King's Fund

# Total Purchasing

## A step towards Primary Care Groups

### National Evaluation of Total Purchasing Pilot Projects

Nicholas Mays, Nick Goodwin, Amanda Killoran and Gill Malbon

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'Total purchasing' was introduced to the National Health Service in 1995 as a three-year pilot extension for volunteer fundholders of the controversial general practitioner (GP) fundholding scheme. Total purchasing pilots (TPPs) comprise one or a group of standard fundholding (SFH) general practices which receive a delegated budget from their local health authority to purchase (or commission) potentially all the hospital and community health services for their registered populations. Total purchasing was widely seen as heralding a potential shift of all health services' purchasing to GP-led bodies and away from health authorities. Thus, in key respects, TPPs can be seen as forerunners of the *Primary Care Groups (PCGs)* announced in the December 1997 English White Paper, *The New NHS.* As a result, the lessons learned from the performance of the TPPs have an important bearing on the future organisation of the NHS.

This report draws together the interim findings from the first two years of a three year evaluation of all first and second wave TPPs in England and Scotland which began in October 1995, led by the King's Fund. The report discusses whether first wave TPPs have developed the organisational requirements for effective purchasing, the extent of their achievements during 1996/97 (the first wave TPPs' first 'live' purchasing year), and the factors associated with their progress in terms of their *contexts,* the *content* of their objectives, and the *processes* adopted to implement total purchasing at each project. The report concludes by discussing the implications of the total purchasing experiment for the development of PCGs.

National Evaluation of Total Purchasing
Pilot Projects

# Total purchasing: a step towards Primary Care Groups

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**The Total Purchasing National Evaluation Team (TP-NET)**

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

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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 interim report provides an overview of the findings from the first two years of a three year 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. The interim report is supported by a series of working papers are listed on page i.

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 in England and Scotland are being studied.

Further details about the evaluation design and methods are given in Chapter 3. Full details are 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.

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King's Fund, London
April 1998

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## GLOSSARY

| | |
|---|---|
| A&E | Accident and Emergency |
| CHC | Community Health Council |
| CHS | Community Health Services |
| CMHT | Community Mental Health Team |
| CPN | Community Psychiatric Nurse |
| DH | Department of Health |
| DHA | District Health Authority |
| DRG | Diagnosis-Related Group |
| EBM | Evidence-Based Medicine |
| EFH | Extended Fundholding |
| EL | Executive Letter |
| FCE | Finished Consultant Episode |
| FHSA | Family Health Services Authority |
| GMS | General Medical Services |
| HA | Health Authority |
| HB | Health Board |
| HCHS | Hospital and Community Health Services |
| HES | Hospital Episode Statistics |
| HIP | Health Improvement Programme |
| HRG | Hospital Resource Group |
| IT | Information Technology |
| LBD | Lost Bed Day |
| NHS | National Health Service |
| NHSE | National Health Service Executive |
| OBD | Occupied Bed Day |
| PACT | ProActive Care Team |
| PCG | Primary Care Group |
| PEI | Purchaser Efficiency Index |
| SFH | Standard Fundholding |
| TP | Total Purchasing |
| TPP | Total Purchasing Pilot |
| TP-NET | Total Purchasing National Evaluation Team |

## SUMMARY

This report provides an overview of the interim findings from the first two years of the three year evaluation of first and second wave national Total Purchasing Pilot Projects (TPPs) in England and Scotland which began in October 1995. TPPs comprise one or a group of standard fundholding (SFH) general practices which have volunteered on a three-year pilot basis to take a delegated budget from their local health authority to purchase (or commission) potentially all the hospital and community health services (HCHS) for their registered populations.

In particular, the report addresses whether first wave TPPs have developed the organisational requirements for effective purchasing (Chapter 5) and the extent of their achievements during 1996/97, their first 'live' purchasing year (Chapter 6). The report then attempts to explain their progress and early achievements through an examination of the relations between their *context*, the *content* of their changes and the *process* through which they have implemented total purchasing (TP) (Chapter 7). Since TP is, in many respects, the forerunner of the Primary Care Groups (PCGs), proposed in the December 1997 government White Paper for England, the *New NHS (Secretary of State for Health, 1997)*, the implications of the evaluation for the transition to PCGs are examined (Chapter 8), bearing in mind that the TPPs are time-limited pilots whereas PCGs will have a firm status in English NHS policy.

**Developing effective purchasing organisations**

The main goal of any purchasing or service commissioning organisation is to secure the delivery of high quality, effective, acceptable and equitable health care at minimum cost. The prerequisites for this to occur which were identified in Chapter 5, relate to processes required to meet the goals of purchasing and the qualities of the purchaser organisation. The extent to which first wave TPPs exhibited such prerequisites for effective purchasing can be summarised as follows:

- Most TPPs did not formally *assess patient needs* when setting purchasing objectives, preferring instead to rely on the personal knowledge of the general practitioner. This was related to the small scale and practice-specific nature of many of the objectives pursued.
- *Setting priorities* was an implicit process amongst TPPs since all were *selective purchasers* whilst priorities between projects varied widely.
- Most TPPs perceived their information systems and the quality of their cost and activity data to be inadequate. Most attempted to *obtain and use adequate information about services* even though many were not always sure as to the exact nature of the information they required.

- *Informing and involving patients in purchasing decisions* was not a high priority for TPPs during 1996/97.
- There was little HA action to *monitor equity* between TPP and non-TPP populations, although the majority of HAs were concerned to pursue a fair budget allocation process for all devolved purchasers whether TPPs or not.
- Total purchasers added to, rather than minimised, *transaction costs* overall despite the fact that they appeared to reduce costs for acute providers due to contracting for groups of practices. Most of the additional transaction costs attributable to TP were borne by the pilots themselves with 24 per cent borne by the general practitioners.
- Since TPPs have been *selective purchasers* they have had few problems in *managing financial risk,* with few projects developing risk assessment strategies or contingency funds.
- Large, multi-practice TPPs found it harder to *manage budgets* as effectively as the smaller and single practice projects, whilst all TPP responses to financial pressures tended to be crude (e.g. putting patients on waiting lists).
- The *sustainability* of TPPs is questionable since projects depended on very few people to manage the process who also had to endure high workloads. In many cases, it was difficult to identify potential successor lead general practitioners or how the level of HA input could be sustained.
- In terms of an *appropriate skill-mix,* there was generally a good level of HA support for the TPPs although skill-mix varied according to the objectives of the projects.
- TPPs are subsumed within the overall *accountability* mechanism which applies to their local HA and are not separately identified. Financially, as with SFH, there is a strict accountability mechanism, but there is no system of value-for-money assessments of TPP decisions and little concern to require pilots to attain national policy goals. Accountability to patients and the public is weak.

**The achievements of total purchasers in 1996/97**

Chapter 6 reviews the extent to which first wave TPPs attained their main purchasing/commissioning objectives in 1996/97 and analyses the factors associated with higher and lower levels of TPP achievement. The assessment of achievements highlighted the following:

- TPPs found it harder to meet their own objectives than they had originally anticipated with only 3/52 projects meeting all their four main objectives during 1996/97.

- Achievements were skewed towards incremental, small scale, locally generated and primary care-focused changes.
- Many of the achievements reported in 1996/97 related to preparations for bringing about service change in the future such as better information and improved relations with hospitals rather than specific changes to service delivery.
- Most TPPs reported that they wanted to bring about more service change and development in the future, particularly in service areas new to general practitioner-led purchasing/commissioning (i.e. TP-related areas).

The main factors associated with achievement in 1996/97 were:

- TPPs with smaller populations, fewer general practitioners and with no more than five practices achieved more than other TPPs.
- Smaller projects, particularly single practices, were able to achieve their own objectives with relatively little organisational development, whilst larger TPPs had to establish more complex organisations before they could make progress which was, therefore, less likely to have occurred in the first 'live' year.
- TPPs with higher per capita direct management costs achieved more in the first year than the remainder.
- Higher achieving TPPs were more likely to report that their local HA was providing 'fair' or 'good' support to the project than lower achieving projects.
- Total Purchasers with at least some of their own independent contracts were more commonly found in the higher performing group than in the lower.
- Higher achieving projects were also more likely to have greater future ambitions.

**Explaining progress and achievements of TPPs**

The ability of a TPP to achieve its objectives can be regarded as the product of a specific mix of variables which either act as barriers or catalysts to change. Local *contexts*, for example, influenced both the content of what TPPs wanted to achieve and the pace of progress. Table 7.1 summarises the key contextual themes emerging from the evaluation. The more 'receptive' the contexts within which TPPs operated the more likely it was for achievements to be made in the first 'live' year.

The way in which the *process* of TP was implemented also had an impact on the ability of projects to achieve their objectives. Three factors related to the TP process were associated with attaining achievements:

- TPPs with a number of *key individuals leading change* tended to be the more successful projects. This was manifest in committed lead general practitioners, highly skilled project managers, supportive HA lead managers and provider clinicians who took an active interest in the TPPs' objectives.
- The fostering of *inter-agency co-operation* was important to the pace of progress. Where relationships between different agencies were co-operative or collaborative, it was more likely for TPPs to achieve their objectives.
- *Budget holding* was important for making progress with the *potential* to contract being just as important as the actual act of contracting.

The content and pace of developments differed widely between TPPs due to the specific local interaction between context and process. Successful TPPs developed processes capable of manipulating local contexts to their best advantage.

**Implications for the development of Primary Care Groups in future**

- Since TPPs which received their own budgets and which contracted independently made the most progress during 1996/97, the decision in the White Paper of December 1997 to retain the potential for PCGs to assume increasing budgetary control and a wide range of independent contracts is desirable.
- Negotiating local methods for setting TPP budgets proved to be the single most problematic issue in the preparatory year of the first wave TPPs, indicating that a national capitation formula for PCGs is the best way forward. The evidence from the TPPs suggests that a bottom-up approach, based on calculating and then aggregating individual practice budgets, led to major technical problems in estimating past and current spending.
- Skilled and motivated individuals, good leadership and mature relations with providers are essential to facilitate close working relationships and the fostering of trust in PCGs since the evidence from the first wave TPPs suggests that such a combination is beneficial in bringing about service change.
- PCGs will need to be set up and allowed to operate with a degree of local flexibility if they are to achieve similar objectives in different local contexts. In particular, 'natural communities' are likely to vary in size depending on local circumstances, thereby determining the most appropriate population base for each PCG.
- The scale of PCGs while potentially giving them greater strategic weight, poses a major organisational development challenge since the larger TPPs, tended to achieve less in 1996/97 and required significant time to develop mature and effective organisations before

making progress. The challenge will be greater for PCGs since their geographical basis will mean that most will contain a mix of more and less experienced SFH practices, non-fundholders and practices ideologically opposed to managing budgets.

- Unlike the volunteer SFH and TP, participation in PCGs will be compulsory for practices. All will have to play some part in collectively managing resources. The evidence from TP suggests that budgetary management worked best when all general practitioners were involved and had some experience of seeing themselves as part of a clinical group. Engendering good inter-practice relations and supporting the less motivated practitioners will be essential in PCGs if they are to function effectively both as commissioners and providers of better primary care.
- The sustainability of TPPs was often questionable due to a heavy reliance on a small number of individuals with high workloads to run the process. Larger TPPs often progressed slowly because not all practices in the project were active participants which meant that the behaviour and resource consumption of each practice was often uncontrolled. PCGs are larger groups than TPPs and it is likely to prove even more difficult to ensure active participation from each practice. Developing appropriate incentives and sanctions for practices will be a major organisational development task.
- The more successful TPPs were associated with the more supportive HAs. Since PCGs are likely to have less overall experience of commissioning and resource management and include wider variations in clinical behaviour and resource use, HA support is likely to be even more essential.
- Higher direct management costs were associated with greater achievements in the first year of TP. The December 1997 White Paper plans to reduce the total costs of running HAs and general practitioner commissioning by £200m per year for five years, yet, in the short term, it is highly likely that costs will need to *rise* as PCGs are established since HAs will have to continue to operate as important commissioners locally until all the local PCGs are at least at Level 2 and possibly Level 3. If anything, during this period, it may be necessary for additional resources to be made available to the HA to enable it to develop PCGs rather than the planned reduction in management spending.
- Highly competent and skilled project managers were associated with better TP, yet it is unclear how 500 PCGs will acquire such skilled staff when 90 or so HAs have found it difficult to obtain the necessary skills for commissioning specialised services.
- PCGs will need access to far better sources of information on cost and quality of services than was available to the vast majority of TPPs, implying high IT investment.
- The objectives of TPPs were often thwarted by trust resistance, or by the fact that changes could only sensibly be implemented on a wider scale than a single TPP. Whilst larger PCGs are likely to carry more purchasing weight, the objectives of PCGs will need to be incorporated within the context of wider Health Improvement Programmes if any significant shift of resources from acute and mental health trusts can be achieved.

# 1 INTRODUCTION

When general practitioner fundholding was introduced into the United Kingdom (UK) National Health Service (NHS) in 1991 following the *Working for Patients* White Paper (Secretaries of State, 1989), there had been no previous piloting of the concept. None of the practices which volunteered to go into the first wave of standard fundholding (SFH) had had any previous experience of managing a cash-limited sum comprising part of the hospital and community health services (HCHS) resources previously managed exclusively by the health authority (HA) or health board (HB) in Scotland and Northern Ireland (in the remainder of this report, HA will be used to refer to both HAs in England and HBs elsewhere). Following the December 1997 White Paper on the NHS in England (Secretary of State for Health, 1997), all general practices, not just volunteer fundholders, will be required by April 1999 to become part of a Primary Care Group (PCG) of practices which will, at a minimum, manage a cash-limited budget covering the prescribing expenditure of the practices involved and their cash-limited practice infrastructural expenses. Over time, all PCGs will be required to develop so that eventually each is responsible for at least 85 per cent of the total HCHS and all the General Medical Services (GMS) (i.e. the resources used to support general practice in the NHS) expenditure for its population. This means that all general practitioners in England will, effectively, become collective fundholders responsible for a far larger proportion of the total NHS budget than was the case under SFH which, for instance, only included the elective (non-urgent) parts of HCHS plus general practitioner prescribing costs and practice staff. In addition, by the end of the scheme, fundholding still only covered approximately 60 per cent of the general practices in England. The development of PCGs is more ambitious and begs a number of questions.

How will the new groupings of general practices come together? What incentives will there be for practices to take an active part? What will be the best way to organise and run a PCG? What will the PCGs be able to achieve? How much will they cost? Will patients notice any improvement in the services which they receive?

Fortunately, and in contrast to the position before the widespread introduction of SFH, the NHS does have up-to-date experience of involving fundholding and non-fundholding general practitioners in a range of schemes at local level for purchasing or commissioning HCHS beyond the scope of SFH. Perhaps the most relevant to setting up PCGs is Total Purchasing (TP). Under TP, SFH practices volunteered to take a delegated budget from their local HA to commission potentially all HCHS for their patients on a pilot basis. Each Total Purchasing Pilot (TPP) was established for an initial period of three years (1995-98) as an experiment in extending the scope of SFH. At the same time, the Department of Health (DH) commissioned a major programme of evaluative research to run alongside the TPPs. As a result, the Service

has access to a considerable body of findings and insights which, it is hoped, can be used to inform the introduction of PCGs in England, together with the different arrangements which will be put in place in the other countries of the UK.

The aim of this report is to draw together, reasonably succinctly, the main evidence available after two of the three years of the study concerning the TP initiative in England and Scotland in such a way that it provides practical insights for the development of PCGs. The report draws on data and conclusions from all the component parts of the evaluation programme each of which is represented by a supporting working paper. The working papers are listed at the beginning of the report and provide considerably more detail, particularly on the methods used to obtain and analyse the data.

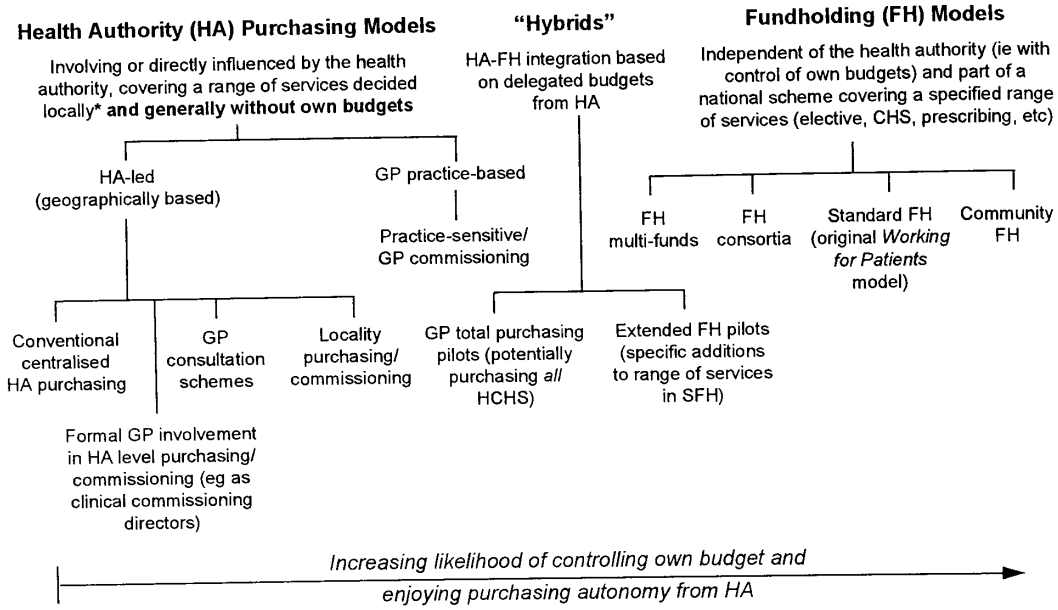
# 2 TOTAL PURCHASING IN THE CHANGING POLICY CONTEXT

A diverse range of primary care commissioning models has evolved during the 1990s in the NHS. Each district now has its own mixture of different types of models. These have grown from national government policy (specifically fundholding) and health authorities' own initiatives for devolving commissioning to a local level. The Executive Letter (EL) *Developing NHS purchasing and general practitioner fundholding* (National Health Service Executive (NHSE), 1994) was particularly significant in reinforcing the trend towards diversity and multiple approaches to purchasing within districts. It introduced community fundholding and TPPs as well as Extended Standard Fundholding (EFH) options.

**A typology of purchasing organisations**

Figure 2.1 summarises the different models which have evolved. The models vary in the scope of their commissioning responsibilities, and particularly the degree of budgetary delegation they enjoy. The research evidence available, though far from ideal, suggests that models in which budgetary delegation was more formal tended to be more likely to be associated with improvements in quality, choice and responsiveness of services, at least in the short term (Le Grand, Mays, Mulligan *et al.*, 1997). Although originally having its genesis as an extension of fundholding, TP is actually a 'hybrid' model, combining characteristics of both locality commissioning schemes (with indicative budgets) and fundholding (with formal budgets). A population focus combines with a concern to bring about changes at the level of individual patients. Thus by the 1997 General Election a certain operational convergence between models had emerged (Mays and Dixon, 1996).

**Figure 2.1: A Typology of Purchasing Organisations in the NHS, 1996/97**




* *Some FH practice involvement in some schemes, but generally involving non-FH practices*

## The typology updated

The rationale for devolved models of commissioning was derived from the broader policy thrust of 'a primary care-led NHS', embracing an overall desire to shift from a hospital-led service to a patient-centred service. Primary care was viewed as being best placed to make decisions about the needs of patients and addressing the trade-offs between completing claims on resources. General practitioners were regarded as perhaps the best proxies for individual patient choices, able to express the distinct and diverse needs of their populations. It was believed that they would encourage innovation which would lead to greater responsiveness of services. Also there was a belief that delegating budgets to general practitioners, with incentives for them to make 'savings', would lead to better control of costs as they became more aware of the resource consequences of their decisions and were thus encouraged to seek more cost-effective responses to needs. Thus TPPs with budgets for potentially all HCHS can be seen as a UK version of one of the many types of managed care organisation in the United States in which there are incentives to find new ways of providing care in order to 'save' or redeploy resources to the benefit of patients (Robinson and Steiner, 1997). To a limited degree, in their preparatory year (1995/96) TPPs were developing limited versions of techniques familiar from the experience of US managed care organisations. For example, they were planning to reallocate resources between secondary and primary care and attempting to

reduce unnecessary use of hospital facilities by reviewing patterns of utilisation and developing alternatives (such as minor injuries units or other local community facilities) (Mays, Goodwin, Bevan *et al.*, 1997).

Now *The New NHS* White Paper sets out the way forward for primary care commissioning (Secretary of State for Health, 1997). It provides for the consolidation and future evolution of primary care commissioning within a more coherent framework. (It should be recognised that there are separate White Papers for Scotland and Wales which envisage different forms of development of commissioning). The principles of a primary care-led NHS are reiterated in the White Paper, and, specifically, the merits of primary care-driven commissioning linking clinical and resource management decisions at the same point in the system.

PCGs are to be established in all parts of the country by April 1999. Groups will have a comprehensive range of responsibilities. They are to commission virtually all health care, but also be concerned with promoting the health of the populations they serve and developing primary care.

A spectrum of opportunities will be available with a clear expectation that PCGs will progress from lower to higher levels (Box 2.1). As a minimum PCGs would act in an advisory capacity to HAs, while the most advanced Groups would be free standing Primary Care Trusts, accountable to the HA for commissioning care and the provision of community services. This could involve groups of general practices merging with Community Trusts. Groups will cover 'natural communities' and serve populations of about 100,000. However, some flexibility will be allowed. Each Group will have a unified budget covering HCHS, prescribing and general practice infrastructure and will be able to use any savings to develop services locally.

**Box 2.1: Options for Primary Care Groups**

Primary care groups will:

Level 1: at a minimum, support the HA in commissioning care for its population, acting in an advisory capacity.

Level 2: take devolved responsibility for managing a delegated budget for health care in the area, formally, as a sub-committee of the HA.

Level 3: become established as a free-standing body accountable to the HA for commissioning care.

Level 4: become established as free-standing bodies accountable to the HA for commissioning care and with added responsibility for the provision of community health services (CHS) for their population.

A combined HA and PCG management cost envelope will be set for each HA area. The will include re-deployment of the general practitioner Fundholding Practice Fund Management Allowance to support the running costs of the PCGs. PCGs are to have their own dedicated management support, but they will be expected to share, not duplicate, functions with the HA. Management support costs will be re-deployed over time from HAs as PCGs take on more responsibilities.

Although the White Paper provides for radically new ways in which health care is ultimately commissioned and provided locally, the development of PCGs will be evolutionary. Groups will 'grow out' of the existing range of commissioning models (fundholding, multi-funds, TP, locality and general practitioner commissioning), in Figure 2.1.

TPPs, in particular, are well placed to take advantage of the new opportunities. There are now eighty-eight projects. Fifty-three first wave TPPs were established in April 1995, followed by thirty-five second wave pilots in April 1996 (four projects have withdrawn from the scheme). A further four sites originally pioneered the concept before the official launch of TP.

TPPs bear a strong resemblance to PCGs, since TP involves general practices being delegated a budget to purchase potentially all the HCHS for their populations (above SFH services). As indicated above TPPs combine a population focus with concern for service development and delivery at the individual patient level. TPPs are essentially operating as Level 2 PCGs, since without the necessary legislation, projects have been required to function as sub-committees of the HA with delegated HA budgets.

Given the underlying conceptual similarity between TPPs and the way in which the government plans to establish PCGs, it is important when interpreting the findings from the

national evaluation of TPPs to be equally aware of the differences between the two forms of organisation. The first obvious difference lies in the fact that PCGs will be compulsory, whereas the practices which in TP volunteered to enter the scheme were supposedly all fundholders and were part of a pilot for three years. As volunteers, they were also free to choose with whom they wished to collaborate. As a result, the vast majority of the multi-practice projects do not comprise a locality, but are consortia of individual practices. As fundholders, the TPP practices had previous experience of managing resources and purchasing services which not all PCG participants will have been exposed to. TP has given them additional valuable experience which, again, most PCG participants will not have had. On the other hand, the TPPs were time-limited pilots which may have inhibited some HAs from investing too heavily in their support. The context will be different for PCGs in that they will have a firm status in NHS policy through the White Paper of December 1997 and will not be seen as an innovation with any uncertain future. Table 8.1, (Chapter 8), summarises the similarities and differences between TPPs and PCGs.

The implications of the similarities and differences between TPPs and PCGs will be explored in the remainder of this report which shows how first wave projects, in particular, have implemented TP and with what consequences in terms of achievements after one 'live' year.

As there was no central blueprint, projects have interpreted TP in different ways and consequently different 'types' of TPPs are emerging. Their development has been shaped by the national policy debate leading up to the May 1997 General Election and the subsequent Labour victory. They vary in scale and scope of their commissioning responsibilities, particularly in the extent to which they have taken budgets and contracted independently. They also vary in their focus of ambition and levels of achievement.

For many, TP has been the stimulus to developing multi-practice organisations with a broadening range of commissioning and providing functions. Consequently, projects are likely to become important core components of many newly emerging PCGs, while the larger TPPs could quickly progress to Levels 3 or 4 and Primary Care Trust status (see Box 2.1). However, while the intention of the government is to base PCGs on localities or 'natural communities' of around 100,000 population, TPPs have been organised around individual practices or groups of practices which have generally chosen to work together on a pilot basis. The pilots have enabled general practitioners, practice and fundholding managers, and staff in HAs and local trusts to begin to understand each other's perspectives and interests better.

This process has improved our understanding of the implications for the local health system of the move to PCGs.

The new White Paper presents a future in which well managed primary care organisations promote the health of their local communities, and commission and provide health care services to meet their health care needs, within the context of district-wide Health Improvement Programmes (HIPs). TPPs represent one step towards becoming such organisations. The experience of pilots provides some important insights into the difficulties and opportunities in creating this future.

Many of the key characteristics of such managed care organisations (at least in the USA) involve the use of clinical guidelines, prescribing formularies, referral protocols, preferred provider contracts, utilisation management systems, physician profiling, financial incentives, integrated IT systems, vertical integration and capitated and integrated budgets (Hunter and Fairfield, 1997). Many of these features are becoming apparent, at least in embryo, in the development of TPPs (Robinson and Steiner, 1997). Such features are likely to be embodied at Levels 2 to 4 PCGs.

Future local health systems, and particularly the pace and degree of decentralisation, will need to be the product of a number of trade-offs: specifically the desire for local sensitivity versus equity and efficiency. While local sensitivity in commissioning and service provision requires decentralisation, equity between groups and across populations, and cost-effective use of expensive specialist skills and expertise in commissioning is likely to favour more centralisation (Smith, 1997). These tensions will undoubtedly underlie the next phase of primary care commissioning, as they have the development of TPPs as a model of purchasing/commissioning which fits somewhere between the HA and the single SFH practice.

# 3 COMPONENTS OF THE EVALUATION

**Aims and objectives**

The aims and objectives of TP were never clearly defined by the NHSE. The evaluation team, therefore, initially relied on the research brief prepared by DH Research and Development Division for an indication of the effects which the architects of TP believed that the TPPs might produce and, indirectly, thereby, for an idea of the objectives of the scheme. The brief was clear that TP was 'the extension of general practitioner fundholding' (Department of Health R&D Division, 1995), indicating that, in general terms, the Department and NHSE were expecting similar consequences to SFH.

The aim of the evaluation was 'to assess the costs and benefits attributable to total purchasing'. The objectives identified in 1995 were to collect evidence on:

- 'the factors associated with successful set-up and operation of total purchasing;
- the costs and effectiveness of total purchasing; and
- the benefits to patients through total purchasing'

in order to indicate the 'best models for further development of fundholder-based purchasing in a primary care-led NHS' (Department of Health, R&D Division, 1995, pp1-2). The evaluation programme was also to include, where appropriate, evaluation of a number of extended fundholding pilots (EFHs) in which SFH practices volunteered to take responsibility for purchasing in a single service area over and above the scope of SFH. EFH pilots in maternity services and mental health services were thus included in the national evaluation of TPPs.

Under the *costs* of TP, the research brief included a focus on the operating costs of the scheme, transaction costs (i.e. the total costs of negotiating, specifying and monitoring contracts and managing spending between purchasers and providers) and policies to minimise these costs, since there was a concern that TPPs might increase the overall management and transaction costs in the NHS internal market by increasing the total number of purchasing organisations. The research brief also included research on budgetary management policies on overspends and under-spends and the use made of any 'savings' from TPPs' budgets on the grounds that there might be straightforward budgetary incentives in TP similar to those in SFH, linked to the ability of projects to make and spend their own 'savings'. However, it was not clear how this would be handled given that the resources of the TPPs were to remain technically the responsibility of their parent health authorities (HAs).

The brief divided the *effects* of TP into two parts, 'benefits to patients' and 'effectiveness'. Under 'effectiveness', a range of aspects of health services where TPPs might have been expected to bring about measurable changes such as in referral and investigation patterns, quality standards in contracts, prescribing patterns, the balance between primary and secondary-based care and provider configuration were listed. There was also an interest in detecting any divergence between TPP, HA and national purchasing priorities and strategies. 'Benefits to patients' suggested that the DH believed it possible that the TPPs might be able to bring about measurable improvements such as a greater responsiveness to patients' wishes in the services which they purchased, or better access to primary and secondary care, or higher levels of patient satisfaction, or, even, improved health outcomes. Researchers were encouraged to give some thought as to how these effects might be assessed.

Finally, the research brief highlighted a number of specific services for special attention as part of the evaluation. The list included services which had not previously been included in the SFH scheme such as accident and emergency (A&E) services, emergency medical inpatient care, services for the seriously mentally ill and community care. There was a concern to assess the extent to which the TPPs opted to use different providers, altered the content of services, differed from the local HA in their strategies and met the requirements of national policy, where relevant (e.g. the *Changing Childbirth* initiative in England (Department of Health, 1993)) in these new service areas.

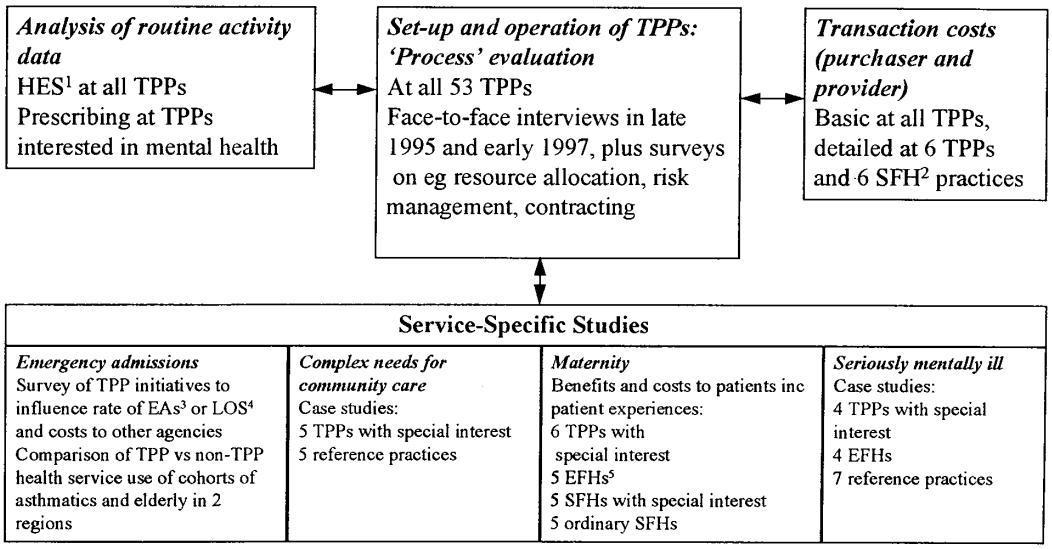
**The design of the national evaluation of TPPs**

Since the timing of the launch of the national TP scheme, the large number or pilots permitted to enter the scheme and the commitment to evaluate *all* the projects were decisions taken without reference to the design of the evaluation, the study could not be experimental. It was not possible, for example, to compare TPPs with groups of similar general practices eligible for the scheme, but not entered, and strictly matched on a range of features regarded as predictive of the likely costs and benefits of TP. In addition, it was clearly not feasible to insist that no other policy initiatives should be undertaken which might affect local patterns of provision or the apparent consequences of TP. Instead, where practicable, comparisons are being made in different parts of the evaluation between sub-samples of 'first wave' TPPs and EFH practices, SFH practices, non-fundholding practices and HAs. Sometimes, the focus is on the patients of different types of purchaser organisation; at other points, the focus is on the processes undertaken in the organisations themselves. In addition, there are important comparisons to be made between the first and second wave TPPs.

*Evaluation of first wave TPPs, 1995-97*

The evaluation of the 'first wave' projects has a large number of interrelated components some of which are being carried out at all projects, others at sub-samples of TPPs. Figure 3.1 shows the design of the study for first wave TPPs.

## Figure 3.1 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] LOS = length of stay [5] EFH = extended fundholding pilot*

Set up and operation of the TPPs ('Process' evaluation)

This part of the evaluation was undertaken at all first wave projects, and began in the second half of their preparatory year (1995/96) between September and December 1995. The first round of data collection covered how TP had been implemented and was undertaken through a combination of face-to-face interviews, diary cards, postal questionnaires, telephone interviews, analysis of routine data and the analysis of documents. Approximately 300 face-to-face semi-structured interviews were conducted with key general practitioners, fund/TP project managers, HA/HB leads on TP, representatives of acute and community trusts and with social services departments (social work departments in Scotland) staff. In addition, a

series of surveys was run in parallel on contracting, risk management, financial management and budget setting. A second set of interviews was undertaken using the same methods in February to March 1997 which concentrated on pilots' experience of TP in the first 'live' year (1996/97), their overall perceptions of how successful their projects had been, their specific achievements against their main objectives and the enabling factors and obstacles which they had encountered. Data were also collected at interview on the amount spent on managing the project, whether the project had held a budget, whether the project stayed within budget and the project's plans for 1997/98. Further data will be collected on the progress made by first wave projects in 1997/98 at the end of the second purchasing cycle.

Transaction costs (purchaser and provider)

The managerial and transaction costs associated with TPP purchasing compared to HA purchasing, with and without the involvement of SFH practices, are being analysed in detail at a sub-sample of TPPs.

Analysis of routine activity changes

The changes in activity (e.g. patient episodes, lengths of stay, prescribing patterns and prescribing costs in specific areas, etc.) before and after the advent of TP are being compared between TPP and non-TPP populations at all HAs with TPPs in the study, using routine NHS data.

Costs and patients' experiences of specific services which general practitioners are purchasing for the first time

Four separate sub-studies are being conducted to examine the patterns of care, service costs and patients' reactions to specific services purchased by the TPPs in comparison with the same services purchased by HAs. The particular emphasis here is an attempt to assess the benefits to patients of TP. The four services are community and continuing care for people with complex needs, emergency admissions, services for people with serious mental health problems and maternity care. In the case of the latter two services, the evaluation of the impact of TP is linked to evaluation of the pilot extensions of SFH (EFHs). In each service area, the focus is on a sub-sample of TPPs which have made the particular service area a priority in their purchasing strategy (see Figure 3.1).

Findings from the 'process evaluation', transaction costs, activity changes and the service-specific components of the evaluation are all presented in this overview interim report.

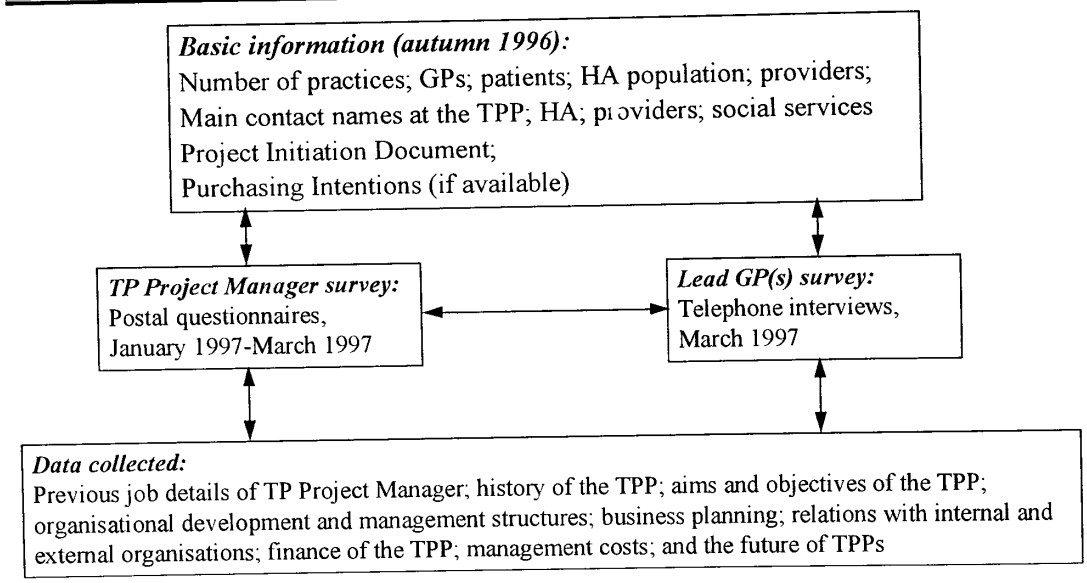
Further details about the evaluation and detailed findings from each component are contained in the series of working papers listed at the front of this report.

*Evaluation of second wave TPPs, 1996-98*

Data are also being collected at second wave TPPs which started their preparations for TP a year later than the first wave. Telephone interviews and postal questionnaires were sent out to lead general practitioners and TP project managers during their preparatory year between October 1996 and March 1997. The methods employed to collect information differ. Second wave TPPs are being studied through postal questionnaire and telephone interview whereas the first wave is mainly being studied via face-to-face interview. A range of supplementary data such as purchasing plans and documents is also being collected.

Figure 3.2 shows the main topics covered in the postal questionnaire and telephone interviews with TP project managers and lead general practitioners carried out to date. The majority of questions in the second wave evaluation are structured and pre-coded: these codes were based on analysis of the data collected from the first wave. The data were entered into a database and analysed using basic bi-variate techniques. Investigation was informed by findings from the first wave evaluation, and comparisons have been made between the two waves of TPPs wherever possible. Only baseline second wave data will appear in this report, as data on the achievements of the second wave have yet to be collected. Second wave TPPs will be re-surveyed in Spring 1998 to collect evidence of their achievements after one 'live' year, similar to information collected from first wave TPPs.

## Figure 3.2 Data collection on the national evaluation of second wave total purchasing pilot projects, to date




*Third year of the evaluation, 1997/98*

The third year of the national evaluation of TPPs spans October 1997 to September 1998. The aim is to identify different types of TPPs and their impact (benefits and costs) within their local context in order to be able to identify the ingredients of successful devolved purchasing based in primary care. To do this, 12 first wave TPPs have been selected for more detailed case study investigation while the remaining first and second wave TPPs will be monitored in less depth. The case studies have been selected in order to enable investigation of the emerging types of TPPs, their organisational features, the tools and levers necessary to bring about change, the extent to which TPPs contribute to and complement existing and future locality commissioning arrangements (e.g. PCGs), the management investment required to support TP, the ability of the TPPs to bring about change and the implications for maintaining such investment in the longer term. By highlighting examples of best practice, the findings will provide the basis for practical guidance to inform the development of future local commissioning arrangements such as the PCGs proposed in *The New NHS* White Paper in England (Secretary of State for Health, 1997).

The case studies will be complemented by the collection of monitoring data at all first and second wave TPPs. The monitoring will concentrate mainly on the TPPs' achievements and their management costs. This will be done using structured postal/ telephone interviews and a standard form for the collection of financial data.

The study is due to report finally in the late autumn of 1998 by which time the 53 first wave TPPs will have entered their third purchasing and contracting cycle (1996/97, 1997/98 and 1998/99) and the 35 second wave projects will have begun their second year of purchasing and contracting (1997/98 and 1998/99).

# 4 PROFILE OF THE TOTAL PURCHASING PILOT PROJECTS IN THE NATIONAL EVALUATION

The national evaluation covers all 53 'first wave' projects and all 35 'second wave' projects. First wave TPPs began 'live' purchasing in April 1996. Second wave TPPs began purchasing in April 1997. Both first and second wave TPPs are a mixture of volunteer SFH practices which wished to develop TP themselves, together with other SFH practices encouraged by HAs to pilot the scheme.

In April 1996, before beginning to purchase, the 53 first wave projects consisted of 191 general practitioner practices, involving 960 general practitioners. In April 1997, just before going 'live', the 35 second wave TPPs consisted of 155 general practitioner practices and 674 general practitioners. Of the 53 first wave projects, one four practice project split into four distinct projects, and four first wave TPPs withdrew, making a total of 52 TPPs analysed in the first wave. Two projects in the second wave had also withdrawn from the scheme by August 1997. More detailed characteristics of first wave projects were documented in an earlier preliminary report (Mays, Goodwin, Bevan *et al.*, 1997). A similar baseline report covering second wave TPPs is also available (Malbon, Mays, Killoran *et al.*, 1998).

This chapter presents a brief profile of first and second wave TPPs and highlights the differences between first and second wave projects. By contrast, the remainder of this report concentrates on the first wave of pilots for which data are available on their first 'live' year. Table 4.1 shows the basic characteristics of first and second wave TPPs. The principal points of interest are as follows:

## Table 4.1 Basic characteristics of first and second wave TPPs

| | *First wave, April 1996* | *Second wave, April 1997* | *All* |
|---|---|---|---|
| *Basic features* | | | |
| Number of projects | 53[1] | 35[2] | 88 |
| Percentage of single-practice TPPs | 36% | 40% | 37% |
| Percentage of multi-practice TPPs | 64% | 60% | 63% |
| *Size* | | | |
| Mean number of practices per project | 3 | 4 | 4 |
| Median number of practices | 3 | 2 | 3 |
| Mean number of general practitioners | 17 | 20 | 18 |
| Median number of general practitioners | 16 | 10 | 12 |
| *TPP patient population* | | | |
| Range in patient population | 8,100-84,700 | 8,500-319,280[3] | 8,100-319,280[3] |
| Mean TPP patient population | 31,300 | 34,900 | 32,700 |
| Median TPP patient population | 28,200 | 18,000 | 23,000 |
| *HA patient population* | | | |
| Mean percentage of HA population served by the TPPs | 6% | 10% | 7% |
| Median percentage of HA population served by the TPPs | 6% | 4% | 5% |
| Mid-range (25%-75%) of HA population served by the TPPs | 3%-8% | 3%-9% | 3%-9% |
| *Organisational features* | | | |
| Proportion of TPPs with a dedicated project manager | 66% | 43% | 59% |
| Proportion of TPPs with a 'complex' organisational structure | 38% | 40% | 39% |
| Proportion of TPPs with a 'simple' organisational structure | 30% | 11% | 24% |
| *Experience of fundholding* | | | |
| Percentage of TPPs with first or second wave fundholders | 73% | 40% | 60% |
| Percentage of TPPs without first or second wave fundholders (i.e. third to sixth wave fundholders) | 27% | 60% | 40% |
| *Management costs in the preparatory year* | | | |
| Mean per capita cost in the preparatory year, wave 1 *(n=51)* in 1995/96 adjusted to 1996/97 prices and wave 2 *(n=29)* in 1996/97 | £2.79 | £2.40 | £2.65 |
| Median per capita cost in the preparatory year, wave 1 in 1995/96 adjusted to 1996/97 prices and wave 2 in 1996/97 | £2.71 | £2.09 | £2.48 |
| *Management costs in the first 'live' year of purchasing: first wave (n=50), 1996/97* | | | |
| Mean per capita cost in the first 'live' year | £2.90 | - | £2.90 |
| Median per capita cost in the first live year | £2.78 | - | £2.78 |
| *Future ambition for 1997/98* | | | |
| Percentage of TPPs whose future ambition is to do more in TP-specific areas | 77% | - | 77% |

[1] *Four first wave TPPs withdrew from the scheme*
[2] *Two second wave TPPs withdrew from the scheme*
[3] *One second wave TPP includes 'unofficial' group of nine non-fundholding practices.*

- There are more single practice TPPs in the second wave than the first - 40 per cent compared with 36 per cent.
- There is more variation in size amongst second wave TPPs than was observed in the first wave, this is due to the partly 'unofficial' nature of some of the second wave projects, some of which included non-fundholding practices, which greatly increased their size.
- Second wave TPPs are on average smaller than first wave projects, with fewer general practitioners, fewer practices per TPP and a smaller median patient population. The mean population suggests otherwise, but this is due to the variability of size of second wave projects, as noted above, and the fact that there is one district-wide TPP in the second wave comprising 45 general practitioner practices.

In addition, first wave TPPs are considerably more likely to employ a dedicated TP project manager than second wave projects. This is likely to relate to the higher number of single practice projects in the second wave. However, second wave TPPs are less likely than first wave TPPs to have a 'simple' organisational structure as assessed by looking at the number of formal committees and sub-groups in the TPP (see Mays, Goodwin, Bevan *et al.*, 1997 for details of this organisational classification) despite being smaller. Eighty per cent of second wave TPPs have developed either a 'complex' or 'intermediate' structure to manage TP compared with 70 per cent in the first wave.

Interestingly, first wave TPPs have far more fundholding experience than second wave projects. Almost three-quarters of the practices involved in TP in the first wave had joined the SFH scheme by March 1993 (i.e. first or second wave SFH). Only 40 per cent of second wave TPPs had practices with experience of five or more years of fundholding (i.e. first or second wave SFH). Yet fewer of the second wave pilots have dedicated project managers to help them implement TP.

Table 4.1 also shows that second wave TPP reported lower direct management costs per patient in their preparatory year than first wave TPPs, presumably because fewer had dedicated project managers. It will be interesting to see how the second wave TPPs' first 'live' year of management costs compare with the management costs observed in the first wave TPPs' first 'live' year of purchasing.

A further difference observed between first and second wave TPPs is the number of projects that lie inside the centres of major towns and cities. As noted in the earlier baseline report on first wave TPPs (Mays, Goodwin, Bevan *et al.*, 1997), most were located in suburban and rural areas. However, approximately 20-25 per cent of second wave projects are to be found in three of England's major cities, Manchester, Birmingham and London.

Ten second wave projects were within HAs which also contained a first wave TPP. The projects varied in size across the regions with the largest TPPs (on average) in the North Thames region and the North West for first wave projects and in the South Thames and the Northern and Yorkshire regions for the second wave. Altogether, the first wave national TPPs (n=52) cover a patient population of about 1.75 million and the second wave cover a population of 1.19 million. Taken together, approximately 5 per cent of patients in England and Wales are covered by TPPs in the NHSE scheme.

Overall, then, second wave projects are smaller with less fundholding experience than first wave TPPs and spend less on management. However, they are more likely to have more complex organisational structures to manage TP than in the first wave. All this suggests that they may take longer to develop than the first wave TPPs (Mays, Goodwin, Malbon *et al.*, 1998).

# 5 REQUIREMENTS FOR EFFECTIVE COMMISSIONING ORGANISATIONS

The main goal of any purchasing or service commissioning organisation is to secure the delivery of high quality, effective, acceptable and equitable health care at minimum cost. To what extent are first wave TPPs likely to be able to accomplish this goal over their two years of TP (1996/97 and 1997/98)? In turn, what can we learn from their experience which will contribute to the successful development of PCGs now that the government has its preferred model of local commissioning from the range previously in existence (see Figure 2.1). One way of attempting to answer these questions is to set out the main processes and functions required for health services commissioning. It is then possible to see to what extent, in principle and in practice, the wide diversity of TPPs described in the previous section, is capable of fulfilling these requirements. The requirements are selected on *a priori* grounds and, as a result, possessing all of them does not necessarily guarantee effective purchasing/commissioning in specific circumstances. They are necessary, but not sufficient requirements. A number of other ingredients, in particular, the *context* in which organisations are operating, will play a part in effective TP and other forms of purchasing/commissioning. These additional ingredients are discussed for TPPs in the next two chapters of this report; the first of which (Chapter 6) looks at the formal characteristics of projects and their behaviour associated with their relative achievements in the first 'live' year of purchasing; and the second of which (Chapter 7) looks more broadly at the interaction between the *content* of change, the *context* of change and the *process* of change at TPPs. Part of the *process* relates to the prerequisites discussed in this chapter. Any organisation with pretensions to securing health services for its population which cannot demonstrate that it has in place most or all of the prerequisites set out below, is highly unlikely to begin to be able to purchase/commission effectively irrespective of the content or context of the changes which it wishes to bring about.

**Prerequisites for effective purchasing/commissioning**

Mays and Dixon (1996) set out two sets of prerequisites or basic requirements for purchaser organisations in an NHS environment; one set related to *processes required to meet the goals of purchasing*; the other set related to the *qualities of the purchaser organisation*.

*Processes required to meet the goals of purchasing*

These were as follows:

- *assessing patient needs* - since the patients who demand care do not always need it and since general practitioners' clinically informed perceptions of the needs of their patients are

inevitably partial, effective purchasing requires at least some acknowledgement of the importance of attempting to undertake systematic, population-focused, needs assessment exercises incorporating a variety of user and professional perspectives;

- *setting appropriate priorities* - purchasing organisations need mechanisms for deciding the balance of resources which they wish to devote to different service areas and patient groups, including methods for deciding how to manage treatment for patients with rare and/or costly service requirements for which it is unlikely that prior service agreements or contracts will have been negotiated. Purchaser organisations need to decide the level at which different types of priority setting decision should be taken, depending, for example, on the availability of the necessary expertise in different parts of the health system;
- *obtaining and using adequate information about services* - purchasing organisations must have the capacity to obtain both descriptive information about the cost and quality of the services currently used by its population and generalisable evaluative evidence about the effectiveness and cost-effectiveness of treatments;
- *informing and involving patients in purchasing decisions* - as increased responsibility for shaping health services moves from HAs which are accountable (however imperfectly) to the Secretary of State for Health and onward to Parliament for their decisions, to groups of general practices run by independent contractor practitioners, it becomes increasingly important that patients understand the basis on which decisions have been taken and have some opportunity to influence them. This is still more important when the practitioner-led organisations are growing in size so that the theoretical possibility of patient 'exit' diminishes;
- *monitoring and maintaining equity* - given that equity of access to services for those in equal need is a basic principle of the NHS, it is a requirement of purchasing organisations that they should not only be concerned with the efficiency and quality of the services which they secure for their patients, but also with monitoring the use of those services in order to ensure that there is fair access between social groups and geographic areas in relation to estimates of need. As purchasing decisions are devolved to bodies serving smaller populations, the risk of inequity of access between and within each population is likely to increase;
- *minimising transaction costs* - a greater number of smaller purchasing organisations, particularly when these are based on the principles of general practitioner fundholding, risks increasing the volume and complexity of contracting within the system and, thereby, the level of transaction costs. It is the responsibility of purchasers to attempt to find ways of reducing unnecessary transaction costs (for instance, by negotiating simpler or longer

term agreements where these are compatible with maintaining incentives to quality and efficiency);

- *managing financial risk* - it is an obvious, but essential part of the role of a purchasing organisation in the cash-limited NHS that each purchaser should be able to live within its means. In order to ensure fair funding between different populations served by the NHS, it is now accepted that each purchaser, however small, should as far as possible, receive a budget based on some form of needs-weighted capitation formula. This arrangement means that budgets for services are constructed without reference to the actual level of demand for services, but rather in relation to estimated relative need. As a result, purchasers will face situations in which either because of random fluctuations in the demand for particular services (especially those for rare conditions) or because of new treatments or because of longer term trends in demand, they are in danger of overspending. They should take steps to manage these situations, preferably in advance. A number of strategies may be feasible such as handing the responsibility for purchasing services for rare conditions the incidence of which is difficult to predict over, say, a year, to another organisation serving a larger population. Another response is to arrange to share risk with other similar purchasing organisations, perhaps in the form of an annual levy 'top-sliced' from the budget of each or even to seek to use commercial insurance.
- *managing budgets* - as well as taking steps in advance to manage financial risk, a cash-limited purchasing organisation needs to be able to manage the level of demand for services and ensure that the volume of services delivered on its behalf equates to the resources it has committed to each through its contracts or service agreements with providers. For example, purchasers should be able to influence the rate of referral of patients to specialists, in-year if necessary, to stay within budget. One of the potential advantages foreseen for TP was that pilots would have incentives to tackle the twin problems facing the NHS as a whole in the 1990s of contract 'over-performance' by trusts and the seemingly uncontrollable rise in unplanned and emergency hospital admissions which were leading to HA purchaser deficits. However, to do this well, would require effective co-operation between previously entirely separate practices.

*Qualities of the purchaser organisation*

As well as having in place strategies and processes to undertake tasks such as needs assessment, contracting and risk management, Mays and Dixon (1996) identified a number of qualities which purchaser organisations should embody, as follows: .

- *sustainability* - purchaser organisations need to be robust enough to survive changes in key personnel, particularly the replacement of those who were instrumental in getting the organisation off the ground in the first place. In general practice-based organisations,

there are two particular concerns: that each practice involved participates actively in the management of the organisation; and that the managerial workload is shared sufficiently to prevent 'burnout' among the leading participants and enable successors to feel sufficiently confident to take over in due time. This also requires appropriate support and remuneration to practices to enable general practitioners to take part;

- *appropriate mix of skills* - in order to be sustainable and effective, local purchasing organisations require access to a wide range of skills such as in public health (for population needs assessment and understanding evidence of effectiveness and cost of treatments and service options), accountancy, information science, ethics, management development and so on. In addition, purchasing organisations at this level need access to high grade managers. The Audit Commission's study of fundholding concluded that practices which were better organised and which had invested in better management were able to bring about more changes in local services than those which were less well developed managerially (Audit Commission, 1996);
- *accountability* - this was a belated requirement for fundholders, but as more and more NHS resources are placed in the hands of local purchasing organisations below the level of the HA, it becomes increasingly important in a public service to ensure that adequate structures and mechanisms of accountability have been put in place by HAs. Formal systems of accountability are especially necessary where individual users are relatively poorly informed and powerless directly to influence what is done in their name as in the NHS;
- *minimising conflicts of interest* - any organisation of purchasing or commissioning which places general practitioners, community nurses and other primary care professionals in charge of budgets which include the resources for the services which they themselves have traditionally provided, runs the risk that conflicts of interest will develop. For example, self-interested providers could choose to provide those services which maximise their incomes or which relate most closely to their personal clinical interests. Some providers could offer services for which they lacked the expertise or experience, or which were inappropriate, for example, adding unnecessarily to, rather than substituting for secondary care. In these circumstances, there is need for external accreditation of providers and monitoring of the quality and appropriateness of the services provided when these are new to a non-hospital setting.

Having set out a number of requirements both for effective purchasing and effective purchasing organisations, the next step is to see to what extent the first wave TPPs have matched up to these prerequisites.

## Total purchasing pilots and the requirements for successful purchasing

*Assessing patient needs*

Standard fundholding was heavily predicated on the notion that general practitioners were capable of acting as well informed agents for their patients to secure for them better and more appropriate health services than HAs could. This assumption has not been explored critically hitherto. Interview data collected at first wave TPPs both in the preparatory period and towards the end of the first purchasing year, 1996/97 showed that the level of understanding of health needs assessment for purchasing, the importance attached to the process and the extent to which it was a feature of TPP purchasing varied widely. While three-quarters of TPPs reported that they had undertaken some sort of health needs assessment activity (Mahon, Stoddart, Leese and Baxter, 1998), the vast majority of purchasing objectives and intended service changes for 1996/97 were based not on an assessment of population needs, but on the experience of the general practitioners as primary care providers and their resultant views on local services.

Projects recognised the potentially central role which health needs assessment might play and many were given guidance and help by their HA public health medicine departments which they generally found to be useful. However, the depth of understanding of the techniques of health needs assessment varied widely with TPPs generally asking for guidance as to what the process entailed and how to undertake it. There was wide variation between projects in terms of what they regarded as needs assessment.

One possible reason for the limited use of needs assessment was the fact that many of the TPPs' purchasing objectives related to services outside acute hospitals where routine data which might have been relevant are poor or non-existent (Mahon, Stoddart, Leese and Baxter, 1998). Another possible explanation comes from studying those TPPs which had given particular priority to developing community and continuing care for patients with complex needs (Myles, Wyke, Popay *et al.*, 1998). None of these pilots showed any interest in adopting a strategic focus at a population level, for example, by attempting to relate needs to the development of an integrated pattern of services. Instead, their focus was on micro-level, operational links between agencies in health and social services for which formal needs assessment was not essential (although important opportunities for preventive action on behalf of older people in the community may have been missed as a result). The pilots which had given particular priority to purchasing and developing specialist mental health service were similarly uninvolved in undertaking psychiatric needs assessment at a population level relying

instead on the local knowledge and experience of the general practitioners (Gask, Lee, Donnan and Roland, 1998).

*Setting appropriate priorities*

Again, setting appropriate purchasing priorities appeared to be largely an informal process typically involving the practitioners in the project rather than any wider grouping. This reflected the fact that the projects had been set up quite deliberately with one or a small number of the general practitioners in a dominant executive position. All the TPPs had adopted a policy of *selective* purchasing, despite their title, partly in order to manage clinical and financial risk and partly because of the lead general practitioners' knowledge of, and interest in, specific types of provision. However, the decisions concerning which services to include and which to exclude or 'block back' to the HA varied from TPP to TPP. Not surprisingly multi-practice TPPs tended to find priority setting decisions more difficult to organise and implement than smaller and single practice TPPs (Mays, Goodwin, Malbon *et al.*, 1998).

Within each service area, the TPPs tended to be 'micro-level fixers' of perceived problems rather broad strategists (see Chapter 6, below, on their achievements in 1996/97). Pilots tended to work to extend existing primary and community-based services rather than to alter services provided in secondary care settings or to develop radically different styles of care in community settings (Mays, Goodwin, Malbon *et al.*, 1998; Myles, Wyke, Popay *et al.*, 1998). Thus for example, the main aims of those TPPs interested in changing mental health services were to acquire additional community psychiatric nurses and to improve communication between the practices and specialist providers of mental health care. A major thrust of national policy in the mental health field is directed at giving priority to improving provision for people with severe, long term problems whereas the TPPs have concentrated on increasing provision in primary care where those with less severe problems are more likely to receive more of their treatment (Gask, Lee, Donnan *et al.*, 1998). This raises questions concerning the appropriateness of TPPs' priorities and, in turn, the issue of who should be responsible for assessing the appropriateness of such decisions (see below for more on this).

In the field of providing care for elderly people with complex needs living in the community, TPPs did not undertake assessments of the needs of their older populations and so lost opportunities to develop early interventions aimed at preventing deterioration of these patients. Instead, their approach was to 'fix' what was obviously 'broken' in their local

services. In most cases, the latter was their perception that their patients' care in the community was disjointed and far from the 'seamless' ideal of joint health and social services working. Their solution was to recruit or obtain a generic 'care manager' to organise packages of health and social care for the registered general practice population (Myles, Wyke, Popay *et al.*, 1998).

*Obtaining and using adequate information about services*

The theoretical benefits of devolving budgets and the process of negotiating services between general practitioners and specialist providers in terms of improvements in the quality and cost of services will not be realised unless general practitioners have the information to be able to articulate their requirements for good quality, cost-effective services. When interviewed, at the end of the first 'live' purchasing year, project managers and lead general practitioners in most TPPs indicated that information systems and the availability of information, for example, on the pattern and nature of services used by the TPP population, were inadequate. There were major perceived problems generated by the lack of central guidance on information systems and an absence of standard software for TP. Each project had to start from scratch when thinking about their information requirements for TP. Most used modified fundholding software which was usually found to be inadequate and a few devised their own systems. Since TPPs were introduced as time-limited pilots, this may explain why there was no attempt to develop an information system for TP.

Equally, TPP themselves were not sure what information they wanted from trusts and in what format in the preparatory stages, making it difficult for providers to respond (Mahon, Stoddart, Leese *et al.*, 1998). TPPs were suspicious of HA information and there was poor understanding between projects and their parent HAs about the information necessary to support devolved purchasing.

TPPs further reported that poor activity and cost data had hampered their efforts to change services through negotiating new contracts and monitoring their implementation. This was a particular problem for mental health services and community health services where many trusts were unable to produce adequate information on the use of services by TPP patients and their resultant costs to support devolved purchasing. HAs appeared to manage with very little detailed information about the services which their finances for mental health and community health services obtained. Nonetheless, TPPs generally reported that there had been an improvement in the accuracy and timeliness of information during 1996/97 which they regarded as due, at least in part, to the contracting process beyond standard fundholding (Robinson, Robison and Raftery, 1998). In this regard, TPPs were acting as catalysts for change by alerting the practices themselves, trusts and HAs to the information requirements of

primary care-based purchasers and pressing for better systems to be put in place (Mahon, Stoddart, Leese *et al.*, 1998).

Turning to the use of research evidence for purchasing, for example, on the effectiveness and cost-effectiveness of particular treatments and services, most TPPs reported that they recognised the importance of using such evidence as a guide to their local decisions, at least in theory. However, they made little use of such evidence. Part of the explanation for this lies in the fact that so called Evidence-Based Medicine (EBM) tends to be disease-specific while most of the changes proposed by the TPPs were defined not by disease or procedure but as generic changes to the ways in which services were delivered such as reducing admissions, improving the quality of rehabilitation after discharge or making better use of community hospitals and other forms of intermediate care. In addition, there was no consensus at TPP level as to what constituted 'good evidence'. TPPs appeared to need some guidance on this and on how to obtain evidence and use it in practice. Much of the 'evidence' used to support their main purchasing objectives was 'soft' rather than 'hard' (i.e. predominantly based on local knowledge of a local 'problem' rather than underpinned by any published research). There were exceptions such as the use of research evidence to develop protocols for the treatment of leg ulcers and strokes in the community which were then incorporated in contracts. Generally, purchasing objectives were pursued either because a local service was regarded by the general practitioners as poor or because there was a threat of change from the HA (e.g. closure of a community hospital), or because of the particular clinical interest of one of the lead general practitioners. In mitigation, the shift from secondary to primary or community settings which was a feature of many of the purchasing goals of the TPPs could not easily be supported by specific research evidence (Coulter, 1996).

It is not surprising that TPPs made relatively little use of 'evidence' to support their purchasing since most HAs and trusts had no strategy on improving clinical effectiveness during the same period (Walshe and Ham, 1997).

*Informing and involving patients in purchasing decisions*

Informing, consulting and involving patients in developing or implementing purchasing plans and in reviewing the progress of projects was not a high priority for TPPs. If anything, the rationale for fundholding that general practitioners are well informed agents based on their long term, clinical relationships with their patients tended to encourage them to downplay the potential value or necessity for involving patients more formally. Lead general practitioners

were frequently aware of the difficulties and dilemmas inherent in attempts to involve patients. As a result, perhaps, purchasing priorities appeared to emerge from the views of a small number of practitioners with varying degrees of input from the local health authority.

Only two out of 53 projects formally involved the local Community Health Council (CHC) in their management during the preparatory year (Mays, Goodwin, Bevan and Wyke, 1997). Forty-six per cent of lead general practitioners said that they had done nothing to consult or involve their practice populations in the TPP. However, 40 per cent of lead general practitioners reported that they had actively consulted their patients through mechanisms such as surveys or patient fora or meetings (Dixon, Mays and Goodwin, 1998).

When considering how TPPs approached the development of particular services, the same picture emerges. Both in the field of mental health services (Gask, Lee, Donnan *et al.*, 1998) and in community and continuing care for elderly people (Myles, Wyke, Popay *et al.*, 1998), very little effort had been made to involve users either in assessing current services or in specifying how services should be modified in future and little to consult users over decisions. For example, only one of the five TPPs specifically chosen for detailed study because of their particular interest in developing community care for older people had taken any active steps to involve users. Myles *et al.* (1998) attribute this, at least in part, to the low level of awareness among project managers and lead general practitioners of current policy debate and guidance.

On the other hand, some of the TPPs and all the EFH practices involved in purchasing maternity care had taken steps to consult women about their experiences of care and to modify some aspects of the pattern of care in response. EFH practices were particularly conscious of the need to adopt this sort of approach. Wyke *et al.* (1998) attribute this behaviour to the strong, national policy guidance provided by the *Changing Childbirth* initiative (Department of Health, 1993) and the availability of well publicised examples and methods for collecting women's views of their maternity care.

*Monitoring and maintaining equity*

There are a number of different ways in which the development of TPPs could have influenced the equitable nature of the local health system:

- firstly, through the methods used by HAs to set their purchasing budgets;
- secondly, through the effect of their negotiations with local providers on patterns of access to and use of particular services by their own patients and those of non-TPP practices;
- thirdly, through the priorities they chose between specific patient groups and types of treatment; and

- fourthly, through the extent to which TPPs were expected to disseminate any examples of 'good practice' or service improvement locally to other bodies such as locality commissioning groups and to work collaboratively with others.

Budget setting remained a difficult area for both first and second wave TPPs (Mays, Goodwin, Bevan *et al.*, 1997; Malbon, Mays, Killoran *et al.*, 1998) with delays in agreeing both the methods to be used to calculate allocations and the final sums to be delegated to the projects. Although most HAs used elements of the national capitation formula for HAs to estimate the fair share of expenditure to which each TPP was entitled, most moderated its effect by making allocations with reference to capitation *and* to past levels of service use and cost. The common result of applying any element of capitation to sub-district populations is that the 'target' share of the TPPs differ from their recent past and current expenditure. Although this presents a potentially awkward management problem, it also offers an opportunity to investigate the reasons for such differences to see whether they are caused by provider prices, the underlying needs of the populations, or variations in clinical practice at both general practitioner and practice levels (Bevan, 1998).

On the second aspect of equity, namely that associated with equity of access to services between TPP and non-TPP populations, it was apparent that HAs were increasingly concerned to avoid circumstances in which it could be construed that TPP patients were receiving preferential treatment. This was most likely a response to the changing policy climate and to the growing possibility during 1996/97 that the government would change from Conservative to Labour. However, relatively little was being done to monitor service use in relation to population needs within each HA area in order to check whether services were becoming more or less equitable in use, perhaps because this requires moderately sophisticated data and analysis.

On the third aspect of equity between different patient groups with different needs, there is little or no evidence from the evaluation as to how individual projects arrived at their implicit and explicit purchasing priorities and whether participants considered the distributional consequences of their decisions for equity between patient groups. Since all the TPPs were *selective* purchasers in 1996/97, it is unlikely that they would have felt the need to adopt any sort of comprehensive view on priorities since the HA will have remained responsible for large parts of the services used by TPP patients.

On the fourth aspect of equity concerning sharing learning and working collaboratively with others, it was apparent that many HA leads viewed their TPP as a local development agency as well as a body purchasing services for its own enrolled population. Since the projects generally involved a considerable amount of interaction between TPP and HA staff, there was considerable opportunity for any innovations developed by the TPP to be made available more widely. The opposite was also apparent in the interviews with some HA lead managers in the preparatory period, with managers reporting that they saw TP as a means of getting their own ideas and plans taken up and implemented by the general practitioners. In this sense, HAs were, indeed, using the TPP as a development agency. Public health staff, for example, were able on occasions to suggest changes which were subsequently adopted by the TPPs as their own priorities. Given the Labour government's particular concern to maintain equity between commissioners and populations served, it is likely that more explicit requirements will be placed on PCGs in England in future to share information about innovations and 'good practice' with each other.

*Minimising transaction costs*

Standard fundholders were far more likely than HAs to adopt cost per case contracts for a wider range of circumstances (Goodwin, 1997). This increased the transaction costs of the NHS borne both by providers and fundholding practices. Increased costs were also generated when fundholders demanded more, better and more timely information from providers in order to monitor the services which their patients were receiving. There are signs that TPPs continued this tradition.

Unlike SFH, the costs of managing and supporting TPPs had to be met by HAs locally from within their existing budgets. Direct management costs were negotiated between the practices involved in each TPP and their local HA. Since the TP initiative increased the number of purchasing organisations within the boundaries of the HAs affected, it was likely that it would increase the direct management costs of local purchasing since this was now taking place in SFH practices, in TPPs, through a variety of locality and general practitioner commissioning groups and at HA level (Mays and Dixon, 1996). However, from about the time when TP was introduced government policy has been focused on an attempt to reduce the overall costs of running the NHS. This policy was given renewed impetus with the publication in late 1997 and early 1998 of NHS White Papers in each part of the UK. All three emphasise the desire of the government to reduce management spending. The English White Paper, for example, aims to take £500 million per year for five years from the current level of management spending by moving to longer term service agreements rather than annual contracts and eliminating cost per case agreements (Secretary of State for Health, 1997). As a result of this commitment, the management costs and broader transaction cost of TP and of the new PCGs in England, Local

Health Groups in Wales and Locality Co-operatives in Scotland will come under increasing scrutiny.

The direct management costs of the TPPs in the first wave (i.e. the costs of staff explicitly deployed to work on the project including some HA staff time if it was recognised in this way, plus all capital (e.g. equipment) and consumables costs at project level) varied extremely widely (from £5,100 to £339,000 in the preparatory year, mid-range £35,900-£115,900). There was little difference between the start-up year and the first live year and little difference between single and multi-practice TPPs in per capita costs The mean cost of TPPs was £2.82 for 1995/96 and £2.90 for 1996/97 (at 1996/97 prices) for both years with little difference for different sizes of project. Again, the range of per capita costs was very wide from £0.02 to £7.08 in 1996/97 (median £2.78; inter-quartile range £1.79-£3.80), suggesting that some TPPs at the lower end of the distribution were receiving considerable support from staff whose time did not appear as a direct charge on the management budget.

**Table 5.1 Direct per capita management costs of first wave TPPs, 1996-97, by size of TPP**

| Size of the TPP | Mean | Median | Range | Mid-Range | (n) |
|---|---|---|---|---|---|
| Single practice TPP | £2.70 | £2.76 | £0.69-£4.73 | £1.66-£3.63 | 18 |
| Two or more practices | £3.02 | £2.82 | £0.02-£7.08 | £1.83-£3.88 | 32 |
| Three or more practices | £3.02 | £2.76 | £0.02-£7.08 | £1.85-£3.86 | 29 |
| Four or more practices | £2.79 | £2.77 | £0.02-£7.08 | £2.07-£3.60 | 21 |
| All TPPs | £2.90 | £2.78 | £0.02-£7.08 | £1.79-£3.80 | 50 |

There seemed to be no systematic relation between management costs and the characteristics of the population served, further suggesting an arbitrariness and lack of consistency in the way in which HAs and TP practices had negotiated each TPP's management budget (Posnett, Goodwin, Griffiths *et al.*, 1998). This is not surprising given the novelty of TP and the absence of any NHS Executive framework setting out what was expected of TPPs. The basic idea behind the TP initiative has been interpreted in widely different ways across the projects and this is reflected in their management costs (Strawderman, Mays and Goodwin, 1996; Mays, Goodwin, Malbon *et al.*, 1998).

In a sub-sample of eight TPPs where the full transaction costs of TP were studied in detail, the incremental transaction costs of TP over SFH (i.e. *all* the costs incurred at project level, at the HA and by local providers) were found to vary between £1.42 and £4.18 per capita with a mean of £2.83 which is little different from the direct management costs which were derived from *all* TPPs, suggesting that the transaction costs calculated from the particular sub-sample are likely to be a low estimate of the possible range of costs. Eighty-five per cent of these costs related to the management and co-ordination of the TPP itself rather than costs generated at the HA or within local providers. While the bulk of these costs related to the direct management costs of the TPPs (e.g. project managers' salaries), 24 per cent of the total transaction costs were borne by the general practitioners themselves. Only 3 per cent of the additional transaction costs was generated at the trusts through the contracting process, suggesting that reducing the number of contracts or extending their duration as the government has recently proposed (Secretary of State, 1997) may do relatively little to reduce the transaction costs associated with devolved purchasing which seem to relate to the existence of separate purchasing entities at practice level (Posnett, Goodwin, Griffiths *et al.*, 1998). It was especially noteworthy the extent to which the additional management costs of TPPs were related to co-ordination and communication activities between practices and between practices and the HA. Given their considerably larger size, this suggests that the transaction costs of PCGs, at least initially, will be very similar, if not higher.

TPPs in the highest quartile in terms of their management spending at project level (over £3.70 per capita) were among the more active and higher achieving TPPs in 1996/97 (see Chapters 6. and 7., below for more on the factors associated with achievements). Their higher management costs were mainly explained by the extent to which general practitioners and other practice staff were reimbursed for their time on the project. Overall, these findings suggest that extending devolved purchasing/commissioning effectively beyond SFH will tend to *increase* rather than reduce the total management and transaction costs in the NHS, assuming that all other things remain the same.

*Managing financial risk*

There was a tendency to believe at the outset of the TP initiative that many of the pilots would prove to be too small in population terms (median 28,200; range 8,100 to 84,700) to manage the full range of financial risk to which they would be exposed. However, it became apparent during the preparatory period (1995/96) that all the TPPs were intending to purchase *selectively* for the foreseeable future, thereby reducing their exposure to certain types of risk and that, since the pilots were sub-committees of the HA and remained an integral part of the NHS, there were opportunities for sharing risk, thereby simulating the effect of having a larger population. In addition, simulations of the effects of rare costly referrals for different sizes of

TPP, showed that pilots with around 30,000 population were likely to be well able to manage these risks in terms of the likelihood of costly referrals (Bachmann and Bevan, 1996).

Projects had also taken practical steps to manage risk in that 73 per cent shared risk with the HA and 31 per cent had an arrangement to spread risk over more than one year (again, this involves the HA making a calculation of the odds of other parts of its area under-spending). However, few of the projects had undertaken thorough risk assessments and few had kept any contingency funds, for example, for rare costly referrals, perhaps because they assumed that the HA would always bale them out (Bevan, Baxter, and Bachmann, 1998). Few TPPs were able to review their first live year to assess the extent to which good fortune versus good management had played a part in their reaching the year-end without an overspend. A key limitation, both for analysis and action to manage risk was the lack of timely activity and spending data and district-wide rates for rare, costly treatments.

In the event, only four pilots (8 per cent) spent more than they had budgeted for on rare costly referrals, suggesting that the initial fears about risk management were ill-founded even for populations the size of TPPs. Surprisingly, however, the population size of the TPP did not affect either the risk management methods used or the consequences, except that *smaller* TPPs (with fewer than 30,000 patients) were more likely to underspend their budgets for rare costly referrals. This indicates, once again, that larger pilots had found it more difficult to organise themselves as purchasers.

The implications for PCGs appear to be, that 100,000 population is more than adequate for managing risk in an actuarial sense, but that to do it well requires that all the general practitioners are actively involved in resource management.

*Managing budgets*

Looking at the routine management of budgets by TPPs, the smaller projects were less likely to report overspending. Larger, multi-practice projects found it more difficult than single practice TPPs to adjust their patterns and levels of spending during the year to remain within projected levels. At first sight, this appears strange in that one would have expected larger projects to have had more predictable patterns and levels of expenditure and, therefore, to have been more likely to stay within budget. However, since the size of any random variation in spending might be expected to be greater in smaller TPPs, the finding could simply have arisen by chance in the smaller projects. In another year they might all overspend! Another,

very different kind of explanation seems to be at least equally plausible and that is the greater organisational challenge posed by budgetary management in larger, multi-practice TPPs than in smaller, single practice pilots. This explanation draws attention to the vital importance for TPPs, and, by extension, PCGs in the future, of developing a robust inter-practice organisation. Evidence to support this explanation is shown in the fact that multi-practice projects were far more likely than single practice projects to leave responsibility for reviewing expenditure against budgets to the lead general practitioner alone. They were also far more likely to have reported dissatisfaction with their arrangements for managing expenditure and to have planned a new system for 1997/98, attempting to involve more of the practitioners.

In general, the response of the TPPs to financial pressures was to delay non-urgent treatments rather than, for example, to influence the referral rate, which is similar to the approach taken by most HAs. All this indicates that, although the structure of PCGs is moving towards the integration of primary care provision, secondary care financing and the 'gatekeeping' of access to secondary care (especially at Levels 3 and 4), this does not mean that all the general practitioners will spontaneously act to link clinical and resource decision making.

## The qualities of total purchasing pilot projects as organisations

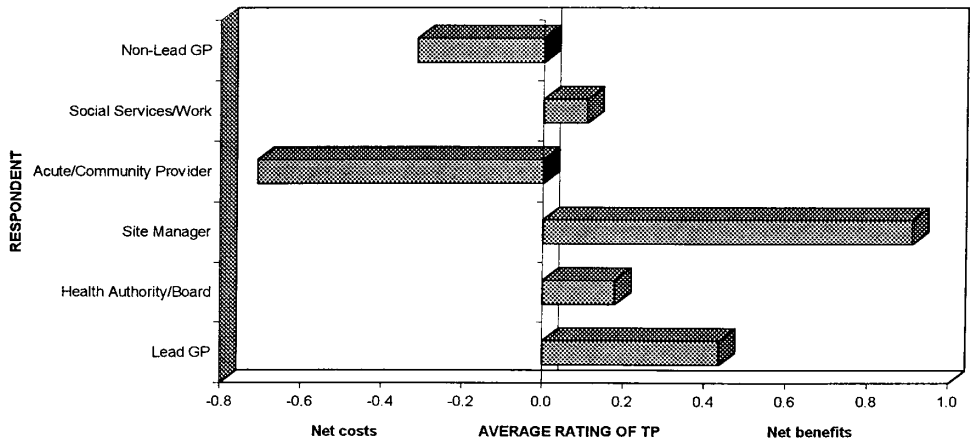
### *Sustainability*

If TPPs or other practice-based organisations are to comprise the basic building block of the NHS in strategic terms, their resilience becomes an issue of general importance. The fact that the bulk of the transaction costs of TP was borne at project level, particularly by the general practitioners (see above), supports the concern expressed by the TPP lead general practitioners in the preparatory year (1995/96) about the level of additional work generated by the scheme and whether the level of commitment required could be sustained in the longer term (Mays, Goodwin, Bevan *et al.*, 1997). Time constraints and general practitioner managerial workload were the most commonly cited drawbacks of TP, followed by the negative effect of TP on the relations between the lead general practitioner(s) and his/her partners, brought about by the conflicting demands of running a pilot and a series of general practices at the same time. Similarly, after the first purchasing year (1996/97), both lead general practitioners and project managers identified lack of general practitioner time as the most common potential obstacle to the successful implementation of TP (see Table 8 in Mays, Goodwin, Malbon *et al.*, 1998). High general practitioner workload was implicated in the withdrawal of three of the four projects to pull out by mid-way through 1996/97. The conclusion reached after studying the preparatory period thus remains. TPPs appear to be heavily dependent on the creativity and energy of a relatively small number of people, especially the lead general practitioner(s) and to a growing extent the project manager. The

pivotal role of the general practitioners, particularly in setting and implementing the purchasing plans of the organisation raise questions about their longer term ability to cope with TP work pressures when these are combined with their remaining clinical roles.

There is also the related concern as to the nature of the incentives for general practitioners to make a major commitment to managing a TPP given that automatic practice allowances and staff support were not on offer unlike the arrangements for SFH. Very early in the course of the evaluation the lack of clear incentives for general practitioner participation was identified by the evaluation team as a potential weakness of TP (Mays, Goodwin, Bevan and Wyke, 1997). This remains an issue, particularly if and when the highly motivated lead practitioners who were involved in the establishment of TPPs wish to step down in favour of their colleagues. It is not at all clear that obvious successors exist in all projects. Indeed, in many TPPs the non-lead practitioners only tolerate the scheme as long as its operation does not impinge on their clinical work or time. Other evidence for the lack of non-lead general practitioner involvement came from the work on financial management which showed that in almost two-thirds of TPPs only the lead general practitioner was involved in reviewing and making decisions about the expenditure against budgets (see above, this chapter) (Bevan, Baxter and Bachmann, 1998).

**Figure 5.1 Key participants' average global assessments of benefits minus costs of total purchasing, February 1996 to December 1997**



The issue of sustainability and, particularly, of who will succeed the current lead general practitioners in the future was underlined in the data collected each month from samples of lead and non-lead general practitioners, project managers, HA leads, social services representatives and provider representatives at first wave TPPs on their global perceptions of the costs and benefits of TP (Mays, Goodwin, Bevan and Wyke, 1997). Figure 5.1 summarises these data by presenting the average net perceived global benefits of TP for each group of participants for the period February 1996 (the end of the preparatory year) to December 1997 (mid-way through the second 'live' year, 1997/98) (Jacinta Lee and Sally Wyke, personal communication). It shows that on average the project manager, lead general practitioner and, to a lesser extent, the HA lead assessed the benefits exceeding the costs whereas the non-lead general practitioner and provider representatives assessed the costs exceeding the benefits. The response rate among the non-lead general practitioners was also the lowest of all the groups and considerably lower on average than the response rate among the lead practitioners (37 per cent versus 53 per cent). Although the relatively low response rates overall to the monthly assessment of costs and benefits means that the results should be treated with caution, the very low response rate among the non-lead general practitioners does suggest that the existence of the TPP had little salience for them, perhaps because in many cases they were not very involved in the project.

Looking at global perceptions of costs and benefits over time in each participant group (see Appendix 1 for details) shows that the project managers (perhaps not surprisingly) rated the benefits higher than the costs every month in the 23 month period, whereas providers only rated the benefits as higher than the costs in three of the 23 months. The lead general practitioners appeared to have become more supportive of TP over time since in four of the first five months they rated the costs as greater than the benefits, yet thenceforward they rated benefits greater than costs, and to an increasing degree, with each passing month. A similar pattern of increasing support for TP was shown by the HA staff who responded. These patterns of responses suggest that the benefits of TP are recognised by those most closely involved in each project.

*Appropriate mix of skills*

By selecting which services actively to purchase and which to 'block back' to the HA, the TPPs effectively reduced their requirements for expertise and information over a wide area of service. Nonetheless, projects still required support from their local HA. By collaborating with their local HAs, TPPs were able to obtain access to a range of skilled staff in disciplines such as public health medicine, information management, commissioning/purchasing, contracting, finance, etc. There were signs in the interviews with lead general practitioners of an increasing awareness and appreciation of the contribution of such staff to the success of the

TPPs between the preparatory period and the first 'live' year. In addition, those TPPs which had 'co-purchased' (i.e. a process of joint contract specification, negotiation and monitoring with the HA) services were able to report that it had been largely a beneficial process (Robinson, Robison and Raftery, 1998). Finally, it is interesting to note that high achieving pilots in the first 'live' year were more likely than low achieving projects to report a 'fair' or 'good' level of support from the HA (Mays, Goodwin, Malbon *et al.*, 1998). Indeed, the only major concern at one of the highest performing TPPs in the first 'live' year (see Chapter 6, below for more on how this was determined) was whether the HA would be able to sustain the level of support it had put in hitherto, as it was required increasingly in the future to develop devolved forms of commissioning elsewhere in its area, including a requirement for PCGs involving all practices by April 1999 (Secretary of State for Health, 1997).

In addition to access to appropriate skills at the HA, there is little doubt that projects required a good project manager to be able to continue unless they were very small, single practice projects. In this regard, it is worth noting that none of the four first wave TPPs which dropped out of the scheme had full-time TP managers. One TPP which had struggled to make progress was transformed when it was able to appoint its own project manager after a lengthy delay.

*Accountability*

The *administrative or managerial* accountability arrangements of the TPPs are a product of at least two things: the fact that the projects were deliberately established without a detailed specification of aims, objectives and methods of working to encourage local innovation; and the experimental or 'pilot' nature of the scheme which meant that the resources managed by the TPP had to remain the responsibility ultimately of the HA, unlike the position in SFH where the budget is the legal responsibility of the fundholding practice accountable to the Regional Office of the NHSE. As a result, all TPPs are technically sub-committees of their parent HAs and, in this case, it was judged that no additional steps needed to be taken by the Regional Offices to hold the projects to account for their use of resources other than the normal performance management arrangements which were in place for their parent HAs (Strawderman, Mays and Goodwin, 1996). As far as Regional managers were concerned, the TPPs' performance was the responsibility of the local HAs and no separate reporting was required. This was reflected in the low level of contact between Regional staff and TPPs (Dixon, Mays and Goodwin, 1998). Likewise, the HAs with TPPs believed that it would have been inappropriate to institute formal corporate contracts between themselves and their TPPs

since the pilots were technically part of the HA because the HA was legally responsible for their spending.

TPPs are monitored and held to account for their performance through their project boards which are normally comprised of selected HA executive directors and lead general practitioners from some or all of the TPP practices. The framework and currency of accountability is derived almost entirely from that developed for fundholding. Indeed, the NHSE instructed HAs to use this approach for their TPPs in 1996 (NHS Executive, 1996). As a result, all TPPs have to produce an annual purchasing intentions document and are subject to a regime of standard financial accountability which includes conventional assessment of the probity of expenditure, regular monitoring of spending against budgets, identifying variances and encouraging action to avoid potential over-spending. This aspect of accountability was dominated by narrowly financial concerns with only about 10 per cent of HA leads mentioning the issue of the quality of services purchased by the TPP. None of the HA leads mentioned investigating the appropriateness or value-for-money of what the TPPs purchased (Dixon, Mays and Goodwin, 1998).

Other aspects of managerial accountability are far looser and more informal than the financial monitoring. For example, six months before the TPPs went 'live' none of their lead general practitioners reported that they had been specifically required to work towards national policy targets except in relation to Patient's Charter standards (Dixon, Mays and Goodwin, 1998). Mid-way through the first 'live' year (1996/97) HA lead managers responsible for TPPs were asked what their TPPs were expected to achieve in relation to a range of major national policy goals (e.g. *Health of the Nation* (Department of Health, 1992), the Patient's Charter (Department of Health, 1991a), etc and their equivalents in Scotland). While there was an *expectation* in the majority of cases that pilots would work towards such policy objectives, there was little or no specific monitoring to see that this happened. There was some evidence that this was due, firstly, to a lack of management capacity at HA level; secondly, to a lack of accurate data with which to monitor performance; and, thirdly, some ambivalence shared between the projects and the HAs about the appropriateness of certain of the targets at the level of individual practices (e.g. *Health of the Nation* targets) or the apparent conflicts between targets (e.g. between developing a *Primary care-led NHS* and pursuing the logic of the former Purchaser Efficiency Index (PEI) which encouraged purchasers to maximise *hospital* activity since this could be measured and included in the PEI).

On *public or patient* accountability, just over half the TPPs had done something to inform or consult their patients about their purchasing intentions, leaving just under half which had done nothing at all (see above for more on this). The relatively low level of attention given to patient or public aspects of accountability was explained by the lead general practitioners in

terms of their high level of knowledge of their patients' needs and wants derived from their day-to-day clinical experience. Some of the lead general practitioners went further suggesting that their accountability to their patients as total purchasers was fulfilled by their clinical accountability for the welfare of their individual patients. Indeed, this attitude is consistent with the rationale for both SFH and TP which identifies the general practitioner as an especially well informed and able purchaser and agent for his/her patients due to his/her involvement with them as individuals, usually over a considerable period of time. Since the TPPs were set up specifically with the general practitioners occupying the leading executive roles, it is scarcely surprising that they should place heavy reliance on their own knowledge of their patients rather than more formal methods of informing and consulting them. This is also consistent with the finding reported above, that the main purchasing objectives of the first wave pilots for their first 'live' year were derived from the experience of the general practitioners rather than from needs assessment exercises, service reviews and other sources of intelligence, including patient consultation. Whilst these general practitioner attitudes and TPP behaviour are understandable, they do not amount to a sound basis for patient or public involvement or accountability in the future.

Finally, lead general practitioners and project managers were aware of the practical difficulties of involving patients and the wider public in meaningful discussion and this may have inhibited them from investing too much time and effort in setting up fora for patient involvement in the TPP with so much else to do. A number of lead general practitioners recalled meetings and consultation groups which had either been very poorly attended or which had had to be cancelled for lack of interest (Dixon, Mays and Goodwin, 1998). Pilots could also point to the limited success of local HA initiatives to consult or involve the public despite the fact that HAs (and presumably, by implication, TPPs) are required to demonstrate a commitment to public consultation and involvement under the terms of the *Local Voices* initiative (Department of Health, 1991b).

*Minimisation of conflicts of interest*

TP was introduced into the NHS as the experimental extension of the SFH scheme to allow fundholders to purchase a wider range of HCHS. Although it was conceived primarily as a form of devolved *purchasing* (NHS Executive, 1994), like SFH, it was also likely to affect the practices involved in their more traditional roles as *providers* of General Medical Services (GMS) and other primary care services. From its inception, SFH had blurred the distinction between the purchasing and providing of health care. For example, the fundholding budget

included both elective HCHS and general practitioner prescribing resources and fundholders had the capacity to vire monies between 'savings' on their CHS allocations and, for example, investing in extra equipment for their practices. By contrast, elsewhere in the internal market, there was a very clear separation between HAs as purchasers and NHS trusts as providers. Although the TPPs were instructed via their parent HAs to manage their GMS, SFH and TP budgets separately, in practice, these distinctions came under pressure when TPPs wished to shift services from secondary care providers to primary, intermediate and community settings, including their own practices. Indeed, it was apparent by the end of the first 'live' year that a minority of pilots were acting predominantly as '*Primary care developers*' rather than as '*Commissioning*' projects (see Chapter 6, below for definitions of these terms).

Typically, the blurring of purchaser and provider roles occurred when TPPs used their TP budgets to extend the scope and scale of services provided via the primary health care team, sometimes investing in staff who were employed in the practices rather than by the local trusts. Another development associated with TPPs was to shift resources from the acute sector into a local community or general practitioner hospital or a nursing home with the TPP general practitioners providing the medical cover rather than hospital consultants. In one TPP, the practices extended the range of outpatient services which were provided in primary care, but with the general practitioners themselves receiving remuneration for staffing the clinics. It was apparent from the analysis of the first wave TPPs' achievements in the first 'live' year that pilots found it far easier to implement purchasing objectives where these involved elaborating the primary care team rather than altering secondary care provided by specialist agencies (Mays, Goodwin, Malbon *et al.*, 1998). These trends could be regarded as helpful developments towards a more vertically integrated service linking formerly separate primary, intermediate and secondary services together through the agency of the TPP. However, they also pose a novel regulatory problem for the health system and, particularly, for the local HA, since the general practitioners are effectively acting as purchasers of their own services and those of their employees. As far as can be ascertained, this issue was dealt with by HAs in 1996/97 on an ad hoc basis. For example, some HAs established protocols which specified in some detail the content of the services which TPP practices could provide from their TP budgets and set up simple accreditation criteria to ensure that the staff providing the new service were trained and/or competent to do so. Such procedures are likely to become increasingly relevant in future with the evolution of PCGs in England into Primary Care Trusts (Level 4 PCGs - see Box 2.1) contracted by their local HA to purchase and provide a near comprehensive range of health services for an enrolled population (Secretary of State for Health, 1997). This may be less of an issue elsewhere in the UK, for example, in Scotland where the commissioning of general practice is to be downplayed in future.

## Implications of the development of the total purchasing pilot projects for Primary Care Groups (PCGs)

*How did the total purchasing pilots shape up against the prerequisites for effective purchasing/commissioning?*

Table 5.2 summarises the degree to which the first wave TPPs appeared to be able to undertake the processes required for effective purchasing/commissioning and the degree to which they embodied the necessary qualities as organisations. It shows that after a year's preparation and one year of purchasing TPPs were still largely small-scale, informal organisations relying on the experience and views of the leading general practitioners to set their purchasing intentions, without access to good information and without involving their patients in their decisions. In this sense, they were acting in very much the same way as they did as general practices providing primary care to their lists of patients rather than as public bodies managing a delegated budget on behalf of the health authority. The way in which the TPPs operated was also a reflection of their pilot status and the desire of the NHSE not to stifle the general practitioners with more than an absolute minimum of formality, rules and systems of accountability. That this was possible is probably due mainly to the fact that rather than being genuinely *total* purchasers, the TPPs were all *selective* purchasers. This allowed them to limit their exposure to financial risk, but also meant that they could avoid service areas where they might lack information or expertise and avoid the necessity to set priorities across the full range of health services which could entail controversy with their patients and the wider public.

## Table 5.2 Extent to which TPPs exhibited prerequisites for effective purchasing/ commissioning from Mays and Dixon (1996)

| Prerequisites for effective purchasing/ commissioning | Extent to which first wave TPPs exhibited prerequisites, 1996/97 |
|---|---|
| *Processes required to meet goals of purchasing/commissioning* | |
| Assessing patient needs | Mostly not, in that most purchasing objectives based on general practitioners' experience. TPPs were 'micro-level fixers' rather than population strategists |
| Setting appropriate priorities | Arrived at by general practitioners through a largely implicit process. All projects were selective purchasers, but what was selected varied between projects |
| Obtaining and using adequate information about services | Information systems and quality of data within them perceived to be inadequate by most TPPs. TPPs were encouraging better cost and activity data to be collected (e.g. from community trusts) |
| Informing and involving patients in purchasing decisions | Not a high priority in first 'live' year. Only half had taken any steps to consult patients. Low level of awareness of national guidance in this respect |
| Monitoring and maintaining equity | Little HA action to monitor access to services between TPP and non-TPP populations. HAs increasingly concerned to set fair budgets for all devolved purchasers |
| Minimising transaction costs | TP added to transaction costs overall, but evidence of reduced costs for acute providers due to practices contracting together. Most additional costs at project level related to running the organisation rather than contracting process |
| Managing financial risk | Selective approach to purchasing enabled TPPs to manage risk, but few had undertaken thorough risk assessments |
| Managing budgets | Responses to financial pressures tended to be crude (e.g. use of waiting lists) and there was a low level of involvement from non-lead general practitioners |
| *Qualities of the purchaser organisation* | |
| Sustainability | Projects depended on very few people at practice level especially lead general practitioner and project manager. Non-lead general practitioners view costs exceeding benefits of participation. May be difficult to identify replacement lead general practitioners and sustain levels of HA input |
| Appropriate mix of skills | Generally good level of HA support, increasingly appreciated by pilots, but some HAs concerned about sustaining level of input given needs of other parts of district |
| Accountability | Part of overall HA accountability, not separately identified. Modelled on system for SFH with conventional financial oversight, but no value-for-money assessment and little concern about national goals. Weak patient and public accountability |
| Minimising conflicts of interest | TPPs continued blurring between purchaser and provider begun under SFH and purchased an increasing range of services from themselves . Developed more potentially vertically integrated patterns of services |

*Implications for Primary Care Groups (PCGs)*

Compared with TPPs, PCGs will be greater in size and in the extent of their responsibilities. They will not be time-limited experimental, pilot projects, but the basic local building blocks of the NHS. As a result, HAs will not have to take a potentially risky investment decision as to whether to support them or not; rather they will all be *required* to develop PCGs. The experience of the TPPs reported in this chapter indicates that PCGs will have to have, from at least 'level 2' (i.e. when they take budgetary responsibility), explicit information, management and accountability systems. There will have to be less reliance on 'happenstance' and ad hoc solutions, if only because PCGs will not have the luxury of relying on volunteer practices and practitioners. Systems and methods of working will have to be developed with the needs of inexperienced practices in mind as much as experienced former fundholders and total purchasers.

While TPPs are, in theory, 'level 2' PCGs, using the terminology of *The new NHS* White Paper (Secretary of State for Health, 1997), there are clearly significant changes required and issues to be addressed by most if they are to advance to levels 3 & 4 (see Box 2.1, above, for definitions of levels). The establishment of PCGs is about the creation of primary care organisations that promote the health of their communities and commission provide services. Therefore, the range of requirements to be competent as a PCG extend beyond purchasing. The HA's role in accreditation of the competence of PCGs to operate at the four different levels will be central to the development of PCGs.

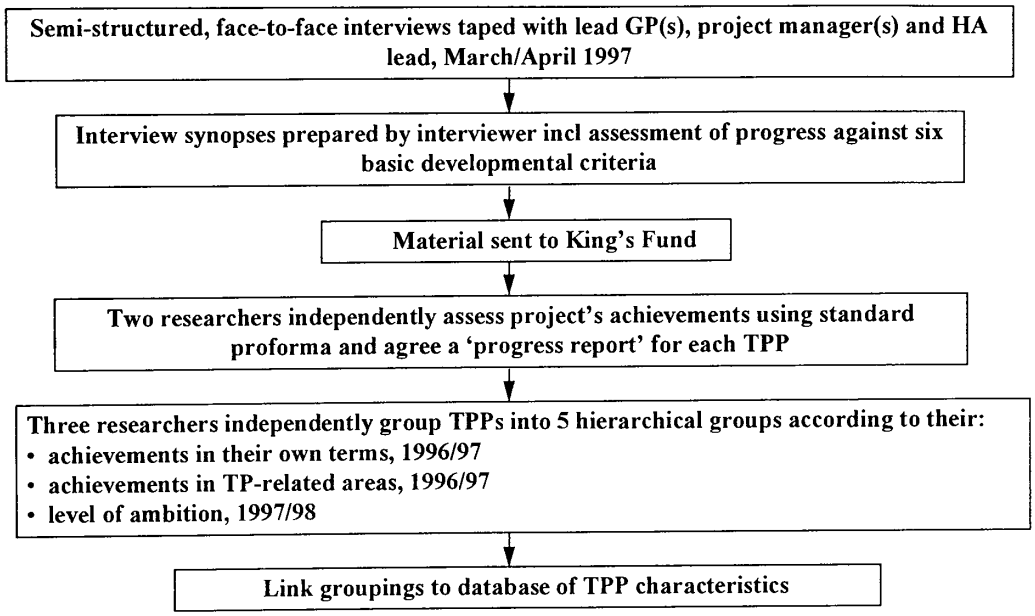
# 6 ACHIEVEMENTS IN THE FIRST 'LIVE' YEAR AND POTENTIAL FOR THE FUTURE

This chapter reviews the extent to which the first wave TPPs attained their main purchasing/ commissioning objectives in 1996/97 together with preliminary analyses of the degree to which TPP service changes were detectable in patterns of inpatient utilisation recorded in routine data systems. It also highlights some of the innovations brought about by the leading TPPs in order to give an indication of how TPPs bring about service change and, thereby, the potential of TP, when circumstances are favourable, for improving health services. The chapter continues by presenting an analysis of factors which appear to be associated with higher and lower levels of TPP achievement in the first 'live' year before concluding with a typology of the first wave pilots based on their pattern of development in the first two years, the sorts of service changes which they have focused on and their level of achievement.

## Assessing TPP progress and achievements in 1996/97

Figure 6.1 summarises the steps in data collection and analysis used to assess each first wave project's progress against six basic developmental criteria and in terms of the extent to which it met its principal objectives for 1996/97. Full details of the methods are given in a supporting National Evaluation of Total Purchasing Pilot Projects Working Paper (Mays, Goodwin, Malbon *et al.*, 1998).

## Figure 6.1 Stages in Data Collection and Analysis




The six developmental criteria selected by the research team before the projects went 'live' as purchasers were whether the TPP had:

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

Although it is possible to argue with some of the criteria (e.g. 'brought about any service changes' implies that TPP action should always be aimed at change. What if a TPP has intended *not* to change local services, perhaps in the face of a HA plan to make a change which the practices disapprove of and has succeeded in this?), taken together they comprise a simple assessment of the degree to which the project has developed along the lines implicit in the original Executive Letter (EL) which announced the scheme (NHS Executive, 1994). The criteria presume that TPPs were intending to develop as independent purchasers, hence the

second indicator listed above. As the findings presented below show, not all have interpreted TP in this manner, as the policy context has altered over the life of the pilots.

In order to assess the reported achievements of each project in relation to its purchasing and other main objectives for 1996/97, summaries of 'progress' during the year based on the face-to-face interviews were used by three researchers at the King's Fund acting independently to place each TPP in one of five hierarchical groups according to the project's ability to achieve its objectives *in its own terms*. This meant without taking any account of the scope or scale of the achievement. Achievements could also include developments in the organisation of the project, its internal and external relations and its information systems, which were not necessarily directly related to service change or development.

A second assessment of achievements was undertaken in the same way, but this time focusing exclusively on achievements *in TP-related service areas*. This meant looking only at achievements in the service areas which were new to general practice-based purchasing as a result of practices joining a TPP (i.e. achievements reported in areas such as maternity, services for the seriously mentally ill, care of the frail elderly in the community, accident and emergency services and emergency and unplanned medical admissions, including admission avoidance and reducing lengths of stay).

Thirdly, TPPs were placed into the five hierarchical groups, but this time according to their *future level of ambition* for 1997/98, irrespective of how much they had achieved in 1996/97.

Thus the achievements discussed below are largely derived from the accounts given by the main participants at each pilot and may have been influenced by their desire to present themselves in a good light. However, there are no very good reasons for thinking that the level of honest self-criticism varied systematically across the TPPs. In addition, reported achievements were only included where they could be corroborated by the lead general practitioner(s), project manager and HA lead on TP.

**Progress against six basic developmental criteria**

Four of the first wave TPPs had withdrawn from the scheme either permanently or temporarily by the beginning of the first 'live' year. Two were single practice project and two were multi-practice. Although the precise combination of reasons varied, common features were unsustainable time and managerial pressures on the lead general practitioner and difficulties either in agreeing a budget with the HA or managing one between practices. None of the TPPs which had to withdraw in the first wave had a dedicated project manager.

Of the remaining TPPs, one multi-practice project had effectively split into four single practice projects during the preparatory year and, so, allowing for the four projects which had dropped out, there were 52 TPPs whose achievements could be assessed against the basic developmental criteria in 1996/97. Five met only one of the criteria. Despite the fact that each developmental criterion was met on approximately 60-80 per cent of occasions, only 9/52 (17 per cent) of the pilots managed to attain all of them. Thirty-eight per cent of the projects exhibited half or fewer of the criteria.

There were some differences in the proportion of projects reporting that they had met each of the basic developmental criteria. Thus of those which had received a budget (approximately 60 per cent of first wave projects in 1996/97) and knew their financial position at the end of the year, 83 per cent (20/24) managed to keep to that budget, whereas only 61 per cent (31/51) reported that they had brought about any service changes. Of course, not all TPPs in the first 'live' year necessarily wished to bring about service change, and some wished to maintain services in the face of plans by others to make changes. Sixty-two per cent reported that they had purchased at least one service directly which exactly mirrors data on contracting collected from a different route elsewhere in the study (Robinson, Robison and Raftery, 1998). Sixty-five per cent reported that some activity had shifted into a primary care setting (without necessarily changing the nature of the service). A high proportion (79 per cent, 39/49) were assessed as having made 'effective external links' and, finally, 76 per cent (25/32) of the multi-practice projects had remained together over the first two years.

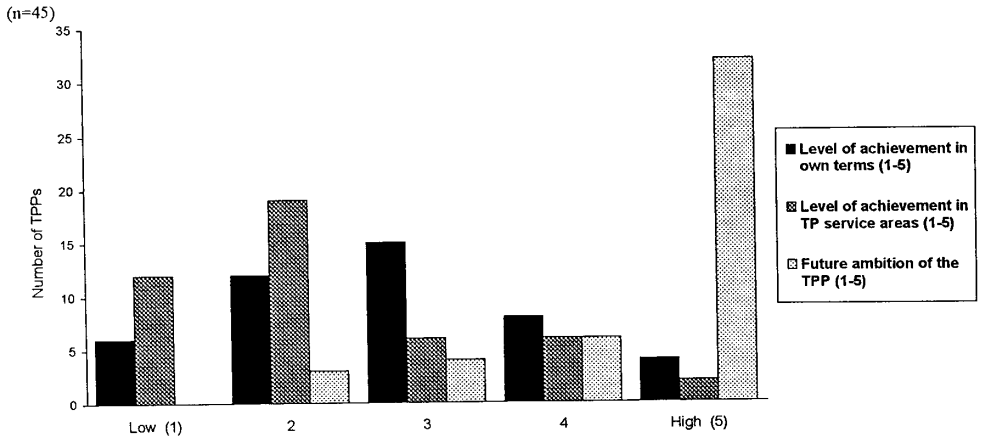
Clearly, not all the criteria will be regarded as being of equal importance as developmental markers for TP and there will be different views as to which these are, depending on judgements about the basic aims of TP. However, if purchasing services directly and changing services are thought of as more demanding criteria and closer to the NHSE's original vision of what TPPs were to do, then it is apparent that over a third of projects had not yet managed to reach these criteria after the first 'live' year.

**Achievement of main objectives**

Figure 6.2 shows the distribution of first wave projects between the five hierarchical groups, starting with the left hand columns which refer to TPPs' achievements in their own terms (see above for a definition). It shows the wide range of achievement which matches the range of attainment of basic developmental criteria. Most of the pilots had over-estimated what they could achieve in the first year. Only three of the 52 reported that they had been able to

achieve all four of the purchasing objectives which they had previously stated to be their main goals for 1996/97. These TPPs were placed in Group 5. At the other end of the rankings, two-thirds of the Group 1 TPPs failed to achieve any of their stated objectives.

**Figure 6.2 TPPs in five groups according to their level of achievement in their own terms, their level of achievement in TP service areas and their future ambitions**




The middle columns in Figure 6.2 show the distribution of projects on the basis of their level of achievement specifically in TP-related areas. Compared with the previous assessment of all their objectives, this ranking tends to depress the level of achievement (i.e. there are relatively fewer TPPs in the higher achievement groups), indicating that a noticeable proportion of TPPs' achievements were in service areas already included in SFH. For example, sometimes the existence of a TPP had enabled practices to work together in new ways in relation to their fundholding purchasing and provision. In other TPPs, the TP budget had been used to purchase additional services such as community psychiatric nursing which were already included in the SFH envelope.

Detailed case studies of TPPs which were high, middling and low achievers both in their own terms and in TP-related service areas are given in one of the working papers which accompany this report (Mays, Goodwin, Malbon *et al.*, 1998).

## Content of reported achievements

Table 6.1 shows the extent to which TPPs reported being able to achieve their four main objectives for 1996/97 by broad service area. The first five service areas listed in Table 1 represent the main new areas of purchasing introduced to practices when they moved from SFH to TP status. They are also the sorts of service areas in which it would be reasonable to expect that TPP action would have a significant effect on local health services.

**Table 6.1 Achievements and non-achievements of first wave pilots by service area, 1996/97**

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

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

Overall, just over half the main objectives were met, but this varied widely from 39 per cent in mental health to 87 per cent of the objectives which related to expanding the primary health care team (i.e. mainly CHS and others not necessarily new to general practitioner purchasing). It is perhaps not surprising that service development in the field of provision for people with serious mental health problems proved the most taxing area given its complexity and controversial nature. Indeed, even within this area, the majority of the reported achievements concerned enhancements to community mental health teams and practice-based community psychiatric nursing rather than developments in mental health trusts (Mays, Goodwin, Malbon *et al.*, 1998). This is not to say that there were no innovative or potentially important developments in mental health at the TPPs. One example of the potential of TP in mental health is discussed later in this section.

However, the general approach of the TPPs in mental health is in line with earlier evidence concerning the impact of SFH on the pattern of mental health services. This showed that fundholders tended to invest in more practice-based mental health staff, thereby increasing provision for patients with less severe forms of mental illness who are more likely to be manageable in primary care settings (Corney, 1996). This was occurring despite the emphasis of recent national policy on caring preferentially for the most seriously mentally ill (Gask, Lee, Donnan *et al.*, 1998), but may have come about, at least partly, because of the reluctance of specialist providers to respond to the requirements of the TPPs. For example, one pilot wished to refer all its cases preferentially to only one of the local mental health trust's consultant psychiatrists whose prescribing it approved of, but was resisted in this by the trust. The HA chose not to support the TPP.

Analysis of the achievements and non-achievements within service areas other than mental health demonstrated a similar pattern in which the achievements were more likely to be within primary care and the non-achievements in the first year were more likely to involve either negotiating changes in secondary or specialist providers or fairly major service developments such as minor injuries units which six pilots wished to establish in the first year and in which none succeeded.

**Future ambitions**

As well as collecting information on reported achievements in 1996/97, data were also collected on the future ambitions of the first wave TPPs for 1997/98 in order to have goals against which to assess their progress in the second 'live' year and in order to have some indication of the potential of TP in the longer term. The right hand columns in Figure 6.2 presents an assessment of the level of future ambition which was made in the same manner as the previous assessment of achievements. The vast majority of the projects (37/52) appeared in Group 5 which was defined as 'TPPs which intend to do more than previously and in TP-related areas'. This suggests that some of the projects had used 1996/97 largely as a developmental or further preparatory year (see below, this chapter for more on types of TPPs) rather than aiming to undertake significant amounts of independent purchasing. It is interesting to note that the more successful TPPs in the first 'live' year were also more ambitious for the second year of the scheme. This may indicate that achievements are in part a function of a pilot developing a clear sense of what it wishes to bring about (see below, this Chapter and Chapter 7, for more on the factors associated with different levels of achievement in the first year).

## The potential of the TPPs

Hitherto in this chapter, the achievements and ambitions of the first wave TPPs have been described in general terms, but it is also important to have an understanding of *what* TPPs typically wish to change and *how* they set about doing so at local level in order to have a sense of the scope, scale and potential of this type of general practice-led purchasing in future. There is evidence that the first wave TPPs are beginning to develop and use a number of home-grown variants on techniques and approaches familiar for some time to US managed care organisations (Robinson and Steiner, 1997). For example, TPPs have used utilisation review and subsequent utilisation management to attempt to reduce unnecessary admissions or days of hospital stay. They have employed discharge liaison nurses for the latter purpose. Other TPPs are in the very early stages of using guidelines and treatments protocols to attempt to reduce unjustifiable variations between secondary care providers and their own practitioners in clinical behaviour and resource use.

One way of investigating the potential of TP is to look in more detail at the reported achievements of some of the 'best' TPPs in the first year (i.e. those placed in the highest achievement groups whether assessed purely in their own terms, in TP-related service areas, or in terms of their future level of ambition). At this stage in the evaluation, it is not possible to be certain that all the consequences reported here actually occurred in the way predicted by the TPPs. Nonetheless, the examples given below give an indication of the nature of TPP action at local level.

*Developing forms of integrated care aimed predominantly at admission avoidance*

A large part of the rationale for giving practices wider budgetary responsibility, initially under SFH and later more widely under TP, was to encourage practices to consider the effects of their actions on resource use irrespective of whether this occurred in hospital or in the community and to consider the potential for making better use of facilities in secondary care in which previously they had had little or no interest. Since under full-blown TP, all or most care would come from the same budget, practices would have an incentive to make the best use of their resources wherever patients received their treatment through various forms of vertical and horizontal service integration (i.e. linking hospital and non-hospital forms of care *vertically* and linking health and social care in the community *horizontally*). In addition, to budgetary incentives, general practitioners could take advantage of the opportunities presented by TP to provide service more locally and accessibly for their patients, particularly in rural

areas where patients may have had to travel long distances to hospitals. Thus it is not surprising that many TPPs have devoted a large part of their energies to initiatives which either substitute primary and community for secondary care or which involve the development of various forms of intermediate care to support care in the community and to reduce reliance on acute hospital facilities or reduce length of stay, thereby, it is hoped, freeing up resources for other purposes. A related aim in many of these initiatives is to offer services which are closer to patients' homes and more accessible for themselves and their relatives than the previous pattern of provision.

For example, Box 6.1 summarises the four main objectives for 1996/97 of one of the TPPs which was most successful in achieving its objectives in TP-related service areas.

**Box 6.1: Four main objectives in 1996/97 of a TPP focusing on integrated care**

1. developing the local community hospital as the base for a 24-hour primary care-based accident and emergency centre with general practitioner cover in order to reduce use of the A&E department at the acute hospital;
2. developing the role of the local community hospital as a day and inpatient provider with general practitioner medical input to reduce medical admissions and length of stay at the main acute hospital;
3. setting up a practice-based pre-operative assessment service to reduce surgical length of stay; and, finally,
4. extending the number of practice-based outpatient and other clinics in order to shift a range of activity such as follow-up clinics from the acute hospital.

All four objectives involved shifting work out of the acute sector by making increased use of other facilities and non-acute sector skills, including a non-acute hospital and practice-level services. In part, these objectives were influenced and made possible by the presence of a relatively developed local community hospital to which the general practitioners had previously provided some medical cover, by the fact that the main acute hospital was relatively remote and by the fact that the TP budget could be used to pay the general practitioners to provide new services in the community. The TPP was also involved in a project to improve horizontal integration by improving collaboration between the practices and the local social services to reduce the number of patients admitted to acute psychiatric beds and improve care for people with complex needs as well as a vertical integration project to develop shared care for asthmatics linking secondary and primary care.

Another example of a TP which was attempting to develop horizontally and vertically integrated care is outlined in Box 6.2. It is known as the ProActive Care Team (PACT) initiative.

**Box 6.2: The Proactive Care Team (PACT)**

The PACT initiative aims to manage patients with mental health problems in a more individualised and integrated way than hitherto across primary, community and secondary care sectors through a multi-disciplinary, multi-agency team which includes general practitioners, community psychiatric nurses (CPNs) (acting as key workers for clients), consultant psychiatrists, counsellors. social workers, a pharmacist, a clinical psychologist and a local authority housing manager. The team works alongside the community mental health teams (CMHTs) of the mental health trust, but unlike them, it is practice-based and practice-managed through the TPP with strong general practitioner involvement. Protocols have been developed between the PACT and the CMHTs of the mental health trust. A similar team is being developed for elderly patients in this TPP.

The lead general practitioner estimates that, in the first year of PACT operating across all six of the TPP's practices, there was a reduction of a third in acute mental hospital admissions. On this basis, the TPP estimates that the PACT team could pay for itself in admissions averted in its second year of operation. However, the TPP was unable to obtain the support of the acute provider to release funds commensurate with the reported reduction in admissions. In this sense, a crucial part of vertical integration has yet to be put in place in this TPP. This was a commonly reported experience for TPPs in 1996/97. By contrast, the TPP and the PACT initiative had improved horizontal integration with close co-operation and information (if not budgetary) sharing between health and social services at practice level.

Another example of planned admission avoidance comes from a multi-practice TPP which reported a dramatic reduction in the level of psychiatric admissions brought about by extending the level and range of mental health provision available at individual practice level and building a CMHT at TPP level. The initiative was based on the experience of one of the practices in the pilot in appointing practice-based CPNs under SFH. The lead general practitioner from the pioneering practice took the lead role and promoted the approach to the other practices. During 1996/7, the TPP developed and expanded the level and mix of CPNs attached to member practices whilst developing a project-wide CMHT including psychologists and counsellors. The aim was twofold; firstly, to reduce the number of psychiatric admissions ; and, secondly, to improve the quality of care for mentally ill patients in the community. The

contract placed with the main mental health provider was also changed to one based on occupied bed days in order to encourage shorter lengths of stay.

Table 6.2 shows that the TPP managed to reduce the number of occupied bed days (OBDs) for psychiatric admissions for the under 65s by 16 per cent in the first year of 'live' total purchasing. This period coincided with the piloting of the CMHT in one of the TPPs practices with a gradual rolling-out to others during the year as the effects became apparent. It is estimated that there will a further 35 per cent reduction in psychiatric OBDs in 1997/98 as the CMHT develops across all the practices in the TPP. In two years, therefore, the estimated number of OBDs has reduced from 4,638 to 2,540 a year - a reduction of approximately 45 per cent. The HA estimates that the project had spent approximately £70,000 up to March 1998 on employing CPNs and other staff in the CMHT whilst avoiding approximately £200,000 in terms of admissions. The TPP has managed to redeploy the resources saved on other activities.

The reductions in OBDs in the TPP compare favourably with the trend in the rest of the HA where psychiatric admissions have risen during the same period. Indeed, there has been no overall reduction in admissions at the local mental health provider. Rather, comparatively more non-TPP patients have been treated thus costing the HA more. On the other hand, the HA has detected a reduction in the number of mental health ECRs, particularly to the private sector, since the pressure on NHS beds has been reduced by the actions of the TPP. The HA is considering the feasibility of rolling-out the TPP's initiative to the whole district, but is pessimistic since its judgement is that the few other general practices would be interested in or capable of implementing the CMHT approach.

**Table 6.2 Effect of a TPP Community Mental Health Team (CMHT) initiative on occupied bed days in psychiatry, 1995/96 - 1997/98**

| Year | Number of psychiatric OBDs under 65 years | Percentage reduction in OBDs |
|---|---|---|
| 1995/96 | 4,638 | 0 |
| 1996/97 | 3,901 | 16 |
| 1997/98 (estimate based on first 7 months of 1997/98) | 2,540 | 35 |
| **Estimated Overall Reduction 1996-98 (24 months)** | **2,098** | **45** |
| **Actual reduction in 19 months** | **1,531** | **35** |

*Developing forms of integrated care predominantly aimed at reducing length of stay*

It is common to find TPPs concerned to tackle what they perceive to be the twin problems of the inappropriate use of acute beds by patients who no longer need the facilities of the acute hospital and of 'bed-blocking' by such patients preventing more urgent cases being easily admitted. There have been a comparatively large number of examples among the higher achieving TPPs in 1996/97 of successful attempts to reduce lengths of stay, particularly through the use of discharge liaison nurses following the pioneering example of Bromsgrove TPP (Bromsgrove Total Purchasing Project, 1997). Table 6.1 showed how much more easily TPPs found it to reduce lengths of stay than to avert entire admissions.

In most cases, these initiatives have been allied to the development of community-based substitutes for hospital care in the form of hospital-at-home schemes and/or the purchase and use of general practitioner or nursing home beds. In many cases, there has often been a heated debate about the appropriateness of such initiatives and many clinicians within trusts have been understandably reluctant to hand over responsibility for discharge to TPP-employed discharge nurses. The consequences of early discharge schemes (e.g. in terms of re-admission rates and the possibility that the 'slots' created are simply occupied by more patients from non-TPP practices) need to be fully explored before such schemes can be considered successful. Nevertheless, there are examples which show that projects can substantially reduce lengths of stay.

Box 6.3 summarises the actions of a TPP which aimed to unblock beds in 1996/97 by discharging elderly patients sooner than they had previously been through increasing the number of community hospital beds, developing domiciliary care and investing in a project co-ordinator. In 1996/97, its actions were largely ineffective in that 'bed blocking' in the acute hospital was simply replicated in the community hospital. However, early reports from the project's second 'live' year (1997/98) indicate that with the appointment of a nurse co-ordinator and a more active discharge policy throughout the local inpatient system, substantial changes have been brought about in the number of days patients spend inappropriately in hospital.

**Box 6.3: Actions of a TPP aiming to reduce lengths of acute hospital stay, 1996/97 and 1997/98**

The TPP invested in three additional beds in 1996/97 to add to 10 at the local community hospital into which patients could be transferred from acute hospitals when they no longer required intensive treatment. In addition, a project nurse was employed to facilitate the transfer of patients whilst general practitioners within the TPP were paid from the TP budget for the additional clinical responsibilities in caring for these patients.

Initially, the discharge scheme was less effective than envisaged since the community hospital beds themselves became 'blocked' because the TPP was unable to gain access to adequate social care. In response to this problem, the project developed a community discharge team in co-operation with the community trust to help primary care staff manage patients at home who would otherwise have been admitted to, or remained, in hospital. A project nurse was appointed towards the end of the first 'live' year specifically to co-ordinate the scheme.

Recent evidence of 'lost' bed days (LBDs) (i.e. days wasted when a patient is in hospital for no other reason than awaiting discharge) at all its main providers suggests that the TPP's initiatives have had a substantial impact in 1997/98. The table shows that numbers of LBDs fell each month from July 1997 to the point when they were almost eliminated in January 1998. Significantly, the number of LBDs at the local community hospital (where the problem of bed-blocking had been the greatest) had shown the greatest fall.

**TPP Lost Bed Days, June 1997 to January 1998**

| Cumulative LBDs* | June | July | Aug | Sept | Oct | Nov | Dec | Jan |
|---|---|---|---|---|---|---|---|---|
| Health Authority | 1856 | 2196 | 2011 | 2187 | 2424 | 1739 | - | - |
| Total Purchasing Pilot | 298 | 421 | 208 | 191 | 167 | 117 | 43 | 3 |
| TPP Percentage LBDs | 16.0 | 19.1 | 10.3 | 8.7 | 6.9 | 6.7 | - | - |
| TPP Main Provider A | 27 | 31 | 11 | 21 | 22 | 30 | 22 | 0 |
| TPP Main Provider B | 57 | 71 | 43 | 27 | 0 | 0 | 0 | 0 |
| Community Hospital | 214 | 319 | 154 | 143 | 145 | 87 | 21 | 3 |

**Lost bed days i.e. days in hospital when patient no longer needed hospital care.*

Whilst the number of days spent by patients simply waiting for hospital discharge fell for the HA as a whole over the period of the scheme summarised in Box 6.3, the TPP's reduction was far greater, despite the fact that both the HA and the TPP had received additional resources during the second half of 1997/98 as part of the government's initiative to reduce the expected winter pressure on beds. The dramatic drop in 'lost bed days' among the patients of the TPP

appears to be causally related to the new discharge team and, especially, to the activities of the nurse managing the scheme. As a result, the project nurse and TPP manager remain confident that LBDs in the TPP can be kept to a very low level during the remainder of 1997/98 and beyond.

In another initiative aimed at reducing length of stay for non-psychiatric patients, one of the 'high achieving' TPPs has developed its own rehabilitation service at a local community hospital for patients after stroke, hip fracture and other orthopaedic surgery, together with frail elderly patients (see Box 6.4).

**Box 6.4: A TPP intensive rehabilitation team**

The aim of the team is to discharge patients earlier than would normally be expected from the main acute hospital and to support them via a multi-disciplinary team comprising a rehabilitation co-ordinator (a full-time nurse), a physiotherapist, an occupational therapist, a speech therapist and a dietician. As well as facilitating earlier discharge, the team has also reported being able to prevent admissions to the acute hospital.

Unfortunately, the project was not able to release the expected level of resources from its acute hospital contracts for further investment in rehabilitation and similar services because the acute trust refused in 1996/97 to change the contract currency which was based on Finished Consultant Episodes (FCEs). As a result, the acute provider was able to obtain the same remuneration for keeping the TPP's patients in hospital for a shorter length of time. The TPP was in a weak position since it could take little of its business easily away from the acute provider and its patients formed only a small part of the acute provider's income.

Despite reducing lengths of stay, the TPP in Box 6.4 was unable to release resources from its contracts with the local acute trust. This is similar to the experience of the PACT initiative discussed earlier (Box 6.2). Both examples show that the incentive for the TPP to continue to work to reduce the use of more expensive acute hospital resources and replace them with intermediate and community care will disappear if the TPP is unable to release any resources from an acute hospital which is determined to maintain its past income levels. In the rehabilitation example (Box 6.4), the hospital had a substantial deficit and was unwilling to cede any resources when work was shifted into the community. Without access to resources from the acute hospital, this TPP will not be able to sustain the rehabilitation team in the future.

Another relatively successful TPP faced a similar problem in 1996/97 in altering the contract currency in its acute contracts in order to be able to release resources for re-investment elsewhere. In this case, the TPP wished to alter the contract currency for emergency medical admissions from FCEs to Hospital Resource Groups (HRGs), the British equivalent of North American Diagnosis-Related Groups (DRGs), in order to reflect the shorter length of stay achieved by a discharge liaison team set up by the TPP. This sort of problem was repeated at a number of TPPs in 1996/97 and reflected the severe financial position of many acute trusts during the year. For example, a number of projects had disputes with their local acute trust about the 'over-performance' of contracts and demands from the trust for additional payment in-year. In other cases, there were disputes about the calculation of the 'savings' to be released from acute contracts following reductions in admissions or lengths of stay. Typically, arguments between TPPs and acute trusts centred on whether savings should be calculated on the basis of average or marginal costs and, in the case of marginal costs, the extent of fixed costs in the hospital. In one case of dispute, the HA found money to transfer in *advance* to the TPP for its *planned* savings in medical admissions by investing in an out-of-hours primary care service. The HA in its turn obtained the funds from its own acute hospital contracts. TPPs which attempted to claw back 'savings' retrospectively were largely doomed to failure.

Most of the TPPs which were trying to reduce medical lengths of stay altered their contract currency from FCEs to costs per diem. However, on occasions this produced a tactical response from the acute provider. For example, one TPP which was attempting both to reduce the lengths of stay of its patients at the local acute hospital and to release the resultant resources, was forced to alter the pricing structure of its medical inpatient contract in-year. The provider's response to a reducing length of stay had been to increase the price of the early days of stay (which tend to be the more costly in any event) in order to minimise the income loss produced by the shorter stays aimed for by the TPP. As a result, the savings which the TPP had planned to make for re-investment elsewhere were not materialising despite a reduction in length of stay. Instead, per diem prices for later days of stay were increased and those for earlier days reduced accordingly in a bid to generate some savings from a shorter length of stay. However, it is possible in this case that an aware provider would respond by lengthening stay again, thereby undermining the original objective of the TPP!

The lesson for aspiring TPPs or future PCGs from the experience of the first wave TPPs in their relations with acute trusts appears to be that resources are unlikely to be released during the purchasing and financial cycle by primary care purchasers as evidence of reductions in admissions and bed days becomes apparent. Acute providers will always be able to marshal convincing arguments to show why resources should not shift out of their budgets to reflect such changes. Instead, the purchaser has to be bold and negotiate to remove the resources on

the basis of the *projected* reductions in resource consumption at the beginning of the process. Otherwise, the purchaser has surrendered any leverage it might have had.

*Developing peer review and influencing clinical behaviour*

Another feature of some but by no means all of the higher achieving TPPs was to begin to build inter-practice systems of peer review of clinical activity, for example in the fields of prescribing and elective referrals. Although many of the activities audited were already contained within SFH rather than TP, the existence of an organisation linking practices encouraged and made such a review process possible. However, in order to undertake such reviews effectively TPPs needed access to reliable information at practice level on patterns of clinical activity and expenditure.

One TPP reported that the cost difference between the highest and lowest referring general practitioners in the three practices of the TPP in its preparatory year had been £120,000 per year. By the end of the first 'live' year it was reported that this had fallen to around £10,000 per year through a process of sharing information and auditing activity against guidelines for best practice. At the same time, there was reported to have been an increase in procedures known to have a good outcome (e.g. elective hip replacement) and a fall in operations known to have poorer outcomes (e.g. some types of prostatic surgery). Although much of this work of reviewing referrals could have taken place in a SFH consortium or multi-fund without TPP status, it was the TPP which prompted the inter-practice action and clinical response.

Another leading TPP in the first 'live' year reported that it had worked with the local acute provider to develop protocols for the management of thrombosis, asthma, diabetes, fractured neck of femur and stroke in order to ensure that resources were only used for care regarded as 'appropriate' in hospital and in primary care. Similarly, the general practitioners had collected and audited general practitioner-specific, but anonymised data on their direct admissions and outpatient referrals against agreed criteria in order to stimulate each doctor to reconsider his or her pattern of use of hospital resources. The general practitioners were also given information about the costs of admissions and outpatient attendances in order to make them aware of the costs of their decisions.

## Changes in hospital activity

At the time of writing, the analysis of changes in hospital activity between 1995/96 and 1996/97 for the first wave TPPs is not yet complete (Raftery and McLeod, 1998). The analysis uses Hospital Episode Statistics (HES) data supplied by health authorities, and some health authorities have found it difficult to supply their data. Furthermore, not all TPPs attempted to change the pattern of activity at their hospitals in 1996/97. Pilots emphasised the management of secondary care to varying degrees such that only 23 TPPs could be classified as 'Commissioning TPPs' which negotiated independent contracts with hospitals, with a further eight TPPs classified as 'Co-purchasing TPPs' which sought to influence secondary care by joint contracting with the HA. The remainder were not involved in influencing secondary care directly. The most common service development attempted by nine of the 'Commissioning' TPPs, related to changes in hospital discharge arrangements, where objectives included reducing acute length of stay or admissions (Robinson, Robison and Raftery, 1998). The activity analysis is complete for six of these nine Commissioning TPPs. In the remaining three cases analysis has been delayed by the incompleteness of local data. Four TPPs succeeded in their main objectives in relation to acute hospital utilisation and two achieved some progress. The following examples from this group illustrate the potential of TPPs to alter patterns of hospital activity.

One of the 'successful' TPPs, an urban multi-practice pilot, aimed, for example, to reduce total activity at its main acute provider by 10 per cent, by early discharge of geriatric cases to a new rehabilitation facility in the local community hospital. The TPP succeeded in reducing total OBDs for all medical and surgical activity by 10.7 per cent at its main provider. Average length of stay at the main provider for TPP geriatric cases fell from 15.9 days in 1995/96 to 10.9 days in 1996/97, while for the practices sharing the TPP's main provider, the comparable figures were 16.2 days and 15.6 days, respectively. In 1996/97 108 of the 115 TPP geriatric admissions to the community hospital rehabilitation facility were transfers from the main acute trust. These transfer cases accounted for 1,802 OBDs at the community unit. The per diem cost to the TPP of the rehabilitation beds was less than that for geriatric cases at the main acute provider. The transfer of patients to the rehabilitation unit was facilitated by the TPP's 'resource utilisation nurse/nurse facilitator'.

Another urban multi-practice pilot employed a 'discharge planning co-ordinator' and aimed to reduce both acute length of stay and inappropriate admissions. The TPP reported that it had reduced admissions by increasing the resources of an existing hospital-at-home scheme. At the level of total activity for all medical emergencies, the TPP reduced ordinary admissions by 0.3 per cent in contrast to increases of 8.1 per cent for local practices sharing the TPP's two main providers, and 6.2 per cent for all practices in the HA apart from the TPP practices.

One of the TPPs which made only limited progress in implementing its objectives was a non-urban single practice TPP. It reported that the introduction of a nurse co-ordinator to facilitate early discharge, particularly for acute medical inpatients, was one of the most important changes made in 1996/97. Nevertheless, the appointment was made in the second half of the year and had little time in which to make an impact. Medical admissions were priced using length of stay bands, and average length of stay for emergency medical specialties for the TPP across all providers decreased by under 1 per cent, while it increased by 4.3 per cent for neighbouring practices. However, while the TPP reduced ordinary admissions for medical emergencies by 4.9 per cent, the reduction for other local practices was 11.7 per cent. Hence, total OBDs for the TPP decreased by 5.7 per cent which was less than the 7.9 per cent decrease for the local practices. The smaller reduction in admissions and total OBDs by the TPP, compared to the local practices, has to be balanced against the fact that in both years the TPP had the lower average LOS (7.1 days compared to 7.8 days in 1996/97).

While the activity analysis is incomplete, it is clear that some TPPs with specific objectives to alter patterns of acute hospital use have been able to influence their use of these potentially expensive services. These TPPs have not followed a single strategy. Instead, a range of options designed to influence the number of acute admissions and length of stay have been tested, including the use of discharge nurses, cottage hospitals, nursing homes and hospital-at-home schemes. Many of these techniques are familiar in the USA under the broad heading of 'Utilization review' (UR) and are widely used by managed care organisations. It is interesting to note that despite the fact that levels of hospital use are generally far lower in the UK than the USA, there still appears to be scope for the application of utilisation management, at least on the inpatient side, in this country. This confirms the preliminary findings from one additional TPP not yet included in the current HES analysis but presented by Robinson and Steiner (1998) when reviewing the potential for TPPs to develop managed care approaches in the UK. It is worth making one note of caution about these impressive-seeming reductions in hospital use. Without data on the resource consequences, it is not possible to be sure what the effects were on non-TPP patients. The changes could conceivably leave the HAs bearing all the fixed costs of the acute hospital and, thereby, unable to purchase as much care as previously, while the TPPs remove resources at average cost.

## Explaining variations in achievements in the first 'live' year

The Audit Commission's study of fundholding showed that those SFH practices which were able to make best use of their budgetary leverage to change and improve services tended to be better managed and more outward-looking (i.e. taking part in wider decisions affecting the pattern of services available locally, sharing information and experience with other practices, helping to develop local providers and working with the HA) than their less enterprising counterparts. They also appeared to have thought carefully about what they could achieve by joining the scheme (Audit Commission, 1996). After the first year of TP, a similar effort was made to tease out some of the factors associated with more and less successful projects. In this analysis, the TPP and its context were taken together (i.e. focus was on the project's characteristics irrespective of whether the wider context was favourable or unfavourable). In the next chapter, the separate influence of context is explained.

This aspect of the evaluation is still not definitive since the number of influences which could potentially act to separate the more from the less successful projects is wide and it only relates to a single year. Nonetheless, it has been possible to explore a set of features of TPPs themselves which were expected to be related to 'success'. For example, it was hypothesised that projects with their own dedicated TP managers, with higher management spending, with the autonomy brought about by having their own devolved budgets and independent contracts, and those with a previous history of working together would make faster progress in the first 'live' year than those without (Robinson and Steiner, 1998). After the first year of TP (1996/97), the following variables appear to be most strongly associated with a higher level of reported achievements (irrespective of their scale or scope):

- smaller populations and fewer general practitioners;
- not more than five practices in the pilot;
- a 'simple' organisational structure which was particularly common in single practice TPPs;
- reporting a 'fair' or 'good' level of support from the local HA;
- a higher level of spending on management of the project;
- purchasing some services directly through contracts separate from those of the HA;
- a higher level of ambition for the following purchasing year (1997/98) (Mays, Goodwin, Malbon *et al.*, 1998)

Whereas the first five variables listed may be seen as organisational and resource prerequisites for more 'successful' TP (at least in the first year), the sixth (purchasing directly) and seventh (ambition for the future) could be regarded as a *consequence* of the first five features; i.e. well

organised and supported pilots were able to take on more budgetary responsibility and planned, therefore, to do more in the future.

Some features of the TPPs which might have been assumed to be related to achievement such as the extent of previous experience of the practices in working together (e.g. in a multi-fund or out-of-hours co-operative) did not seem to be associated with higher achievements. This may be because the preponderance of smaller and single practice TPPs in the most successful groups obscured any relation. For example, none of the multi-practice projects with six practices or more were in the two highest achievement groups (Groups 4 and 5 in Figure 6.2, above). Other factors may emerge in subsequent analyses based on data from the second year of 'live' TP. Another possible explanation for this finding was the fact that all the projects comprised volunteer practices and the vast majority had considerable fundholding experience.

The finding that larger, more 'complex' TPPs appear to have made less progress in implementing their purchasing objectives in the first 'live' year indicates that the advantage enjoyed by the smaller projects is likely to have lain in the fact that they could bring about their objectives with relatively little need to build a new form of organisation to manage TP (see Chapter 7 for more on this). Single practice TPPs, in particular, did not have to work to design a way of working which would link previously independent practices. They could get by with informal, 'simple' structures and ways of working. Since TP was *selective* purchasing in 1996/97, the smaller projects were also able to protect themselves from the financial risks to which they might have been exposed by a wider scope of purchasing responsibility. In addition, they could choose purchasing objectives which did not necessarily require the deployment of large scale purchasing leverage. For example, many of the purchasing objectives of the TPPs related to extending services close to the practice level rather than negotiating to alter secondary providers' services directly (see Table 6.1 and, for more detail, Mays, Goodwin, Malbon *et al.*, 1998). On the other hand, it is apparent from a number of the examples described earlier in this chapter that TPPs were limited in 1996/97 by their inability on occasions to release resources from the secondary care sector. This is likely to have been a result of their small size and lack of financial leverage.

It will be interesting to see whether the larger, more 'complex' TPPs can 'catch up' with their smaller counterparts in 1997/98 and whether they are able to bring about more strategic, larger scale changes in the future than smaller projects. By contrast, it is possible that smaller TPPs with simpler organisations may find it more difficult to sustain the level of additional managerial work required by TP in the longer term since they, typically, rely on a small

number of people. For example, approximately 25 per cent of the total managerial cost of TP tends to be accounted for by the general practitioners (Posnett, Goodwin, Griffiths *et al.*, 1998) and in smaller projects this contribution tends to come from a single doctor. It is relevant here to note that all but one of the TPPs which had had to withdraw from the TP scheme had made specific arrangements for TPP management, relying instead on SFH or practice managers.

This concern with sustainability also emerged when the lead practitioners and project managers were asked to identify the main obstacles to the effective implementation of TP. Lack of time for those general practitioners who were supportive to enable them to contribute to TP and an inability to obtain input from other general practitioners were the two obstacles most frequently mentioned (Mays, Goodwin, Malbon *et al.*, 1998). Other main obstacles were problems in agreeing a budget with the HA, poor relations or a lack of HA support, poor relations with the local acute providers and inadequate information systems to support TP. Chapter 7 develops the discussion of the role of the contextual factors in more detail.

The finding that the projects which were reported to be more successful in their own terms, at least in the first 'live' year, tended to be those with their own budgets and independent contracts can be interpreted, straightforwardly, as an endorsement for the basic mechanisms of fundholding; i.e. that the essential prerequisite for effective practice-led purchasing is control over a budget and the ability to negotiate contracts separately from the HA. On the other hand, it must be recognised that not receiving a budget and, therefore, not having independent contracts, was not always the choice of the TPP, rather it could reflect wider financial and other obstacles faced by the project in its context (see Chapter 7 for more on this). While it may well be the case that having a budget and independent contracts, or at least the *potential* to have these, is necessary for effective practice-led purchasing, particularly where there are differences of view between the practices and local provider organisations, it is unlikely to be sufficient. For example, single practice and smaller multi-practice TPPs were more likely than the rest to have their own contracts for at least some selected services. This may have come about, primarily, because such projects were more likely to have established a consensus as to their purchasing priorities than larger projects in which more differences of view would have had to have been reconciled before plans could have been agreed. The data on the main obstacles to effective TP and the other features associated with the more successful projects suggest that much else is needed in addition to a budget and contracts to bring about changes in health services through TP, such as an able project manager, strong general practitioner involvement, good information on services and their cost and appropriate skilled support from the HA (see Chapter 7 for more on this).

A clear sense of what needed to be altered in local services and the motivation to bring this about may have been as important as the financial clout derived from having a budget and, thereby, the capacity to shift resources between providers and types of care. This may be seen most clearly when studying some of the TPPs which achieved little in the first 'live' year. They generally had little ambition and some lacked a coherent vision of why they were in the TP scheme and what they wanted to achieve by participation. By contrast, the highest achieving projects were also those with major ambitions for the future (see Figure 6.2). This does not necessarily indicate that the vision came from the practices. In the case of maternity care, the ideas for service development and change came from midwives and were taken up by the TPPs (Wyke, Hewison, Piercy *et al.*, 1998). Boxes 6.5 and 6.6 give summary profiles of a 'low' and 'high' achieving TPP for illustration of these points.

## Box 6.5: An example of a Group 1 TPP

***45,000 population***
***8 practices***
***Locality***

### PROGRESS BY BASIC CRITERIA

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

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

*Additional achievements*

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

**Box 6.6: An example of a Group 5 TPP**

***58,000 population;***
***5 practices;***
***Non-locality;***
***Suburban***

**PROGRESS BY BASIC CRITERIA**

| Criterion | Yes/No? | Details |
|---|---|---|
| Stayed together? | ✓ | Good relations between practices have been crucial to the development of the TPP. This trust developed through fundholding and has been enhanced through TP. |
| Purchased directly? | ✓ | The TPP has developed innovative contracts that differ significantly from HA contracts, particularly in terms of clinical specifications. |
| Changed service provision? | ✓ | see below |
| Shift in location of care? | ✓ | Greater use of GP unit and nursing homes. The TPP wants to increase its provider role in the future. |
| Effective external links? | Mostly | Good links forged with the health authority and local providers. The lack of provider will to concede to some TPP demands is not a result of poor communications. Links with social services remain ad-hoc and underdeveloped. |
| Stayed within budget? | ✗ | The TPP was heading for an overspend in 1996/7. |

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

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

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

The association between higher direct management costs and better reported performance in 1996/97 requires interpretation and comment. Since the level of management spending was a matter for local negotiation between each project and its parent HA, it is possible that the level allocated reflected both the confidence which the authority's staff placed in the abilities of the projects' participants to make good use of the resources granted and the level of ambition shown in the projects' purchasing objectives for the first 'live' year. The more a project wished to do, the more it might be able to make a case for management infrastructure. However, it is also possible that higher spending on managing a project had a direct effect on the project's ability to realise its objectives. This is strongly hinted at in the fact that the median management cost of TPPs which were low achievers in TP-related service areas (Groups 1 and 2) in 1996/97 was £2.78 per capita and for high achievers (Groups 4 and 5) it was £3.82 per capita (Posnett, Goodwin, Griffiths *et al.*, 1998). One feature worth highlighting which distinguished the higher spenders from the lower spenders was the extent to which they paid not only for general practitioner locum cover for their lead and other doctors, but also how they frequently received an allowance for each practitioner to take part in the project and sometimes an allowance per practice so that other staff could be involved. These figures are in addition to the level of spending in the relevant practices on SFH and suggest that the success in future of the government's PCGs (Secretary of State for Health, 1997) may depend in large part in the resources which can be made available to support them (see below for more on this).

**A typology of first wave TPPs at the end of the first 'live' year**

Having now reviewed how each TPP set about TP (in Chapter 5), the extent to which each project exhibited each of six basic developmental criteria together with the nature of its main objectives and the extent to which these were realised in the first 'live' year (in Chapter 6), it is possible to bring these findings together to typify each pilot according to how it chose to interpret the aims of the NHSE's scheme to extend general practitioner-based purchasing/commissioning beyond the limits of SFH. Individual TPPs have interpreted the concept of TP in different ways so that a number of distinct 'types' have emerged. These types reflect both the stage of development of projects and their focus of objectives, achievements and future ambitions. The types are to some extent an assessment of how ready TPPs are to become PCGs, and it is possible that such a range of types will also be a feature of the development of PCGs.

On the basis of a review of their progress against the six basic developmental criteria discussed above and the focus of their objectives, achievements and ambitions, projects can be categorised accordingly:

**Under-performing TPPs** - projects not achieving or intending to achieve in TP-related service areas. These project showed signs that they were not likely to continue far into 1997/98.

**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, but not achieving such changes in 1996/97.

**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 in 1996/97.

**Primary Care Developer TPPs** - projects focusing mainly on the development of primary care in TP-related areas. Projects have not brought about changes in secondary care. These projects could achieve changes through co-purchasing or through holding a budget and having their own independent contracts.

**Commissioning TPPs** - projects which directly purchase in TP-related service areas to achieve changes in secondary care as well as primary care. Such projects held budgets and had independent contracts in 1996/97.

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

Each project was categorised according to the most 'developed' type reflected in aspects of its work. The results are shown in Table 6.3.

**Table 6.3 Different types of TPPs, 1996/97**

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

Twenty three out of fifty two (44 per cent) were of the 'commissioning' type, followed by 11/52 (21 per cent) which were categorised as 'developmental'. Fifteen per cent of projects were classified as 'co-purchasers', and a further 15 per cent as 'primary care developers'. Only two projects were assessed as not achieving or wishing to advance in TP-related areas. No TPP had so far become fully 'integrated'. This is largely because the pilot status of TP meant that technically projects were unable to integrate their different budgets for GMS, SFH and TP. However, a small number of projects are well advanced in preparing to become integrated. This means that they had adopted an integrated approach to planning and service developments, pooling SFH and TP budgets to negotiate contracts with providers, and analysing and presenting SFH and TP activity and expenditure data together, by practice, supported by common information systems. These TPPs were also moving towards more integrated management structures with fund staff increasingly working at the TPP level.

Further analysis reveals in more detail the characteristics of the different types of TPPs. Selected characteristics are shown in Table 6.4. The distinct features of the two 'under performing' TPPs were their large size combined with especially low management costs. 'Developmental' projects were the largest of the types, with a median of 23 general practitioners per project and median population of 37,000. They were the most likely to have 'complex' management structures (55 per cent of the projects having such a structure) and they had comparatively high management costs (£2.86 cost per capita in 1996/97). By definition these TPPs were lower achievers judged by the extent to which they met the six basic criteria and had their own and TP-related objectives. However, 82 per cent of 'developmental' TPPs had high future ambitions.

## Table 6.4 Different types of TPPs by selected characteristics

| | Under-performing *(n=2)* | Developmental *(n=11)* | Co-purchasing *(n=8)* | Primary Care Developer *(n=8)* | Commissioning *(n=23)* |
|---|---|---|---|---|---|
| *Size* | | | | | |
| Median number of practices | 6 | 4 | 3 | 2 | 3 |
| Median number of general practitioners | 17 | 23 | 13 | 16 | 13 |
| Median population of the TPP | 32,689 | 36,590 | 24,750 | 27,500 | 25,000 |
| Range of TPP population | 20018-45359 | 10500-66643 | 19137-138832 | 12943-33000 | 8100-79300 |
| *Organisational structure* | | | | | |
| % Complex/ mature | 50% | 55% | 25% | 25% | 39% |
| % Intermediate | 50% | 27% | 50% | 38% | 26% |
| % Simple | 0% | 18% | 25% | 38% | 35% |
| *Direct management costs (n=50)* | | | | | |
| Median total costs (96/97) | £18,500 | £95,000 | £53,134 | £62,878 | £71,701 |
| Range of total costs (96/97) | 1000-36000 | 35000-261127 | 22970-143161 | 30400-103000 | 10442-267180 |
| Median costs per patient (96/97) | £0.91 | £2.86 | £1.61 | £2.80 | £3.10 |
| Range of costs per patient (96/97) | 0.02-1.80 | 1.43-5.80 | 0.86-4.00 | 1.69-3.89 | 0.69-7.08 |
| *Six basic developmental criteria met, (1-6) 1996/97** | | | | | |
| Low (1-2) | 100% | 64% | 12% | 12% | 0% |
| Medium (3-4) | 0% | 27% | 88% | 50% | 22% |
| High (5-6) | 0% | 9% | 0% | 38% | 78% |
| *Levels of achievement 1996/97** | | | | | |
| % Low in own terms (1&2) | 100% | 73% | 38% | 25% | 17% |
| % Medium in own terms (3) | 0% | 18% | 50% | 63% | 26% |
| % High in own terms (4&5) | 0% | 9% | 13% | 13% | 57% |
| % Low in TP-related terms (1&2) | 100% | 82% | 88% | 75% | 26% |
| % Medium in TP-related terms (3) | 0% | 0% | 13% | 25% | 26% |
| % High in TP-related terms (4&5) | 0% | 0% | 0% | 0% | 48% |
| *Future ambition for 1997/98** | | | | | |
| % More and in TP areas | 0% | 82% | 50% | 63% | 83% |
| *Previous experience* | | | | | |
| % Worked together previously | 50% | 50% | 25% | 33% | 60% |
| % Had 1st & 2nd wave fundholders | 0% | 78% | 63% | 75% | 83% |
| *Contracting, 1996/97* | | | | | |
| % Contracting independently | 0% | 33% | 17% | 71% | 100% |

* see above this chapter (or Mays, Goodwin, Malbon *et al.*, 1998) for an explanation of these assessments of performance in 1996/97

'Co-purchasing' TPPs were the smallest of the types of TPPs with a median of 13 general practitioners and a median population served of 25,000. The majority of 'co-purchasers' had 'intermediate' management structures, and they had the lowest management costs (excluding 'under-performing' TPPs) with a median cost per capita of £1.61 in 1996/97). Seventy five per cent of projects had never worked together previously. They were generally in the middle of the distribution of development and achievements. They tended to be slightly less ambitious in their future plans for developing services in TP-related areas than 'primary care developers' or 'commissioning' TPPs.

'Primary care developers' were slightly larger than 'co-purchasers', with a median population served of 28,000. They had a median management cost per capita of £2.80 in 1996/97 (slightly more than 'co-purchasers'). Two-thirds of the projects had never worked together previously. Five of eight 'primary care developers' (71 per cent) purchased services directly in their first year. 'Primary care developers' were likely to be placed in the middle of the range of performance (slightly more likely than 'co-purchasers').

'Commissioning' TPPs were a similar size to 'co-purchasers' with median number of general practitioners of 13 and a median population served of 25,000. However, this group had a greater range of size of projects (8,100–79,300). This group also showed an associated greater range of management structures; 39 per cent having 'simple' structures and 35 per cent having 'complex' structures. 'Commissioning' TPPs had the highest management costs (£3.30 cost per capita in 1996/97). This type had the highest proportion of projects where general practitioners had previously worked together (60 per cent). By definition all projects in this group purchased services directly and the majority negotiated independent contracts in acute, community and mental health services. 'Commissioning' TPPs were likely to be high achievers in their own terms and in TP-related areas.

There was also some geographical pattern in the distribution of the different types of TPPs. 'Co-purchasers' and 'commissioning' TPPs were more likely to be located in North and South Thames Regions. Projects in the North West, Northern and Yorkshire were most likely to be 'developmental' in their first 'live' year. 'Primary care developers' tended to be located in the Trent region and Scotland. The reasons for this are not known.

In conclusion, the analysis of types reinforces the finding that it is not possible for multi-practice projects to make progress without adequate investment in developing management capability. In addition, the analysis suggests that it is likely to take longer for larger projects to achieve changes, even when there has been management investment. Large projects need more complex management structures if they intend to take forward 'ambitious' plans for TP related-services. A higher level of management costs appears to be linked to the ability of

projects to become 'commissioning' TPPs in the preparatory year, and achieve changes in TP-related service areas in the first 'live' year. 'Co-purchasing' seems to be a relatively economical option in management cost terms for smaller projects which achieves mid-ranging achievements in the first 'live' year. This accords with the findings of the research on contracting which showed that 'co-purchasing' TPPs placed considerable confidence in this approach (Robinson, Robison and Raftery, 1998).

Perhaps most interestingly, the typology shows that the dominant focus of an important proportion of TPPs was the development of primary care, with commissioning as a vehicle for achieving this. These TPPs were relatively far less interested in using their purchasing power to alter the way in which secondary providers operated.

# 7 EXPLAINING PROGRESS AND ACHIEVEMENTS OF TPPs: THE ROLE OF CONTENT, CONTEXT AND PROCESS

## Theoretical approach

One of the most noticeable features in the evolution of TP has been the extremely heterogeneous way in which it has been implemented and the very wide variation between the projects in terms of their level of achievement. The previous chapter showed that the achievements of the TPPs in 1996/97 appeared to be associated with a number of variables. In particular, differences in the achievements of the TPPs were associated with size of project, contracting independently, the level of direct management costs and the perceived quality of HA support. Whilst it was rare for TPPs without these characteristics to achieve changes, it was a far more common observation that some TPPs had *not* been able to progress despite having some or all of these characteristics associated with achievement. This suggests that whilst a number of key variables are associated with achieving change across all the projects, a wider and more complex range of factors influence TP development in individual cases.

This chapter explores the ability of TPPs to achieve change using a contextual approach developed by Pettigrew *et al.* in their work on understanding strategic change in the NHS (Pettigrew, Ferlie and McKee, 1992). Pettigrew and colleagues showed that much research on organisational change had tended to be '*ahistorical, aprocessual and acontextual in character*'. In particular, they found that remarkably few studies allowed the change process to reveal itself in any kind of temporal or contextual manner. Consequently, research into the ability of projects to implement change often failed to provide an analysis of the mechanisms and processes through which changes were brought about *within the context in which they were implemented.* One advantage of the national evaluation of TP is that it includes considerable contextual as well as processual information.

The first section of this chapter explores the *content* of change, or the 'what' of change, which refers to the particular transformations that have resulted from the development of TP. The content of change considers not only specific outcomes, such as service developments and new organisational forms, but also considers other aspects such as whether change was implemented radically or incrementally, or whether change involved shifts in the roles of staff.

The second section of the chapter explores the *context* of change which affects 'why' some changes occur and others do not in different projects. An examination of context is important for understanding the environment within which TPPs operate since contextual factors have an impact on the ability of projects to succeed. It should be recognised that there is both a local context and a wider context influencing the development of a TPP. The wider context affects

all projects and refers to the national economic and political environment within which TP operates. At the local level, context refers to the cultures, strategy, management and political processes which shape the everyday actions of individuals and the thinking behind the change process in a particular project. As shall be shown below, different local contexts have had an important bearing on the abilities of projects to achieve their desired changes.

The third section of the chapter examines the *process*, or the 'how', of change. The process of change refers to the dynamics of how TP has been implemented - the actions, reactions and interactions of the various individuals and interest groups involved in implementing TP, at each site.

The final section of the chapter attempts to link the *context*, *content* and *process* of change over time to help to begin to explain differential achievements between the TPPs in 1996/97. It is argued that one of the most critical connections in understanding the progress of specific TPPs is the link between *context* and *process*. Specifically, the ability of projects to achieve is dependent on the various stakeholders in the process providing legitimacy for change whilst, at the same time, overcoming any contextual barriers to change. The chapter concludes with a summary of the key themes emerging which have helped or hindered the development of TP in 1996/97.

**The influence of the content of TPP achievements, organisation and decision-making**

This section examines both recurrent themes related to the content of what total purchasers have been able to achieve (service and non-service specific) and also themes related to the content of TPP organisation and decision-making.

There was a wide variation in the ability of projects to achieve their own objectives in their first 'live' year (see Chapter 6) and great variation in the scope and ambition of TPPs. Within this diversity, however, a number of factors appeared to be associated with making successful changes.

*Primary care development rather than secondary care change*

In general, TPPs that placed greater emphasis on making changes within primary care than in secondary care during the 1996/97 purchasing year were more likely to achieve their objectives. Secondary care objectives were more difficult to achieve, firstly, because the

potential impact that secondary care changes tended to have on Trusts resulted in substantial resistance to change; secondly, because the potential detrimental impact on the wider patient population that became apparent as the full ramifications of TPP changes were thought through often led the HA to block proposed changes; and thirdly, because the lack of experience and skills in commissioning secondary care in TP-related areas handicapped TPPs in their relationships with providers.

*Local operational issues rather than strategic planning*

Service changes brought about by TPPs tended to be based on *local* health services issues. For example, service changes pursued were not strategic, but tended to focus on service provision at practice level. TPPs were also less interested in implementing nationally-specified policy goals and much more interested in 'fixing something that was broken' in an attempt to get a better deal for local patients. For example, in relation to community and continuing care:

> *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* (Myles, Wyke, Popay *et al.*, 1998).

Additionally, practices tended to address issues with which a key general practitioner was identified. The lack of progress made by some TPPs with a more strategic focus might also have been due to the fact that the effects of such changes are inevitably slower to be seen. Consequently, an important future issue will be the extent to which projects attempting larger scale changes are able to demonstrate achievements in the longer term.

*Organisational development rather than specific service changes*

Whilst the comparative progress of the TPPs has been assessed primarily in terms of their ability to achieve their main purchasing priorities, 1996/97 was also characterised by appreciable progress in developing the TPP infrastructure and in fostering external and internal relationships. Most projects, for example, had undertaken a great deal of work in information gathering to improve the basis on which future commissioning could be made which was, in turn, one of the factors behind the substantial time and costs involved in developing IT systems:

> *The evidence from this study suggests that TPPs may be acting as catalysts for change in alerting practices, trusts and health authorities to the information requirements of primary care organisations as providers and purchasers of care.* (Mahon, Leese, Baxter *et al.*, 1998)

Participants at most of the projects also pointed to the fact that 1996/97 had been a year of relationship building with other agencies, particularly with the HA and with clinicians from local trusts. The development of shared learning and education between these agencies has undoubtedly facilitated the change process (see the section on *process* below). Much of the 'success' claimed by TPPs in 1996/97 has thus been in establishing new relationships on the basis of which service developments were planned for the future. Within the TPPs, particularly in the larger organisations, substantial time was also taken in developing appropriate organisational structures which has again been shown to be a prerequisite for effective TP.

*Incremental rather than radical change*

The experience of TP to date suggests strongly that an incremental approach works more effectively than the 'big bang' approach. Consequently, the more effective projects have tended to begin by selecting a small number of realistic objectives, usually with a strong primary care focus, from which they have progressed to influencing more services. The most successful projects have also allied this incremental approach to an ambitious longer term vision.

All TPPs have been selective in the services which they have attempted to influence. Although there are examples where a radical approach, involving large scale changes to secondary care provision (such as a change in provider), has been achieved, these projects have been exceptions to the general pattern. In essence, the incremental approach has been more successful because it has not over-burdened the projects with developmental issues in the early stages whilst providing some early examples of success to demonstrate to others what can be achieved. The ability to demonstrate what TPPs can achieve has been an important part of the process of change, since without it, participants, such as non-lead general practitioners, can become disillusioned (see below).

*Organisational forms associated with achievement*

Each TPP has developed its own management structure and organisational arrangements. However, depending on the size of the TPP, some organisational forms were more effective than others. In particular, a high proportion of smaller projects, particularly single practices, were able to achieve their own objectives with relatively little organisational development whilst the larger TPPs had to establish more complex organisations before they could make progress (see Chapter 6 for more on factors associated with a higher level of achievement).

One organisational pre-requisite for the progress of large multi-practice TPPs has been the employment of a competent project manager with sufficient skills to be able to cover a wide range of tasks. Three of the four first-wave projects which withdrew from the scheme, for example, did so because of perceived excessive general practitioner time commitments and/or poor project management as a result of failing to employ a project manager.

*General practitioner involvement and project sustainability*

Although the ability of TPPs to make progress has, in part, been dependent on developing sound project management to keep the level of general practitioner involvement in organisational issues to sustainable levels, the most successful projects have still required a very substantial commitment from general practitioners. Setting aside the role of the project manager, TPPs appear to be run by a few key practitioners at each project. Typically, one 'lead' general practitioner from each practice is represented on the TPP's project board, but beyond this there is usually little further enthusiasm for taking an active part in the pilot. The majority of TPPs only gain, at best, tacit approval from the other non-lead practitioners and there appears to be a high level of ambivalence towards TP from non-lead practitioners (see the data on the perceptions of costs and benefits in Figure 5.1).

Since TPPs tend to be run by a few key players, there is also a sense in many TPPs of project fragility. In particular, the loss to the process of a motivated individual can have devastating consequences to the future of a TPP. As one lead general practitioner put it:

> *We owe an awful lot to [our project manager] and would be lost without her since she has been particularly successful in building personal relationships with [the main acute trust] and with the health authority. She has gained a lot of personal knowledge and really is irreplaceable. I fear that if, for example, she was run over by a bus tomorrow, the project would fold pretty quickly.*

The sustainability of general practitioner involvement also remains questionable due to the high workloads involved and the fact that most of this time remains unpaid. A few, more fortunate projects, have managed to negotiate direct remuneration for general practitioner time (on top of payments for locum cover) in their TP management allowance from the HA, without which participation in the project would not be forthcoming (Posnett, Goodwin, Griffiths *et al.*, 1998). That the better resourced projects have also tended to be higher achievers is an important finding in this regard (Mays, Goodwin, Malbon *et al.*, 1998). However, most TPPs do not have this level of resources and have had to rely solely on highly motivated individuals. Therefore, one must question the extent to which the TP model is sustainable and generalisable without incurring substantial additional direct management costs.

*Lack of evidence in decision making*

One of the potential advantages of TP was to encourage the adoption of so called 'evidence-based medicine' and health needs assessment. However, as Chapter 5 has noted, whilst most projects have recognised the theoretical importance of using evidence on the effectiveness of treatments, few have used such research-derived 'evidence' as a main input to purchasing decisions.

The study of TPPs and mental health services, for example, revealed that one third of TPPs continued to rely solely on the 'gut feeling' of the lead clinicians when developing policy objectives and that, more generally, opinion and experience continued to rule over the use of evidence (Gask, Lee, Donnan and Roland, 1998). Moreover, most objectives have been related to long-standing local service issues whilst information systems for TP have been inadequate. These difficulties have meant that developments were heavily influenced by experience and hunch rather than local analysis and evidence. Clearly, the developmental tasks of the evidence-based approach will need to be addressed in the formation of PCGs.

*Lack of user involvement*

A final recurrent theme in the content of what total purchasers do is the low level of involvement of users in informing purchasing decisions. Thus accountability to patients and the public remained underdeveloped in most TPPs in 1996/97 (Dixon, Mays and Goodwin, 1998). It appeared that most TPPs were paying lip service to the policy goal of patient involvement. Most general practitioner respondents in the TPPs had not regarded patient

involvement as either a priority or as a useful addition to the decision-making process (see Chapter 5 for more information on TPP activity in this area).

## The impact of context

### *Bridging the cultural divide*

A common contextual theme in the development of TP reported by the participants at interview has been the cultural 'divide' between different stakeholders in the process, most significantly between the general practitioners of the TPP and managers within the host HA. 'Culture' here refers to deep-seated assumptions and values that permeate organisations and which have an impact on individual action and behaviour. Cultural values have historical roots and shape the expectations of what can and cannot be achieved. TP has challenged established practice and relations between general practitioners, within HAs and between practices and HAs. In many cases, it has also had an impact on providers and social services departments. The ability of TPPs to progress has been influenced by this 'cultural' context.

As a barrier to the development of TP, the 'cultural' context can be seen to be particularly relevant to relationships between the TPP and its host HA. For example, a common reaction to the TPP, reported by HA leads during interviews undertaken at the end of 1995, was of 'culture shock'. The TP was trying to challenge established practice. The following reaction from a HA lead was typical:

> [Total purchasing] *has posed an obstacle to integrated working and has led to a cultural climate which is, at the least, ambivalent towards the scheme. This has manifested itself at both the health authority board level and among health authority managers ... I would say that some managers feel threatened by general practitioner-led purchasing and Total Purchasing is the extreme of these threats. However, I believe that these are largely cultural problems and much of the early period of the TPP's development process has been devoted to overcoming these problems.*

During 1995/96, the cultural divide between pilot project and host HA was often very wide and both had to take considerable time to understand each other's aspirations and needs. Since the process involved a great many issues it was often far from easy and relationships tended to be characterised by friction. The response of one lead general practitioner to the process exemplifies this friction, in particular, the common perception that the HA was not supportive enough of the project while at the same time not being willing to give the TPP greater autonomy in commissioning:

> *Initially, relations were difficult. A recurrent problem was that the health authority felt that the TPP project manager was not up to scratch with the corresponding feeling that the TPP as a whole could not be left to get up to its own devices. The issue of who is answerable to who remains a problem unresolved. This is a problem with the potential to bust the TPP apart.*

Whilst the process of change has been characterised by friction, over time relationships between key stakeholders have undoubtedly improved in the more successful projects. The language, in particular, has changed with phrases like 'from culture shock to culture shared', 'added value', 'breaking down barriers', 'mutual learning', and 'change of ethos' appearing in the interviews undertaken in 1997. A later interview undertaken with the same general practitioner who had highlighted substantial friction between the TPP and its HA in the preparatory period emphasised this shift:

> *The strengths of our relationship with [the health authority] have come later and have been manifest in greater dialogue, such that we [the general practitioners] have a greater understanding of health authority problems and priorities. The level of relationship with the health authority - the balance between paternalism and autonomy - remains unresolved [but] there has developed some form of partnership with the health authority.*

The ability of projects to bridge cultural differences has varied, contributing to the wide variation in levels of progress observed in the first 'live' purchasing year in 1996/97 and the fact that lead general practitioners and project managers reporting 'good' or 'fair' levels of HA support tended to be found in higher achieving TPPs. This can also be seen in Mahon, Leese, Baxter *et al.'s* (1998) examination of the use of health needs assessment at project level which highlighted significant differences in the abilities of projects to work with physicians in public health medicine. They concluded that where a lack of commitment to health needs assessment from the general practitioners had occurred, it was a result of a substantial cultural divide between the two:

> *The two different cultures of general practice and public health have in some cases been overcome, but in others acted as an obstacle to joint working. General practitioners were not often sure what questions they should be asking about public health and, likewise, public health were very HA orientated and not at ease with general practitioner information systems. Those projects where there was real*

> *integration in terms of a general practitioner working in public health or a public health doctor seconded to the project appeared to progress most.*

Further evidence of differing cultural attitudes contributing to inertia in the system is provided in the sub-study of TPPs' involvement in commissioning mental health care (Gask, Lee, Donnan *et al.*, 1998). The study revealed that considerable inertia existed in developing CMHTs due to rigid working routines that persisted, despite apparent multi-disciplinarity.

The experience of TP has revealed widely differing cultural values between the groups involved in its development. On the whole, these differing cultural contexts have acted as barriers to progress and the extent to which a TPP has been able to 'bridge the cultural divide' can be seen as one of the prerequisites for success in bringing about service changes. Key requirements in the cultural change process include the development of a supportive organisational culture; working in an environment of openness and trust; developing shared values and a commonality of approach; and embracing innovation with the ability to challenge established practice (Pettigrew, Ferlie and McKee, 1992). However, whilst the experience of TP suggests that some of these requirements have been embraced by some of the groups and stakeholders involved, resistance to change is inherent in many parts of the system leading to differences in the extent to which cultural barriers can and have been overcome.

*History and relationships*

A second common contextual theme in the development of TP has been the extent to which local NHS history has played a part in shaping the way in which projects have developed. In particular, the historical context has played an important part in defining the objectives of TPPs. Frequently, TPPs have concentrated on issues that have been of importance locally for many years and/or have used TP as a catalyst to promote initiatives or ideas developed previously. The study of TPPs involved in community care for people with complex needs highlighted the importance of the historical context showing that most TPP initiatives in community care were not new:

> [The objectives of total purchasers in community care] *are rooted in and strongly shaped by past experience of the practices involved in the TPP and the wider agency relationships within which the TPP is operating ... Practically all of the TPPs' developments were based on previous initiatives ... none of the sites, even with their history of involvement in the community and continuing care area, opted to try anything new or innovative as a TPP* (Myles, Wyke, Popay *et al.*, 1998).

Furthermore, there is evidence to suggest that the more successful pilots have needed an issue with a history to provide a clear focus for their work. It appears that the genesis of TPPs is important in this regard, since those that developed from the 'bottom-up' (those that were clearly general practitioner-led) appeared to have more specific goals and objectives than those which had been formed through 'top-down' pressure (for example, those orchestrated by HAs). Therefore, projects with a specific local agenda for change and generated from the 'bottom-up' tended to progress more quickly. This process is revealed by Mahon, Leese, Baxter *et al.* (1998) who show that early service-specific priorities for TPPs stemmed from perceived long term local problems with which the general practitioners were familiar. Evidence to suggest that total purchasers needed such a background for change in order to progress quickly can be seen from the community care study which concluded:

> *The two case study sites which exhibited the least historical experience in community and continuing care initiatives and more difficult inter-agency relations (either poor interpersonal/working relations or reluctance to share budgets) were also the two sites which proved to be least well developed in terms of integrated purchasing and provision* (Myles, Wyke, Popay *et al.*, 1998).

History has thus played an important part in shaping the objectives of TP and the pace of change has been quickest in those projects which have based their objectives on some clearly defined, previously identified local issue. In many cases, therefore, TPPs have not been pursuing new ideas, but have, instead, used their new found status as total purchasers to address unresolved long term issues.

In addition to influencing the *content* of what total purchasers have influenced, the history of relationships between key individuals and groups locally has had an important impact on the pace of change. The mental health study, for example, showed that a history of joint working between general practitioners and the managers of mental health providers gave certain projects a comparative advantage in developing new contracts and service agreements over TPPs where relationships were underdeveloped (Gask, Lee, Donnan *et al.*, 1998). Moreover, whilst every total purchaser appeared to find problems associated with information generation and compatibility between IT systems, the study found significant differences in the pace of progress on mental health issues related to the extent to which communication links and IT systems had been developed previously.

*The national and local political context*

The national political context has been, at various junctures, both positive and negative for TP and, in many cases, shaped the content of what TPPs wanted to achieve. Similarly, the local political agenda has been a force in both supporting TPP objectives (TPPs, for example, took up the challenge of defending local health services with the backing of local pressure groups) and in preventing change, particularly where proposed changes were unpopular.

The national political context within which TP has operated has seen a number of shifts which have had an impact on the pilots. In its beginnings, for example, TP was the brainchild of a small number of ambitious fundholders who were convinced that they could purchase services successfully beyond the scope of SFH. It was rapidly adopted by a Conservative Government convinced that general practitioners should be given as much influence over the purchasing of HCHS as possible. The development was part of the political drive towards extending the internal market in health care and enhancing the role of general practitioner-led purchasing. Over time, however, political priorities have changed and the initial emphasis on TPPs as independent purchasers in the fundholding sense was gradually supplanted even before the 1997 General Election by a greater emphasis on the role of general practitioner commissioning in *partnership* with HAs. It might be argued that this was always the intention, since the pilots were officially set up as sub-committees of HAs and were to purchase HCHS with money that remained the legal responsibility of the host HA. However, it is clear that most TPPs, particularly single practice TPPs, when they began TP did not expect this to be the case beyond the pilot phase. As a result, friction was characteristic of the early period of relationships between TPPs and HAs. This influenced the degree to which a shared agenda or a clear set of rules of engagement developed.

The way in which TPPs were introduced also had a significant impact on their development. For example, whilst all projects were to some degree 'volunteers', it was by no means the case that all were highly and equally enthusiastic to take part. Most, of course, were those which had a specific interest in developing as a TPP, but, in some cases, groups of practices were sought by HAs to take part in the scheme. These practices did not necessarily have an understanding of what they were being asked to do nor any particular commitment to TP. A wide regional spread of pilot schemes across England and Scotland was sought and some HAs actively searched for potential practices which could be persuaded to take part (Strawderman, Mays and Goodwin, 1996). Thus, one possible reason for the observation of different levels of achievement may be the way in which projects were initially selected. The larger TPPs tended to contain some practices which were relatively uncommitted to TP.

Another important influence on the development of TP was the 'hands-off' approach adopted by the NHSE through the decision to give as little guidance or organisational development support to the projects as possible in attempt to see 'a thousand flowers bloom' (Strawderman, Mays and Goodwin, 1996). A highly heterogeneous set of projects has since developed as a consequence. The absence of central guidance has influenced the pace at which projects have developed, since those with more skilled individuals and a clearer sense of purpose have been more likely to move forward than those which were looking for more help and facilitation. This may be one reason for the apparent success of small, particularly single practice TPPs, in the first 'live' purchasing year, since most of these were experienced fundholders with purchasing experience in contrast to the more mixed composition of some of the larger TPPs.

The change to a Labour Government has also had its impact. As the expectation grew that Labour would be elected, total purchasers were left very uncertain as to whether their pilot schemes would be continued beyond the 1996/97 purchasing cycle since the abolition of fundholding (and, hence, potentially TP as well) was a clear manifesto pledge. Many of the projects reported that in the months before the General Election (i.e. the latter stages of the first 'live' year), there was a significant period of uncertainty and demotivation. Total purchasers were also affected by the in-built insecurity of their three-year pilot status and, although some have since negotiated an informal continuation with their local HAs, the time limited nature of the pilots was a source of instability irrespective of the change of government. Indeed, there are several cases of TP project managers, whose positions were directly affected by whether TP would continue, leaving projects for other jobs, or attempting to combine their role as project manager with some other post, most often in the HA. The pilot status of the initiative and the uncertainties of what Labour would do after the Election had a negative impact on the progress of TPPs at a crucial stage. Teething problems had been largely resolved by mid-1996/97 and TPPs were aware of the scale of effort required to make an impact through TP. The real possibility that their investment in TP would be dissipated by Labour changes meant that some general practitioners came to see putting time into TP as less and less likely to be worthwhile. On the other hand, most pilots continued with some TP innovations in the hope, if not the certainty, that their projects would be a part of future Health Service developments. As it has turned out, the White Paper of December 1997 has ruled out any future for small and single practice projects (though these practices may prove to be leaders in PCGs of the future), whilst handing larger projects new challenges, opportunities and threats to grapple with as *all* general practitioners have to come to terms with becoming a part of what are, in many senses, large TPPs. (The implications for the future of larger TPPs in the transition towards PCGs is given consideration in the final chapter).

If the shifting national political context has proved important in shaping the progress of TPPs, so too the development of national policy on specific services has influenced the content of changes that TPPs have chosen to initiate. The clearest indication for this is in maternity care where the dominant motivation for involvement was a desire to achieve the objectives of *Changing Childbirth* (Department of Health, 1993). Considerations of cost, efficiency or cost-effectiveness in local provision were rarely mentioned by those motivated to influence maternity services, suggesting that *Changing Childbirth's* philosophy was the stronger influence (Wyke, Hewison, Piercy *et al.*, 1998). In other cases, the complexity of national policy far outside the sphere of TP influence, affected the ability of the TPPs to influence local service provision. In mental health services, for example, there appeared to be conflicting messages in national policy lending support to the pursuit of a number of different, potentially incompatible goals simultaneously. This seemed to confuse many of the initiatives attempted by the projects at local level (Gask, Lee, Donnan *et al.*, 1998).

*Local geography*

The characteristics of the local geographical environment play a role in shaping the way projects have addressed TP. For example, barriers to change have resulted from boundary problems between TPPs and other agencies. A typical problem has been a TPP with a population which straddles more than one HA. Considerable extra time has been spent in budgetary negotiations in these circumstances. In such cases, it has proved highly problematic to establish a devolved budget for the whole TPP. In one case where a TPP's patients were split approximately 80:20 between two HAs, it proved impossible to negotiate a budget, or a management allowance from the HA containing the smaller proportion. The problem arose because the HA responsible for the larger proportion of patients had been supportive of the TPP's development whilst the other HA had traditionally been strongly opposed to fundholding and to general practitioner-led models of purchasing. In most cases, projects have moved ahead using a budget from the HA in which the greater proportion of the project's population was found. As a result, TP has only been implemented for part of the population of the practices. Although this has been the only feasible solution to a difficult boundary problem, it has complicated the management of the TPPs involved.

Boundary problems have also caused problems in developing relations between TPPs and local social services departments since their areas have rarely matched. For example, the difference between local social services 'patches' and TPP areas has contributed to the failure of some attempts to foster more integrated care, such as the addition of a care co-ordinator to a primary care health team. Similarly, provider catchment areas, enshrined in HA contracts, have proved barriers to progress where TPPs have wanted to make changes. For example, one TPP

wanted to improve maternity care through having a named midwife for each patient with deliveries undertaken at a preferred hospital. However, the midwifery team's catchment area prevented it taking patients to the hospital of the TPP's choice and progress was halted by the inability to solve this problem.

As in fundholding, the location of TPPs relative to providers has proved important in the style of project that develops. Clearly, a project which faces a monopoly provider has fewer opportunities to use its potential budgetary power by shifting a contract than a TPP with a range of providers. It has been by no means impossible for TPPs with a monopolistic provider market to make service improvements through contracting but, in these cases, developments have been more attributable to the development of a shared TPP-provider agenda than to the contracting function. (This distinction is discussed in more detail in the section on budget holding below.)

A final important point to make about the geographical context of projects is related to their potential transformation into PCGs in the future. Whilst a minority of the TPPs could be regarded as 'natural communities' or locality projects, a high proportion are projects based on like-minded practices purchasing for a non-contiguous patient population. In the move towards PCGs, the locality TPPs may have a comparative advantage over their non-locality counterparts. The geographical implications of PCGs are discussed in the conclusion of this report.

*The financial environment*

As in the early years of SFH, there were concerns that TPPs would attract a disproportionate amount both of managerial resources and resources for purchasing services compared to other local groupings. Evidence from the sub-study of TPPs and maternity services appears to underline this concern since it showed that the TPPs studied each had a higher level of resources for delivering their maternity care than neighbouring practice populations (Wyke, Hewison, Piercy *et al.*, 1998). If TPPs are being systematically over-funded relative to the rest of the HA's population, either through historical accident or their lobbying for resources, this has clear implications for equity and for the interpretation of their achievements. However, the evaluation team has been unable, so far, to collect reliable data on the relative levels of funding of TPPs and the remainder of their host HAs' populations for 1996/97 due to the complexity and variability in the scope and processes of budget-setting and financial

allocation in the first 'live' year (Mays, Goodwin, Bevan *et al.*, 1997). Data will be collected for 1997/98 to enable an analysis of the relation between achievements and financing of TPPs.

The state of local NHS finances has also had an important bearing on the funding of TPPs. This has been manifest in many ways and examples include the following:

- a TPP which was forced to withdraw from the scheme because the HA believed that the project would be unable to keep within the strict financial budgetary limits required for the coming year;
- the 'over-performance' of SFH contracts during the final quarter of the financial year which forced the HA to declare a moratorium on SFH referrals. The financial crisis became the focus of the HA's work, and had a severe impact on the financial support given to the TPP;
- a severe financial crisis in a local acute trust which forced a HA to introduce a rescue package that precluded the local TPP from making any changes to contracts with the trust that might have had an impact on its level of income.

On the whole, despite the possibility that TPPs may have been relatively over-funded, the financial context in 1996/97 was adverse for most TPPs. The TPP and mental health sub-study, for example, showed that progress was hampered by the lack of resources in the NHS as a whole and in the localities which were attempting to address mental health issues (Gask, Lee, Donnan *et al.*, 1998). Negotiation of budgets, too, was a highly protracted and difficult process, largely because TPPs were unwilling to receive a budget lower than their historic spend whilst those that found that they would receive a higher allocation under capitation had to fight hard to have their budgets enlarged. In the former case, the HA could not impose a lower figure for fear that the TPP would withdraw from the scheme, whilst, in the latter case, it was under pressure to release more funds to the TPP.

Furthermore, Posnett, Goodwin, Griffiths *et al.* (1998) have shown the importance of the financial context in terms of the level of direct management costs available for projects. Again, managerial resources were a matter for local negotiation and the level given varied depending on a number of interrelated factors, one of which was the extent of financial problems in the local NHS. For example, it was difficult for a HA with a deficit to keep a sustainable level of management support to its TPP. On the other hand, there was no correlation between the level of per capita management expenditure of the HA and its generosity to its TPP. The level of per capita direct management costs was associated with the ability of projects to achieve their objectives in 1996/97 and was related, in part, to the local financial climate.

*Conclusion on the influence of the context of TPPs*

The above analysis shows the importance of the context within which every TPP operates in influencing its ability to achieve change. In particular, the analysis highlights the importance of the local context in defining both the *pace* of change (how quickly a TPP has been able to progress) and the *content* of change (what the TPP changes).

Table 7.1 summarises the argument thus far, distinguishing between what Pettigrew, Ferlie and McKee (1992) term '*receptive*' and '*non-receptive*' contexts for change. Generally, 'receptive' contexts are those that act in favour of the development and progress of a TPP whilst 'non-receptive' contexts act as barriers to progress. Thus a TPP with good relations and an agreed agenda for change with its local HA would have been more likely to progress than one which had to invest far more time in 'bridging the cultural divide' between itself and the HA. Similar factors doubtless account for HAs ability to bring about change through their own purchasing activities.

The mix of contextual factors in any one TPP has a significant bearing on the ability of the individuals and groups involved to make progress. The existence of varying local contexts within a national policy context which encouraged flexibility between different approaches to TP explains in large part why TPPs developed in such a heterogeneous manner. The largest TPPs, which made the least progress during 1996/97, also faced greater contextual barriers in terms of the cultural changes required to develop new inter-practice organisations.

**Table 7.1 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 TP | Macro-political environment unfavourable to development of TP |
| | National political backing for service changes (e.g. Changing Childbirth) | National/local opposition to service changes proposed |
| | Coherence of national policy objectives | Incoherent/conflicting national 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-developed and incompatible IT systems with little previous exchange of information on activity and costs. |
| | TPP established through practice/ general practitioner-led initiative | HA developed TPP without initial grass-roots support |
| | Local historical issues supporting the need for changes to, or protection of, local NHS services | Lack of purpose behind development of TPP; no local historical issues to base service developments on |
| **Geographical** | TPP patient population entirely within one health authority | TPP patient population spread across more than one health authority |
| | Provider/social services 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 between budgets allowed | Inflexible or ring-fenced budgets |

## The influence of the process of bringing about change in total purchasing

Whilst *context* can be seen to be highly relevant in determining the pace of change within TPPs, the mechanics, or *process*, by which TP is implemented ultimately determines the ability of projects to succeed. This is because people, not contexts, bring about change and because, even in the worst of contexts, some scope to make changes (albeit limited) still exists.

The findings to date from the programme of studies in the national evaluation have revealed three central and recurring themes in the process of change which enabled TPPs to achieve their objectives:

- key individuals leading change;
- inter-agency co-operation;
- budget holding.

*Key individuals leading change*

Key individuals have a very important role in providing legitimacy for change for TPPs. Indeed projects with the following characteristics were more likely to make progress:

- where lead general practitioners were willing to put additional time into the project and were able to demonstrate the advantages (potential and actual) of TP to the other general practitioners;
- where the project manager had a high degree of technical and managerial skill to act internally as co-ordinator and facilitator to the project and externally as its main representative to external agencies;
- where HA leads were willing to support TPPs; and
- where provider groups, particularly clinicians, were willing to take an active interest in the objectives of TPPs and to contribute to service developments.

Chapter 5 revealed that TP was being implemented by a few highly committed individuals. In particular, the success of projects appeared to rely on the willingness of a small number of motivated lead general practitioners at each project who incurred high additional workloads. Indeed, one can identify at the more successful total purchasers the existence of a range of highly committed key individuals, including project managers, HA leads and provider

clinicians. Future success of TP may depend ultimately on the willingness of these individuals to continue the high level of commitment shown. However, since there are usually few other key players willing to commit themselves in most projects, the process of TP remains fragile, raising questions about the longer term sustainability of the scheme.

Key individuals have also been vitally important in demonstrating the advantages of total purchasing, both real and potential, to those more sceptical individuals and groups affected by its development. Lead general practitioners, for example, have been particularly important in persuading partners to support, or at least not to oppose, TP. In this regard, it appears that the more senior and respected the partners who participate in TP are, the higher the standing of the project in the eyes of non-lead practitioners. Similarly, senior HA managers have played an important role in persuading more junior staff to co-operate with TPP demands. For example, one TPP which had been attempting to change its mental health provider found no support for the change within its host health authority until its chief executive backed the developments personally. The opposition to the proposed shift in the TPP's mental health provider '*melted away*' once the chief executive had given his backing to the proposals. The personality of lead managers or clinicians in provider groups has also been seen to be important in either driving change forward or blocking change completely (Gask, Lee, Donnan *et al,* 1998).

*Inter-agency co-operation*

The character of relationships between the various stakeholders in TP has also influenced the process of change. In short, where relationships between different agencies have been co-operative or collaborative, TPPs have been more likely to achieve their objectives. This is particularly true of the TPP-HA relationship (see Chapter 6), but it is also true of TP relations with providers where an approach characterised by dialogue and joint working has been far more effective than an adversarial approach in which TPPs have attempted to force changes upon providers through the contracting process without first securing input or feedback from the providers on the implications of the contract changes. The work on maternity services, for example, revealed that change was facilitated when working relationships between HA staff, Trust managers and midwives were close. Moreover, despite a history of poor joint working relationships between the TPP, HA, local authorities and social services, joint working between social services and TPPs had improved steadily (Myles, Wyke, Popay *et al,* 1998), a finding mirrored by the study of contracting which found an overall improvement in the level of communication between primary and secondary care over time (Robinson, Robison and Raftery, 1998).

The fact that inter-agency co-operation is stressed so forcefully by participants as an enabling factor in the process of change confirms that the abilities needed to be a successful TPP are

somewhat different from those required in fundholding. Relationships with trusts, in particular, have benefited from greater communication, since trusts found it very difficult in the initial stages to assess the impact that TP would have on their organisations. TPPs that did not progress in 1996/97 were those where dialogue between trusts and the TPP was poorly developed in the preparatory period (Mahon, Stoddart, Leese *et al.*, 1998).

*Holding a budget*

A final theme in the process of TP is the strong indication that holding a budget was an important prerequisite for making progress (Mays, Goodwin, Malbon *et al.*, 1998). However, the evidence from this research suggests that budget-holding (or having the *ability* to contract) has been just as, if not more, important than the actual process of contracting, in securing change.

In maternity services, for example, the *potential* to negotiate separate contracts was an important lever for change, but contract setting had rarely been used in 1996/97 since most changes had occurred through co-purchasing agreements with the HA. Similarly, the mental health sub-study concluded that most progress was made through closer working relationships with providers, especially personal contact, rather than through the contracting process. In both these studies, it was clear that the status of TPPs as commissioners, with their *potential* power to change contracts and/or providers, was a catalyst to greater joint working with providers. Thus, there were elements of both 'carrot' and 'stick' in this arrangement - the 'carrot' being closer working relationships and a chance for providers to have input into service developments and the 'stick' being the contractual power of the TPP which could be used in extreme cases. As a result, many respondents felt that the fostering of personal and agency relationships was as important in driving change as the potential use of budgetary and contractual leverage. This dual approach appears to have been the most effective in bringing about service changes during the TPPs first 'live' year. These findings resonate with the findings of the sophisticated sociological studies of NHS internal market contracting undertaken as part of the Economic and Social Research Council's *'Contracts and Competition'* research programme (Flynn and Williams, 1997).

*Conclusion on the process of change*

TPPs with all the positive aspects reviewed above (key individuals, co-operation between agencies and the ability to hold budgets) have been the ones most likely to achieve their objectives. Successful projects in the maternity study, for example, were seen to be the ones where all three positive process factors came together:

> *The particular confluence of factors in most of the general practice purchasing sites (the perceived ability to purchase, enthusiastic midwifery staff, the ability to negotiate extra resources, general practitioners enthusiastic for maternity care and for fundholding) may have resulted in an ability for general practitioners to influence the strategic development of the organisation of care, or to ask for detailed information on which future purchasing could be based. The* potential *ability to purchase may have catalysed change and ensured that Trust management met with and listened to general practice and other staff (community midwives in particular).*

Thus TPPs are likely to achieve more if they have:

- a delegated budget with which to contract independently (although the *potential* to contract seems as influential as the contract itself);
- a range of key individuals within the TPP, HA, providers and other agencies with the ability and will to promote TP;
- co-operative/collaborative relationships and negotiations between key stakeholders.

In the first year of 'live' purchasing considerable variation between the TPPs in the extent to which these characteristics had been developed has contributed to the variations in achievements observed.

**The interplay between context and process over time**

The fact that different TPPs have progressed to varying degrees can be most fully explained by the *interplay* between context and process. In other words, the ability of a project to achieve its 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 particularly TPP being able to progress, therefore, depends on the overall energy for change at the project's inception and the abilities of those involved in the process to overcome contextual barriers or capitalise on potential advantages as the project develops. This means that it is possible for change to be made in an adverse context (such as a local financial crisis) if the abilities of individuals and their inter-relationships can overcome these barriers. Similarly, a helpful context will not necessarily

ensure change if the abilities and relationships between individuals and groups in the process are poor.

The mental health sub-study, for example, revealed the importance of both local circumstances, particularly the level of finance, and the role of key individuals in the TP process:

> *Each* [TPP with a special interest in mental health] *is developing along the dimensions we have identified at a different pace, depending on local circumstances, resources, personalities and their interests. Variations in the level and quality of mental health service provision across the country also mean that sites have embarked on TP from very different starting points.*

The maternity sub-study also highlighted the importance of the interplay between process and context by showing that the ability to make changes was not only related to positive process variables - the ability to purchase and having enthusiastic midwifery staff and general practitioners - but that changes were being made in a highly receptive national context provided by the supportive framework of *Changing Childbirth* (Department of Health, 1993). The assessment of the purchasing achievements of TPPs in 1996/97 also concluded that the range of achievement reflected a mix of contextual and processual factors (i.e. extrinsic and intrinsic variables), with some TPPs coping better than others in the same contexts (Mays, Goodwin, Malbon *et al.*, 1998) (see Chapter 6).

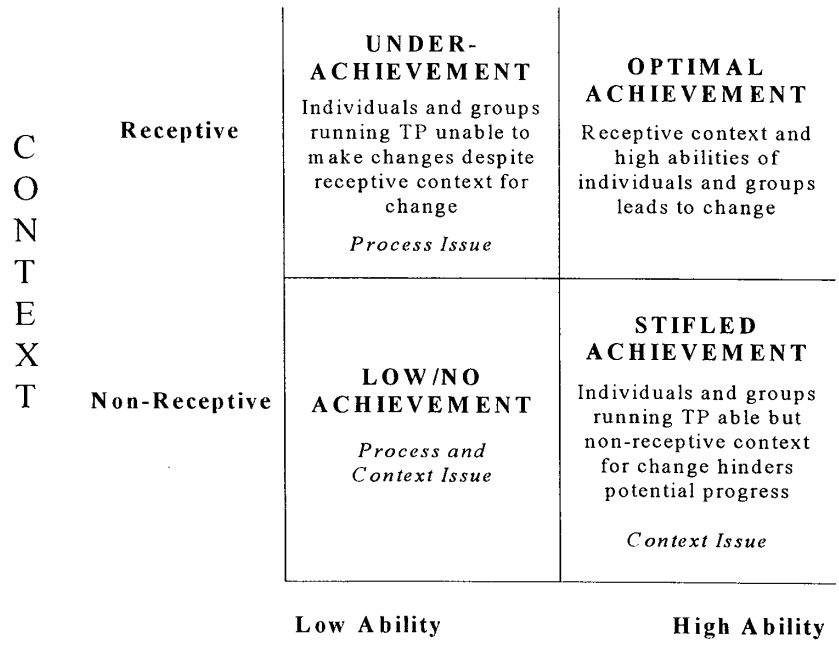
In addition, time should be recognised as a factor. This chapter has shown that TPPs did not begin from the same starting points. The quality of relationships with providers and the extent to which practices and general practitioners in the TPPs had worked together previously varied. In particular, it has been argued that the larger TPPs required considerably more time to set up appropriate organisations before they could progress compared to smaller projects. Thus, whilst smaller rather than larger TPPs appeared to achieve more in the first year, over time the larger projects might 'catch up'.

Since TP began, there have been some common developments over time that have allowed TPPs as a whole to make progress. Perhaps the most noticeable change has been a shrinking of the cultural divide between organisations, manifest, for example, in greater input to TPPs from HA public health staff and a shift towards co-working, co-operation and partnership. Information gathering and improved IT systems have also been a developmental feature of

TPPs which, more generally, appear to have alerted practices, trusts and HAs to the information requirements of primary care organisations as providers and purchasers of care.

Figure 7.1 attempts to show the interplay between context and process over time diagramatically. The vertical axis represents the context in which TPPs operate and the horizontal axis the process, or the way in which TPPs go 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 process is characterised by 'high ability' this has the effect of making achievements more likely, the opposite again being true for a process characterised by 'low ability'.

**Figure 7.1 Achieving objectives in total purchasing - the interplay between context and process**




The cells in Figure 7.1 represent the likely consequences for a TPP. Thus, where context is 'receptive' and process characterised by 'high ability', 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. However, it is clear that most projects have struggled to reach this stage since a mix of contextual and processual problems have restricted progress.

The top-left cell in Figure 7.1 describes a situation in which the context for change is 'receptive', but there is 'low ability' in process terms. In such circumstances, some aspect of the process of undertaking TP has blocked progress. Examples would include a project manager without sufficient skills to facilitate the project, the lack of general practitioners to act as leaders and poor communications and relations between the TPP and its host HA. Any achievements in these circumstances are likely to be sub-optimal since the context within which the project was operating was favourable.

A more common experience for TPPs in the first 'live' year is the scenario presented in the bottom-right cell in Figure 7.1 which describes the situation in which the process is characterised by 'high ability' but where contextual barriers have proved problematic to overcome. Any achievements by TPPs in these circumstances are likely to be despite the contextual difficulties faced. Many projects have managed to achieve their own objectives in these circumstances (however limited) which would suggest that some '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 overcome processual problems than wider contextual constraints.

The final cell in figure 7.1 describes the worst scenario - a 'non-receptive' context and a process characterised by 'low ability'. It has been difficult for any achievements to be made by TPPs in this group. These TPPs have had to invest a lot of time attempting to improve processual issues - such as organisational arrangements, information systems, relationships with external agencies - which, in turn, might help mitigate contextual barriers. It should be noted that investment in the process of TP ultimately helps projects to develop, since contextual barriers can only be overcome when the appropriate processes are in place.

*Overcoming processual problems*

The process of TP is made easier when it has the following characteristics:

- key individuals leading change
- inter-agency co-operation
- budget holding TPPs.

The three elements are clearly related. For example, where a TPP has shown that it lacks the appropriate skills or understanding of contracting issues, particularly the potential strategic ramifications that contract changes may have, there has been less chance of the HA allowing the TPP to move ahead with its proposals. On the other hand, a well informed project which puts ideas across in a professional manner has been more likely to gain support, especially financially. Employment of skilled project managers has been important to many projects and, in many cases, training is required to bring project management skills in TPPs as a whole up to the required level.

The association between key individuals leading the process of change and achievement suggests that projects not only require specific and skilled project managers, but enthusiastic lead general practitioners, clinicians and HA leads. At the present time there, is an issue of sustainability in TPPs since the process is being run by relatively few individuals. Added value and momentum to project development might be gained if projects attempted to involve more general practitioners, or if the HA put in more support to facilitate change. Such developments, of course, have financial implications and many projects that may have wanted to pay for general practitioner time or employ more managers to help with project co-ordination have not been able to find the finance to do so.

The strong association between co-operation between stakeholders and achievement has often been the result of a long, and sometimes fractious, period in which relationships have been developed. In the new PCGs, which will involve practices and HAs which have not co-operated before, there may be a strong case for some central guidance particularly since these new organisations must incorporate community nurses within their management framework.

*Overcoming contextual barriers*

Some contextual barriers are more easily overcome than others. For example, the ability to influence geographical contexts, like monopolistic trusts and patient catchment problems are less easily addressed than cultural or historical contexts where those involved can change existing values or working practices. In particular, the experience of TP has shown that much can be achieved in changing the attitudes of interest groups through the conjunction of key people to lead change and the fostering of new relationships. However, since this has been done on a local basis, the process has been slow, highly problematic and not always successful. As the move towards PCGs will involve the need to challenge established values there will be a need for some form of culture change management. Lessons from TP suggest that the process of cultural change is helped when there are leaders acting as role models; where favourable outcomes can be demonstrated at an early stage; and where there are appropriate

rewards available for those participating (although these need not always be pecuniary). Moreover, the features of TPPs that appeared to overcome contextual barriers were organisations that were purpose-designed, where innovations became accepted as the norm, where there was a strong and shared value base culminating in a commonality of approach, and where the TPP had a positive self-image and sense of achievement.

Overcoming contextual barriers has been problematic for TPPs and is likely to remain a problematic and long-term process for PCGs. The community care study, for example, showed that TPPs needed to have or develop a special interest in the issues they were addressing whilst also developing good relations with other agencies before proceeding. The study concluded that time was crucial to overcome the inertia created by historical and cultural barriers and that:

> ... *attempting to roll this model out to practices with little or no experience in developing community and continuing care services (many of which do not enjoy good inter-agency relationships) is even less likely to be successful* (Myles, Wyke, Popay, *et al.*, 1998).

**Conclusions on the interplay of content, context and process**

The achievements of first wave total purchasers in the first 'live' year appear to have been made incrementally with a bias towards local issues and primary care developments. Fewer TPPs have achieved objectives that were radical, strategic or aimed directly at service changes to secondary care. Moreover, TPPs have been managed by a few managers and practitioners. Users' views have not featured highly.

The ability to achieve objectives, particularly the pace and content of change, has been influenced heavily by local contexts. The ability of projects to overcome contextual problems has been a key factor in progress. The ability to bring about changes more easily has been shown to be related to the process through which TP has been implemented.

The future achievements of TPPs, and of the PGCs which will replace them in April 1999, will be shaped by how well processual and contextual barriers can be overcome. Critical to this is the recognition that any approach needs to be flexible enough to take into consideration the different requirements needed to achieve similar objectives in different local contexts. For example, it is doubtful that the move to PCGs based on populations of around 80,000 to

120,000 can be effective in all cases since the size of 'natural communities' in many parts of the country will fall far short of this mark. In addition, contexts will vary in their receptiveness to PCG development. For example, the requirements for developing a primary care-led service in an inner London borough suffering from high levels of deprivation are dramatically different from those elsewhere. This highlights the general point that the future progress of TPPs and PCGs will not be uniform, but will be influenced by specific mixtures of context and process, requiring different levels of support.

# 8 CONCLUSIONS: IMPLICATIONS FOR THE DEVELOPMENT OF PRIMARY CARE GROUPS IN ENGLAND OF THE EVALUATION TO DATE

**Differences and similarities between PCGs and TPPs**

While it is apparent from the findings presented above that there are fundamental similarities between TPPs and PCGs and that the national TPPs are closer to PCGs (particularly, level 2 PCGs) than any other form of devolved purchasing organisation yet seen in the NHS, there are plainly major differences which should be brought out before discussing the implications of the experience of TPPs for the PCGs of the future. Table 8.1 summarises the main differences apparent at this stage between the two initiatives in budgetary delegation and devolution to primary care level. There are some difficulties in summarising the characteristics of the PCGs both because the recent NHS White Paper (Secretary of State for Health, 1997) allows for four different levels of PCG each with a different status and because there are no PCGs currently in existence. Nonetheless, the exercise is helpful in clarifying the likely comparative strengths and weaknesses of the new approach vis-à-vis TP.

**Table 8.1 Comparison of TPPs and PCGs**

| *Total Purchasing Pilot* | *Primary Care Group* |
|---|---|
| • Small (30,000 - 40,000 population) | • Large (approximately 100,000 population) |
| • General practitioner-led | • General practitioner and nurse-led |
| • Volunteer practices and time-limited | • Compulsory - all practices and not time-limited |
| • Rural and suburban | • All parts of England |
| • Many simple/informal projects | • More complex organisations |
| • Few participants | • Many participants |
| • Ring-fenced TP budget and SFH budget (GMS not included) | • Moving towards integrated budgets, inc FH, TP and GMS |
| • Some pilots still with indicative budgets and some with fully delegated budgets after two years | • Moving towards delegated and independent budgets (i.e. legally the responsibility of the PCG at level 3) |
| • Intended to be a purchasing organisation rather than concerned directly with provider role of practices | • Responsibilities for commissioning services plus health improvement and primary care development |
| • No structure of 'clinical governance' between the overarching general practitioners | • Arrangements for 'clinical governance' aimed at improving quality and consistency of primary care |

The first point to note is that PCGs are likely to be substantially larger and more organisationally complex and demanding to run than the TPPs studied here, particularly since they will require the involvement of community nurses alongside general practitioners to steer the Group. The second is that the range of responsibilities of the PCGs is wider than that of TPPs, indicating, again, that managing PCGs will be more taxing than TPPs. All the TPPs were selective purchasers in the first 'live' year whereas it is not entirely clear how much freedom PCGs from level 2 onwards will have to select what they are involved in commissioning directly. The third point is that PCGs will compulsorily involve practices and community nursing staff with widely different levels of experience of managing resources, commissioning services and developing service provision in a single organisation, suggesting that it may take longer for PCGs to develop a corporate identity. The fourth is that PCGs are likely to have substantially greater financial leverage than TPPs, which could, in theory, give

them some advantage over most TPPs in negotiating major service change, especially where this requires extracting significant resources from acute and mental health specialist providers working together, PCGs may provide a local basis for collective planning of acute sector reconfiguration in ways that TPPs were too small and too isolated to do (see discussion of Wakefield, below). However, whether they will be big enough to 'hurt' large acute trusts by shifting their business is not clear (Light, 1998). Boyce and Lamont (1998) argue that PCGs will be neither "small enough to walk" (i.e. manoeuvrable like fundholders), nor "big enough to hurt" (i.e. with the leverage of HAs), but rather somewhere uneasily between the two. On the other hand, they may be able to work together on certain strategic issues (see Wakefield below). They may also be able to take some decisions at sub-PCG level, thereby mimicking some of the manoeuvrability of the former SFH practices.

On the positive side, PCGs will also increasingly break down the traditional divisions between HCHS and GMS in a way which TPPs could only begin to do and may, thereby, be able to make more flexible use of their total resources than TPPs or, indeed, HAs. Whether PCGs use their larger size and bigger budgets to bring about changes which relate to more strategic service reconfiguration will depend largely on the preoccupations of their leading general practitioners and community nurses. If they are like TPPs, they will concentrate on micro-level, 'fixing' of weaknesses in local services which have a bearing on general practice functioning

Taken together, this suggests that PCGs will:

- generally take longer to establish themselves than TPPs;
- require a stronger managerial infrastructure than TPPs; but
- be able in time to engage in more strategic service development within the framework of local Health Improvement Programmes (HIPs).

**Implications of the evaluation findings to date for the development of PCGs**

Given what is now known about the relative rate of progress against principal objectives of the TPPs, operating in different contexts and using different processes to bring about change, the main implications for the development of PCGs appear to be as follows:

- Broadly, the Government was correct in the recent White Paper to retain genuine budgetary delegation and devolution in its plans for PCGs. TPPs which had received

their own budgets and which had at least some independent contracts were far more likely to make progress against their main purchasing objectives than those which did not. However, budgetary control and independent contracts appear to be necessary rather than sufficient in their own right for bringing about desired service change at TPP level. Contracts in themselves may have potential importance in shaping health care, but they are not the sole or even the major influence. Skilled and motivated individuals, good leadership and mature relations with providers are also essential since service change appears to be brought about most effectively by a combination of developing close working relationships with providers and the contracting process itself with its dual ability to develop communication and trust while at the same time emphasising the possibility of contestability (i.e. that the TPP might take its resources elsewhere) (Williams and Flynn, 1997).

- The context in which a TPP is established cannot be ignored in attempting to understand its potential. Different TPPs progressed to varying degrees in the first 'live' year through the interplay between context and the process (e.g. the skills and commitment of the principal participants and their ability to overcome cultural and organisational barriers to change) of implementing TP. Able TPP staff were capable on occasions of overcoming unreceptive contexts. One implication of this insight for PCGs is that the process of developing individual PCGs will have to be shaped by an analysis of the nature of the context in which the PCG is attempting to operate. In turn, this suggests a degree of flexibility in how PCGs are set up and operate if they are required to achieve similar objectives in different local contexts. For example, 'natural communities' are likely to vary in size depending on the setting, thereby influencing the decision about the best size of PCG.
- The scale of the new PCGs with an approximate size of 100,000 patients will pose a major organisational development challenge since the single practice and smaller multi-practice TPPs tended to achieve more in the first year than the rest, primarily because they did not need to take the time to develop a new form of organisation. While it is possible that the larger first wave TPPs will 'catch up' the smaller projects in the second 'live' year, since none of the first wave TPPs is as large as the projected size of PCGs, the more relevant implication for PCGs of these findings is what they show about the salience of organisational development (or its absence) for effective multi-practice commissioning. For PCGs, the increase in scale is made more challenging since the intention is to organise them around the boundaries of 'natural communities' rather than the affiliations of practices with one another which are often based on a previous history of working together on earlier initiatives. Although the geographical focus should reduce the possibility that practices serving similarly affluent populations will be able to choose to work together to the disadvantage of less affluent populations in the same HA area, it will ensure that most PCGs contain more and less experienced SFH practices

together with non-fundholders and practices ideologically opposed to any involvement in managing NHS resources at local level on behalf of the state.

- The element of compulsion in PCGs is entirely different from the circumstances surrounding the early development of TPPs which comprised volunteer practices even when HAs felt obliged to orchestrate applications for TPP status from suitable local fundholders. Despite all being volunteers, there has been a wide range of achievement in the first 'live' year between TPPs. In addition, SFH practices in TPPs have been free to retain their own individual practice level SFH budgets and to manage them themselves if they so wished and most have chosen to do so. This will not be possible in the same way under PCGs where all resources are likely to be managed ultimately in common, suggesting that it will be more of a challenge to involve general practitioners in PCGs, but that it will be vitally important in PCGs to take the time to develop good inter-practice relations. In 1996/97, budgetary management within TPPs appeared to work better at single practice pilots where it was far easier actively to involve *all* the general practitioners and prevent 'free riders' since they had at least some experience of seeing themselves as a clinical group. It was easier in a single practice to develop a sense of responsibility for the management of the TP budget without having to set up any structure of 'clinical governance'. However, the internal 'clinical governance' and resource management of much larger PCGs by their executive board members will be more difficult, yet vital to their capacity to function effectively both as commissioners and providers of services.
- TPPs tend to rely on a relatively small number of leading participants, particularly general practitioners operating in a relatively informal manner. Many TPPs operated with relatively little input from the vast majority of the practitioners. Yet, the most frequently mentioned barrier to successful TP raised by the main participants at project level was the lack of general practitioner time to contribute to the project and the difficulty of guaranteeing this time. The evaluation has also shown that TPPs are relatively fragile organisations because of this reliance on a handful of people. The implications for PCGs are that a more robust, more formal organisation which gives attention to succession planning, especially for the general practitioners involved, will be required. Since PCG are far larger, multi-practice groups than TPPs, it will be increasingly important to ensure active participation from each practice since the behaviour and resource consumption of each practice will affect all the other practices in the PCG. There were 'free-rider' practices and practitioners even in TPPs which comprised volunteers, so the issue is likely to be more problematic in PCGs which will include many general practitioners with little interest in the approach.

- The support of the HA both practically and politically has been important to TPPs, particularly the more successful ones since they were only pilots rather than established features of the NHS. If anything, however, HA input will be even more important for developing PCGs, given their likely lower level of collective experience of commissioning and resource management and the fact that as larger groupings there are more likely to be wide variations between the practices in clinical behaviour and use of resources. HAs will be stretched to initiate and support PCGs involving all their local practices rather than small groups of experienced volunteers. There will be particularly important development work to be done to raise a level 1 PCG to level 2 where the group has budgetary responsibility for the first time.
- The December 1997 White Paper plans to reduce the total management costs of the NHS in a variety of ways associated with the abolition of the internal market including the replacement of single practice SFH by fewer, larger PCGs. However, the evidence available so far suggests that higher management costs were associated (albeit not strongly) with greater achievements in the first 'live' year. The pattern of management spending of the most active TPPs was characterised by payments for locum cover for the general practitioners payments for additional practitioner time on the project and high investment in information technology. In addition, there is little evidence from the evaluation so far of obvious scale economies in the management costs of running the larger TPPs. The likelihood is that the larger TPPs present a more complex co-ordination task as more general practitioners become involved which more than offsets any scale effects due to greater size. This may also reflect the fact that the level of management budget was the product of local negotiation between the TPP and the HA rather than a rational assessment of the cost of managing an organisation with a specified set of functions. For example, the HA will have to produce the local Health Improvement Programme (HIP) or strategy, set local PCG targets, allocate PCG budgets, hold the PCG accountable and support the PCG in its operations. This may cancel out any reduction in direct HA contracting. There are no data relevant to the likely costs of managing bodies of 100,000 based on previously independent general practices. As a result, the 'optimal' size of PCG/TPP based on minimising management costs is unknown. However, it seems unlikely that the advent of PCGs will enable substantial reductions in the combined management costs of primary care-based commissioning and residual HA commissioning (plus other HA functions) to be achieved. Overall management costs will be influenced not only by the size of the PCGs, but also by the size and number of HAs, the level of ambition of the PCGs, the extent to which functions are transferred from the HA to the PCGs, the extent to which practice level budgets are maintained, the extent of active general practitioner involvement and the impact on trusts.

- The evaluation to date suggests that altering local services requires excellent TPP-level managers to support the lead general practitioners. Unfortunately, the skills of effective service commissioning appear to be in scarce supply at HA level in the NHS (Audit Commission, 1997). It is unclear how 500 PCGs will acquire these skilled staff.
- The early reported achievements of the TPPs suggest that primary care-based purchasing/commissioning organisations do have the potential to improve the efficiency and accessibility of services by developing a range of forms of vertically and horizontally integrated services and by, for example, reducing lengths of acute stay. However, to do this consistently, TPPs and PCGs will need access to far better sources of information on cost and quality of services than the vast majority of the first wave TPPs. Investing in such information will also make the reduction of management costs more difficult.
- In addition to good information, the objectives of PCGs will need to be incorporated within wider HA strategy if PCGs are to bring about any significant shift of resources from acute and mental health trusts in support of their commissioning. Many of the more ambitious service changes and related resource shifts desired by the TPPs were prevented by either the straightforward resistance of the trusts or by the fact that such changes and shifts could only sensibly be implemented across a larger area than a single TPP. TPPs were able to reduce lengths of stay and 'save' bed days, but often without releasing any resources for redeployment. Even a PCG of 100,000 will find itself in situations where the realisation of its objectives are dependent on reaching an agreement with other commissioning organisations representing the interests of other populations. As a result, the first year achievements of TPPs were skewed towards incremental, relatively small scale, locally generated changes, especially in the field of extended primary care. TPPs tended to avoid or were less successful in negotiating changes in the way in which specialist secondary care providers operated. Many developments in the first 'live' year were in setting up systems and improving relationships and understanding rather than implementing purchasing objectives. This mirrors the findings from the one in-depth evaluation of a 'pioneer' (pre-first wave) TPP which has so far been published (Walsh, Shapiro, Davidge and Raftery, 1997).
- Although TPPs seemed to have more success is changing and developing primary and community health services in the first 'live' year, this was due to their size and the time required for the other types of service changes to be implemented, rather than a reflection of the fact that they could not manage the risk associated with more specialised services. Despite the fact that not all TPPs had adequate risk assessment and management arrangements in place, the evidence from the TPPs and from simulations carried out as part of the national evaluation (Bachmann and Bevan, 1997) is that PCGs

with populations of around 100,000 should be large enough, with sensible management, to manage almost all risks. The evidence available does not suggest that there is a need for special ECR arrangements via the HA or the Regional Office of the NHSE for any but a tiny handful of exceptionally costly and rarely used services such as forensic psychiatry. In order to encourage managed care and avoid 'moral hazard', it is preferable for PCGs to accept nearly all risks.

- On the setting of budgets for TPPs and, by implication, for PCGs, the struggles of TPPs and their HAs to devise workable formulae show clearly the advantage of a national capitation formula for PCGs in the future. A bottom-up approach based on aggregating the budgets of individual practices within a PCG is likely to face major technical problems in estimating what each currently spends.

The combination of the imperative to involve all practices and practitioners actively in resource management, the size of PCG required for risk management and the lack of obvious scale economies in management costs as population rises, suggest that 100,000 population may be unnecessarily large for a PCG if the goals are to minimise management costs, maximise general practitioner engagement and stay within budget. This conclusion cannot be definitive since the largest first wave TPP has only about 85,000 population and there is little or no scope even including the second wave to make a systematic comparison between, say, TPPs (and by implication PCGs) with 50,000 patients and 100,000.

Wakefield *Partners in Health*

Since PCGs are not scheduled to come into being until April 1999, drawing out the implications of TPP experience for PCGs is, inevitably, somewhat hypothetical. However, in one HA, the main elements of the new Labour-inspired NHS already exist (see Box 8.1), so it is possible to see at least part of the future pattern of implementation unfolding in the present. In Wakefield, uniquely, the entire district has turned itself into a giant TPP. The infrastructure is being put in place to devolve commissioning to five general practitioner-led localities based on aggregates of general practice catchments. Although these localities are slightly smaller than the suggested size of PCGs in the December 1997 White Paper (Secretary of State for Health, 1997), they are probably the nearest we currently have to a set of Level 2 PCGs (See Box 2.1) working together with the HA to generate its strategy and manage its resources.

The development of Wakefield's *Partners in Health* scheme demonstrates a number of features likely to be prominent in the future, as follows:

- A moderately elaborate system of HA-wide and locality level boards and meetings, including formal arrangements for dialogue with acute and community trust clinicians and managers.

- Redefined relationships between the HA and the practices including the respective roles of the HA and the five localities. This required a detailed review of activities and competencies throughout the district and plans for a staged redistribution of HA management costs and reallocation of staff.
- A considerable time for development. Organising five localities and reconfiguring the HA to work with, and support, all five has taken approximately two and a half years. As a result, the first, so called 'live' year (1997/98) has yielded progress predominantly in developing *Partners in health* as an organisation and in developing service specifications on which to base future service changes. The development of inter-practice, inter-practitioner and HA-general practitioner relationships even in an area with a high proportion (over 85 per cent) of fundholders takes considerable time throughout a district.
- The initial preparatory phase has involved 'copurchasing' of services with the HA; localities have not engaged in direct, independent contracting.
- A district-wide information system providing activity and expenditure data by practice has been developed and has helped engage general practitioners with their localities and has enabled steps to be taken to discuss variations in clinical practice.
- With time, energetic leadership, evolving information systems and an ambitious vision of a new sort of local health system, it is possible to recruit *all* the general practitioners in a district of 317,000 to a series of near-PCGs.
- Wakefield *Partners in health* aims to plan and implement a major reconfiguration of Wakefield's acute services affecting the entire population through an organisation which is constituted by its five localities rather than led by the HA. It would not have been possible for any of the localities alone to have led this process, but together they are large enough to handle the issues involved.

**Box 8.1: Wakefield *Partners in Health***

Wakefield became a, so far unique, district-wide TPP covering a population of 317,000 (involving 45 practices) during 1996/97, replacing a first wave TPP which had covered part of the population. It went live in 1997/98. *Partners in Health* is a 'way of working ...the way we do business'; according to the HA. It is an expression of the district's vision of collaborative working.

The service agenda is dominated by a planned major acute service reconfiguration and implementation of a 'financial recovery plan', aimed at eliminating a substantial HA deficit.

*Partners in Health* is based on five localities (aggregates of general practitioner practices), ranging in size from 55,000 to 77,000 population which relate to social services boundaries. A Strategy Board, five Locality Boards and Locality managers are the core of the management structure. 'Tripartite meetings' between the HA, lead general practitioners and acute trusts have established dialogue between general practitioners and clinicians; and similarly with the community trust.

There is a performance management framework based on locality corporate contracts and a series of review meetings.

A highly participative organisation development project has reviewed future roles and responsibilities of the HA and localities as the basis for organisational development and reducing management costs. A model of a new HA is now being adopted based on three overlapping functions and a consequential distribution of management resources:

- Locality based commissioning and implementation (50 per cent of management resources)
- Shared strategic functions (30 per cent)
- Core HA functions (20 per cent)

Weighted HCHS capitation budgets are allocated to localities. In 1998/99 locality budgets are based on the weighted capitation allocation built up from practice level (including both fundholding and TP) with freedom to manage the budgets as a single sum. The first live year of purchasing (1997/98) involved localities 'copurchasing' services with the HA.

Achievements in 1997/98 have mainly related to putting the infrastructure of *Partners in Health* in place, specifically:

- Locality arrangements and working methods
- General practitioner involvement in and increased understanding of strategic issues
- Growing relationships between general practitioners within localities
- Development of the relationship between the HA and general practitioners
- Financial management framework, supported by development of information systems
- Performance management framework
- General practitioners sharing information on activity and spending across practices, and discussing variations in clinical practice
- Involvement and understanding of plans for organisational development
- Agreement of a framework for 'patient participation'

Reported service developments included:

- significant progress in planning the acute service reconfiguration
- Progress towards meeting the terms of the financial recovery plan through action on elective admissions
- Start of development of integrated nursing teams
- Collaborative development of a district drug formulary
- Bed audit undertaken through collaboration between two localities
- Development of protocols for cardiology
- Piloting a new service model for methadone prescribing and services for drug users
- Consultations on service specification for family planning and for school health services
- Development of service specification for development of ophthalmology services

**Trade-offs between different models of purchasing/commissioning**

Locality commissioning, SFH, TP and PCGs each represents a different way of resolving the inevitable trade-offs between the strengths and weaknesses of different scales and types of purchasing/commissioning organisation. Each is likely to be able to deliver different purchasing objectives over different service areas. For example, TP can be seen as an attempt to bring together the best of the 'bottom-up', demand-led, individual patient-focused manoeuvrable, approach associated with SFH and the 'top-down', needs-based, population-orientated, strategic approach associated with HA commissioning (Mays, Goodwin, Bevan and Wyke, 1997).

A number of commentators have recognised that these trade-offs lie behind much current debate about the merits of different approaches (Le Grand, Mays, Mulligan *et al.*, 1997; Light, 1998; Mays and Dixon, 1996; Smith 1997). Choosing between approaches depends which goals in which order of priority have been set for the purchasing/commissioning process. For example, purchasing could aim to:

- maximise service efficiency, which might indicate a need for larger, stronger purchasing organisations with genuine bargaining power;
- ensure equity between populations and areas which would imply larger rather than smaller organisations and national policy frameworks;
- maximise sensitivity to local needs or patient wants which would imply smaller organisations with good intelligence about what users think;

- shift resources out of expensive acute settings and build primary care-based alternatives which would indicate the need for local, primary care-led organisations with integrated budgets;
- maximise accessibility to a wide range of services which would indicate a requirement for local purchasers;
- minimise administrative and managerial costs while procuring services which would indicate the need for fewer, larger purchasing organisations to spread costs;
- improve service quality which would tend to indicate the need for larger, better informed, 'intelligent' purchasers able to collect good data on price and quality and make informed comparisons between providers;
- plan services (e.g. acute hospitals) strategically which would indicate the need for large organisations, perhaps considerably larger than current HAs.

There are other functions which might also influence the design of the purchaser/commissioner side of the NHS such as whether the role of the organisations is to purchase most or all services for its population (larger, stronger bodies are implied) or to purchase only a selected range (smaller bodies may suffice). For example, a recent survey of different approaches to NHS commissioning in England concluded from questionnaires to HA managers that fundholding-derived models such as multifunds and fundholding consortia appeared to have a greater impact than other approaches on general practitioner prescribing, provision of extended primary care services, referrals and inpatient waiting times. By contrast, locality commissioning and HA-wide general practitioner groups appeared to have had greater impact than multifunds and fundholding consortia on services for chronically mentally ill people and continuing care arrangements (Smith, Barnes, Ham and Martin, 1997).

Table 8.2 adapted from Smith (1997) summarises the trade-offs generated by the interaction between the different possible goals or criteria by which purchasing/commissioning may be judged by contrasting largely 'centralised' and 'decentralised' systems. Although it is possible to argue with certain of the judgements made, it reveals the difficulty of pursuing a policy of increased devolution (such as the move to PCGs) with its associated potential for patient participation (not yet realised in the case of TPPs) and local sensitivity to need without increasing the management costs of the system. Indeed, Table 8.2 demonstrates vividly the very real possibility that if two or more criteria of purchasing performance are considered paramount, then no single model is likely to appear superior. However, the table does suggest that there may be configurations which provide acceptable trade-offs between a number of the assessment criteria without optimising any single one. For example, PCGs may be seen as operating somewhere between Smith's 'centralised' and 'devolved' systems and PCGs themselves could both team together for certain more strategic activities while at the same time having practice level or sub-group structures for other purposes (e.g. commissioning

highly localised services). However, since PCGs will be based on general practices with very varying levels of motivation and experience for the wider role now expected of them, PCGs will rely on the continuing existence of HAs (i.e. major parts of the 'centralised' system will remain) and, at the same time, will require some functions to be discharged at practice level. This may mean, for example, that the total management costs of the resulting system are closer to those of Smith's 'devolved' system than to his 'centralised' system in order to enhance criteria such as equity, sensitivity to local needs and cost control.

In any event, the NHS is far better placed to manage the implementation of the new PCGs through the contribution of the current evaluation of TPPs than has been the case with many other recent policy changes. The contrast with the introduction of SFH is marked. It is to be hoped that the observation and learning processes can be extended into the future as the embryos (the TPPs) develop into fully fledged PCGs.

**Table 8.2 Potential impact of devolved versus centralised purchasing arrangements**

| Assessment Criterion | Centralised System (eg HA control) | Devolved System (eg all HCHS allocated to individual practices as in genuine single practice TP) |
|---|---|---|
| Management costs | Low | High |
| Equity | High | Low |
| Sensitivity to local needs | Low | High |
| Cost restraint | Low | High |
| Stability of providers | High | Low |
| Accountability to local citizens | ? | ? |

From: Smith P (1997). *Devolved purchasing in health care: a review of the issues.* London: Nuffield Provincial Hospitals Trust.

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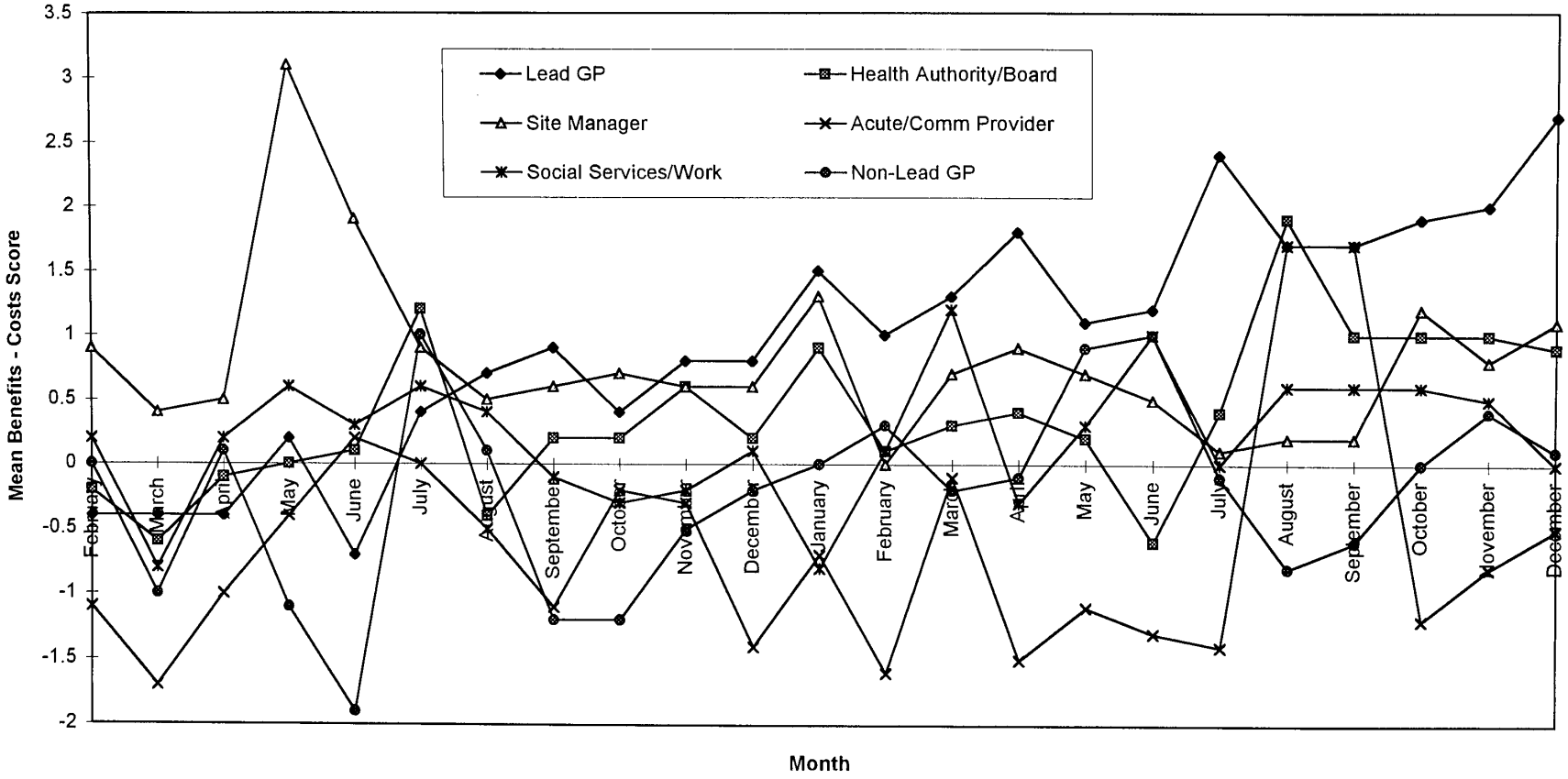
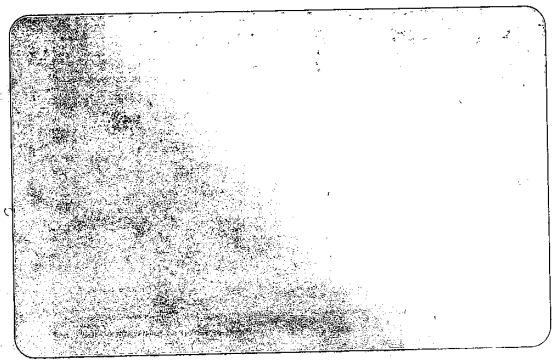
**Appendix 1**

## Key participants' average global assessments of benefits minus costs of total purchasing





# Total Purchasing National Evaluation Team (TP-NET)

*The evaluation is led by Nicholas Mays, Director of Health Systems Programme at the King's Fund, London. The different consortium members are listed below, together with their research responsibilities.*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***Lead:*** Nicholas Mays
***Other members:*** Nick Goodwin, Gill Malbon, Julian Le Grand, Jennifer Dixon, Amanda Killoran, Jo-Ann Mulligan

***Project Responsibilities:*** Hertford, Hemel Hempstead, Hillingdon, New River, St Albans, Stevenage, Attleborough, South Bucks, Belper, Keyworth, Long Eaton, Melton Mowbray, Wakefield. All second wave TPP projects.

***Other Main Responsibilities:*** Process evaluation co-ordination (Mays, Goodwin); A&E services and emergency admissions (Dixon, Mays, Mulligan); monitoring at all TPPs (Mays and Malbon); case studies (Mays, Goodwin, Killoran, Malbon).

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***Leads:*** Brenda Leese (Manchester and CHE), Linda Gask (Manchester), Jennie Popay (Salford), John Posnett (YHEC)
***Other members:*** Martin Roland, Stuart Donnan, John Lee, Andrew Street

***Project Responsibilities:*** High Peak, North Lincolnshire, Rotherham, Sheffield South, Ellesmere Port, Knutsford, Liverpool Neighbourhood, Newton le Willows, Wilmslow, Ribblesdale, Southbank, North Bradford, York.

***Other Main Responsibilities:*** Transaction costs (Posnett and Street); service provision for the seriously mentally ill (Gask, Roland, Donnan and Lee); service provision for people with complex needs for community care services (Popay); relations with health authorities (Leese); maternity (Posnett).

**DEPARTMENT OF SOCIAL MEDICINE, UNIVERSITY OF BRISTOL**
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***Lead:*** Kate Baxter
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***Project Responsibilities:*** Bewdley, Birmingham, Bridgnorth, Coventry, Solihull, Worcester, Saltash, South West Devon, Thatcham.

***Other Main Responsibilities:*** Budgetary management (Baxter); risk management (Bachmann); use of evidence in purchasing (Stoddart); case studies (Baxter).

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***Project Responsibilities:*** Durham, Newcastle, Tynedale, Aberdeen West, Ardersier & Nairn, Grampian Counties, Lothian, Strathkelvin

***Other Main Responsibilities:*** Maternity (Wyke); monitoring of participants' views (Wyke); prescribing (Howie); community care (Wyke and Scott).

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***Lead:*** Ray Robinson
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***Project Responsibilities:*** Dorset, Romsey, Trowbridge Bath & Frome, Winchester, Bexhill, East Grinstead, Epsom, Kingston & Richmond, Merton Sutton & Wandsworth, West Byfleet.

***Other Main Responsibilities:*** Contracting methods (Robinson, Raftery, HSMC and Robison; case studies (Evans).

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***Lead:*** James Raftery
***Other member:*** Hugh McLeod

***Main Responsibilities:*** Activity changes in inpatient services; contracting methods (with Robinson and Robison, IHPS); service costs and purchaser efficiency (with Le Grand).

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***Main Responsibilities:*** Resource allocation methods.



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