King's Fund

National Evaluation of Total Purchasing Pilot Projects Working Paper

Total Purchasing and Community and Continuing Care: Lessons for future policy developments in the NHS

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

The Total Purchasing National Evaluation Team (TP-NET)

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

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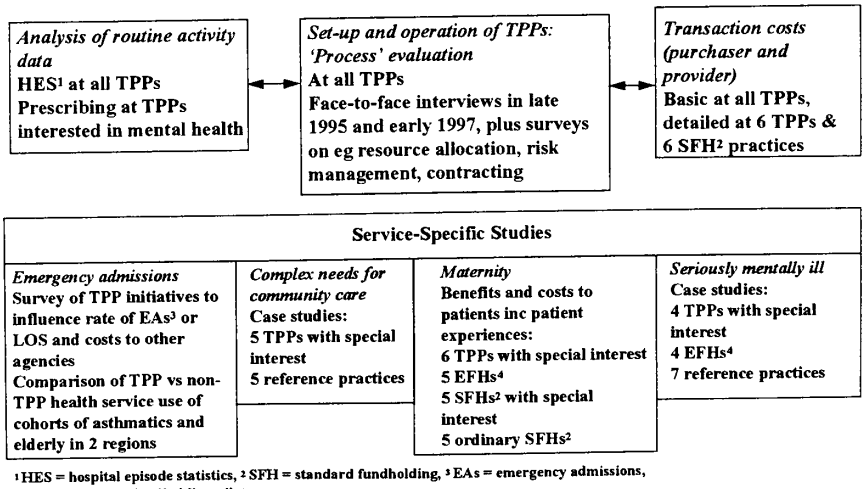
Preface: The National Evaluation of Total Purchasing Pilot Projects

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 on page iii.

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)
King's Fund, London
January 1998

National Evaluation of Total Purchasing Pilot Projects
Main Reports and Working Papers

Title and Authors	*ISBN*

Main Reports

Nicholas Mays, Nick Goodwin, Gwyn Bevan, Sally Wyke on behalf of the Total Purchasing National Evaluation Team (1997). *Total purchasing: a profile of the national pilot projects*	1 85717 138 1
Nicholas Mays, Nick Goodwin, Amanda Killoran, Gill Malbon on behalf of the Total Purchasing National Evaluation Team (1998). *Total purchasing: a step towards primary care groups*	1 85717 187 X

Working Papers

The interim report of the evaluation, *Total purchasing: a step towards primary care groups*, is supported by a series of more detailed Working Papers available during the first half of 1998, as follows:

Nicholas Mays, Nick Goodwin, Gill Malbon, Brenda Leese, Ann Mahon, Sally Wyke *What were the achievements of total purchasing pilots in their first year and how can they be explained?*	1 85717 188 8
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1 Defining the problem

The gap between rhetoric and reality within the National Health Service (NHS) has been nowhere more evident than in the field of Community Care. As Richard Titmuss pointed out some forty years ago:

> *In the public mind, the aspirations of reformers are transmuted by the touch of a phrase, into hard-won reality and what of the everlasting cottage-garden trailer, 'Community Care'? Does it not conjure up a sense of warmth and human kindness essentially personal and comforting, as loving as the wild flowers so enchantingly described by Lawrence in Lady Chatterley's Lover?* (Titmuss, 1961, p.104)

Clearly, this description is a long way from the reality of community care in the 1990s. The problems were well summarised in the Audit Commission's report in 1986, which defined Community Care as being about *'changing the balance of services and finding the most suitable placement for people from a wide range of options'* (Audit Commission 1986). The report noted that although there has been worthwhile progress in some areas and most authorities have at least made a start *'care in the community is far from being a reality in many places'.*

In response to the problems identified in the Audit Commission's report the NHS and Community Care Act was passed in 1990. The Act aimed to promote a shift from residential to home care; greater choice and independence for people in need of continuing health and social care; and needs-led rather than professionally defined services. Services were to be responsive to users and carers and proper client assessment and good case management were to be cornerstones of high quality care (Department of Health, 1989).

Following the passing of the NHS and Community Care Act (1990) a wide ranging reform of the Community Care landscape has been undertaken. Subsequent policy developments have served to reinforce and complement much of the care in the community legislation of 1990. Most notable has been the guidance for health and local authorities to develop and implement plans for the provision of NHS continuing care (Department of Health, 1995a and b), and guidance on joint commissioning between health and local authorities (Department of Health 1995b; Poxton, 1996). However, some eleven years on from the Audit Commission's report, and seven years since the legislation was passed, many problems associated with the effective implementation of community care policies seem as intractable as ever. This is despite the fact that it is possible to identify from the considerable literature researching and debating the

issues what might be termed a 'policy consensus' around the developments that would be needed to deliver this important policy agenda.

2 The policy consensus around continuing and community care

The consensus around what is required to develop and implement community care policy is bound up with two key questions: who has a legitimate right to define community (and now continuing) care needs; and who has an obligation to develop and implement the policy agenda in this field?

User and carer defined needs

User and carer empowerment and the facilitation of choice and self determination are of central importance in the policy consensus around continuing and community care. The Community Care legislation and related policy guidance (Department of Health, 1990) has clearly signalled the central place for users and their carers in identifying community and continuing care needs and in deciding how these are best met. Users should be centrally involved in planning and monitoring care at both macro (population) level through involvement in strategic planning and commissioning groups and at micro (individual) level through needs assessment processes which emphasise user defined rather than professionally defined need. The extent to which Community Care initiatives seek to involve and empower users and their carers is an important criteria by which they can be judged (Griffiths, 1988; Department of Health, 1991a).

Obligation to develop and implement policy and provision

Since 1993, when the policy requirement for assessment and care management took statutory effect, formal responsibility for developing and implementing community care policy has rested with local authorities. However, they are required to collaborate closely with health authorities and to consult a wide range of other interested parties, including the voluntary and provider sectors. In the same way, whilst health authorities are responsible for producing policies and eligibility criteria for NHS continuing care, they are required to do this in collaboration with local authorities - whose agreement they were asked to obtain - and in consultation with other stakeholders. These collaborations should result in joint strategies for community care which should be based on population level assessment of need for care rather than simply responding to existing demand. This means that priority setting should be a critical agenda item for discussions of joint community care plans (Department of Health, 1991c).

Thus the consensus that has emerged regarding the development and implementation of continuing and community care policy is crucially dependent upon inter agency collaboration and partnership. This partnership is expected to include primary care practitioners, particularly

general practitioners (Department of Health, 1994) and indeed the Labour Government's plans extending general practitioner commissioning more extensively to include community care aim to break down the barriers that separate it from health care (Warden, 1997). Currently, whilst local authorities have a legal obligation to develop and implement policy, general practitioners can be argued to have an equally compelling 'presumptive obligation' at least to deliver continuing and community care to their patients. This delivery is expected to include: involvement with health authorities and local authorities in the development of the local policy agenda; involvement in joint individual needs assessments and commissioning of care to meet these needs; and involvement in the direct provision of care, through the co-ordination of services, through streamlining hospital admissions, discharges and information systems (Leedham and Wistow, 1992; Department of Health, 1994; Pearson, 1994).

A variety of approaches aimed at meeting the policy obligations have emerged, but all involve joint working between the NHS and local authorities and recognise a need for integrated purchasing, integrated provision, or both. Integrated purchasing involves the integration of actual, or indicative, health and social care budgets, resulting in a form of economic management of 'total' packages of care for individuals across the primary, secondary and community care interfaces. In theory, this would be informed by both strategic needs assessment and individual care management processes. Integrated provision involves horizontally integrated services from well aligned health and social care teams working in the community and vertical integration between community, primary and secondary care services. The ultimate result of such joint working would be a form of total managed care across sectors with users and carers centrally involved in all aspects of the process, including setting and monitoring quality standards (see Myles *et al* (submitted 1997) for a more detailed discussion of managed care in this context). The key issues in the emerging policy consensus are summarised in Box 1.

Box 1. Key points of policy consensus around continuing and community care

- Joint commissioning between the NHS and local authorities is essential to achieve integrated care both in the community (horizontal integration) and between hospital ad community (vertical integration).
- Commissioning should be informed by both population level needs assessment and individual care management approaches.
- Users and carers should participate in the development of continuing and community care policy and their own definitions of care should shape individual packages of care.
- Primary care and general practitioners in particular, have a key role to play in the commissioning, co-ordination and provision of continuing and community care.

3 The potential for total purchasing to deliver the policy consensus around community and continuing care

It was against this background in the development of policy for continuing and community care that total purchasing was introduced into the NHS in autumn 1994, with the 53 'first wave' total purchasing pilot projects (TPPs) starting their development in April 1995 (see TP-NET 1997, and Mays *et al* 1997, for detailed descriptions of the introduction of total purchasing and of the characteristics and main aims of the projects). Total purchasing introduced significant new opportunities for general practitioners to be involved in both the strategic and operational development of community and continuing care for people with complex needs. The TPPs have, in theory, greater power and responsibilities for the commissioning and purchasing of community and continuing care services to meet the policy goals, than is available to other general practices.

TPPs are formally part of their health authorities, as sub-committees with varying levels of autonomy (TP-NET, 1997). As such, they could be charged with, or take up, the responsibility for strategic joint developments with social services departments which are currently the responsibility of health authorities. They have the potential to use their whole budget flexibly and strategically to provide, or purchase, services designed to prevent expensive crises, including hospital admission and subsequent need for long term continuing NHS care or nursing home care. The need for services which might prevent deterioration or crises, and maintain quality of life, could be identified in the defined population registered with TPP practices, and these services (such as respite care, carer support services, day care services, domiciliary support) could be purchased and/or provided. If they have good local contacts and networks, general practitioners within TPPs have the potential to work with users' and carers' groups at the macro level in the planning of services, and also at the micro level insisting upon joint needs assessments which give priority to users' and carers' defined needs rather than needs defined by professionals.

Thus, total purchasing is, arguably, one of the most important developments in the community and continuing care area. The question is the extent to which it can deliver some, or all, of the features flagged up within the policy consensus on what constitutes 'good' continuing and community care from within the literature and practice. This is the landscape against which TPP initiatives in relation to continuing and community care must be assessed. It clearly defines the issues with which the TPPs have to engage if they are to make significant inroads in this complex area. The evaluation of TPP initiatives in the field of continuing and community care was therefore designed to begin to provide answers to three key questions linked to these issues:

- to what extent were the TPPs aware of the policy consensus that has emerged in relation to the planning and delivery of continuing and community care services and was this reflected in the motivations and/or philosophy underpinning their initiatives?;
- are the TPPs involved in joint commissioning to developing a) integrated purchasing and b) integrated providing arrangements and are these informed by populations based needs assessments?;
- is there any evidence that the TPPs are seeking innovative ways to involve and empower users, carers and/or voluntary agencies in their continuing and community care plans?

This working paper aims first of all to begin to address these questions using data collected from five case study TPPs which had decided to focus on continuing and community care in their preparatory year (1995-96). It goes on to examine the importance of historical relationships and of control over budgets and contracts as levers for change in continuing and community care at the case study projects. Finally, some of the key issues for future policy development are drawn out in the context of the newly emerging labour health policy.

4 Methods

Case study approach to collecting data from TPPs

Because total purchasing was set up with no national 'blueprint' for development (Mays *et al,* 1997), and because we did not know how TPPs would go about the development of continuing and community care services, we needed an approach to data collection which gave us flexibility to examine both the structures and processes being established by TPPs, and to gain some understanding of the experiences, perceptions and actions of a range of actors working in numerous agencies. We also needed to be able to follow leads provided by the projects in the early part of the fieldwork so that a detailed picture of the development of continuing and community care services in each total purchasing project could be built up. A case study approach (Yin, 1994) allowed us to use data from a range of sources to do this. However, the case study approach is labour intensive, fieldwork is time consuming, as is the analysis of multiple sources of data. For this reason, the number of projects sampled for in depth study was limited to five. The main sources of data were semi structured interviews with a range of participants working in a range of settings with a range of different agencies; non participant observation of key meetings; and collation of documentary evidence. (For more detailed description of the data collection methods used see Appendix).

Sampling of cases

Nineteen out of the 53 'first wave' TPPs were actively engaged in developing continuing and community care services in 1996/7 (TP-NET, 1997). Telephone interviews were conducted with project managers at each of these 19 TPPs, which gathered information about the services they were planning, the organisational framework for implementing these plans, where they got information from to inform their developments, progress with developments of contracts for care, relations with their local health authority, relations with their local authority social services department, local market conditions for community care, and any problems they had so far encountered in implementing their plans. These data allowed an assessment of whether the projects seemed to be adopting a strategic or operational approach to developments, and whether their relationship with their social service department was likely to facilitate or hinder the progress of the developments. The five case study projects were thus sampled to include two TPPs adopting a strategic approach to service development (having contact with social services departments at senior level); two taking an operational approach (no contact with senior staff working in social services departments, changes being developed 'on the ground'); and one which appeared to be operating at both the strategic and operational levels. The case study projects also reported a range in the quality of relationship with social services departments.

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Analysis

Profiles of each case study project, using all three sources of data, were constructed, drawing on both a priori and emergent themes from the data. They outlined: the local context for the development of continuing and community care services (market factors, perceptions of strengths and weaknesses of historical provision); the TPPs previous initiatives in community care; motivations for focusing on continuing and community care as part of their TPP strategy); details of the TPPs initiatives; the information base to support their developments; organisational arrangements; extent to which developments were different from other developments in the health authority area; interagency relationships; budgetary and contracting issues; and perceptions of enabling and disabling factor in the developments. These features of the development of continuing and community care services at the 5 TPPs were examined case by case to answer the three questions posed above, and to investigate possible explanations for the TPPs current state of development.

5 Findings

The TPP case studies

The five case study projects were located in the South, the Midlands, and the North of England and in Scotland. They varied in size from one general practice including 7 GPs and 16,000 patients, to 4 practices with 46,000 patients. Two of the projects attracted deprivation payments. The proportion of the practice populations aged 75 and over varied from 4.7% to 11%. There was also diversity in terms of local NHS and social care markets. Tables 1-5 provide summary information on the five case-study projects, including information on: the characteristics of the practices involved; details of the continuing and community care initiatives they were focusing on; the extent to which they were developing integrated purchasing and integrated provision of care; motivations for choosing to focus of continuing and community care; and whether there was any explicit reference to key elements of the CCC policy consensus described earlier (tables situated at end of section 5). The tables also summarise the historical relations at the project and the extent to which holding budgets and contracting were used as levers for change.

TPPs' awareness of the policy agenda

There was relatively little explicit reference by the TPP respondents to national community care policy initiatives or to relevant documentation or guidance. Indeed, there were few examples where respondents were able to give direct answers to questions concerning the TPPs motivations and/or their philosophy for developing work in the community care area as a priority for the early stage of total purchasing. Most respondents thought that the general practitioners were responding to problems they identified that their patients commonly experienced in their attempts to access good quality, seamless community services. Researchers' notes on the motivations for involvement in community care at project A make this point:

> *Working towards providing patients with a seamless service and building on previous developments for a practice based multidisciplinary team were the main motivations for the TPPs involvement in community care.* (Notes, motivations, Project A).

Only one of the general practitioners at the 5 case study TPPs were actively involved with health authorities in defining eligibility criteria for continuing NHS care (Project A) although general practitioners at 2 TPPs (D and E) were consulted on them. All 'blocked back' this element of service commissioning to their health authority. The main reasons given for this decision were the high cost and therefore risk associated with these clients; the absence of

information to inform purchasing and contracts; and the complex inter agency 'politics' involved in negotiations over funding responsibilities for continuing care needs. However, their lack of involvement indicates a lack of engagement with policy around joint planning for NHS continuing care.

This said, it was clear that the *initiatives* projects were developing addressed some of the major themes underpinning the wider community care agenda. For example, most of the TPP respondents - both GPs and project managers - had an understanding of the need for joint working between health and social care at the level of individual patients. This was directly linked to general practitioners' awareness of problems experienced by individual patients in accessing social services. For example, a respondent from TPP B spoke about the difficulties in co-ordinating services:

> *Services have not been co-ordinated very well, with everyone doing their own thing in isolation. Services are there if you can find them, but they are not easy to access.* (TPP2, Project B).

This concern with lack of co-ordination of services at patient level was reflected in the initiatives the case study TPPs sought to develop. Most of the initiatives focused on including social work within the primary health care team (at projects A, C and D) or close working in a joint 'proactive care team' or community mental health team (at projects B and E), though the extent to which they were intended to act as care managers with delegated budgetary and purchasing responsibilities, rather than as co-ordinators and/or providers of services, varied between the TPPs.

Thus the majority of the initiatives being developed appear to be directed at improving the co-ordination of existing services at the patient level, rather than developing new services or addressing strategic policy issues. In some instances, however, the TPPs focus on the experiences of individual patients had clearly led to more strategic working higher up in the key statutory agencies and, in one instance, to voluntary sector involvement at project B (albeit that this had resulted from a chance encounter between a TPP GP and voluntary sector representative at a local meeting). Some of the social services and voluntary sector respondents recognised potential in the patient focus of TPPs as a driver for change at a more strategic level. For example, when answering a question about the TPPs motivations for developing community services a respondent from a voluntary agency at project B stated:

> *the doctors knew that the service was breaking down quite dramatically, and they were all sensible enough to know that this was not going to change, not unless we get a change of government, and maybe not even then. So the onus is now on much more localised care from the GP surgery.* (VO2, Project B).

Improving efficiency and securing value for money were also prominent themes articulated by TPP respondents and underpinned many of the initiatives. For example, numerous accounts were given of a wish to reduce the TPPs use of acute beds and to 'unblock beds' through improved discharge procedures and through work to reduce emergency admissions (see Tables 3 and 4 in particular).

Joint commissioning based on population-based needs assessment for integrated purchasing and provision of continuing and community care

Four of the projects identified closer working with social services as a key aim in their developments, and by the time of our interviews, early in their first live year of purchasing, they had developed some joint working with them. Evidence for this is provided by projects A, C and D which had agreed with social services to bring care management or social work into their practices, these were also jointly funded by the TPPs and social services. A fifth project, E, was also using their TPP budget to support an auxiliary worker providing social care services within their local community mental health team.

In some cases this joint working had improved relationships between social services and the TPP. For example, the local social services department at project A had long standing good relationships with the health authority, but were initially distrustful and cynical regarding the motivations of total purchasing general practitioners. Involvement with the TPP helped to overcome this initial distrust, as described by one social services respondent:

> *there is now an atmosphere where all parties feel that they can trust each other and could feel that they could even take risks.....[this is because the TPP had] enthusiasm, flexibility, a positive attitude, and genuine interest in co-working which has overcome our initial caution"* (S1, project A).

However, as noted above, most of this joint working is taking place at an operational level and is designed to overcome problems TPPs perceived for patients in their practices. It should also be mentioned that at one project (B) there was no contact between TPP and social service department at any strategic level at all - the only contact they had was with a care manager who attended the PACT meetings (see Table 2 for a description of PACT).

Population-based needs assessments

None of the case study projects were involved in macro level strategic needs assessment with either their local health authorities or local authorities. Likewise, they had not undertaken any systematic practice population needs assessment or priority setting exercises. Rather, general

practitioners appeared to be 'demand led' in their desire to improve community care services for their patients - they saw that there were obvious problems with the current system and sought to 'fix' them. They were clearly not taking a population perspective to prevention by identifying needs for services which might prevent deterioration or crises in the whole TPP defined population.

Integrated purchasing

Many of the TPP respondents recognised the difficulties that separation between health and social care budgets brought. For example, in response to a question about the strengths and weaknesses of services prior to total purchasing, a general practitioner described the historic weaknesses as:

> *Bed blocking, overall lack of money and divides between health and social care moneys, with one being means tested and the other not* (GP2, project D).

In talking about the potential of joint budgets, this general practitioner went on to say:

> *This is something we would like to work on. This might be in the next year, when we have had a chance to identify the problems. I would like to see joint budgets with social services and with housing.* (GP2, project D).

However, at the time of fieldwork, during the first 'live' year of purchasing, the only evidence of actual integrated purchasing by TPPs with social services, was at project E, at which the TPP was financing contingency social care arrangements during peak holiday times. These arrangements were not, however, formalised via actual or indicative joint budgets between the TPP and social services department.

Although existing developments around integrated purchasing were fairly limited, four of these projects had begun to investigate the *potential* to undertake more comprehensive integrated purchasing. For example, projects A, D and E had begun work on costing total packages of health and social care, breaking down social care costs to the practice level, with a view to agreeing joint budgets, thus removing the artificial health and social care budgetary divisions which they found to be constraining, and allowing them to extend their integrated purchasing efforts. Projects C and D had gone a little further, in that, they had begun tentative discussions with their social services departments around different ways of managing admissions and discharges which would involve integrated purchasing of joint transitional care arrangements, with joint funding. However, these discussions were clearly at an early stage (see Tables 3 and

4). Project B appeared not to have considered pursuing integrated purchasing via actual or indicative joint health and social care budgets, as yet.

Integrated provision

As described earlier, integrated provision would encompass both horizontally integrated services from well aligned health and social care teams working in the community, and vertical integration between community, primary and secondary care services. Three projects, E, B and A, had developed fairly sophisticated models of integrated provision, both horizontally and vertically. Project E's model of integrated community care, which involved developing a multidisciplinary day centre at the local community hospital linked in with the education and housing sectors, was most advanced, although it had been being developed for several years. However, complete implementation of integrated provision at this project is dependent upon the upgrading and new build of facilities (see table 5). Project B's PACT model was also more holistic, focusing well beyond health care considerations, incorporating input from housing associations, the borough council and a recently appointed carers' adviser working for a voluntary agency. Once again however, this model predated TPP (although it had been significantly extended) (see table 2). Project A's elderly resource team model appears at first glance to be narrower, focusing mainly on planning health care. However, considerable input was also expected to this team from the project's community care co-ordinator, an experienced social worker, with direct access to a budget which would serve to broaden out the team's focus (see Table 1).

Sites C and D had also developed integrated provision, but to a lesser extent. They were both addressing vertical integration through a focus on discharge planning. Tentative discussions had also begun exploring the potential for development in relation to transitional care and complete patient career paths through health and social care services but, as noted above, these developments were embryonic. Horizontal integration was being developed in that both of these projects had recruited attached social workers under TPP, however, their remits are fairly narrow and they lack the clear budgetary access routes and entry points to social services associated with similar developments at other projects (see tables 3 and 4).

Overall, projects E and A seemed to exhibit most potential to achieve both integrated purchasing and provision, however, quite a lot of further development was still necessary. Project B had made considerable inroads in developing integrated provision, but had still a fair way to go in terms of integrated purchasing. Conversely, projects C and D were beginning to explore interesting models to secure integrated purchasing but fell down in terms of integrated provision.

Involvement and empowerment of users and carers and the involvement of voluntary agencies

There was some understanding of the importance of user defined needs by general practitioners expressed at a rhetorical level. For example, when asked about motivations for focusing on community care as a part of TP, a general practitioner at project B said:

> *to identify and select out vulnerable groups in the patient population to ensure that they [the practices] take account of their actual needs, rather than the practice's perception of their needs, and to deliver these in a co-ordinated way.* (GP1 Project B).

However, there was no evidence that any of the TPPs were developing specific initiatives to ensure that users and carers defined their own needs in the way that joint assessments were carried out. Indeed, few respondents at any of the TPPs explicitly mentioned their approaches to joint needs assessments at the individual patient level, even when the subject was raised by the researcher.

There is clearly scope for lay involvement, in the planning of initiatives for the TPP populations, in the same way as health authorities are required to 'listen' to local people in their needs assessment processes and in planning the commissioning of services. However, at only one of the projects was there any evidence of the involvement of the voluntary sector in planning developments. The health and local authority with which project E works has set up Community Care Forums in each locality, and it has been long active in project E's area. the Forum encompasses both individuals and voluntary agencies, and was actively involved in the planning of community services based in the local community hospital. At project A, a CHC representative was invited to the overall project board meetings, but their views on the development of community care were not explicitly canvassed. Thus only at project E was the voluntary sector considered anywhere near an equal or key partner in primary and community care. Further, in a few instances, TPP respondents explicitly noted that they felt the direct input of patients and carers would not be of value. For example, a general practitioner at project B outlined why he felt that consultation with patients or voluntary groups was not necessary and would be difficult:

> *We feel that we have patient representation through our 12000 patients, most of whom we see at least once every 3 years, and for the most vulnerable groups, at least half a dozen times a year. We pick up from this what our patients needs are. To go out and get a small sub-group of them to tell us what they want is not the slightest bit representative and is heavily bureaucratic. .....In reality we do*

> *liaise with patients, and to try to make it 'PC', to try to have patient user groups, I'm afraid just doesn't wash.* (GP2, project B).

More frequently, however, there was a sense that such involvement happened as an afterthought or that they had not had time to think about this aspect of purchasing yet. For example a respondent working at the TPP at project C said:

> *The GPs will use the voluntary agencies but they would rather go through the conventional channels first.* (TPP3, project C)

One explanation for general practitioners' lack of engagement with participative approaches to development may be that they have long been told that they are 'good purchasers' because they are 'closer to the patient' than health authority purchasers. Whilst there is no evidence that general practitioners, used to responding to demand rather than need for care, are good at understanding the health needs of their whole practice population (as opposed to the needs of those who visit them), they may *believe* themselves to be good proxies for their patients, and so do not need to involve them as individuals or as groups in defining either individual care needs or service developments. This was certainly the case for the general practitioner at project B, quoted above.

Thus, it seems that the case study TPPs motivations for getting involved in the area of community care, and the philosophy underpinning their approach, was centrally concerned with efficiency and effectiveness; appropriateness, at least as defined by patients and their carers was still largely to be addressed. Alternately, one could argue that appropriateness was assumed by the TPPs to be self-evident. However, this is an assumption that needs to be explored further.

Box 2 summarises the findings from the 5 case study TPPs in relation to the questions about their ability to deliver the policy consensus around continuing and community care.

Box 2. Summary of findings

Progress of the case study TPPs in relation to delivering the policy consensus around continuing and community care within their first 'live' year of purchasing in 1996-7?

Awareness of policy consensus

- Little reference to national or local policy initiatives.
- Minimal involvement in definitions of eligibility for continuing care; all continuing care 'blocked back' to health authority.
- Operational level initiatives did address some of the policy issues, in particular a recognition of the need for joint working at the practice level.

Population based needs assessments

- No systematic population based needs assessment.
- Demand led understanding designed to 'fix something that was obviously broken'.

Joint commissioning - integrated purchasing and provision

- Some joint planning, with 'closer working with social services' a key aim at 4 of the 5 case study TPPs.
- By autumn 1996, only one case study TPP had undertaken any joint purchasing.
- Four case study TPPs had begun to investigate the potential for integrated purchasing.
- Three case study TPPs had relatively sophisticated models of both horizontally and vertically integrated provision of care.

Involvement and empowerment of users and carers and voluntary agencies

- Little explicit mention of joint assessments based on user defined needs.
- Voluntary agency consultation at only one of the 5 case study TPPs.

Table 1 - Case Study A

	CHARACTERISTICS OF THE TPP AND INITIATIVES	AWARENESS OF POLICY CONSENSUS	HISTORICAL RELATIONSHIPS	BUDGET ISSUES, LEVERS FOR CHANGE AND CONTRACTS
Field work dates: May-June 1996 **Number of Interviews:** 13	**The TPP Context** • Single practice; 7 GPs; 16,000 patients (3.4% of HA pop). Two surgeries, geographically distanced. • Second wave fundholders. • 46% population attract Jarman deprivation payments. • 4.7% population >75 years old. **CCC Initiatives** ***Integrated purchasing*** • **Community Care Co-ordinator** funded jointly by TPP and Social Services. • Started work on costing total packages of health and social care. • Overall TPP budget not agreed at time of interview so could not integrate health and social care budgets. ***Integrated provision*** • **Community Care Co-ordinator** based at practice as part of PHCT, but managed through social services. • Will facilitate and co-ordinate care between PHCT and social care staff. • **Elderly Resource Team** will gain input from consultant geriatric physician - aims for more proactive care for elderly people. • The team will try to integrate care between community social and health staff and hospital staff. • Co-ordination of health and social care documentation. • Linking TPP and SSD information systems.	**Motivations** • Concerned that patients not getting best service because of lack of communication. • Also mention of discharge difficulties, over reliance on residential care and lack of responsiveness of community health services. • Wanted to develop 'seamless care'. • Wanted to use a multidisciplinary, practice based team to provide this. • Explicitly wanted to include social services in team. **Explicit mention of policy issues** • No macro level strategic needs assessment. • No *explicit* discussion of policy issues around CCC. • Continuing care 'blocked back'. • TPP minimally involved in discussions of eligibility criteria. **User/carer involvement** • Little explicit reference to user/carer involvement or choice. • No direct approach to voluntary sector. • CHC representative on TPP steering group felt useful.	• Good relationships reported between HA and TPP, although support for TP was not unanimous in the HA, this was not experienced as a difficulty. • Initial coolness in relationship between SSD and TPP developed to one of mutual trust. One SSD respondent said there was *"enthusiasm, flexibility, positive attitude and genuine interest in co-working".* • CHC representative on TPP steering committee, but no involvement of other user groups. • Good relationships between HA and SSD over a period of time. • Resource constraints at both HA and LA can be severe.	• Overall TP budget not set at time of interviews. • No progress in identifying a CCC element of overall TP budget. • Most respondents at TP felt that holding a budget was an important instrument to influence decision making. • One TPP and HA respondent felt that as much might have been achieved under joint commissioning, but perhaps at a slower rate. • TPP has moved contract for community health services as part of standard fundholding. • TPP actively contracting for consultant involvement to train the elderly resource team, elderly day care and community geriatric care.

Table 2 - Case Study B

	CHARACTERISTICS OF THE TPP AND INITIATIVES	AWARENESS OF POLICY CONSENSUS	HISTORICAL RELATIONSHIPS	BUDGET ISSUES, LEVERS FOR CHANGE AND CONTRACTS
Field work dates: June 1996 **Number of Interviews:** 10	**The TPP Context** • Three practices; 11 GPs; 23,000 patients (12.1% HA population). • All first wave fundholders. • No deprivation payments. • 7.7% population >75 years old. **CCC Initiatives** ***Integrated purchasing*** • No initiatives designed to achieve integrated purchasing or commissioning. ***Integrated provision*** • **Pro-active care team (PACT)** approach to caring for elderly people initiated by one of the practices pre TPP - they planned to roll it out to other practices as part of TP. • The PACT approach involves 13 multidisciplinary professionals meeting twice a month to review referrals and cases. Key workers, case plan and set review dates used. Unified record cards are used for domiciliary carers. • **Carers adviser post** funded by SSD attends. • Housing association may get involved. • **Discharge liaison/elderly care nurse** is a member of PACT, with a remit to focus on prevention to reduce risk of emergency admission.	**Motivations** • Poor availability of services, particularly for social care because of resource constraints. • Need to improve patient care - historically a focus on a service rather than a user orientation. • To be part of the expansion of primary care "to engineer the reality of primary care led services". **Explicit mention of policy issues** • No macro level strategic needs assessment. • No *explicit* discussion of policy issues around CCC. • Continuing care 'blocked back'. • TPP not really involved in discussions of eligibility criteria. **User/carer involvement** • No apparent user/carer involvement or choice. • Explicit concern about "pc patient user groups" due to feelings that they know patients concerns through contact with patients. • No direct approach to voluntary sector - carer support involvement through "chance meeting". • However, there was support for PACT from voluntary user groups.	• Good relationships reported between HA and TPP. • Despite persistent efforts, it proved impossible to interview anyone from SSD at this TPP. No respondents mentioned any relationships at a strategic level. • Mixed reports of relationships with social workers and care managers at operational level. In PACT it was good, but outside PACT there were difficulties in communication. • HA reports of little understanding of the two cultures between TPP and SSD. Few outside TPP understood what TP is, and few involved in TP understood how an SSD works. • No involvement of voluntary or user groups in development of TP - carers advisor recently joined PACT. • Resource constraints at LA led to severe difficulties in relationship between HA and SSD. a GP said: *"everyone is fighting their corner"*.	• Overall TP budget had been agreed, but no attempt had been made to identify a CCC element to this. • Difficult negotiations with the community trust in relation to monitoring activity. One GP said *"the vast majority of the community budget is going to providers who are having enormous difficulty identifying what it is spent on"*. • Limited awareness of the potential offered by joint social and health care budgets, but no moves to develop these. • All HA and TPP staff felt holding the budget was crucial in effecting change in CCC and other areas. • Original plans to contract for cost per case activity for small percentage of Acute Trust contract were blocked by Trust proposing to recover 100% of fixed costs from block contract activity. TPP plans to achieve a small 'development fund' in this way to concentrate on nursing care at home for people with complex needs were therefore blocked.

Table 3 - Case Study C

	CHARACTERISTICS OF THE TPP AND INITIATIVES	AWARENESS OF POLICY CONSENSUS	HISTORICAL RELATIONSHIPS	BUDGET ISSUES, LEVERS FOR CHANGE AND CONTRACTS
Field work dates: July-August 1996 **Number of Interviews:** 11	**The TPP Context** • 4 practices; 24 GPs; 46,466 patients; (91% patients in one HA, remainder in two others). • First and second wave fundholders. • No deprivation payments. • 11% population >75 years old. **CCC Initiatives** ***Integrated purchasing*** • **Attached social worker** funded jointly by TPP and Social Services, will work mainly as a care manager but with *no devolved budget.* ***Integrated provision*** • The **attached social worker** will focus on improving communications between SSD and TP, so post would be at a senior level. • Management link though SSD, operational link through TPP practices. • **Emergency admission/discharge liaison nurse** aims to work with people with complex needs to: collect views of users and carers; avoid admission; track TP patients through system; arrange discharge, establish a *'clear care career path'*. • Early days in thinking about use of **cottage hospital** - links with SSD for 'stepped care' a possibility. • Patients in **palliative care** have patient held records across all agencies.	**Motivations** • Focus of TPP respondents on motivations for TPP, not about CCC per se. (They want to develop a PHCT, increase care in primary care settings, use resources more efficiently and increase the influence of primary care). • TPP respondents did mention a need for better integration of primary and secondary care sectors and of health and social care. • No philosophy for CCC as such it was *"just something we have got to do"*. **Explicit mention of policy issues** • No macro level strategic needs assessment. • No *explicit* discussion of policy issues around CCC. • Continuing care 'blocked back'. • TPP not involved in discussions of eligibility criteria. **User/carer involvement** • No direct role articulated for voluntary sector. • No explicit reference to involving users or carers. • Discharge liaison nurse would consult carers about options.	• Good relationships reported between HA and TPP. • No contact between GPs and SSD prior to TP. Welcomed the opportunity to develop a relationship through TP. Some TP frustration with speed at which SSD operates. Contact limited to a few SSD staff and at an operational rather than a strategic level. • No consideration of role of voluntary sector so far, but indicated they were considering this for the future. • Local government reorganisation disrupted SSD/HA relationships.	• Overall TP budget not set at time of interviews. Much discussion about TPs share of the cottage hospital budget. • No progress in identifying a CCC element of the overall TP budget. • TPP respondents felt that holding a budget was the key to developing collaborative relationships. • HA acknowledged TPs view, but felt they had influence with HA through 'blocked back' contracts. TPP noted that they were not using their budgetary muscle as they were committed to local providers. • TPP contracted for community nursing services and for 30% share of cottage hospital but almost all of the CCC budget is 'blocked back' to HA.

Table 4 - Case Study D

	CHARACTERISTICS OF THE TPP AND INITIATIVES	AWARENESS OF POLICY CONSENSUS	HISTORICAL RELATIONSHIPS	BUDGET ISSUES, LEVERS FOR CHANGE AND CONTRACTS
Field work dates: August - September 1996 **Number of Interviews:** 8	**The TPP Context** • 5 practices; 24 GPs; 38,832 patients (12 % of HA population). Practices geographically dispersed in HA area. • First and second wave fundholders and part of a multi-fund covering 90% of HA population. **CCC Initiatives** ***Integrated purchasing*** • **Community Care Manager** funded jointly by TPP and Social Services. Able to commission social care at present. • Started work on costing total packages of health and social care with a view to integrating budgets. ***Integrated provision*** • Community Care Manager overseen by joint committee of SSD and GPs. • Will facilitate and co-ordinate care between PHCT and social care staff through active case management. • **Discharge management** through care manager. • **'Patient oriented pathways'** planned to explore different ways of managing admissions and delayed discharge caused by organisational problems. • **Rapid Assessment Unit** which would involve transitional care arrangements and would be joint funded by TP and SSD.	**Motivations** • Working towards a seamless service and working closely with SSD whilst ensuring most effective use of resources were explicit aims of this TPP. • References were also made to the need to integrate primary and community care services. • Reference to the need to address the artificial budgetary divide between health and social care. **Explicit mention of policy issues** • No macro level strategic needs assessment. • No *explicit* discussion of policy issues around CCC. • Continuing care 'blocked back'. • TPP GPs not involved in discussions of eligibility criteria, but were consulted on them. **User/carer involvement** • No explicit reference to user/carer involvement or choice. • Unable to identify an interviewee from the voluntary sector. The TPP had made no direct approach to voluntary sector, although they recognised that they should in the future.	• HA reasonably supportive of TP, although relations with partners across the general practices involved have been mixed. • Relations between TPP and SSD massively improved since advent of TP. One GP commented *"Having the social worker on the project board, and meeting regularly has improved relation, and continued dialogue is welcome"*. However, the SSD commented that GPs did not understand the accountability framework that SSDs work within and expected things to happen too fast. • No involvement of user groups or voluntary groups. • Relationships between HA and SSD operating at a strategic rather than an operational level. Strategy does not always get implemented. The opposite was felt to be true with the TPP - where the problem was transforming operational ideas into strategic visions.	• Overall TP budget not set at time of interviews. • No progress in identifying a CCC element of overall TP budget. • Monitoring activity against notional budget. • HA respondents felt that holding budget was important to influence change - they felt that the TPP had the combination of financial leverage and credibility which the HA simply couldn't achieve. TPP GPs agreed. One said *"in my experience you can't achieve nearly as much with joint commissioning, which involves hard graft with nothing to show for it. There's a feeling of 'no margin, no mission.'"* • Involvement in formal contract negotiation in the area of CCC fairly minimal to date.

Table 5 - Case Study E

	CHARACTERISTICS OF THE TPP AND INITIATIVES	AWARENESS OF POLICY CONSENSUS	HISTORICAL RELATIONSHIPS	BUDGET ISSUES, LEVERS FOR CHANGE AND CONTRACTS
Field work dates: November 1996 **Number of Interviews:** 7	**The TPP Context** • 2 practices; 10 GPs; 13,200 patients (6.7% HA population). Two practices geographically distanced. • Both second wave fundholders. • 2.63% and 0.65% of the practice populations attract Jarman deprivation payments. • 7.6% of TPP population >75. • HA and SSD localities are co-terminus: TPP is equivalent to locality. • SSD budgets are devolved to locality level. **CCC Initiatives** ***Integrated purchasing*** • Flexibility between health and social care budgets was implicitly and explicitly expressed, and is happening informally and formally. • Work had begun on costing total packages of care. ***Integrated provision*** • Development of **integrated model of community care** which depends on upgrading the local community hospital development into a multi purpose, multidisciplinary day centre. Links with education and housing already made. • **Community Mental Health Team** based in local SSD department and in weekly contact with TPP. • Development of a **Shared Information System** with links between providers in different agencies.	**Motivations** • CCC was the motivation for embarking on TPP. • Long held commitment to CCC. • Ability to address historical problems between primary and secondary care and 'grey' areas between health and social care. • Patient centred approach to services - with focus on highest quality of care as close to home as possible. • Recognition that wanted highest quality secondary care. **Explicit mention of policy issues** • No macro level strategic needs assessment. • No *explicit* discussion of policy issues around CCC. • Continuing care 'blocked back'. • TPP GPs not involved in discussions of eligibility criteria, but were consulted on them. **User/carer involvement** • Community Care Forum and through it various user and voluntary groups involved in planning initiative for development of the community hospital and the scheme for integrating health and social care in TPP area.	• In this rural area long term personal relationships between those working in the public sector are important. • HA/TP relations initially mixed, but developed with greater understanding. • Relations between TPP and SSD characterised *"by trust and mutual support"*. • Long term involvement of voluntary groups and lay individuals through Community Care Forums. These provided a framework for getting participation of voluntary groups at local and regional level. • Relationships between HA and SSD expressed in personal terms in that key people know each other and they were *'going the same way'*.	• Historically based, notional budget set, but no separate budget for CCC. • Flexible approach to budgets and finance between TPP and local SSD. • Contracting matrix being developed: this was seen by TPP as crucial to effecting change. HA and Trusts beginning to see the potential of this approach. • HA respondent felt that holding a budget had enabled the TPP to undertake joint commissioning of care with the SSD coterminous locality. It made them take the initiative. • The GP respondent said that he had been trying to work on these issues for years - only when he held a budget did he make any difference.

6 Explaining developments

The importance of the historical context

Few of the initiatives being actively developed by the 5 case study TPPs were completely new. Rather, they appear to be rooted in, and strongly shaped by, past experiences of the practices involved in the TPP and the wider agency relationships within which the TPPs were operating.

For example, project A had been a part of a pilot study by social services which had attached social workers to general practices. The general practice found this to be a very positive experience and although the pilot was not felt to have been a success by the social services department, the TPPs experience influenced their desire to develop in this area. Similarly, the PACT approach to caring for elderly people developed at project B was originally developed at one of the member practices prior to the TPP being established. Team members had been very enthusiastic about this method of multidisciplinary working and had 'sold' the model to other practices within the TP. At project D, practices had been involved in several short term pilots designed to improve community care including a hospital at home scheme and a nurse as care manager on a discharge scheme. At project E, a major charitable company had been set up under the auspices of the Community Care Forum and League of Friends, but with the active support and participation of the local general practice (soon to become a TPP) which aimed to "improve local health, social care, and supported housing services through a community led model of community care services". It was only at project C that no previous history of the development of community care services was described, although the general practitioners involved in this project had long standing involvement with a community staffed hospital.

Whilst historical relationships between general practitioners and social services departments in the 5 case study projects were reported not to have been antagonistic, they were felt to be improving at 4 of the 5 projects. The exception to this was at project B, where although relationships at an operational level between a care manager and the other members of the PACT team were good, there were no relationships at strategic level, and a health authority respondent reported little understanding between the TPP and the social services department. Relationships between TPPs and other agencies were reported to be generally supportive.

Thus total purchasing does not seem to have acted as an initiator of innovative approaches to continuing and community care by general practitioners, rather, it appears to have worked as a catalyst for them to use existing local models with which they were familiar to plan changes in the configuration of services, designed to 'fix something that was obviously broken' and 'put

things right' for their patients. They were helped in this by a lack of overt antagonism between general practitioners and social services in the first instance, and the contacts they have developed seem to have led to an improvement in relations and the development of mutual respect in most cases.

Control over budgets and contracts

At the time of field work in 1996, the total purchasing budget had only been formally agreed in one of the five case-study TPPs and none of them had attempted to identity an element of the budget - whether notional or not - for community care initiatives. Despite this, 3 of the projects had been able to negotiate with the social services departments over the placing of a care manager or social worker with the project, and had agreed to jointly resource these posts, and project E had been able to commit resources to social care over the busy holiday period. This provides some evidence that the perception of other agencies (in this case social service departments) that TPPs 'hold' a budget (clearly in most instances notional) may be important in achieving change. The national evaluation of general practice based purchasing of maternity care, (Wyke et al 1997) also suggests that it may not be the actual budget which is important in achieving change, but the perception that general practices might have a budget at some point which encourages providers to negotiate with them.

All of the TPP respondents expressed the view that holding a budget was a critical factor in driving change. For example, the TPP respondent at project B said:

> *I think that holding a budget is very important. I think that unless you have the budget, there is no way you could initiate these sorts of changes, as they are quite costly for people.* (TPP2, project B)

Similarly, a general practitioner at project D stated:

> *Yes [holding a budget is important]. In my experience you can't achieve nearly as much via joint commissioning, which often involves hard graft with little to show for it. There's a feeling of 'no margin, no mission.* (GP2, project D).

However, all of the practices involved in these TPPs had been either first or second wave fundholders, which might be expected to have shaped these views. Health authority respondents were more likely to express some ambivalence about the model of budget holding as a driver for change, some of them believing that, in the community care area in particular, there may be other more powerful drivers for change associated with personal and agency relationships. For example, at project A, a respondent from the health authority recognised the importance that the TPP put on holding a budget, but queried whether, when they

understood the system better, they would question the level of control the budget had actually given them. He said:

> *I'm not sure that the TP actually think that any more [that holding a budget is a critical driver of change]. Initially they probably did think that, but now their views may be changing as they develop a growing understanding of how the system works.* (Health authority 5, project A).

Despite the projects' belief that the holding of a budget was a key driver for change, they did not always appear to be using their newly acquired budgetary powers to full advantage. These TPPs, as with the other TPPs across the country, had had very minimal involvement in contracting in the first year of TP (see Robinson, Robison and Raftery, 1997). Partly this was explained by intransigence from trusts (projects B and E) and partly because changes were being made through commissioning rather than through contracting (projects C and D).

7 Discussion

Interpretation of findings

The case study approach gave us rich data, which allowed us to pursue themes of interest in the multiple sources we had available to us from each project. Thus, for example, respondents' descriptions of projects, or the importance of particular relationships, could be checked against each other and against descriptions in written documentation or observations of meetings, to build up a detailed picture which we were confident we understood and which reflected developments at each project. The intensive case study approach means that we were not overly reliant on the views of a few respondents. However, we cannot be sure that we have not missed a critical informant, whose account would have changed our perception of the projects. All the accounts we are able to give about developments are necessarily partial.

In addition, the 5 TPPs included in the case studies were purposively sampled to reflect two key issues we felt were likely to be important in whether the developments were a success. These were whether they were taking an operational or a strategic approach to service development, and their relations with social services departments. However, the 5 were sampled out of all of those who had said that they were going to focus on community care. Thus, they are the keen and enthusiastic TPPs, who could be expected to be at the forefront of general practitioner involvement with continuing and community care and who already had significant experience in this area already. Any success attributable to their involvement must be interpreted in this context. Other groups of general practitioners involved in devolved commissioning would not be likely to make similar achievements unless they were at least as keen, enthusiastic and experienced as the TPPs in this study.

Finally, it is important to recognise that the findings are provisional. Fieldwork was undertaken when the TPPs were only into their first few months of 'live' purchasing. They were clearly at relatively early stages in their plans so that changes they had put in place were unlikely to have impacted yet upon patients' experiences. However, one would expect that this would happen, and that if the initiatives were successful, this would result in patients experiencing more integrated care. The TPPs also had other ideas which they wanted to develop. Thus it is too early to finally judge the five case study TPPs developments in terms of their potential to meet the policy consensus around what is necessary for good continuing and community care. We can only tentatively suggest which approaches are likely to meet the goals of the policy consensus and which are not. We will go back to follow up development at 4 of the 5 case study projects in winter and spring 1998 (the Scottish Office is not funding the third year of the evaluation which means we are unable to follow up the Scottish project). The follow up will enable us to examine the progress the projects have made both in terms of

meetings the goals of the policy consensus and meeting their own goals for the development of continuing and community care services. The follow up will also investigate mechanisms through which changes were brought about (comparing approaches based on contracting and budgets as levers for change with approaches based on discussion and planning) and factors which inhibited or facilitated progress.

Lessons for future policy development in the NHS

This working paper has been written in the period immediately preceding the expected White Paper on the future organisation of the NHS, including the internal market. However, the newly emerging health policy does still seem to favour devolved commissioning as a way forward for a 'primary care focused NHS', whilst seeming also to prefer models of locality commissioning rather than total purchasing, and 'collaborative purchasing agreements' rather than contracting as a means to achieve change.

Our understanding of the emerging policy suggests that new developments at GP level, such as GP locality commissioning pilots, will continue to emphasise two policy issues:

- the strategic development of health services **linked** to health needs at a local population level; and
- to improve the quality and integration of services.

Recent policy announcements also strengthen the previous government's commitment to user involvement at all levels in the planning and provision of care.

The 'lessons' to be learnt from the case studies of 5 TPPs involvement in continuing and community care differ according to which of these policy imperatives is considered.

Strategic development of health services linked to health needs in the local population

The findings we have presented above suggests that general practitioner involvement in continuing and community care through total purchasing does not 'fix' the problem of how to develop effective or appropriate commissioning at the level of local populations. None of the case study TPPs undertook a systematic assessment of need for care in the local populations, even with the help of their health or local authorities. Instead they were 'demand led' seeking to fix things they saw as wrong (principally a lack of co-ordination between health and social services). This means that the potential to identify needs for services which might prevent deterioration or crises, and maintain quality of life, may have been lost, and that there may be

negative consequences for equity. If GP locality commissioning pilots seek to focus on the area of continuing and community care, then health and local authorities need to be aware of the need to support population based approaches to planning, as well as providing, care.

Quality and integration of services

The findings in this paper do suggest that general practitioners in the total purchasing projects involved in this study were making inroads into some of the intractable problems at the interface between health and social care. They were making important operational links with social services at the level of practices and TPPs, and were developing ideas for future innovations which at least hold out the potential to create more integrated vertical and horizontal provision of services for people with complex needs.

However, the changes they had made and were planning were not innovative; they were extensions of things that they had done in the past. Thus total purchasing seems to have acted as a catalyst rather than as an initiator of change. These developments were possible because those involved in TP were perceived by themselves and by others (especially social services departments) to have control over resources. This may have prompted otherwise reluctant social service departments and community trusts to discuss service developments with TPPs which they might not otherwise have done. The confluence of factors (interest in continuing and community care, having had previous plans or involvement and having the potential to hold a budget) suggests that holding a budget (or the potential to hold a budget) may be a necessary but not a sufficient condition for changes to be made. This point will be further explored in the final year of the national evaluation of total purchasing, as well as in the sub study of continuing and community care. Thus, our study suggests that there is potential for general practitioners involved in either total purchasing or GP commissioning groups to develop services likely to improve integration of care both vertically and horizontally. However, to achieve this potential they are likely to have to be interested in the area, to have reasonable working relationships with staff in other agencies, have had previous involvement and knowledge in the area, and may need to have control or influence over a budget as a potential lever for change.

User involvement at all levels of planning

This study has shown that the general practitioners in the 5 case study TPPs were not at the cutting edge of developing user participation. Only one of the case study TPPs had explicitly involved service users (either directly, through voluntary agencies, or through CHCs) in their commissioning process of decision making at any level. The views reported earlier suggest that there is little evidence that this would be likely to happen as the TPPs matured, although

we will investigate this at the next stage of the evaluation. This suggests that GP locality commissioning pilots should be given strong policy endorsement and guidance on models of good practice for the involvement of users in service planning and delivery. It is no longer sustainable for general practitioners to consider themselves to be reliable proxies for their patients or to be confident that they are aware of all their needs.

8 Conclusions

In conclusion, it can be argued that the community care initiatives being developed by the five case study TPPs are largely models of good or at least better practice introduced in a new context. They certainly give a sense of boundaries being challenged and appear to offer potential to develop integrated purchasing and provision. However, it remains to be seen whether this potential will be realised. It will be necessary for strong policy endorsement to encourage general practitioner commissioning groups to develop population based perspectives and to embrace users' and carers' views if the integrated purchasing and provision of continuing and community care are to be realised.

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Appendix

Detailed description of data collection methods used

Semi structured interviews

Face to face semi-structured interviews were undertaken in the summer and autumn of 1996, 18 months after the introduction of the total purchasing pilot scheme and 6 months into 'live' purchasing. Between eight to thirteen interviews were conducted at each project, with key TPP, health authority, social service department and provider (statutory and voluntary) personnel involved in the TPPs plans for continuing and community care. A total of 48 interviews were undertaken, lasting between 30 minutes and 2 hours each. Topics covered which are relevant to this paper included: motivations for focusing on continuing and community care as a part of their total purchasing pilot (Mays et al 1997 explains that most TPPs were *selective* rather than *total* purchasers); details of the initiatives the projects were developing and mechanisms for achieving their desired changes; the information base they had or were developing to support their proposed developments; relationships with other agencies, including health authorities, social services departments, and voluntary agencies; and the extent to which users of services and their carers appeared to be involved in setting the agenda for care at a personal level, or for service developments at a policy level. The interviews were tape recorded, respondents' guaranteed anonymity, and the tapes used to write up detailed field notes. A small number of interviews were transcribed.

Non participant observation

Where opportunities arose during fieldwork, researchers observed key TPP project meetings which usually included representatives from health authorities and social services departments. Attendance at these meetings provided a more detailed understanding of the processes and context within which decisions around the TP projects' were developing their plans for continuing and community care, and insight into the complex inter-relationships between different organisations and the key personalities involved. (Flynn, Williams and Pickard, 1996) These meetings were documented using notes made whilst they were taking place, and subsequent fieldnotes. These data provided a helpful complement to the interview data, providing additional insight into the intra and inter organisational relationships.

Collation of documentary evidence

Copies of relevant TPP project information were collated including practice profiles, purchasing intentions documents and business plans. In addition, during case study visits, the researchers asked respondents to provide any extra documentary information pertinent to their plans for continuing and community care. This yielded a huge amount of paper information, from a wide range of organisations, including: community care plans; draft eligibility criteria for NHS continuing care; assessment and treatment protocols; and minutes of working groups. This documentary evidence was used to corroborate and augment the analysis of evidence from the interviews and observation of key meetings, thus assisting with methodological triangulation.

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