King's Fund

National Evaluation of Total Purchasing Pilot Projects

What were the achievements of Total Purchasing Pilots in their second year (1997/98) and how can they be explained?

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The Total Purchasing National Evaluation Team (TP-NET)

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

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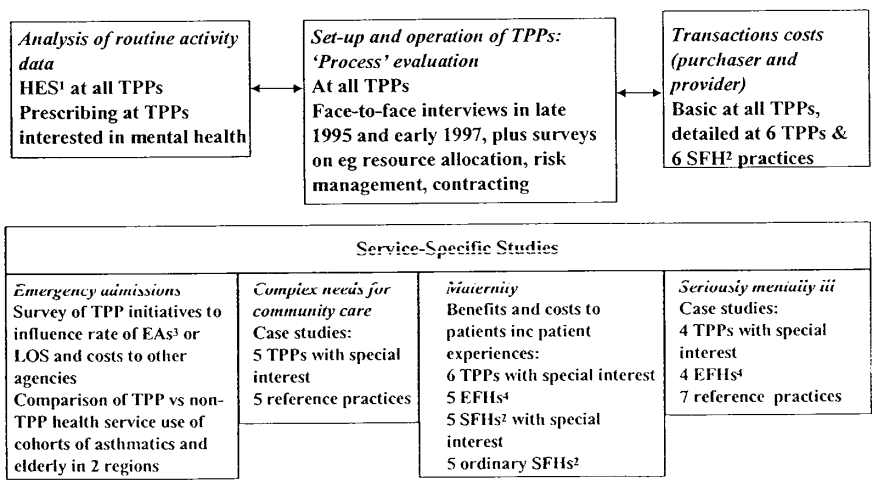
Preface: The National Evaluation of Total Purchasing Pilot Projects

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

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

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



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

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

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

Nicholas Mays
Co-ordinator, Total Purchasing National Evaluation Team (TP-NET)
August 1999

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

Title and Authors	*ISBN*
Main Reports	
Nicholas Mays, Nick Goodwin, Gwyn Bevan, Sally Wyke on behalf of the Total Purchasing National Evaluation Team (1997). *Total purchasing: a profile of the national pilot projects*	1 85717 138 1
Nicholas Mays, Nick Goodwin, Amanda Killoran, Gill Malbon on behalf of the Total Purchasing National Evaluation Team (1998). *Total purchasing: a step towards primary care groups*	1 85717 187 X
Amanda Killoran, Nicholas Mays, Sally Wyke, Gill Malbon (1999) *Total Purchasing: A step towards new primary care organisations.* London: King's Fund	1-85717-242-6
Working Papers	
Nicholas Mays, Nick Goodwin, Gill Malbon, Brenda Leese, Ann Mahon, Sally Wyke *What were the achievements of total purchasing pilots in their first year and how can they be explained?*	1 85717 188 8
Gwyn Bevan *Resource Allocation within health authorities: lessons from total purchasing pilots*	1 85717 176 4
Ann Mahon, Brenda Leese, Kate Baxter, Nick Goodwin, Judith Scott *Developing success criteria for total purchasing pilot projects*	1 85717 191 8
Ray Robinson, Judy Robison, James Raftery *Contracting by total purchasing pilot projects, 1996-97*	1 85717 189 6
Kate Baxter, Max Bachmann, Gwyn Bevan *Survey of budgetary and risk management of total purchasing pilot projects, 1996-97*	1 85717 190 X
Ann Mahon, Helen Stoddart, Brenda Leese, Kate Baxter *How do total purchasing projects inform themselves for purchasing?*	1 85717 197 7
John Posnett, Nick Goodwin, Jenny Griffiths, Amanda Killoran, Gill Malbon, Nicholas Mays, Michael Place, Andrew Street *The transactions costs of total purchasing*	1 85717 193 4

Jennifer Dixon, Nicholas Mays, Nick Goodwin *Accountability of total purchasing pilot projects*	1 85717 194 2
James Raftery, Hugh McLeod *Hospital activity changes and total purchasing*	1 85717 196 9
Sally Wyke, Jenny Hewison, James Piercy, John Posnett, Linda Macleod, Lesley Page, Gavin Young *National evaluation of general practice-based purchasing of maternity care: preliminary findings.*	1 85717 198 5
Linda Gask, John Lee, Stuart Donnan, Martin Roland *Total purchasing and extended fundholding of mental health services*	1 85717 199 3
Susan Myles, Sally Wyke, Jennie Popay, Judith Scott, Andrea Campbell, Jeff Girling *Total purchasing and community and continuing care: lessons for future policy developments in the NHS*	1 85717 200 0
Gill Malbon, Nicholas Mays, Amanda Killoran, Nick Goodwin *A profile of second wave total purchasing pilots: lessons learned from the first wave*	1 85717 195 0
Amanda Killoran, Jenny Griffiths, John Posnett, Nicholas Mays *What can we learn from the total purchasing pilots about the management costs of Primary Care Groups? A briefing paper for health authorities*	1 85717 201 9
Street A, Place M *The Management Challenge for Primary Care Groups*	1 85717 227 2
Michael Place, John Posnett, Andrew Street *An analysis of the transactions costs of total purchasing pilots. Final report*	1 85717 244 2
Judy Robison, Ray Robinson, James Raftery, Hugh McLeod *Contracting by total purchasing pilot projects 1997-98*	1 85717 249 3
Lee J, Gask L, Roland M, Donnan S (1999) *Total Purchasing and Extended Fundholding of Mental Health Services: Final Report.*	1-85717-288-4
Wyke S, Mays N, Abbott S, Bevan G, Goodwin N, Killoran A, Malbon G, McLeod H, Posnett J, Raftery J, Robinson R (1999) *Developing Primary Care in the new NHS: Lessons from Total Purchasing.* King's Fund Publishing	1-85717-296-5
Killoran A, Abbott S, Malbon G, Mays N, Wyke S, Goodwin N (1999) *The transition from TPPs to PCGs: lessons for PCG development.*	1-85717-289-2
Malbon G, Mays N, Killoran A, Wyke S, Goodwin N (1999) *What were the achievements of TPPs in their second year and how can they be explained?*	1-85717-293-0

Forthcoming reports from the final year of the national evaluation

Goodwin N, Abbott S, Baxter K, Evans D, Killoran A, Malbon G, Mays N, Scott J, Wyke S (1999) *Analysis and implications of eleven case studies.* 1-85717-294-9

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

Forthcoming book from the national evaluation of TPPs

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

Summary

Key findings from the second year, 1997/98

- The larger TPPs were now becoming higher achievers (in both own and TP-related areas) in the second year. High achievement was also associated with higher Management costs.
- A group of TPPs (43%) improved their level of performance over two years, about a quarter remained at the same level and about a third dropped out.
- A greater proportion of TPPs were concentrating on the so-called 'easier' areas, suggesting that TPPs were using their experience from the previous year to concentrate on areas where progress could be made.
- A smaller number of TPPs were tackling the more 'complex' areas (i.e. those in TP-related areas: seriously mentally ill; emergency admissions, inpatient length of stay and so on) in their second year, 1997/98. However, this sub-group was able to make progress in these chosen areas. Typically, the mechanisms they employed were primarily through developing primary and community services.
- In most TPPs, the preferred mechanism for progress was through primary care development.
- TPPs made less impact on services using commissioning mechanisms in the second year, although it was still seen as important.

Implications of the TPP achievements analysis on Primary Care Groups

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

The first implication is that it will take considerable time for PCGs to construct robust organisations capable of bringing about important changes in local health services. Large multi-practice TPPs took considerably longer than single practice and small multi-practice TPPs to reach the point of bringing about service changes. Since the PCGs will be much larger than most of the TPPs (an average population of 30,000 versus 100,000), the likelihood

is that even more time will be required to decide on purchasing priorities and implement them. The White Paper wisely refrains from specifying the period over which the government expects the PCGs to develop to their fullest form.

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

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

1. Introduction

General practitioner (GP) fundholding was introduced into the National Health Service (NHS) as part of the 1991 internal market changes. The main rationale was that passing the elective part of the hospital and community health services (HCHS) budget over to clinically informed GPs to manage, with the added incentive of being able to keep any 'savings' made, would encourage GPs to negotiate better contracts with providers than their health authority (HA) counterparts. As a consequence, they would be able to improve the responsiveness of services to patients' needs as well as increasing efficiency. In the event, the performance of GP fundholders varied widely (Audit Commission, 1996) despite the fact that all of them were subject to the same economic incentives. A similar pattern has been observed for the Total Purchasing Pilot projects (TPPs). These were standard GP fundholding practices which volunteered to take an additional, delegated budget from their local health authority to purchase (or 'commission') potentially all the HCHS for their registered populations (Mays, Goodwin, Bevan and Wyke, 1997). The TPPs are of continuing relevance under the Labour Government's plans for the future organisation of the NHS since they had a great deal in common with the new Primary Care Groups (PCGs) which will start commissioning local HCHS in April 1999 (Secretary of State, 1997). However, the PCGs will be considerably larger than the average TPP (40,000-230,000 patients versus 30,000) and will be compulsory for all practices rather than for volunteers (Mays and Goodwin, 1998).

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

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

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

- TPPs with smaller populations, fewer GPs and with no more than five practices achieved more than other pilots;
- Smaller projects, particularly single practices, were able to achieve their own objectives with relatively little additional organisational development, whereas larger TPPs had to establish more complex organisations before they could progress which was, therefore, less likely to have been completed in the first 'live' year;
- TPPs with higher direct management costs achieved more in the first year than the remainder;
- Higher achieving TPPs were more likely to report a 'fair' to 'high' level of support from the local HA than lower achieving projects;
- TPPs with at least some of their own independent contracts were more commonly found in the higher performing groups than in the lower; and
- Higher achieving projects were also more likely to have greater ambition for the future (Mays, Goodwin, Malbon, Leese and Mahon, 1998).

Thus there appeared to be a strong link between the degree of TPPs' organisational maturity (for example, their ability to forge a corporate identity between previously separate practices) and their ability to realise their commissioning goals. Larger TPPs with more practices to co-ordinate had found it more time-consuming to forge an effective organisation capable of determining priorities, negotiating contracts, monitoring services and managing expenditure. This has significant implications for the development of PCGs in England which are discussed elsewhere (Killoran, Mays, Wyke and Malbon, 1999).

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

monitoring the rest in outline. This was to be able to look much more intensively at *how* the more successful TPPs brought about service change and development. In the second 'live' year, it would also be possible to investigate whether, in some sense, the larger TPPs 'caught up' with and, perhaps, overtook their smaller counterparts.

It also became apparent towards the end of the 1996/97 year that there might be a Labour Government after the May 1997 General Election and that it would be likely to alter both standard single practice fundholding and experiments like TP. In pre-election policy documents, Labour had signalled an intention to retain the concept of budget holding by general practices, but to move towards exclusively collective versions of this approach on a scale larger than either standard fundholding or any of the TPPs (Labour Party, 1995). With these considerations in mind, it was decided only to include larger, multi-practice TPPs, operating in a range of different contexts, in the sample of pilots for intensive research in the second 'live' year. Projects which were unlikely to be able to sustain themselves through the post–General Election period were also excluded. There was a likelihood that, in some cases, HAs would reduce or withdraw their support from particular TPPs in anticipation of a change in policy. The risk was that this would affect single practice projects disproportionately. There would be little point in studying pilots which succumbed in these circumstances not because of intrinsic weaknesses, but because of impending national policy shifts. As Labour's plans unfolded during the second 'live' year of TP, further alterations were made to the focus of the evaluation to ensure that the findings remained relevant to the new government's decision to set up PCGs throughout England (Secretary of State for Health, 1997). For example, it was decided to collect data on how the TPPs were becoming involved in the transition to the new PCGs since they contained many of the most experienced GP service commissioners (Malbon and Mays, 1998). More information about the objectives and design of the case studies is given in the sections which follow. The second 'live' year (the third year of the evaluation) exemplifies many of the challenges facing evaluators in a changing policy environment who, nonetheless, wish their findings to resonate with the concerns of contemporary policy makers.

TPPs were subject to a three-year evaluation led by the King's Fund during 1995-98. This report presents the third and final year of evidence on the achievements of all first wave Total Purchasing Pilot projects (TPPs) in 1997/98 in England and Scotland which began in October 1995. In particular, the report addresses the extent of first wave TPPs achievements

during 1997/98, their second 'live' purchasing year compared to their first (1996/97). The report then describes the TPPs' achievements in some detail and examines associations between achievements and other characteristics and reported features of the projects. Since TP is, in many respects, the forerunner of the Primary Care Groups (PCGs), proposed in the December 1997 government White Paper, the *New NHS* (Secretary of State for Health, 1997), the implications of the evaluation for the transition to PCGs are examined.

This report forms the second in a series of three working papers from the national evaluation of TPPs (Goodwin et al, 1999 and Killoran et al, 1999).

2. Objectives

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

- to assess the extent to which TPPs achieved their main purchasing objectives in 1997/98 (as cited in interviews held during 1996/97)
- to assess the extent to which they achieved other objectives which had not been identified during 1997/98 (the TPP's second 'live' year)
- to assess the extent to which their achievements were in service areas included in Total Purchasing (i.e. new to GP-led purchasing as a result of the TP initiative) rather than in service areas already included in Standard Fundholding
- to explain the TPPs' achievements in terms of features of the pilots and their external relationships
- to compare TPPs' level range and content of achievement in 1996/97 with 1997/98
- and to discuss how the findings inform the development of PCGs in England.

3. Methods

3.1 Data Collection

Two methods were employed to collect data from first wave TPPs in the third and final year of the national evaluation.

Fifty-five structured postal questionnaires were sent out in June 1998 after the end of the 1997/98 purchasing year to all first wave lead GPs and their TP project managers. The questionnaires comprised three sections: the TPP's main objectives as stated in interviews conducted during 1997; the direct management costs of the TPP (1997/98); and questions on the TPP's experience of moving towards a PCG. Forty-one out of 55 TPPs responded (75%).

In addition, 12 multi-practice TPPs chosen to reflect a range of size settings and complexity were selected for in-depth case study analysis during 1997/98 (see Goodwin et al's report for details of selection criteria). Interviews were conducted with lead GPs, TP project managers, HA staff, social service representatives and others. This work was carried out between January 1998 and August 1998.

In the case of the TPPs which participated in the case study work, a researcher completed the questionnaire on behalf of the lead GP and TP project manager, based on a series of interviews held with the above respondents.

3.2 Analysis

Stage 1: Data on achievements in relation to objectives

Each TPP was sent a questionnaire which listed each of its *four main* objectives as identified in the previous round of face-to-face interviews at the end of 1996/97 (Mays et al, 1998). The TPP was asked to describe what it had done concerning each objective, indicating which mechanisms it thought were attributable to success and which areas it considered may have hindered the project's progress. The TPP was asked to provide, where possible, quantitative data, including, reports, tables and print-outs in support. In addition, the TPP was also asked to supply a relevant contact name (at the practice, acute provider, community trust, social services or any other agency) who could provide additional information on each objective.

A similar procedure was carried out for any other objective(s) (met or not), which the TPP had not mentioned as a priority at the beginning of the second 'live' year.

Stage 2: Grouping the projects by level of achievement

Using the data from this part of the questionnaire, three researchers at the King's Fund, independently placed each TPP in to one of five performance groups as follows:

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

The groupings were then discussed by the three researchers wherever there was disagreement to arrive at an agreed set of groupings. The procedure for reaching a consensus was: firstly, to accept all cases in which there was 100% agreement between the three raters, without discussion; secondly, to discuss all cases where at least one of the researchers had placed the TPP in group 5 (the highest achieving group) or group 1 (the lowest achieving group), thereby attempting to confirm the nature of the fixed upper and lower groups; thirdly, to discuss those cases where two of the three judges were in agreement; and fourthly, to discuss those cases where there was overall disparity between all three judges, until agreement was made, which sometimes meant re-contacting the TPP for clarification. This approach was the same as that used to assess achievement of TPPs in 1996/97 (Mays et al., 1998). There was a high level of agreement at the initial stages of analysis with only a small number of cases requiring discussion.

In the case of the 12 TPPs involved in the case studies, questionnaire data were used in the same way (as filled out by the researcher responsible for the case study fieldwork). Ratings were discussed with the relevant interviewers to confirm the choice of group, where disagreements had arisen between the three King's Fund researchers.

Stage 3: Relating achievements to project characteristics

The characteristics of each of the TPPs in each of the 'achievement groups' based on its achievements in its own terms were then explored using a database comprising features of the projects hypothesised to be important for successful TP derived from analysis of the progress of the TPPs in their first 'live' year (1996/97). These included: population size; number of practices in the project; wave of fundholding of practices; previous experience of working together; organisational complexity; spending on management/ administration; level of HA support; and market context (e.g. availability of alternative providers, access to nursing homes, etc.).

Thus the notions of success, failure and achievements used in this analysis are relative and based on the interpretation of the participants and the researchers. It should not be assumed that any of the achievements automatically improved either the effectiveness, cost-effectiveness, acceptability or otherwise of local health services, simply that the TPP appeared to have been able to achieve what it set out to do.

3.3 Towards a Typology of TPPs

TPPs were also categorised using six-fold classification 'according to their' level of development:

- *Under-performing* - projects not achieving or not intending to achieve any changes in TP-related service areas;
- *Developmental* - projects at a preparatory stage with the emphasis on developing the infrastructure and undertaking population needs assessment before active purchasing;
- *Primary care developer* - projects which were developing primary care services in TP-related areas, particularly through an emphasis on primary care substituting for secondary care. In this type, TPPs could either co-purchase with the HA or have independent contracts;
- *Commissioning* - projects directly purchasing in TP-related service areas with their own budgets and independent contracts to achieve changes in secondary care;
- *Integrated* - TPPs taking a strategic role, directly purchasing and influencing both secondary and primary care. In this type, TPPs manage an integrated budget spanning SFH, TP and General Medical Services expenditure.

In order to categorise each project relatively simply, given that some projects, inevitably, demonstrated some features of more than one approach to TP, each project was categorised under the most 'developed' type reflected in some aspect of its work. Thus if a TPP was mainly involved in developmental activities, but had at least some independent contracts and intended to change secondary care, it would have been placed in the '*commissioning*' type. The results of this analysis for 1996/97 and 1997/98 shows that a larger proportion of TPPs were of the '*commissioning*' type (in both the first and second 'live' year). However, there was an increase in the proportion of TPPs which came under the heading of *primary care developers* in the second 'live' year. This was evident in the different mechanisms TPPs employed to tackle their objectives (see section 4.5).

There was also an increase in *under-performing* TPPs which may reflect the fact that the TP initiative was due to end in March 1998 and be replaced by the new PCGs in England from April 1999.

No TPP had become 'integrated'. The pilot status of TP meant that projects were unable to integrate their different budgets. However, a small number of projects were well advanced in preparing to become integrated. (Killoran et al, 1999)

4. Results

4.1 The non-responders

Fourteen TPPs did not respond to the questionnaire, despite several phone calls to the practices. Four of the lead GPs said that the TPP had ceased to operate after April 1998.

Characteristics of the non-responders

Since TP was due to officially end in March 1998, there was some ambivalence towards the final stages of the national evaluation. Scottish TPPs officially ended in April 1998. Some TPPs described being in a 'state of paralysis' as they awaited the next set of changes. In addition it also meant that skills were already beginning to disperse and people were no longer available to complete the questionnaire. The change of government in 1997 and the move towards Primary Care Groups all contributed to an unstable climate for TPPs.

The non-responders were as varied as the responders. Given the policy push towards multi-practice organisations, one might have expected more single practice TPPs would be part of the non-responding group. Six out of fourteen were single practice projects, however, this roughly reflects the proportion of single practice projects in the responding group. The average size of a non-responding TPP was two practice projects which is slightly smaller than the responding group (which is three). Similarly, there was a range of achievement in the TPPs own terms and in TP-related terms across the non-responding projects, although the average level of achievement in both own and TP-related terms was in the lower group. When TPPs were asked in 1997 where their future purchasing ambitions lay, the majority said they would be aiming for purchasing services in areas of strategic importance. This view was also held by most of the TPPs which did not respond, which suggests the difficulty in predicting future behaviour. Finally, there was an even spread of developmental, co-purchasing, primary care developers and commissioning projects which did not respond.

4.2 Basic characteristics

Table 4.1 Basic characteristics of first wave TPPs, 1996/97 and 1997/98

Characteristics	1996/97	1997/98
Basic features		
Number of TPPs	53	41*
Number (%) of single-practice TPPs	36%	44%
Number (%) of multi-practice TPPs	64%	56%
Size		
Mean number of practices per TPP	3	3
Median number of practices per TPP	3	3
Mean number of general practitioners per TPP	17	17
Median number of general practitioners per TPP	16	14
TPP patient population		
Range in patient population	8,100-84,700	6,653-81,000
Mean TPP patient population	31,300	29,384
Median TPP patient population	28,200	24,500
HA patient population		
Mean percentage of HA population served by TPPs	6%	6% (n=39)
Median percentage of HA population served by TPPs	6%	5%
Mid-range (25%-75%) of HA population served by TPPs	3%-8%	3%-7%
*Organisational features***		
Proportion of TPPs with a dedicated TP manager	66%	-
Proportion of TPPs with a 'complex' organisational structure	38%	-
Proportion of TPPs with a 'simple' organisational structure	30%	-
Management costs at 1997/98		
Mean per capita cost prices	£2.96	£3.10
Median per capita cost	£2.82	£3.08
Range of per capita cost in	£0.02-£7.08	£0.05-£7.07

* Four TPPs had dropped out of the evaluation by June 1998. Two four-practice projects had divided into eight single practice TPPs (53+6=59 and 59-4=55). Fourteen TPPs did not respond (55-14=41)

** These data were not collected for TPPs in 1997/98

Table 4.1 gives the basic features of the first wave of national TPPs in England and Scotland which were studied between 1995-1998. It underlines their diversity in term of features such as size. Although the first wave TPPs were in all eight English Regions and in five Scottish Health Boards, they were predominantly not in major towns or cities.

As this table shows TPPs continued to vary widely in population size and management costs. There was no sense of convergence on type or organisational set up, reflected in the management costs which show no sign of decreasing despite the fact that set-up costs incurred in years 1 and 2 ought to have come to an end.

TPPs were on average slightly smaller in the second 'live' year than the first. However, this can be directly attributed to the fact that two multi-practice projects broke up into eight separate projects.

4.3 Achievements of TPPs in the second 'live' year (1997/98)

As in the previous year, there was a wide distribution of achievement across the 40 first wave TPPs for which data were available on achievements (one of the TPPs did not complete this section of their questionnaire and we were unable to get data on any of their objectives, hence the remaining paper will discuss 40 TPPs) in both their own view and in TP-related terms (Table 4.2, Figures 1 and 2).

Table 4.2 Own achievements of first wave TPPs in 1996/97 compared with 1997/98

Achievements in own terms	1996/97		1997/98	
	N	%	N	%
Low (1 and 2)	18	*36*	13	*33*
Three	16	*32*	12	*30*
High (4 and 5)	16	*32*	15	*38*
TOTAL	**50**	***100***	**40**	***101***

Figure 1 TPPs in five groups according to their level of achievement in their 'own terms': 1996/97 and 1997/98

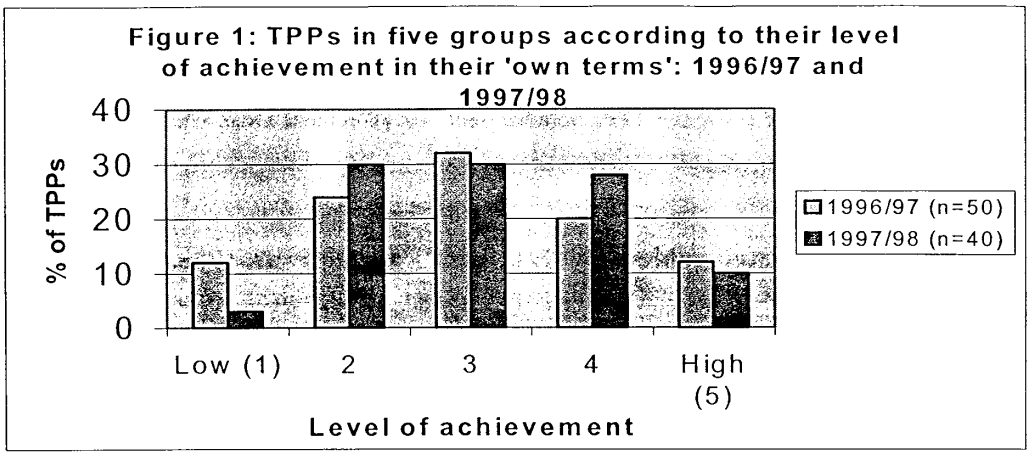


Figure 1 and Table 4.2 represent all the TPPs' reported achievements in 1997/98 distributed into five groups. The distribution of achievement is rated entirely in the TPPs' own terms; i.e. irrespective of the scale of their objectives, where they started from or, indeed, whether the objectives could have been met within SFH or by ordinary general practice developments. The range of achievement is also an assessment of each TPP *in its* context since the overall achievements of each project are likely to reflect the interaction of internal project characteristics with the external environment, including the level and nature of HA support and the extent to which local providers were willing to accede to the wishes of the practices.

The resulting distribution shows the wide range of achievements reported by the projects, a similar pattern was observed in 1996/97.

Despite the similar distribution of projects by achievement in the two years, more projects managed to meet at least one of their main objectives in their second year, 1997/98, thus elevating them into the second group (from 24% in 1996/97 to 32% in 1997/98). The proportion of TPPs which had achieved at least three of their four main objectives (i.e. group 4) had also increased, although the proportion achieving all of their main objectives had reduced in the second 'live' year. Further analysis showed that the content of the objectives of high achieving TPPs in 1997/98 (group 5) was on a larger scale than the objectives for the same group in 1996/97, suggesting that some TPPs were becoming more strategic as they matured. However, this was by no means the case for all the TPPs.

Generally, there was an overall improvement in the achievements of TPPs in their own terms which is evident in the slight shift towards the right-hand side of Figure 1 (i.e. higher achievers). This is particularly apparent in groups two and four which show a larger proportion of projects reaching this standard.

Table 4.3 and Figure 2 show the TPPs achievements in TP-related areas which are new to these projects and more complex.

Table 4.3 TP-related achievements of first wave TPPs in 1996/97, compared with 1997/98

TP-related achievements	1996/97		1997/98	
	n	%	n	%
Low (1 and 2)	30	*60*	23	*57*
Three	9	*18*	12	*30*
High (4 and 5)	11	*22*	5	*13*
TOTAL	**50**	***100***	**40**	***100***

Figure 2 TPPs in five groups according to their level of achievement in TP service areas: 1996/97 and 1997/98

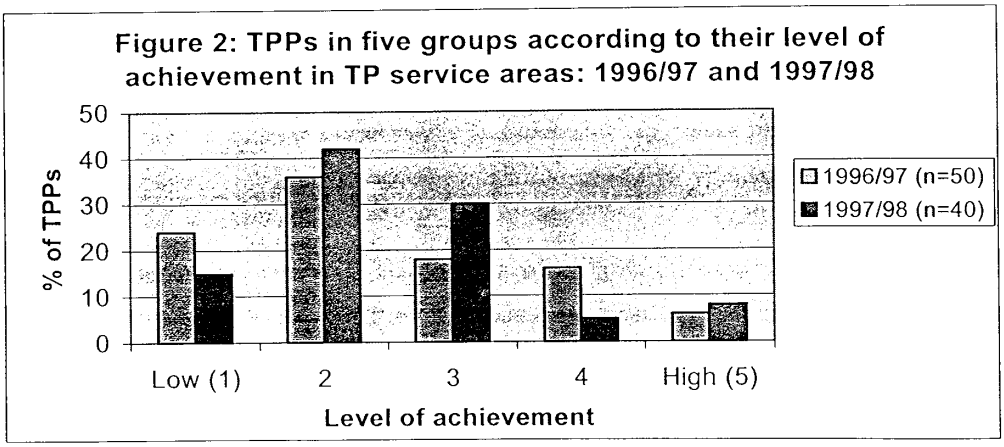


Figure 2 shows the distribution of TPPs in terms of their achievements in TP service areas (i.e. their identifiable achievements in relation to any of the following service areas new to

GP-led purchasing: maternity; services for the seriously mentally ill; care of the frail elderly in the community; A&E services; emergency admissions; inpatient length of stay; and alternatives to acute hospital inpatient services). TPPs making changes in these service areas are more likely than others to be influencing local health services in a major way. The picture which emerges is not straightforward.

The pattern of TPPs achieving in TP-related areas is similar to their own reported achievements. There has been a gradual shift to the right with an overall improvement in the achievement of TPPs in these newer areas, particularly in groups, two, three and five. The biggest difference between the two years was in group 3: just under a third (30%) of TPPs in the second year were in this category (i.e. achieving about half of their TP-related objectives), compared to under a fifth in the first year (18%). About the same proportion of TPPs were low and high achievers in both years in TP-related areas. As Figure 2 shows there was a slight increase in the proportion of TPPs in group 5, i.e. those TPPs achieving all of their TP-related objectives in the second 'live' year.

However, more of the TPPs attempted to influence TP-specific areas in their second year, and had begun to think in more strategic terms, like negotiating and developing more sophisticated contracts with their providers. The upshot however, was that only a minority of TPPs were able to achieve the majority of their objectives when they were in TP-specific areas. One of the most common reasons for this lack of success according to the TPPs was their inability to either negotiate new contracts with current provider(s) or to move contracts to alternative providers, the latter tended to depend more on the attitude of the TPP's host HA.

4.4 Examples of high, medium and low achieving TPPs

In comparing TPPs over time, a clearer picture emerges in terms of their overall progress. For example, 43% (16 TPPs out of 37 - three TPPs did not have a score for 1996/97, since they were previously part of a multi-practice project) of first wave TPPs successfully improved their level of achievement over the two years. Twelve TPPs did less well in their second year, 1997/98 (32%) and just under a quarter remained at the same level (24%). However, if we look at how well high and low achieving TPPs did over time, we can see that all of the higher achieving TPPs in the first year did less well in their second 'live' year. This

may be because the TPPs had achieved all that they had set out to do, or that it was not possible to sustain such a high level of performance. Nearly all the lower achieving TPPs in the first year managed to improve their performance (with the exception of three TPPs which stayed at the same low level). Similarly, this group would be less likely to have achieved their original objectives and therefore still had something to aim for in their second year.

In order to illustrate the differences between the projects in each of the achievement groups, boxes 1, 2 and 3 comprise three case studies of a TPP from each of group 1, 3 and 5. Each TPP fell into the bottom, middle and high achievement group, irrespective of whether the assessment was made in its own terms or exclusively in terms of its actions in relation to TP services.

For each, the pilot's main objectives are summarised together with the mechanisms which were to be used to implement them. The outcomes or consequences of attempting to realise each objective are described. Some contextual information is also provided in order to help disentangle the relationship between internal and external factors in influencing the level of achievement of the project.

Box 1: A low achieving TPP

The project

- 31,000 population (6% of HA)
- 4 practices; 16 GPs
- Affluent market town with rural hinterland in otherwise urban, deprived HA
- 2 acute providers and one community health services provider

Purchasing objective and mechanisms for change	Outcomes or results
To establish case management for all patients with mental health problems by appointing dedicated mental health co-ordinator	Services co-ordinated across the 4 practices. PHCT members supported and trained. Better liaison with social services
To establish a practice agreement with local social services to improve co-ordination after practice-attached social workers withdrawn	Perceived improvement in hospital discharge arrangements
To appoint a health needs assessment officer to assess population needs and plan services	Number of needs assessments undertaken plus contribution to HA locality plan. TPP unusual in making such an appointment
To institute breast care standards for use in primary care	Evidence on effective diagnosis, referral, treatment and management summarised by health needs assessment officer and consensus developed by inter-practice GP and practice nurse group
Others led by health needs assessment officer	Audit of emergency medical admissions; compulsory second opinion for ECRs; development of links with non-NHS agencies

The TPP in Box 1 was able to report a number of achievements mainly associated with better service co-ordination and needs assessment likely to be of benefit in future. Despite having a delegated budget, the TPP was restricted by the HA from making any resource shifts which would affect local providers. This was on the grounds that these providers' main function was to serve a far larger and more needy population than that of the TPP. The HA was more interested in developments elsewhere within its boundaries where it judged that problems were more pressing. Thus the TPP was unable to point to quantifiable service changes brought about by its actions.

Box 2: A TPP in the middle of the distribution of achievement

The project

- 45,000 population (15% of HA)
- 9 practices; 30 GPs
- Relatively affluent rural setting
- Major part of a defined Locality

Purchasing objective and mechanisms for change	Outcomes or results
To establish a local child and adolescent mental health service with consultant, clinical psychologist & 2 CPNs	Local service with named consultant so that patients did not need to travel to city for treatment. No evidence in early stages of improved access leading to more inappropriate referrals to consultant
To improve diabetic services by appointing a specialist diabetic nurse from fundholding savings	Nurse specialist allowed consultant to focus on complex cases. Almost all care now outside hospital
To develop a range of new services at local hospital using fundholding savings	Serum screening for Down's syndrome, GP direct access clinics (e.g. echocardiography), day case chemotherapy, endoscopy sessions, additional radiologist sessions and termination service at local hospital
To extend the range of primary care services at practice level	Community nurses now all practice-attached. Counselling available to all practices
To set up local day care for the elderly	Not established for lack of funds
To develop local drug and alcohol service	Practices yet to agree to financing service

The TPP in Box 2 accounted for the majority of the population of a locality recognised by the local HA for planning purposes. Many of the TPP's initiatives had been related to making better use of the local small hospital the future of which was uncertain. The GPs were strongly committed to the provision of as wide a range of services at the hospital as possible. However, the HA did not always share this vision of the future.

One of the main service developments at the TPP in Box 2 was the new local child and adolescent mental health service which had strong support from all the practices The TPP had invited four local Trusts to bid to provide this service and three had put in proposals. The contract had been awarded to the Trust which had responded to the TPP's requirements and which was already familiar with providing a similar service in an adjacent area.

The final example is of a so called high achieving TPP in 1997/98 and is summarised in Box 3.

Box 3: A high achieving TPP

The project

- 81,000 (12% of HA)
- 8 practices; 42 GPs
- Suburban area with multiple providers
- HA with deficit

Purchasing objective and mechanisms for change	Outcomes or results
To establish self-managed, integrated practice and community nursing teams attached to practices from a single provider – part of competitive tendering of all community health services	Teams at each practice
To develop intermediate care by block purchasing hospital-at-home places and spot purchasing nursing home places by appointing a discharge planning co-ordinator, 4 discharge planning nurses and administrator	2% reduction in acute admissions compared with increase in rest of HA of >6%. 14% of patients diverted on arrival at acute hospital (target 15%). Reduced rate of readmission's. 3% shorter stay than rest of HA for emergency medical admissions
To develop a comprehensive strategy for mental health services via needs assessment, survey of users, review of research evidence, review and cost benchmarking of providers, patient register	No service developments yet in place but groundwork completed
To develop evidence-based service protocols to guide purchasing in a number of service areas (e.g. maternity)	Protocols produced and piloted. Elements of managed care approach.
To review waiting list management at two local acute hospitals	Review undertaken.

The TPP in Box 3 was the largest of the first wave national pilots, but compensated for its size by developing a robust information and managerial infrastructure. From a relatively early stage in TP, the practices were accustomed to sharing information on treatment patterns and resource use. In the future, the TPP plans to integrate all clinical information systems across the practices which will eventually include the new PCG.

Service changes and developments were brought about through a combination of competitive tendering (e.g. for community nursing) where there was a choice of local provider and a determination to shift resources out of the acute sector for reinvestment in alternatives to hospitalisation. However, the TPP faced considerable problems in reducing the level of resources in acute hospital contracts in order to fund alternative patterns of care. For example, although the intermediate care scheme spent less than was budgeted, the 'savings' clawed back from reduced use of the acute sector were considerably less than projected, leaving the TPP with a 12% deficit against budget.

The plans for mental health service development are likely to evolve along similar lines to the other changes since the TPP has a well researched idea of the services it wishes to see put in place and some indication as to how much an efficient pattern of services should cost to provide.

4.5 Content and scope of reported achievements in the second 'live' year (1997/98)

Having identified the wide range of levels of achievement of the TPPs, it is helpful to look at the content of their main achievements. This section looks at the main service areas TPPs identified as a priority in the second year (1996/97), compared with the first, and summarises the extent to which the TPPs were able to achieve their main purchasing objectives in each of the main service areas.

Table 4.4 shows those service areas identified as priorities by the first wave TPPs in their first and second 'live' year. There does seem to have been a genuine shift in priorities between the two years.

Table 4.4 Service areas identified as priorities by first wave TPPs

Service area of four main purchasing objectives	% of TPPs identifying area in 1996/97 (n=50)		% of TPPs identifying area in 1997/98 (n=40)	
	n	%	n	%
Early discharge	21	*42*	16	*40*
Community and continuing care	18	*36*	26	*65*
Maternity services	26	*52*	9	*22*
Managing emergency services	30	*61*	13	*32*
Mental health services	27	*54*	17	*42*
Developing primary health care team	14	*29*	10	*25*
Information/needs assessment	11	*23*	18	*45*
Other*	33	*67*	21	*52*

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

A smaller proportion of TPPs were concentrating on the more 'complex' areas. For example, fewer TPPs attempted to 'manage emergency admissions' in 1997/98, with about 50% fewer identifying this as an area to tackle. Experience from the previous year showed this to be a particularly difficult area to influence: less than half (44%) of the objectives set in managing emergency admissions were achieved in 1996/97 (Table 4.5). This is likely to have had an effect on whether a TPP chose to pursue this objective, in the second year. What this meant was that TPPs were using their experience from the previous year to see where progress

could be made and through which mechanism. Typically, the mechanisms they employed were through developing community and primary services. This was particularly apparent in community and continuing care, where there is an increase in the number of objectives set here.

The second main point of difference is the proportion of TPPs attempting to influence maternity services. Fifty-two per cent identified this area as a priority in 1996/97, compared with just 22% in 1997/98. Achievement was fairly high in this area in both years. One of the reasons for this decline in interest in maternity care may be the declining influence of *Changing Childbirth* which slowly slipped off the priorities of health authorities as the period of the evaluation progressed (Wyke et al, 1998).

The main thrust for most TPPs was primary care development. Most of the mechanisms employed were in primary and community care where TPPs found they were better able to influence change. The main difference between TPPs was their interpretation of the impact these mechanisms had on service delivery. For example, a TPP may have purchased nursing home beds to reduce inpatient length of stay or to encourage early discharge, on the other hand, it could have been part of managing emergency admissions. It depends on the TPPs original objectives.

The majority of TPPs tended to develop areas in the second 'live' year where they had managed to progress during the first year. The exception being where the TPP either set itself a discrete task which they managed to achieve in one year, or when the TPP realised they were unable to secure changes in such a time-limited pilot.

The third main difference in the types of areas identified by the TPPs over the two years was the increase in TPPs embarking on information and needs assessment projects. One might have expected this area to have been more prevalent in the first year, since it is associated with developmental work before live purchasing . However, TPPs may have become more aware of their IT requirements after experiencing their first 'live' year. In addition there had been very little evidence of needs assessment taking place in TPPs in the first year. It was encouraging that more of them took up this issue in their second year.

Table 4.5 examines how well the TPPs met their objectives in each of the main new areas of purchasing introduced when the practices moved from SFH to TP status. They are also the service areas where it would be reasonable to expect that TPP action would have a major impact on local health services. Mays et al (1998) found that by looking at achievements and non-achievements within service areas, TPPs found it easier to achieve changes in primary care based developments. The majority of achievements in 1996/97 were made in primary health care, rather than the more complex areas of TP such as: mental health services, emergency admissions, and length of stay, and care of the frail elderly. In the second 'live' year there was an increase in the proportion of TPPs achieving their objectives in mental health services and managing emergency admissions. However, it should be noted that achievements in these new areas covered by total purchasing were primarily primary care orientated.

Table 4.5 Achievements and non-achievements of first wave pilots by service area, 1996/97 and 1997/98

Service area of four main purchasing objectives	main objectives,	*% reported achieved*	main objectives	*% reported achieved*
	1996/97		1997/98	
Early Discharge (e.g. discharge co-ordinator)	22	*64*	18	*72*
Community and continuing care (e.g. integrated nursing; nursing home beds)	19	*53*	36	*67*
Maternity services (particularly community midwifery)	27	*52*	10	*70*
Managing emergency services (e.g. intermediate care and primary care projects)	32	*44*	16	*75*
Mental health services (primarily community-based)	28	*39*	20	*75*
Develop primary health care team	15	*87*	10	*70*
Information/needs assessment	12	*83*	22	*64*
Other*	35	*59*	40	*72*
	190	*54*	**172**	*70*

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

The most striking point to note here is the overall increase in reported achievements: from just over half (54%) in the first 'live' year to well over two-thirds (70%) of all objectives met in the second 'live' year. As Tables 4 and 5 highlight there has been a shift in terms of mix of objectives and achievements between the first and second 'live' year. For example, fewer TPPs were tackling the more 'complex' difficult areas, such as managing emergency admissions, care of the frail elderly, services for the mentally ill, etc. However, those that did were highly successful, suggesting some maturity within these sub-groups.

As well as fewer TPPs tackling the more 'difficult' areas, there was a reduction in the number of objectives set and achieved in the so-called 'easier' areas (e.g. having a community psychiatric nurse attached to the practice), which suggests some sort of ceiling effect.

Basically, in the second 'live' year, more objectives were being met, but only by a minority of TPPs, the rest were achieving at a similar level to the previous year.

The following three tables show the sorts of objectives within managing emergency admissions, mental health and community and continuing care which TPPs attempted to implement.

Table 4.6 Achievements and non-achievements in managing emergency services, 1997/98

Main objectives	Number of achievements	Number of non-achievements
Change in contract currency	3	1
Intermediate care facility	3	0
Increased primary care to reduce emergency admissions	3	0
Rapid-response out-of-hours team to reduce emergency admissions	1	2
Pre-operative assessment scheme	1	1
Research to assess ways of reducing emergency admissions	1	0
TOTAL	**12**	**4**

Four TPPs attempted to manage emergency admissions through re-negotiations of acute contracts: three of which were successful. Only one TPP in the previous year had attempted to use contracts to manage emergency services and it was not successful. More TPPs in the

second year were classified as *commissioning* TPPs. Thus they may have gained experience from the first year in contracting.

Of those TPPs which attempted to manage emergency services, the mechanisms and objectives which they did *not* employ in the second year are illuminating, and further evidence of TPPs learning from their past experience. For example, none of the TPPs aimed to set up a minor injuries unit or increase GP prescribing to reduce emergency admissions. Neither of these had been successful in the previous year. The TPPs, instead, tended to concentrate on areas where there had been reasonable previous success, such as setting up intermediate care facilities and increasing primary care provision.

Table 4.7 Achievements and non-achievements in mental health, 1997/98

Main objectives	Number of achievements	Number of non-achievements
Enhanced community mental health team (incl. CPNs, counsellors, psychologists, etc.)	7	2
Developing district-wide mental health strategy	3	1
Practice-based CPNs only	2	0
Change of provider	1	0
Common service specification between providers	1	0
Contracting for emergencies	1	1
Change of contract currency	0	1
TOTAL	**15**	**5**

Within mental health services, the approach which proved to be most successful was enhancing the community mental health team (CMHT). Quite a few TPPs (n=6) in the first 'live' year had managed to improve the services and resources of their CMHT. On the other hand there had been nine TPPs which did not manage this in the first year. In the second year, seven out of nine TPPs claimed that they had enhanced their CMHT by improving the accessibility of counselling facilities , and increasing the range of services available, such as a service for people with eating disorders. Findings in the second year of purchasing echoed what was observed in the first, with some improvement in two or three objectives (such as enhancing the CMHT). There was also evidence of TPPs taking on a more district-wide agenda towards mental health, this could be linked to TPPs becoming more 'locality-focused' and recognising the complexities of influencing a service area such as mental health in isolation.

The third area which TPPs decided to concentrate on in their second live year was that of community and continuing care. Success was observed in over two-thirds of the objectives. Table 4.8 highlights the areas which TPPs had attempted and where they had had success.

Table 4.8 Achievements and non-achievements in community and continuing care, 1997/98

Main objectives	Number of achievements	Number of non-achievements
Improving the community team, integrating community and practice nursing	7	1
Purchasing nursing home beds	6	3
Developing care packages and shared protocols with social services	2	0
Employing an attached social worker	2	0
Redirecting resources from acute to community services	2	0
Changing contract currency	1	1
Changing provider	1	0
Developing the local community hospital	1	2
Undertaking health and social care needs assessment	1	0
Setting up a hospital – at - home scheme/ GP out-of-hours service	1	4
Utilising GP-beds	0	1
TOTAL	**24**	**12**

Table 4.8 shows that, not surprisingly improving the community team was easier to achieve than setting up a hospital-at-home scheme, since improvements within a team which is predominantly employed at practice-level are easier to implement than setting up a new system demanding new staff with different roles. Developing the local community hospital was another fairly ambitious task, as was switching providers, which one TPP had managed to do with the backing of their local HA.

Tables 5-8 provide details of the mechanisms TPPs adopted to achieve their objectives. The developments TPPs identified to achieve their goals were remarkably similar between different service areas. For example, three TPPs who said they wanted to manage emergency services (Table 4.6) put in place an intermediate care facility, and nine of those who wanted to develop community care purchased nursing home beds (Table 4.8). Clearly, nursing home beds could be classified as an intermediate care facility and vice versa – thus, many of the

developments are similar whatever the goals. TPPs may have reassigned their goals to another category whilst undertaking the same developments. This behaviour has been observed throughout the life of the TPPs.

Similarly, by looking at the TPPs' mechanisms or developments across all areas, they can be categorised in to four broad categories:

Table 4.9 Broad categorisation of developments identified by TPPs in 1997/98

Mechanism/ development	Number of objectives	Reported achieved (%)
Influencing secondary care (contract currency, change providers)	14	10 (71%)
Difficult primary care developments (requiring complex co-ordination of care out of hours, such as hospital at home or rapid response team to prevent admission)	8	2 (25%)
More straightforward expansion of the primary care team (integrate practice and community nursing, have practice attached community psychiatric nurse)	46	35 (76%)
Strategic developments (district wide protocols and strategies)	5	4 (80%)

This table shows that most TPPs tried to achieve their objectives through 'simple' primary care development and were successful. Many fewer tried to achieve their goals through influencing secondary care through 'traditional' contracting or to develop strategically. Of those which did, most were often successful. A few TPPs tried complex primary care developments, including out of hours care, but most were not successful.

The next section discusses those characteristics which were associated with high and low achievers.

4.6 Characteristics of high and low achievers

There are potentially a very wide range of influences at work acting to separate the more and less successful TPPs. This is evident in both the first and second year. In some of the projects, the explanation for difficulties in achieving objectives in the second year was not hard to grasp from the accounts given in the interviews. For example, in a small number of

cases, TPPs had given up after the defeat of the Conservative government and the announcement of the end of fundholding. In other cases, the loss of key personnel, such as the project manager could not be easily replaced in the context of a time-limited pilot project. Others complained of suffering from change fatigue brought on with the rapid development of Primary Care Groups (PCGs). However, these are the exceptions. For the rest it is likely that explanations will involve subtle interactions between a range of complex factors. For 1996/97, a wide range of the more straightforward features of the TPP and their local settings, such as, their structure, size, level of spending on management, perceived HA support and so on, were explored in simple univariate analyses. The factors found to be associated with higher and lower achievement in 1996/97 were: smaller TPPs (with five or fewer practices) tended to do better in attaining their own purchasing objectives, particularly those with fewer GPs and smaller populations than larger TPPs; single practice TPPs with less complex organisational structures did better than larger multi-practice TPPs which required more complex organisational structures; those TPPs with higher direct management costs tended to achieve more, as did TPPs with their own independent contracts (i.e. commissioning TPPs); and higher achieving TPPs were more likely to report that their local HA provided 'fair' to 'good' support. There was no association between previous experience of working together or amount of fundholding experience and higher achievement (Mays et al, 1998).

This table examines the main characteristics which were seen to influence success of TPPs in their second 'live' year.

Table 4.10 Characteristics of low and high achievers in 1997/98

Characteristics	Low achiever in own terms (n=13)	High achiever in own terms (n=15)	Significant/ Not (95%)
Size			
Mean number of GPs per TPP	14	19	Not sig
Median number of GPs per TPP	12	17	-
Mean number of practices per TPP	3	4	Not sig
Median number of practices per TPP	1	3	-
Mean population size	23,800	34,400	Not sig
Median population size	20,000	29,400	-
Proportion of single practice TPPs	62%	27%	Significant
Proportion of small multi-practice TPPs (2-5 practices)	23%	47%	Significant
Proportion of large multi-practice TPPs (>5 practices)	15%	27%	Significant
Experience and level of support			
Proportion of TPPs with either first, second or third wave fundholders in their pilot	89%	100%	Not sig
Proportion of TPPs which said the HA was providing 'fair-good' support	69%	100%	Not sig
Independent contracting and management costs			
Proportion of TPPs which had independent contracts	50%	77%	Not sig
Mean number of independent contracts, 1997/98	7	4	Not sig
Median number of independent contracts, 1997/98	6	5	-
Mean management costs per capita , 1997/98	£1.63	£3.96	Significant
Median management costs per capita , 1996/97	£1.46	£4.28	-

The findings show a number of similarities in the first two 'live' years. For example, TPPs with early fundholding practices; a supportive local HA; independent contracts; and higher management costs (per patient) all managed to bring about more achievements than those which did not. However, there were one important distinction between TPPs in the first and second 'live' year. In the second 'live' year higher achieving TPPs were bigger on average

than the lower achieving TPPs. They had more practices and were less likely to be single practice projects, which suggests that larger TPPs need an extra year (at least), with management cost implications, to develop sufficiently to be able to achieve their objectives (Mays et al , 1998). However, it could also be linked to the fact that single practice TPPs were handicapped by policy shifting away from single practice fundholding. This has much relevance for the development of PCGs.

Overall, the characteristics of the low and high achieving groups were less clear cut with the exception of management costs: higher achieving TPPs had significantly higher management costs than TPPs in the lower achieving groups. This has implications for setting up PCGs. Generally, TPPs which exhibited features connected with mature organisations, such as: having dedicated staff; good relations within and between practices; a good relationship with the local HA; decent information technology and management; and access to a budget were all more likely to succeed in their objectives than those which did not.

Whether the TPP practices had had previous experience of working with one another did not seem to have influenced the ability to achieve objectives in the first year. However, Table 4.11 shows that, in the second year, experience of working together did appear to influence success. Three-quarters of high achievers had done so. Clearly, this is related to the increase in multi-practice TPPs achieving more in the second 'live' year.

Table 4.11 Relation of achievement to previous experience of working together: multi-practice TPPs only

	Low achiever in own terms (1 & 2)	Middle (3)	High achiever in own terms (4 & 5)
Previous experience		**1996/97 (%)**	
Yes, previous experience	43	80	33
No previous experience	57	20	67
Base = 100%	14	5	6
Previous experience		**1997/98 (%)**	
Yes, previous experience	25	20	75
No previous experience	75	80	25
Base = 100%	4	5	8

Table 4.12 shows the factors which the TPPs Lead GPs considered were influential in achieving their objectives in 1997/98.

Table 4.12 Self-reported factors associated with high and low achievement

Obstacles and enabling factors associated with achievement	Low achiever in own terms (n=13)	High achiever in own terms (n=15)	Significant/ Not (95%)
TPP staff attitude			
Lack of GP enthusiasm	31%	7%	Not sig
Committed TPP staff	77%	93%	Not sig
Enthusiastic lead GP	46%	93%	Not sig
Internal relations			
Good relations within the practice	46%	87%	Not sig
Good relations between the practices	46%	67%	Not sig
Poor relations between the GPs/ practices	8%	0%	Significant
External Relations			
Too much HA control	15%	0%	Significant
Good relations with providers	77%	60%	Not sig
Good relations with social services	31%	40%	Not sig
Organisational structure			
Effective IT system	15%	53%	Significant
Effective organisation	46%	73%	Not sig
Benefit of large size of TPP	0%	20%	Significant
Budgets/ mmgt allowance			
Budget setting problems with the HA	69%	13%	Significant
Possessing a budget	8%	93%	Significant

On the whole factors associated with achievement were similar in the TPPs' first and second 'live' year. Table 4.12 shows that TPP staff attitude towards total purchasing (TP) was an influential factor associated with achievement. Higher achieving TPPs were more likely to

report having an enthusiastic lead GP and committed TP staff. On the other hand, lower achieving TPPs were more likely to report a lack of enthusiasm amongst GPs towards TP. These factors related to relations within and amongst GP practices and again higher achievers reported better relations within their practice and between practices in the TPP than lower achievers. According to the findings, the level of commitment participants had to their project clearly had an impact on what they were able to achieve.

External relations with the TPP's local HA, provider and social services also played an important part in a TPP's ability to develop. For example, lack of control, through an overbearing HA did not allow the TPP to develop sufficiently to achieve its objectives. The role of the HA for PCGs will be critical for their development and achieving the right balance of nurture and control will be difficult.

Whether a TPP had adequate information technology and management resources was also associated with higher achieving projects. In fact, TPPs in groups 4 and 5 (higher groups) were significantly more likely to report having an effective information technology system. Clearly, access to accurate data and the ability to link clinical and financial data was crucial in determining whether the TPP was an effective organisation.

As reported in the previous 'live' year (1996/97), possessing a budget was perceived as being an enabling factor. Possessing a budget may well reflect HA support. Over two-thirds of the lower achieving TPPs reported difficulties in agreeing to set a budget with their local HA, compared to just one in ten TPPs in the higher achieving groups in 1997/98.

Of those TPPs which were set a budget in 1997/98, the proportion that managed to stay within budget varied by the level of reported achievement (Table 4.13).

Table 4.13 Keeping within budget, 1997/98

	Low achiever in own terms (1 & 2)	High achiever in own terms (4 & 5)	Significant or not (95%)
Kept within budget?	%	%	
Overspent	23	29	Not significant
Underspent	15	36	Significant
Stayed within budget	15	36	Significant
Don't know	46	0	Significant
Total = 39*	**13**	**14**	

*One TPP did not answer this question

Half of the lower achieving TPPs were unable to say whether they were underspent, overspent or if they had kept to budget. Possible reasons for this might have been not having good financial or clinical information systems to allow them to monitor their budgetary situation easily. Equally, the TPP might have had difficulty extracting the relevant information from other agencies, such as providers or the HA. In contrast, 72% of TPPs which reported a high level of achievement were successful in remaining within budget or succeeded in achieving an underspend. All of the higher achieving TPPs were aware of the state of their budget.

Finally, when the TPPs were asked whether they thought that they had been adequately resourced in 1997/98, there was no difference in the responses of higher and lower achieving TPPs. Over eighty per cent in each group thought they had been.

Evidently, TPPs reported a whole raft of factors which they associated with the ability to achieve their objectives.

5. Discussion

5.1 Methodological issues in interpreting the findings

Data for this report were taken from two main sources. Firstly, from TPPs which completed the postal questionnaire sent to all first wave lead GPs and TP project managers, and secondly from the in-depth case study projects on 12 TPPs.

Some important issues to consider about the data are listed below.

- Firstly, data on TPPs' achievements are from participants' accounts and may be influenced by the degree to which they are prepared to be honestly self-critical. However, data were corroborated by routine data collected by the TPP's host HA for hospital episodes and length of stay. There was a high level of consistency between the self-report and the routine data. Similar analysis will follow for 1997/98 data (see Raftery and McLeod, 1999).
- Secondly, the amount and quality of the data from each TPP was dependent on the willingness of the interviewees to provide full accounts and the ability of the interviewers to draw them out.
- Thirdly, it is possible that the range of variables available on each project which has been used to begin to explore possible reasons for the different levels of achievement is incomplete in areas crucial to explaining TPP performance. For example, in a large scale study it was simply not possible to collect data on subtleties of local relationships between participants or of past experience. However, we were able to obtain a clearer picture of the range of factors for the 12 case study projects. These are discussed in detail in Goodwin et al's report (1999).
- Fourthly, it has to be stressed that assessing the achievements of the TPPs from participants' accounts is not straightforward and involved a series of individual and group judgements by the researchers which were essentially subjective. Another problem is the fact that the aims of TP were never clearly set out by the NHSE so it is not possible to decide, firstly, that a particular TPP was or was not implementing TP in the manner intended and, secondly, that a particular type and level of achievement was adequate or inadequate for the first live year. It depends on what one expects devolved GP-led purchasing organisations to be able to achieve.

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

Since a complimentary set of methods (i.e. questionnaire and case study techniques, such as face-to-face semi-structured interviews; focus groups; participation observation; and so on) were used over a three-year period to collect data in this part of the evaluation, we are fairly confident that we have managed to achieve a full-range of participants' views which provides opportunities throughout for corroboration and exploration of discrepancies between participants' accounts.

5.2 Interpreting the level of achievement in the second year

In 1996/97 and 1997/98 the level of achievement was modest in relation to the goals of most projects. There had been a slight overall improvement in 1997/98 in the ability of TPPs to meet their objectives as shown in earlier sections. However, there was not obviously a sudden improvement from one year to another. This may be related to the politically uncertain climate in which TPPs existed and the fact that they were time-limited pilots which expected to end in March 1998. Very few TPPs were able to achieve all of their 4 main objectives in the first and second year; many decided subsequently to do other things as well or instead. In addition, the achievements tended to be relatively small scale or close to primary care. Only a minority tackled issues of wider significance successfully. It appeared that the TPPs found achieving change in secondary care more difficult than developing services within a primary care context. As a result, and not surprisingly, many of the commonly reported achievements concerned better information, better understanding of issues and improved relationships, for example with providers.

Of course, interpreting the achievements of the TPPs other than in relation to their own objectives is problematic since such a judgement depends largely on what one would have

expected the projects to have been able to attain. Given that the projects were pilots and the TP concept was experimental, it is not surprising that few TPPs could be regarded as having 'changed the world' locally in 1996/ 97 and 1997/98. It is also worth reflecting on the fact that pilot schemes almost invariably produce their benefits more slowly than their architects expect.

5.2.1 Variation between the projects

Given the absence of a detailed prescription of the ingredients or objectives of TP when it was launched, it is not surprising that there is considerable diversity between the projects in the contents of their purchasing objectives, whether strategic or service-specific, their level of ambition, whether they were allocated a budget or not, whether they contracted independently of the health authority or not and, finally, in their reported level of attainment. As this report and earlier reports (Mays et al, 1998, Robinson, Robison and Raftery, 1998)) have shown TPPs were not a homogeneous group. Indeed, there was no evidence of convergence across the three years of the pilots life-span. Their basic characteristics varied as much at the beginning as they did at the end, in terms of number of practices; number of GPs; population size; and level of management costs.

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

On the other hand, the TPPs appeared to have a number of aspects in common in the second year. They were all involved in *selective* rather than genuinely *total* purchasing. They all had, to varying degrees, collaborative relations with, and a degree of dependence on, the local health authority. Finally, the purchasing goals of the organisation were very much those of the GPs rather than other health care professionals although there is some evidence from the second year, that GPs had begun to think about tackling needs assessment to gain a better understanding of local priorities.

The way TPPs described their objectives also differed between projects. However, the mechanisms employed by the TPPs to achieve these goals were far more similar than the objectives implied. TPPs realised after the first year that progress was more achievable

through the development of primary and community services. In some sense there was a convergence in the type of mechanisms TPPs used, even if the end product were different. For example, one TPP may have interpreted the role of employing a discharge liaison nurse as 'reducing inpatient length of stay', other projects described it in terms of 'improving community and continuing care'. In both years of 'live' purchasing (1996/97 and 1997/98) TPPs discovered that it was more difficult to influence services based in secondary care. This may be related to their status as pilots, their relatively small size or it could be the perceived policy climate in which the TPPs were operating. Without local health authority backing, TPPs were unlikely to be able to alter secondary or acute mental health services.

The scope of objectives differed between TPPs in both years. There were examples of TPPs focusing predominantly on services which affected the immediate practice population and could have been achieved through standard fundholding. For example, employing a counsellor to work in the practice. Other pilots attempted much wider and more ambitious projects, such as developing a district wide MH strategy alongside the local HA, mental health trust and other non-TPP practices. Objectives like this were designed to improve the health of the wider population.

Findings suggest that the type of objectives in the higher groups varied between the first and second 'live' years, in that, higher achieving TPPs in both their own terms and in TP-related terms tended to be more strategic, wider-ranging, with a population focus in the second year. Year one (1996/97) higher achieving TPPs on the other hand had a much narrower set of objectives, in general, which were much more aimed at affecting the health of their practice population, rather than the wider public health agenda, for example, paying to have an attached social worker at the practice.

Finally, we know that some TPPs did mature. This was evident in the types of objectives identified in the first and second 'live' years. Most having learnt from experience that managing emergency admissions was a complex and difficult area to succeed in, opted to develop services in community and continuing care – this had been a more successful area in 1996/97. However, there was a small sub-group of TPPs which did attempt to manage emergency admissions in the second year (1997/98), and of those which did, almost three-quarters succeeded, suggesting a certain level of maturity in dealing with this complex area.

5.2.2 The range of achievement

As in the Audit Commission evaluation of SFH (Audit Commission, 1996), the findings suggest that there is a wide variation in the ability of TPPs to take advantage of their status. Ability to achieve is likely to be due to a mixture of extrinsic (e.g. resistant providers) and intrinsic factors (e.g. weak project management or the difficulty of establishing an effective organisation in multi-practice TPPs). However, in both the first and second year, there were examples of some TPPs coping better than others despite the uniformly adverse financial climate. The range of observed achievement was wider in the second year, with a sub-group of projects attempting to tackle the newer more complex TP-areas and managing to succeed, compared with the majority of TPPs which tended to stick with more community-based objectives. However, despite the nature of the objective, TPPs tended to concentrate the methods within primary and community care, realising that changes were more easily made in these areas, compared with the secondary sector.

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

5.3.1 Size of the project

Findings suggest that the larger projects were able to 'catch up' in the second year. Higher achievers in the second 'live' year, were larger on average than the lower achievers, indeed, none of the single practice projects were high achievers in the second year. This backs up the assumption that larger organisation require a minimum of one year to develop (Mays et al, 1998).

At the same time, it is possible that some of the smaller TPPs with simpler organisational structures found sustaining TP more difficult since typically they rely on a small number of people to manage the project. In this context, it is worth noting that three of the four pilots which had withdrawn from the scheme by the end of 1996/97 had operated without a dedicated project manager, relying instead on GPs and the existing fundholding managers. A further explanation for smaller single-practice TPPs doing less well in the second year may be connected with the size of their original agenda. For example, smaller TPPs may have had a finite number of objectives which they wanted to achieve, particularly if their goal was to 'fix things locally'. Having achieved these objectives during their first 'live' year, they were left with nowhere to go in the second 'live' year. In addition, whether a TPP was a higher

achiever in the first year bore no relation to its level of achievement in the second year (1997/98). In fact, higher achievers in the second 'live' year tended to come from the lower achieving groups.

5.3.2 Having a budget

As was recorded in the previous year, TPPs which had a budget were far more likely to have succeeded in their objectives than those which didn't. This could be connected to the level of local health support the TPP received. Having a budget was not in itself the single most important aspect, as Robison et al (1999) report, the actual process of negotiation was more important in determining the success of one's objectives rather than having a budget per se. Much else is needed to be able to achieve, including an able manager, strong GP involvement, good information, a supportive health authority and so on. Faced with a resistant provider, having a budget is essential if any kind of change is to be negotiated, but it may not be sufficient.

Experience and motivation may be as important as controlling a budget. Lower achieving TPPs were not necessarily projects which set themselves very high unreachable goals, rather they were projects with relatively low ambition and not much enthusiasm to continue working as a TPP. By contrast, the highest achieving projects were usually those with wider objectives.

5.3.3 Previous fundholding experience

On experience, there was no evidence that TPPs which did include any early wave fundholders performed better in the first year than those which did not. Unlike, the first year, there was an association in multi-practice TPPs between level of achievement and previous history of working together. However, this is more likely to be related to the fact that more larger multi-practice projects were higher achievers.

5.3.4 Management costs

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

current evaluation is presented elsewhere (Mays, Goodwin, Killoran and Malbon, 1998; Street, Place and Posnett, 1998; Place, Posnett and Street, 1999), provides a warning to policy makers that effective TP may not be achieved while attempting to reduce the costs of local purchasing of services. The recent government White Paper aims to reduce overall NHS management costs while, at the same time, devolving the vast majority of purchasing responsibilities to groups of practices very similar to TPPs to be called Primary Care Groups (PCGs) (Secretary of State for Health, 1997). Other work on the costs and functions of HAs and GP purchasers, including SFHs and selected TPPs, suggests that GP purchasers generate on average 50% to 90% of the costs of HA purchasers for half the number of functions (Millar, 1997). Many TPPs appear to be higher spenders on management in relation to their range of functions than many HAs, although there is a wide range of costs in both TPPs and HAs.

5.3.5 HA support

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

6. Conclusion

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. The more 'receptive' the *contexts* within which TPPs operated the more likely it was for achievements to be made.

Whilst context can be seen as highly relevant in determining the pace of change within TPPs, the *processes* through which TP was implemented ultimately determined the ability of projects to succeed. This is because people, not contexts, brought about change and because, even in the worst of contexts, some scope to make changes still existed. 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. However, TPPs made less impact on services using commissioning mechanisms in the second year, although it was still seen as important.

Most TPPs tackled their objectives through some form of primary and community development. Indeed different objectives were often achieved through similar mechanisms within primary care development. TPPs also made less impact on services using commissioning mechanisms in the second year, although it was still seen as important.

This report has highlighted the main areas which TPPs targeted and where they managed to make progress, in their two 'live' years, and factors which appeared to influence change. Goodwin et al (1999) and Killoran et al(1999) discuss in more detail the interplay between

content, context and process and specific lessons for developing PCGs, respectively. These reports confirm the conclusions of this report.

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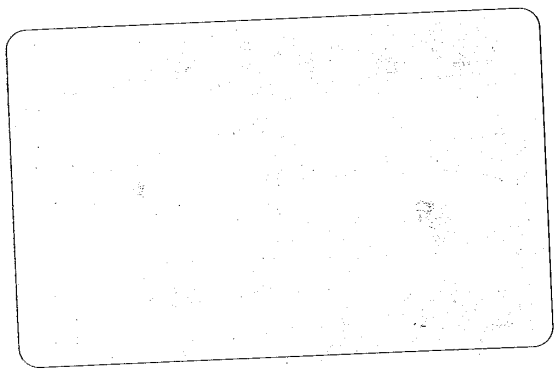

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