King's Fund

National Evaluation of Total Purchasing
Pilot Projects
Working Paper

Contracting by Total Purchasing Pilot Projects, 1996-97

Ray Robinson
Judy Robison
James Raftery

National Evaluation of Total Purchasing Pilot Projects
Working Paper

Contracting by Total Purchasing Pilot Projects, 1996-97

Ray Robinson, Director
Judy Robison, Research Fellow
Institute for Health Policy Studies
University of Southampton

James Raftery, Professor and Director of Health Economics Facility
Health Services Management Centre
University of Birmingham

For further information on this part of the national evaluation contact Judy Robison (tel 01703 593901/fax 01703 593177/email jrihps@socsci.soton.ac.uk).
This working paper forms part of the output of the National Evaluation of Total Purchasing Pilot Projects, which is led by the King's Fund.

Published by
King's Fund
11-13 Cavendish Square
London W1M 0AN

ISBN 1 85717 189 6

A CIP catalogue record for this book is available from the British Library.

Further copies of this report can be obtained from Grantham Book Services Limited, Isaac Newton Way, Alma Park Industrial Estate, Grantham, Lincolnshire NG31 9SD. Tel: 01476 541080, fax 01476 541061; or from the King's Fund Bookshop. Tel: 0171 307 2591

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

The Total Purchasing National Evaluation Team (TP-NET)

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

Acknowledgements

The national evaluation was commissioned and funded by the Department of Health in England (1995-98) and the Scottish Office Health Department (1995-97). However, the views expressed in this paper do not necessarily represent the policy of the two Departments.

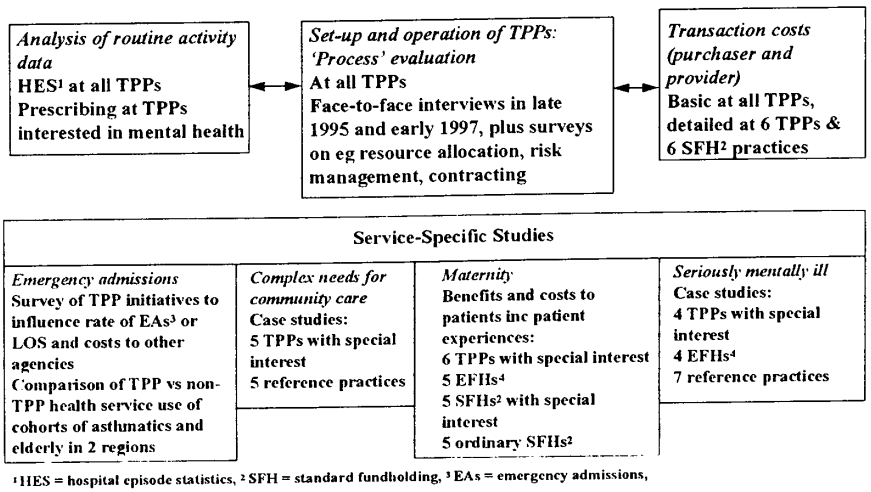
Contents

Preface: The National Evaluation of Total Purchasing Pilot Projects

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

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

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



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

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

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

Nicholas Mays
Co-ordinator, Total Purchasing National Evaluation Team (TP-NET)
King's Fund, London
January 1998

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

Title and Authors — *ISBN*

Main Reports

Nicholas Mays, Nick Goodwin, Gwyn Bevan, Sally Wyke on behalf of the Total Purchasing National Evaluation Team (1997). *Total purchasing: a profile of the national pilot projects* — 1 85717 138 1

Nicholas Mays, Nick Goodwin, Amanda Killoran, Gill Malbon on behalf of the Total Purchasing National Evaluation Team (1998). *Total purchasing: a step towards primary care groups* — 1 85717 187 X

Working Papers

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

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

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, Gywn 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, Amanda Killoran, Gill Malbon, Nicholas Mays, Michael Place, Andrew Street
The transaction costs of total purchasing — 1 85717 193 4

Jennifer Dixon, Nicholas Mays, Nick Goodwin, Brenda Leese, Ann Mahon
Accountability of total purchasing pilot projects — 1 85717 194 2

James Raftery, Hugh Macleod — 1 85717 196 9
Hospital activity changes and total purchasing

Sally Wyke, Jenny Hewison, James Piercy, John Posnett, Linda Macleod, Lesley Page, Gavin Young — 1 85717 198 5
National evaluation of general practice-based purchasing of maternity care: preliminary findings.

Linda Gask, John Lee, Stuart Donnan, Martin Roland — 1 85717 199 3
Total purchasing and extended fundholding of mental health services

Susan Myles, Sally Wyke, Jennie Popay, Judith Scott, Andrea Campbell, Jeff Girling — 1 85717 200 0
Total purchasing and community and continuing care: lessons for future policy developments in the NHS

Gill Malbon, Amanda Killoran, Nicholas Mays, Nick Goodwin — 1 85717 195 0
A profile of second wave total purchasing pilots: lessons learned from the first wave

1 Introduction

Total purchasing represents a major expansion of GP fundholding. It offers pilot practices the scope to purchase potentially all of the community, secondary and tertiary health care not included in standard fundholding. While most GP practices participating in total purchasing have some experience of contracting with health care providers, the extension of their responsibilities has, in many cases, taken them into entirely new areas and posed a new set of challenges for primary care-based purchasing. This paper concentrates on a central element of this new purchasing activity; namely, the contracting process.

Contracts are the essential link between purchasers and providers. They make clear what services are to be provided and the terms on which they are to be supplied. Thus the contract is the mechanism through which the parties agree on the volume, price and quality of care to be purchased and, as such , is significantly linked with the achievement of strategic objectives.

The paper is structured around selected results of a telephone interview survey of contracting arrangements for 1996/97 carried out with all first wave TP pilot sites between November 1996 and January 1997. It is organised as follows: in section 2 we provide some background material on the development of the contract culture in the public sector generally and a brief review of earlier work on contracting in the NHS. On the basis of this review, we identified a number of research questions for the present study: these are specified in section 3. In section 4 we describe how we collected the data through a telephone interview survey. The results of the study - in terms of the pre specified research questions - are presented in section 4. Finally, in section 5 we discuss our results in the light of more general developments surrounding the future of contracting in the NHS.

2 Background

During the 1980s, there was a fundamental reshaping of public sector organisation in the UK. An essential element of the new approach was a move away from hierarchical, or vertically integrated, forms of organisation towards models based upon purchaser-provider separation and contractual relationships (Le Grand and Bartlett, 1993). The government's case for pursuing this strategy was expressed in the White Paper, *Competing for Quality* (Department of Health, 1991:2) in the following terms:

> *Greater competition over the past decade has gone hand in hand with fundamental management reform of the public sector. This means moving away from the traditional pyramid structure of public sector management. The defects of the old approach have been widely recognised: excessively long lines of management with blurred responsibility and accountability; lack of incentives to initiative and innovation; a culture that was more often concerned with procedures than performance. As a result,* ***public services will increasingly move to a culture where relationships are contractual rather than bureaucratic.*** (emphasis added).

Harrison (1993) has pointed out that this policy towards public services was driven by two objectives. On the one hand, the delegation of more responsibility down the line of management was designed to give local managers greater scope for the display of initiative. On the other hand, however, there was a desire for more control to ensure efficient performance. To some extent these two objectives were in conflict with one another. The purchaser-provider split appeared to resolve this conflict. It offered greater autonomy to public sector managers within a system in which supply-side competition was designed to exert pressure on providers for efficient behaviour similar to the competitive process held to operate in the private sector.

Within the NHS, there had been elements of competitive tendering and contracting for ancillary services and some clinical services throughout the 1980s (Ascher, 1987; Ranade and Appleby, 1989). It was, however, the introduction of the internal market in 1991 that signalled the mainstream introduction of the contract culture.

Since 1991 there have been a number of studies that have documented the development of contracting in the NHS. A series of annual surveys of district health authorities (DHAs) carried out by the National Association of Health Authorities and Trusts (NAHAT) has shown how the early years of contracting were dominated by 'steady-state' with little change, but that, over time, greater efforts were made to use contracts to change the mix of services commissioned by DHAs and the

terms on which they received them (Appleby, 1994; Robinson and Le Grand, 1995). In another study, Raftery *et al.* (1996) have shown how DHA purchasers have refined the contracting process to produce a new form of contract - the 'sophisticated block contract' - in response to the need for risk sharing arrangements arising from unplanned events on either the purchaser or the provider side. A number of other studies covering various aspects of DHA contracting were included in the ESRC research programme on *Contracts and Competition* (Flynn and Williams, 1997). These studies highlighted the importance of, *inter alia* the environment within which contracting takes place; oscillation in contracting styles between the adoption of hard (adversarial) and soft (relational) approaches on the part of DHAs; and - despite official expectations - the possibility that contracting, *per se*, 'may not have had a direct, immediate, or overwhelming influence on the production of health care' (Flynn and Williams, *op cit*:155).

As far as contracting by GP fundholders is concerned, Glennerster *et al.* (1994) present an account of its development over the first three years of the reforms. They show that from the outset fundholders used the leverage of contracting to improve the services they received in areas such as pathology, gynaecology, orthopaedics, ophthalmology and dermatology. On the basis of these findings, they argue that fundholders have been better contractors than districts; more prepared to use the power of exit (by switching providers) to improve the quality of hospital services that they receive. Fundholders emphasis on quality has been confirmed in a later study by Paton *et al* (1997); on the basis of a survey of trusts carried out in 1995-96, they report that fundholders attached greater importance to quality than DHAs in the contracting process .

The studies described above - and various others (see, for example, Appleby *et al.*, 1993; National Audit Office, 1995; Audit Commission, 1996) - have analysed contracting on the basis of a range of disciplinary approaches and have drawn upon both theoretical and empirical methods. Scrutiny of this work, and our wider experience of the NHS since the 1991 reforms, provided us with a number of research questions that we wished to address in connection with contracting in total purchasing. These are specified in the next section.

3 The Research Questions

The main research questions posed in the study were:

i) To what extent have the total purchasing pilot sites (TPPs) taken advantage of the freedom to contract independently during their first year?

Our initial expectation was that the *raison d'etre* for total purchasing would be to take advantage of the freedom to contract independently. However, we were aware that taking on this responsibility would, to some extent, depend on the TPPs' satisfaction with services presently purchased on its behalf by the DHA. It would also depend on their readiness to contract independently. For these reasons, it was anticipated that individual TPPs would not be contracting independently for all services within the scope of the total fund. Those services not covered by independent contracts were expected to involve 'joint' contracts and the 'blocking-back' of services. A joint contract - sometimes referred to as 'piggy-backing' - involves the specification of the TPP contract as an identified 'subset' of the overall DHA contract. The terminology implies that there may be some kind of participation on the part of the TPP in the setting and/or monitoring of the contract. Blocking-back refers to an arrangement where the TPP returns its allocated budget for the service(s) to the DHA and the DHA contracts for one or more services on the TPP's behalf. In other circumstances the DHA may have chosen to top slice or ring fence the budget for one or more services and retain the purchasing responsibility.

ii) What were the number, size and form of the independent contracts negotiated by the TPPs?

We focused on the independent contracts negotiated by the TPPs as this was the most marked, new activity made possible through total purchasing. However, there was little *a priori* basis on which to predict how many contracts each site would negotiate; what the size distribution of these contracts would be; whether they would be in the form of simple block, sophisticated block, cost and volume or cost per case (see Table 3.1); or the contracting currencies that would be employed.

Table 3.1: Forms of health care contract

Contract Type	*Definition*
⇒ simple block	Purchasers pay the provider a fixed sum for access to a defined range of services or facilities. Such contracts may include some form of indicative workload agreement or fixed volume.
⇒ sophisticated block	Purchasers pay providers a fixed contract sum for access to a defined range of services or facilities. Indicative patient activity targets or thresholds with 'floors' and 'ceilings' are included in such contracts as well as agreed mechanisms if targets are exceeded. Some elements of case-mix may be included.
⇒ cost and volume	This contract specifies outputs in terms of patient treatment rather than inputs in terms of services or facilities available. Purchasers do not purchase fixed volumes but will develop contracts with a fixed price being paid up to certain volume of treatment and a price per case being paid above it, up to a volume ceiling.
⇒ cost per case	The hospital agrees to provide a range of specified treatments in line with a given contract price.

Source: Purchasing Unit, NHS Executive

iii) What was the TPP experience of contract negotiations?

We were aware that TPPs would be entering new territory in contract negotiations and assuming responsibility for services that were previously purchased by DHAs. For this reason we wished to explore their relationships with both their host DHA and their providers. We wanted to establish how smoothly (or roughly) the initial round of contracting had progressed, and to investigate the nature of contracting styles, i.e. could they be characterised as 'hard' or 'soft'?

iv) What arrangements did TPPs make for monitoring provider performance and managing contracts in terms of activity, costs and quality?

Contracts set out the terms and conditions on which providers are expected to supply services. They are prospective documents. As such, monitoring is necessary to make sure that these terms and conditions are met. Moreover, mechanisms need to be put in place to deal with situations where planned and actual performance differ. Our survey sought to identify how TPPs set out to deal with activity and cost variances; their approach to quality specification; and the use made of financial incentives.

v) What service developments have been achieved through contracting?

Early expectations, following the introduction of purchaser-provider separation, were that contracting would be an important mechanism for bringing about service developments. More recently, however, some researchers have questioned the importance of contracting *per se* and suggested that it may not be central to bringing about change (Flynn and Williams, 1997). Given these conflicting views, we wished to examine the importance attached to the contracting process by the TPP respondents.

vi) Why did some TPPs not undertake independent contracting? What influence did they have in joint contracting with their DHA?

Although we focused our attention on those TPPs that undertook independent contracting, we also wished to examine those that did not do so. Thus we explored the reasons why they had not contracted independently and their level of involvement in joint contracting with their DHA. With the change of government in May 1997, and the current political preference for GP-led locality commissioning, these TPPs may be of more significance than appeared likely when we undertook our survey.

4 The Survey

All first wave TPPs were included in a telephone interview survey of contracting arrangements for 1996/97. Pilot interviews took place during October 1996 and the main survey was carried out between November 1996 and the end of January 1997.

The first phase of the TP-NET process evaluation had indicated that TPP contracting would take place at *site* rather than *practice* level at all but three TPPs. Practices from those three sites were invited to respond separately if they so chose but otherwise one response was sought from each site. As there were uncertainties surrounding numerous aspects of TP contracting including whether the lead TPP GP or the site manager would be the more appropriate respondent, the pilot phase was included in the project timetable to allow for the refinement of both the practical arrangements and the design of the interview schedule.

A draft interview schedule was piloted with lead GPs and/ or project managers at four TPPs in the South & West and South Thames region. Each TPP was then approached by writing to the lead TPP GP(s), copying the letter to the site manager (where one was identified), enclosing an interview guide, and asking them to decide who would be the respondent. The letter was followed by a telephone call to the site manager when the researcher booked a telephone interview appointment with the person designated to be the respondent.

The intention had been to use a computer assisted telephone interview (CATI) format for this survey. This is an appropriate and efficient methodology where the interview seeks to collect predominantly quantitative data and can be closely structured with pre-coded response categories for most questions. As design of the interview schedule progressed it became clear that the likely range of response to many of the questions could not be anticipated with sufficient certainty owing to the widely differing experience of TPPs in a new sphere of activity. The pilot phase of the survey also confirmed that there would be a significant volume of qualitative data in the form of comments and responses to open ended questions which could not be accommodated by the CATI but would be essential to the understanding and interpretation of the quantitative data.

The final version of the interview schedule contained a mix of structured questions with pre-coded response categories and open ended questions where respondents' comments were recorded verbatim as far as possible by the researcher.

Additional documents requested by the researcher were:

- TPP purchasing intentions for 1997/98 where these had been produced at time of interview.
- Copy of the main acute contract where independently negotiated.

As Table 4.1 shows, 48 of the original 53 first wave TPPs took part in the survey. Four sites did not take part because they had either withdrawn from TP or were about to do so. One site was unable to co-operate. Site managers comprised the majority of respondents.

Table 4.1: Category of response to survey

	TPPs
Respondents:	
Lead GP on behalf of TPP	4
Site Manager on behalf of TPP	41
Lead GP *and* Site Manager on behalf of TPP	2
Multiple response from TPP where practices contract separately	1
Non respondents:	
TPP not approached to take part as they had already withdrawn from TPP	2
TPP did not participate in the survey as withdrawal from TPP was imminent	2
TPP unable to co-operate during fieldwork period	1
Total	**53**

Quantitative data have been analysed using the computer package SPSS. Qualitative data, comprising the responses to open-ended questions, have been analysed manually in the first instance with responses being grouped according to identified themes. Where appropriate, subsequent coding of this data according to clear response categories has allowed for calculation of frequencies of response. As the subsequent analysis indicates, some questions call for the expression of opinion by respondents or elicit a personal interpretation of events.

As the majority of TPPs contract as single purchasers, data analysis has proceeded with the TPP as the unit of analysis. However, the survey confirmed that three TPPs were not operating on this basis. In two cases each of the several constituent practices contracted separately and in the third case the practices were operating two separate contracting arrangements. Because of the difficulties encountered in collecting detailed data at practice level from these TPPs, they have not been included in the tabulations which present the survey findings. Thus our reported findings relate to 45 sites.

5 Results

The findings of the survey are reported in terms of the research questions specified in section 3.

i) To what extent have the TPPs taken advantage of the freedom to contract independently?
Twenty-eight TPPs (62%) contracted independently for some services during their first 'live' year, 1996/97. Respondents from 25 of these TPPs described independent contracting as their *predominant* form of contracting; this was defined as comprising the majority of their contract expenditure/volume of activity, being with their main/local provider(s) and representing what they were committed to as total purchasers. All of these sites, however, also had joint contracts with their DHAs and/or the DHAs contracted on their behalf for some services.

It is also noticeable that 15 of the TPPs with independent contracts reported that they were *largely based* on the DHA contract. Within this category, however, variations were made to the DHA contract. Specific variations mentioned related in two cases to more detailed and exacting information requirements; in two cases to a clause specifying that provider clinicians should co-operate with a liaison nurse appointed by the TPP to influence discharge arrangements and in one case to a new specification for maternity services. Two respondents pointed out that although their contract was different to the DHA contract (it was now cost per case) there had been no changes to service or quality specifications.

In contrast, ten respondents stressed that their contracts differed significantly from those of their DHA. These contracts were described variously as *'more patient focused'; 'much clearer'; and 'more positive'* than DHA contracts with *'much more emphasis on activity management and monitoring arrangements'*. Four TPPs mentioned new clinical service specifications in relation to maternity services, two cited new specifications for A&E; one for breast cancer services and another for services for frail elderly people.

Of the 17 TPPs that had no independent contracts ten reported that they had joint contracts across the board; four said that they had a mix of joint and DHA contracts on their behalf; and three said that the DHA contracted on their behalf entirely - in effect they were not 'live' from a contracting perspective.

In an attempt to identify general TPP characteristics that might be associated with the decision to contract independently, we examined site size, organisational complexity and length of experience with fundholding. The patient list size of those sites that contracted independently (range: 12,000-

79,300; mean: 30,944) did not appear to be markedly different from those sites that did not (range: 17,000-66,643; mean:32,561). However, 85% of single practice sites had independent contracts compared with only 53% of sites with more than one practice. This finding was reinforced by a similar pattern in terms of organisational complexity: that is, 80% of sites with 'simple' organisational structures had some independent contracts compared with 50% of those whose structure had been defined as 'complex' (see TP-NET (1996) for definitions of organisational complexity). Finally, 78% of TPPs that included at least one first wave fundholding practice contracted independently in comparison with only 52% of sites that did not include a first wave fundholder.

On the basis of these findings, our tentative conclusion is that single practice sites with less complex organisational structures (and, presumably, fewer problems of inter practice co-ordination) were able to take advantage of independent contracting more rapidly. Complex organisations seemed to inhibit innovation. The inclusion of path breaking first-wave fundholders also appeared to encourage innovation in contracting. These findings should, however, be interpreted alongside those reported in section vi) which suggest that the reasons why many TPPs did not contract independently were often perceived as being beyond their control, e.g. DHA opposition.

ii) What were the number, size and form of the independent contracts negotiated by the TPPs?

The 28 TPPs that contracted independently had a total of 151 independent contracts. Individual TPPs had between one and 22 contracts. The vast majority (82%) had between one and six contracts. The overall mean was 5.4.

Respondents were asked to provide details of their main (largest) contract for acute, community and mental health services. In this paper, we concentrate on the acute contracts.

Twenty-seven TPPs gave details of independently negotiated acute contracts (the remaining TPP was contracting only with a community health services provider). The value of these contracts ranged from £400,000 to £11,700,000 (the latter was a contract with an integrated trust and includes mental health services) (see Table 5.1). The information provided indicates that the main acute contract is an important part of the TPPs contracting business - in 25 cases it represented more than 50% of the TPPs spending on acute services - and justifies our *a priori* decision to concentrate on a single contract on the grounds that one major contract often dominates contracting activity.

Table 5.1: Value of main acute contract

	No. TPPs
Up to £1 million	3
£1-2 million	10
£2-3 million	2
£3-4 million	3
£4-5 million	2
£5-6 million	3
over £6 million	2
Total	**25***

**Data missing in 2 cases*

Case 1 Contract still subject to negotiation at time of interview - value to be finalised

Case 2 Cost per case contract - TPP 'did not give 100% guarantee' so actual value of contract as yet unknown

Sophisticated block contracts were the most commonly reported form of contract (see Table 5.2). This reflects a similar pattern found in an earlier study of DHA contracting involving two of the authors (Raftery et al., 1996). There were, however, seven TPPs that reported 'combination' contracts: these comprised a number of sub-contracts of different types that appeared to have been selected in the light of the TPPs perception of risk in the relevant service area (see Table 5.3).

Table 5.2: Main TPP contracts for acute services by type of contract

Type	*TPPs*
Simple block	4
Sophisticated block	10
Cost and volume	5
Cost per case	1
Combination	7
Total	**27**

Table 5.3: Combination contracts - sub-contract types and services covered

	Contract types	*Services included*
Case 1	Simple block	A&E
		General surgery
		Non-elective admissions
	Cost and Volume	Maternity
	Cost per case	General medicine
		Care of the Elderly
Case 2	Simple block	A&E
		Elderly day care
		Breast screening
		rehabilitation.
		GUM services
	Cost and volume	All other services included in contract
Case 3	Simple block	A&E
		GUM services
		Midwifery
	Cost per case	All other services included in contract
Case 4	Simple Block	A&E
		Diabetes Care
	Cost and volume	All other services included in contract
Case 5	Cost and volume	Emergency admissions
		Obstetrics
	Cost per case	Elective admissions
Case 6	Sophisticated Block	Emergency admissions
	Cost per case	Elective admissions
Case 7	Simple Block	A&E
	Cost and volume	All other services included in contract

As far as contract currencies are concerned, the most common practice was to use finished consultant episodes (FCEs) priced at average specialty cost. This approach was used in approximately 60% of contracts for all specialties. Examples of more sophisticated currencies were reported in a minority of cases. These involved differentiation of episodes by length of stay (e.g. in general medicine and care of the elderly), separate identification of day cases and the use of health related groups (HRGs) for costings (e.g. in cardiology, rheumatology and some surgical specialties).

A number of respondents commented that they had hoped to move away from contracting on the basis of FCEs. This echoes sentiments and intentions expressed in many of the 1996/97 *Purchasing Intentions* documents. At the time of our study, these expectations had been fulfilled to only a very limited extent. Some respondents perceived that Trusts were reluctant to accommodate their wishes. Others pointed out that there was a lot of work involved and were more optimistic that changes would be made in the future.

Box 5.1: Barriers to more sophisticated contract currencies

'We have used FCEs at average specialty cost. We wanted some more sophisticated currencies but the provider wouldn't co-operate. For example we wanted differentiation by length of stay and also asked for prices per live birth for maternity but the provider was unwilling' (ref BE)

'It was our intention to go for a length of stay currency - we started negotiations but abandoned it' (ref BC)

'We're not sure FCE's should be used but, for the providers, there's a lot of work in establishing costs.' (ref AF)

'We wanted HRGs. They can't do it this year but have promised to do so.' (ref AI)

iii) What was the TPP experience of contract negotiations?

Twenty two of those TPPs with independent contracts (i.e. 82%) reported that they had encountered problems in obtaining agreement on some (11 TPPs) or all (11 TPPs) of their contracts. These problems involved 73 contracts in total. The overwhelming majority of problems were associated with acute contracts (72%).

Among the 11 TPPs that reported difficulties in obtaining agreement on all of their contracts, the problems were reported as follows:

- A major difficulty had arisen for 91% of this group because of problems agreeing the TPP budget allocation from the HA;
- had been obliged to wait for HA contract negotiations to be completed before TPP contracts could be finalised;
- had problems predicting or costing activity owing, mainly, to perceived inadequacies in historical data; and
- the same proportion had problems associated with being 'new players' in the contracting game, compounded, in their view, by HA and/or provider reluctance to take them seriously.

Box 5.2 indicates some of the comments from these TPPs about the difficulties they encountered in their relations with DHAs and trusts.

Box 5.2: Problems with contract negotiations

'All contracts were delayed because we didn't have as much help from the HA as would have been desirable.' (ref BC)

'... there was much nervousness on all sides ...' (ref AF)

'The trusts just didn't take us seriously. The health authority had assured them they'd get their money back without conceding any changes. The acute provider occasionally invited us for coffee and biscuits but didn't expect proper negotiations.' (ref DI)

'There was a problem with the perception and understanding of trusts who saw the TPP as taking their money. They behaved as if they were directly managed units, reinforced by the health authority. They assumed they should get the money rather than earning it.'(ref DJ)

In the case of the 11 TPPs that reported problems with some of their contracts, the difficulties tended to be contract specific. Our survey captured data on 22 of the 25 contracts concerned.

All of the TPPs cited difficulties in predicting costs and/or activity as a reason for failure to agree contracts. For nine TPPs significant delays arose as a result of waiting for DHA contract negotiations to be completed. Some TPPs mentioned disputes between the DHA and the provider about the DHA contract 'defund'; that is, the reduction in activity and expenditure in the DHA contract representing the TPP's share of total DHA expenditure. Sometimes the TPPs became involved in these disputes themselves.

Despite all of these difficulties, at the time of our survey, 96% of TPP contracts had been agreed. (Approximately 30% of these had yet to be 'signed-off' but this was regarded as a formality). In all but a few cases the problems had finally been overcome, either through persistence in negotiation or simply through the passage of time. The latter was often the case where the TPP had been obliged to wait until problems with DHA/provider contracts were resolved. While none of the disputed contracts had been the subject of formal arbitration procedures, two respondents referred to conciliation provided by the NHSE regional office

iv) What arrangements did TPPs make for monitoring provider performance and managing contracts in terms of activity, costs and quality

Strategies for managing activity and cost variances within contracts tended to make use of price flexibility. In the case of sophisticated block contracts, TPPs paid providers a fixed contract sum for access to a defined range of services or facilities. Indicative patient activity levels were specified and agreed mechanisms set out for dealing with situations where variances occurred. In the majority of cases, a tolerance range of up to five per cent of indicative volume was allowed before the mechanism was triggered; beyond this range additional activity tended to be priced on an agreed marginal cost basis up to a specified ceiling. In the case of cost and volume contracts, TPPs agreed to pay a fixed price up to a certain volume of activity and thereafter specified a price per case; this price was also often related to marginal cost.

A major difficulty reported in relation to contract monitoring by 17 TPPs with independent contracts was the inadequacy of data received from providers. A total of 42 problems were cited in relation to the coverage, timeliness and accuracy of both cost and activity data. However, 11 of these TPPs commented spontaneously that the quality of the data had improved over time.

In addition to information on activity and costs, respondents were asked about quality specifications in their contracts. Specific issues raised with them included use of performance measures, protocols and guidelines and clinical audit requirements. Because of the variability in the detail of response to these questions, contract documentation was requested in order to check and supplement information. This revealed substantial variation in quality specifications. Typically there were references to separate schedules or appendices on quality standards; these often required compliance with, for example, Patient's Charter or DHA quality standards. Performance measures, where these were included, usually referred to discharge arrangements and/or day case activity targets. On clinical audit, there was often a broad requirement that the provider should undertake a

programme of audit in line with DHA guidelines or strategy. There were few references to specific TPP priorities.

Respondents were asked if any financial incentives or penalties were linked to contract specifications. As Table 5.4 shows, only about one-third of TPPs reported the use of financial penalties and these were mainly linked to information requirements.

Table 5.4: Inclusion of financial penalties in TPP main acute contracts

	No. of TPPs
No financial penalties	18
Penalties linked to information requirements only	6
Penalties linked to quality standard(s) only	2
Penalties linked to both information requirements and quality standard(s)	1
Total	**27**

In most of these cases the TPP could withhold some or all payment if the required clinical letters and/or discharge summaries were not received. The principal concern seemed to be to validate activity data rather than improve clinical practice. Box 5.3 presents comments made by the three TPPs which claimed to use financial penalties to improve quality standards.

Box 5.3: Penalties associated with achievement of quality standards

'There is a £100 penalty linked to discharge arrangements (this has never been invoked)' (ref BE)

'There is a penalty attached to 12 month waiting list quality standard. We have also introduced 3 month max claim for payment which HA has taken on board and replicated in their own contracts.' (ref EG)

'An additional 2% efficiency allocation is to be returned to the trust in instalments on achievement of quality targets - money is held back if targets are not achieved.' (ref DI)

The third of the above comments merits further attention. In the opinion of the respondent, specifying a proportion of the payment that was dependent on the achievement of quality targets was '*using the contracting mechanism to drive clinical improvement*'. Examples of the targets employed were production by the trust of patient information leaflets and daily notification of emergency bed availability.

However, as Table 5.4 shows the use of financial incentives in this way was a minority approach. Comments from respondents who did not use financial incentives in this way ranged from opposition to them (see Box 5.4) to those who were considering their adoption in the future (see Box 5.5).

Box 5.4: Comments from TPPs who are not in favour of penalties

'No penalties yet - we're sabre rattling. We may withhold money on incomplete information but I'm not personally in favour.' (ref AF)

'We decided to work co-operatively this year and are not even following the normal six week rule.' (ref BA)

'We don't have penalties - we've built up relations with the hospital so it doesn't work like that- we can always negotiate'. (ref CJ)

'Penalties aren't motivating - they are the measure of last resort.' (ref EH)

Box 5.5: Comments from TPPs who have different plans for next year

'We are considering some penalties next year e.g. if there is no bed for an emergency admission and this means diversion to another hospital as an ECR while there is under performance in the contract then the TPP shouldn't have to pay.' (ref DB)

'We have no penalties this year but some will be in for next year.' (ref EC)

v) What service developments have been achieved through contracting?

When asked about the importance that they attached to the contracting process as a mechanism for achieving change and the development of services, 76% of those TPPs that contracted independently rated it as 'very' or 'quite' important (see Table 5.5).

Table 5.5: Views about the importance of the contracting process in achieving change

How important is the contracting process?	*% TPPs with some independent contracts (n= 28)*
Very important	39
Quite important	47
Not important	14
Total	**100**

Respondents who viewed the process as very important emphasised the value that they attached to the opportunity to communicate with provider clinicians and to the ability to negotiate from a position of strength with financial leverage over the providers. Box 5.6 contains three representative comments from these respondents.

Box 5.6: The contracting process is very important ...

'Its a springboard to open more doors. We spoke to clinicians and addressed meetings to get their support for the changes we wanted to make We wouldn't have been invited to such meetings if we weren't going down the contracting road.' (ref BF)

'Its very important because it promotes communication - you are talking to people and meeting the separate directorates. We also understand better now what the HA does.' (ref AI)

'Its absolutely critical. There is no new money so you have to make money from within contracts to fund new developments. The HA in my view is pathetic because their contracts are meaningless. The bottom line is that the provider expects 1/12th payment regardless.' (ref AG)

At the other end of the spectrum, there were four independently contracting TPPs that viewed contracting as 'not important'. Typical views from these respondents are given in Box 5.7.

Box 5.7: The contracting process is not important ...

'Its incidental really - if your relationship with your provider means you rely on the contract then it's an obstacle to making change.' (ref AB)

'We are achieving changes to services not through the use of contracts as a mechanism but through clinician to clinician discussion. The contract is only important as a last resort.' (ref EH)

It is also worth noting that the national evaluation of general practice based purchasing of maternity care also casts doubt on the role of contracting as the main mechanism for bringing about service changes (Wyke *et al.* 1997). On the basis of the experience of six TPP sites and five extended fundholding practices, the authors concluded that service changes in maternity care may drive contracting rather than *vice versa*. It is, however, noticeable that in this study only three of the six TPPs and one of the five extended fundholding practices had maternity contracts and that in all cases their DHAs were either relatively or very active in the specification of maternity services. Development of maternity services is also led by the strong policy framework provided by *Changing Childbirth* (Department of Health, 1993), and, as such, this may well be a service area in which TPP contracting was seen as less important.

Turning back to our own study and the actual changes that had been brought about through contracting during 1996/97, 17 of those TPPs (62%) that had contracted independently said that they had made changes this year. In exploring these changes each respondent was asked to give up to three examples of 'service developments achieved through contracting'. Thus, the following data should be regarded as illustrative rather than as an exhaustive audit. The examples given range from relatively simple changes which may be cost neutral within terms of an existing contract to more complex developments which involve shifting the balance of care between providers or sectors. Such complex changes may have to be achieved in stages especially if ways must be found to release resources from one contract to invest in another.

The area of service development most frequently mentioned (9 respondents) was a change to hospital discharge arrangements, commonly involving the use of an intermediate care facility, which hinges on the use of 'length of stay' (LOS) sensitive contract currencies to permit shift of resources (see Box 5.8).

Box 5.8: Contracting strategies for reducing length of stay

'By contracting for LOS in elderly medicine, the intention is to save money and set up a contract for nursing home beds . We may or may not save money and we haven't got the nursing home contract organised yet, but this is the plan' (ref BF)

'We are using occupied bed days as a more responsive contract currency. We have employed a nurse to look at discharge arrangements and may put a cut-off point on LOS.' (ref AF)

'We are buying elderly care and general medicine on a cost per day basis and we have employed a liaison nurse to discuss early discharge to home or into nursing home beds. Its early to be sure about costs savings but we have stopped some admissions to elderly medical rehabilitation by redirecting them to nursing homes. (ref BA)

'We want to bring care out of the hospital into the community by reducing length of stay. We have taken £75k out of the main contract to cover reduced length of stay. This funds an additional GP and also nursing home beds. The provider is not happy and has asked for validation that LOS is reduced. (ref A1)

Other service developments mentioned related principally to maternity or community services and involved reconfiguring existing services or in some cases changing provider (see Box 5.9). Respondents were not always explicit about the role of the contracting process in achieving these changes and some emphasised that other processes such as clinician to clinician discussion had been of more relevance.

Box 5.9: Other services developments achieved through contracting

'An additional CPN has been employed in drug and alcohol abuse services and we have achieved some improvements in paediatrics and elderly care. The changes were negotiated by the sub groups that exist for contracting.' (ref AH)

'We have a new midwifery service. A project nurse is working with the PHCT on prevention of falls in the elderly.' (ref CI)

'We have changed provider for maternity services and are actively exploring a change of provider for mental health.' (ref EC)

Other respondents were less specific about the nature of the service developments they had achieved emphasising instead the means by which they had been accomplished (see Box 5.10).

Box 5.10: The contracting process as a means to service development

'We have used the contract as a vehicle for making change. Service developments worth £330k are being funded from savings in contracts. We've made the savings through having LOS sensitive contracts + penalties attached to information requirements.' (ref AG)

'We asked for extra activity at no extra cost and cash to create a reserve for service developments. One provider (comm/MH) gave us cash in lieu of activity (30%)' (ref BE)

One TPP gave examples of service developments in community services - for example the creation of a GP-led day hospital facility and a primary care-led emergency centre at the local community hospital - which relied upon additional input from members of the PHCT. The TPP had found a means of purchasing non GMS services from the PHCT by blocking back funds to the health authority/board to agree a contract with the TPP.

Five respondents said they felt they could not claim to have achieved change during the first year of independent contracting but were working on changes to take effect in the future. In addition, five respondents who gave examples of changes achieved this year also referred to definite plans for service developments to be achieved in the forthcoming contracting year.

The examples given of *planned* changes reflect concerns to achieve clinical improvements in acute services and to promote primary care developments (see Box 5.11). Once again, some respondents emphasised the intended service outcome whilst others paid more attention to describing the process by which they would achieve it.

Box 5.11: Changes planned through contracting

'In our acute contract next year we shall buy in specialist nurses through the acute provider e.g. for diabetes care' (ref AB)

'We believe that contracts should be based on quality and not activity. We have a block contract with an additional 2% of the contract price being paid to the trust on achievement of (process) quality standards. Next year this will apply to certain clinical outcomes (e.g. % stroke patients discharged to rehabilitation) Failure to meet agreed quality standards will result in financial penalty - in this way we are using the contracting mechanism to drive clinical improvements.' (ref DJ)

'We plan to move more activity into primary care by beefing up the PHCT. This drives having activity based contracts with providers to get flexibility.' (ref CH)

One respondent described how the TPP intended to use the contracting process to exercise some power over the shape of service provision by putting services out to tender (see Box 5.12).

Box 5.12: Exercise of purchasing power ...

'This year we felt we were put under pressure by providers who wanted the defund back. We felt we didn't have the power as a major purchaser. So, we will ask next year for bids to provide non-elective services. We are splitting admissions into groups of 12 and asking for bids for packages in a range of specialties. But, we have to agree to guarantee 2/3 activity to the provider or make change with impact ~£100k in one year. We can contemplate this because we are the monopoly practice in the town. There are 5 major hospitals in a 25 mile radius. The 2 smallest are the most interested while the two largest have the most to fear. (ref BC)

The comments of those TPPs who did not consider that they had made service developments through contracting suggest that they may have found alternative ways of funding or negotiating service developments or that they may feel pessimistic about their prospects of achieving change (see Box 5.13).

Box 5.13: Pessimism about contracting

'Providers are not prepared so there's little opportunity to make change. We need to get a per diem rate and reduction in length of stay ... If we can't get sense in this contracting round we'll completely withdraw.' (ref EJ)

vi) *Why did some TPPs **not** undertake independent contracting? What influence did they have in joint contracting with their DHA?*

Seventeen TPPs (38%) had no independent contracts for 1996/97. Ten said that they had joint contracts across-the-board; four said that they had a mix of joint and DHA contracts; and three reported that the DHA contracted entirely on their behalf. In the majority of cases the decision not to contract independently was determined by events or circumstances perceived to be beyond their control. Only two TPPs claimed to have expressly chosen the current arrangement. One TPP had accepted a shadow budget and postponed going live for 96/97 owing to the difficult financial position of their health authority. Another TPP had been obliged to accept a joint contracting arrangement imposed by their health authority as a compromise settlement when they reached stalemate in independent contract negotiations with their main provider. Two others felt that the HA had obstructed them - in one case by simply *'not allowing'* them to contract separately this year and in another by being less than helpful in explaining the contracting process.

Difficulties agreeing the TPP budget allocation or GP's dissatisfaction with the allocation had caused several TPPs to opt reluctantly for joint contracts. In one case the TPP had been unable to proceed independently because the provider, who was concerned about the 'defund' from the health authority contract, declined to enter contract negotiations.

Seven TPPs had been concerned to minimise risk for a further year because they lacked confidence in activity and cost information or in their own expertise (notably for some who had taken on SFH at the same time).

Even though they were not able to contract independently, many of the TPPs were able to participate in joint contracting in different ways. Table 5.6 shows that all but one of those TPPs with joint contracts received activity data for contract monitoring purposes and that over half of them took part in contract negotiations and setting service specifications for all or some of their contracts. Indeed, the data indicate that these TPPs had a greater level of involvement in joint contracting than those TPPs where joint contracting was supplementary to independent contracting.

Through this involvement, five TPPs indicated that they had *shaped* joint contracts and thereby achieved worthwhile service developments. Specific examples cited included specifications for maternity services (3 cases), cancer services (1 case), school health services (1 case) and community psychiatry (1 case). Another TPP had done the necessary groundwork for three major service developments to come to fruition in the following year: these were a community rehabilitation initiative, changes to child and adolescent health services and a community cardiology service.

Table 5.6: Characteristics of 'joint' contracting arrangements

Characteristic	*Number of TPPs for whom these characteristics apply to 'joint' contracts (n=14)*			
	to all joint contracts	*to some joint contracts*	*to no joint contracts*	Total
TPP took part in contract negotiations	4	4	6	14
TPP took part in setting service specifications	3	5	6	14
Both TPP and HA are signatories to contract	1	0	13	14
TPP receives activity data for contract monitoring purposes	11	2	1	14
TPP is invoiced by provider prior to payments being made by HA	2	1	10	13*
TPP is responsible for keeping activity within specified limits	9	0	4	13*

Note * *Data is missing because one respondent did not give an answer*

6 Discussion

Our survey indicates that 28 TPPs (62%) grasped the opportunity to contract for some services independently. For these TPPs contracting was big business: the value of main acute contracts ranged from £400,000 to £11,700,000 and in practically all cases these represented more than 50% of the TPPs spending on acute services. These TPPs met our initial expectations regarding a major expansion of fundholding. They viewed contracting as a major lever for bringing about service improvements in the way that early fundholders had done. In this connection, it was interesting to note that single practice, less organisationally complex TPPs - often with first-wave fundholder participation - were more likely to contract independently than more complex, multi practice sites.

It would, however, be a mistake to view the existence of independent contracting as the sole litmus test for the success of total purchasing. For one thing, our survey only covered the first live year of total purchasing; it might be expected that more complex organisations would take more time to develop the necessary mechanisms for successful independent contracting. Indeed, this view is supported by the fact that eight of the 17 TPPs that did not contract independently in 1996/97 indicated their intention to do so in 1997/98.

More fundamentally, though, there is evidence from our survey that joint contracting between TPPs and DHAs can be beneficial in its own right. Even those TPPs that contracted independently had joint contracts for some services. Among those sites that did not contract independently there was frequently involvement in joint contract negotiation, service specification and monitoring alongside the DHA. It is certainly possible to view this form of DHA-TPP partnership as a success of total purchasing as well.

If, as the above arguments suggest, it is possible to make a case both for independent and joint contracting, which approach is to be recommended? Our view is that the choice is likely to depend on two factors; namely (i) the nature of the services and functions involved and (ii) local purchaser-provider relationships.

As far as the services are concerned, there is a growing body of opinion that argues that some services are best purchased directly from GP settings in which flexible, individual patient-focused responses are desirable whereas other services require higher-level, population-based perspectives. Similarly, some functions - for the same services - are best dealt with through devolved decision making whereas others require a strategic overview (Mays and Dixon, 1996).

Determining the appropriate mix of joint and independent contracting should involve an assessment of their relative costs and benefits in terms of these services and functions (e.g. assessing patients needs, obtaining and managing information, bringing about service developments, setting priorities, managing risk). An additional contribution that our own survey brings to this process is evidence

that joint contracting through total purchasing can be a powerful vehicle for greater primary care involvement in the DHA purchasing process.

The second factor governing choice between joint and independent contracting - namely, the nature of purchaser-provider relations - can, however, make this process problematic. Our survey revealed a certain amount of antagonism between *some* TPPs and *some* DHAs. The major difficulties encountered during contract negotiations by those TPPs undertaking independent contracting centred on delays in DHA decisions regarding TPP budget allocations and finalising their own contracts. These were major sources of tension. Among those sites that did not contract independently, there were accounts of DHAs *'obstructing'* or *'not allowing'* independent contracting. Elsewhere there were reports of DHAs *'imposing'* joint contracting. Once again, this language does not suggest harmonious partnerships.

Of course, allowance should be made for first year teething problems, especially in relation to budget setting. However, these accounts do highlight a tension felt by many primary care professionals and managers: that DHAs are dominated by managers with acute hospital sector backgrounds and interests and that primary care is fairly low on their lists of priorities. Without the autonomy offered by independent contracting, there is a danger that primary care influence may be eroded.

Finally, we offer a judgement on contracting in the light of possible policy changes in the future. Current ministerial views appear to indicate a preference for *'collaborative service agreements'* rather than contracts as presently used. A large part of this preference seems to stem from dissatisfaction with the heavy transactions costs thought to be associated with contracting in general and primary care-based contracting in particular. Our survey did not encompass transactions costs as these are being examined by other members of the total purchasing national evaluation team (TP-NET). However, we would reiterate the message made by Glennerster *et al* (1994) among others; that is, primary care-based purchasing should be evaluated in terms of both its costs *and* benefits. These benefits can take a variety of forms. The most direct of these involves improvements in services and associated health outcomes. But there are also a range of less tangible process or intermediate benefits (e.g. better communication between primary and secondary sectors, GP job satisfaction and morale, GP involvement in DHA decision making). Our study has shown that primary-care based contracting can make a considerable contribution in many of these areas; in particular it can improve communication across the primary-secondary care interface and play an important part in bringing about service developments. These are clear benefits that need to be preserved.

References

Appleby J. *Developing contracting: a national survey of DHAs, boards and NHS trusts.* Birmingham: National Association of Health Authorities and Trusts, 1994.

Appleby J. Smith P, Ranade W, Little V and Robinson R. Monitoring managed competition. In Robinson R. & Le Grand J, eds. *Evaluating the NHS Reforms.* London: King's Fund, 1994.

Ascher K. *The politics of privatisation: contracting out public services.* London: Macmillan, 1987.

Audit Commission. *What the doctor ordered.* London: HMSO, 1996.

Department of Health. *Competing for quality.* London: HMSO, 1991.

Department of Health. *Changing Childbirth. Report of the Expert Maternity Group.* London: HMSO, 1993.

Flynn R and Williams G, eds. *Contracting for health.* Oxford: Oxford University Press, 1997.

Glennerster H, Matsaganis M, Owens P and Hancock S. *Implementing GP fundholding: wild card or winning hand.* Buckingham: Open University Press, 1994.

Harrison A, ed. *From hierarchy to contract.* Newbury: Policy Journals, 1993.

Le Grand J and Bartlett W, eds. *Quasi-markets and social policy.* London: Macmillan, 1993.

Mays N and Dixon J. *Purchaser and plurality in UK health care.* London: King's Fund, 1996.

Mays N, Goodwin N, Bevan G, Wyke S on behalf of the Total Purchasing National Evaluation Team. *A profile of total purchasing pilot projects in England and Scotland.* London: King's Fund Publishing, 1997.

National Audit Office. *Contracting for acute health care in England.* London: HMSO. 1995.

Paton C, Birch K, Hurst K, Jordan K and Durose J. Counting the costs. *Health Service Journal* 1997; **107**: 24-7.

Raftery J, Robinson R, Mulligan JA and Forrest S. Contracting in the NHS quasi-market. *Health Economics* 1996; **5**: 353-362.

Ranade W and Appleby J. *To market, to market: a study of current trading activities in the NHS and the implications of the government's provider market proposals.* Birmingham: National Association of Health Authorities and Trusts, 1988.

Robinson R and Le Grand J. Contracting and the purchaser-provider split. In Saltman RB and Von Otter C, eds. *Implementing planned markets in health care.* Buckingham: Open University Press, 1994.

Wyke S, Hewison J, Piercy J, Posnett J *et al. National evaluation of general practice based purchasing of maternity care. Interim report to the Department of Health.* Edinburgh: Department of General Practice, University of Edinburgh, 1997.

Total Purchasing National Evaluation Team (TP-NET)

The evaluation is led by Nicholas Mays, Director of Health Services Research at the King's Fund, London. The different consortium members are listed below, together with their research responsibilities.

KING'S FUND
11–13 Cavendish Square, London, W1M 0AN
T: 0171 307 2400 F: 0171 307 2807

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.

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).

NATIONAL PRIMARY CARE R&D CENTRE
Manchester: University of Manchester, 5th Floor, Williamson Building, Oxford Road, Manchester, M13 9PL
T: 0161 275 7600 F: 0161 275 7601
Salford: PHRRC, University of Salford, Davenport House, 4th Floor, Hulme Place, The Crescent, Salford, M5 4QA
T: 0161 743 0023 F: 0161 743 1173
York: YHEC, University of York, YO15 4DD
T: 01904 433620 F: 01904 433628
CHE, University of York, York, YO1 5DD
T: 01904 433669 F: 01904 433644

Leads: Brenda Leese (Manchester and CHE), Linda Gask (Manchester), Jennie Popay (Salford), John Posnett (YHEC)
Other members: Ann Mahon, 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 and Mahon); maternity (Posnett).

DEPARTMENT OF SOCIAL MEDICINE, UNIVERSITY OF BRISTOL
Canynge Hall, Whiteladies Road, Bristol, BS8 2PR
T: 0117 928 7348 F: 0117 928 7339

Lead: Kate Baxter
Other members: Max Bachmann, Helen Stoddart

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).

DEPARTMENT OF GENERAL PRACTICE, UNIVERSITY OF EDINBURGH
20 West Richmond Street, Edinburgh, EH8 9DX
T: 0131 650 2680 F: 0131 650 2681

Lead: Sally Wyke
Other members: Judith Scott, John Howie, Susan Myles

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).

INSTITUTE FOR HEALTH POLICY STUDIES, UNIVERSITY OF SOUTHAMPTON
129 University Road, Highfield, Southampton, SO17 1BJ
T: 01703 593176 F: 01703 593177

Lead: Ray Robinson
Other members: Philippa Hayter, Judy Robison, David Evans

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).

HEALTH ECONOMICS FACILITY, HSMC, UNIVERSITY OF BIRMINGHAM
40 Edgbaston Park Road, Birmingham, B15 2RT
T: 0121 414 6215 F: 0121 414 7051

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).

HEALTH SERVICES RESEARCH UNIT, LONDON SCHOOL OF HYGIENE AND TROPICAL MEDICINE
Keppel Street, London, WC1E 7HT
T: 0171 927 2231 F: 0171 580 8183

Lead: Colin Sanderson with Jennifer Dixon, Nicholas Mays and Jo-Ann Mulligan (King's Fund), James Raftery (HSMC)
Other member: Peter Walls

Main Responsibility: A&E services and emergency admissions.

LSE HEALTH, LONDON SCHOOL OF ECONOMICS AND POLITICAL SCIENCE
Houghton Street, London, WC2A 2AE
T: 0171 955 7540 F: 0171 955 6803

Lead: Gwyn Bevan

Main Responsibilities: Resource allocation methods.

ISBN 1-85717-189-6