objectives. This reflected the continued primary care focus of most of the case study pilots.

The implications of these findings for the future success of primary care organisations are numerous (see Wyke, Mays, Abbott et al, 1999). Given the centrality of primary care to the Government's agenda for the NHS, new primary care organisations are likely to face a more facilitative political and cultural context than TPPs. However, as was concluded in chapter six, policy makers must be careful in the extent to which they dictate the terms by which new primary care organisations operate since there is a clear need for local flexibility to deal with differing local contexts. New primary care organisations must also be given time to establish themselves and develop maturely before further radical changes are considered.

Since it has been established that primary care organisations will be highly sensitive to national shifts in policy, it is essential that, like adding a new ingredient to an evolving recipe, new initiatives are complimentary to the whole. Under TPP, for example, *Changing Childbirth* (Department of Health, 1993) was particularly influential in providing TPPs with guidelines for service development. The introduction of initiatives such as National Service Frameworks and *Modernising Social Services* (Secretary of State for Health, 1998) may therefore have an important impact on the way in which local services and commissioning are developed. Whilst it is inevitable that some conflicts may arise between local needs and wider strategic objectives, new initiatives should, wherever possible, seek to avoid unnecessary discontinuities.

Finally, the NHSE, health authorities and boards will need to be prepared for the demands of new primary care organisations. In particular, new primary care organisations are likely to want to alter the size, shape and scope of acute trusts. If this is not tolerated and supported by national and local policy there will be little point in having primary care-led commissioning at all.

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