King's Fund

National Evaluation of Total Purchasing Pilot Projects Working Paper

National evaluation of general practice-based purchasing of maternity care: preliminary findings

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

The Total Purchasing National Evaluation Team (TP-NET)

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

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We are very grateful to Nicholas Mays, Director of Health Services Research at the King's Fund, and leader of TP-NET, for constructive advice and discussion at all stages in the development of this study and working paper. Thank you also to Diane White of the University of Edinburgh for invaluable secretarial support.

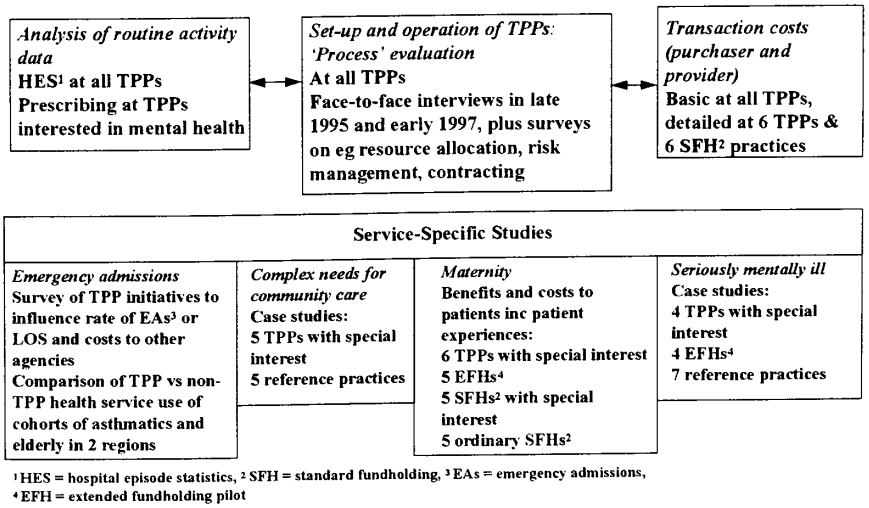
Contents

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.

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King's Fund, London
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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 1 85717 188 8
What were the achievements of total purchasing pilots in their first year and how can they be explained?

Gwyn Bevan 1 85717 176 4
Resource Allocation within health authorities: lessons from total purchasing pilots

Ann Mahon, Brenda Leese, Kate Baxter, Nick Goodwin, Judith Scott 1 85717 191 8
Developing success criteria for total purchasing pilot projects

Ray Robinson, Judy Robison, James Raftery 1 85717 189 6
Contracting by total purchasing pilot projects, 1996-97

Kate Baxter, Max Bachmann, Gwyn Bevan 1 85717 190 X
Survey of budgetary and risk management of total purchasing pilot projects, 1996-97

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How do total purchasing projects inform themselves for purchasing?

John Posnett, Nick Goodwin, Amanda Killoran, Gill Malbon, Nicholas Mays, Michael Place, Andrew Street 1 85717 193 4
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1 Introduction

1.1 *Changing Childbirth*

In August 1993 the Department of Health published *Changing Childbirth*, the Report of the Expert Maternity Group (Department of Health, 1993). This group had been assembled in the previous October, chaired by the then Lady Cumberlege, with a remit: 'to review policy on NHS maternity care, particularly during childbirth, and to make recommendations'. The resulting review was critical and its recommendations far-reaching. It was presented as a manifesto for change in the way that maternity services are planned and provided.

The Group laid out three principles of good maternity care, which centred around: women as the focus of maternity care and in control of what is happening to them; accessible services sensitive to the needs of the local population and based primarily in the community; and women's involvement in the monitoring and planning of maternity services which are also effective and efficient. These three principles were translated into ten objectives for the development of services which highlighted women's involvement in decision making and choice of care, the importance of information and clear, unbiased advice, the community as the setting for most care, and the central role of midwives in providing care. These in turn were translated into 10 'indicators of success' which purchasers and providers should use to monitor their progress in achieving the objectives. At the time, the Group emphasised that the indicators should be used to guide the direction in which changes to maternity services should be made rather than as performance indicators which must be achieved.

Changing Childbirth highlighted the centre role of the midwives in the provision of maternity care, so much so that critics suggested that it was a manifesto for the midwifery profession rather than for maternity care. However, it emphasised the importance of partnership between midwives, general practitioners and obstetricians, and more importantly placed women themselves rather than service providers at the centre of care.

Implementation of *Changing Childbirth's* recommendations was aided by the then Chief Executive of the NHS Management Executive including maternity services in his planning and priorities guidance for 1994/5. This required Health Authorities to review the maternity services they purchased in the light of the recommendations, and to consider a strategy to implement any necessary changes. It was expected that this strategy would be reflected in contracts for 1995/6. In addition, the *Changing Childbirth Implementation Team* was set up with Department of Health funding in July 1994. The Team had a remit to raise awareness about *Changing Childbirth* amongst professionals and the public, and to act as a resource for purchasers, providers and user groups involved in the implementation of the

recommendations. A key role of the team was to oversee the distribution of funds to support innovative developments in maternity care, and many groups all over the country developed projects designed to reconfigure care in the light of *Changing Childbirth*.

The Royal College of General Practitioners welcomed *Changing Childbirth* stating that its principles fit very well with the person-centred approach of general practice (Royal College of General Practitioners, 1995). However, they also emphasised that management of women's pregnancy forms part of general practitioners' continuing care for women and their families, explicitly calling for the maintenance of general practitioners' input into the provision of maternity care by attempting to outline general practices' contribution to women's care.

Thus *Changing Childbirth* has had a far-reaching impact on maternity services across the country. At the time of publication, the Expert Maternity Group reported that there were no plans to include maternity care in the list of services purchased by general practitioners. The Expert Group stated that 'should this occur we would expect fundholders to ensure that women had the full range of options from which to choose' (1, section 2, p36). The 1995 RCGPs' publication 'The Role of General Practice in Maternity Care' also concentrated on the provision rather than the purchasing of commissioning of care (Royal College of General Practitioners, 1995). However, since then, two pilot schemes were introduced which would allow general practitioners to purchase maternity care - the pilot scheme to assess the purchasing of maternity care by extended general practice fundholders (extended fundholders) and the national total purchasing pilot scheme.

1.2 General practice-based purchasing of maternity care

The first official announcement of Government plans to extend standard general practice fundholding to other services came in England in October 1994 as part of an NHS Executive Letter (EL) entitled 'Developing NHS purchasing and general practitioner fundholding' (NHS Executive, 1994). The first report of the Total Purchasing National Evaluation Team (TP-NET) (Mays *et al*, 1997) outlines how in this letter the NHS Executive (NHSE) suggested that extensive consultation over the summer of 1994 had 'underlined the benefits of increasing both the number of general practitioners involved in fundholding and the range of services they can buy'. This paved the way for the subsequent introduction of extensions of standard fundholding to other services (including maternity care, osteopathy and chiropractic, mental illness services and other long stay treatments). The EL also introduced total purchasing: 'where general practitioners in a locality purchase all hospital and community health services

for their patients'. It would, for the first time, allow general practitioners to purchase a range of services which were at the time outside of the scope of standard fundholding, including emergency inpatient care, accident and emergency services, inpatient services for people with severe mental illness, learning disability services, maternity services, community care, palliative care, regional specialisms and health promotion.

After a period of selection and review, in April 1995, 53 total purchasing pilots in all Regions of England and Health Board areas of Scotland started the pilot of total purchasing. The characteristics of these total purchasing pilots, their organisation and management, financing, main objectives and purchasing intentions for their first year, together with participant's views of total purchasing are outlined in TP-NETs' profile of national pilot projects (Mays *et al*, 1997). In late 1995 and early 1996, fieldworkers from TP-NET asked all 53 total purchasing pilots about their purchasing intentions for the first year of total purchasing. At this time 28 total purchasing pilots stated that it was their intention to focus their purchasing on maternity care; Table 1.1 shows their priorities in influencing maternity care, and stated mechanisms for change (Mays *et al*, 1997).

Table 1.1 Total purchasing pilot priorities in influencing maternity care*

Service area	No of sites	Mechanism for change	No of sites
Implementing *Changing Childbirth*	24	Attached midwives and personal care to improve flexibility and continuity of care	24
Improved service provision by providers	5	Change contract currency with provider	3
		Develop maternity unit at local hospital	1
		Develop common protocols between main providers	1
Practice-based provision	2	Develop practice-based maternity services	2

* Reproduced from Mays *et al* (1997) page 35

The identification and selection of potential standard fundholding practices to undertake the pilots of extended fundholding for maternity care lagged a few months behind that of total purchasing. In December 1994, English Regions, through local health authorities, were asked to identify suitable standard fundholding practices and ask them to submit an application. Out

of 22 applications received, 6 were chosen by NHSE purchasing division in association with the Department of Health's *Changing Childbirth* team. The practices were selected for both suitability from a purchasing strategy viewpoint and in the way they addressed the principles of *Changing Childbirth* in their plans for purchasing. Practices' involvement in the provision of maternity care was not formally considered although it was clear that only those practices with a previous interest in the provision of maternity care were likely to have applied for funding status.

The Minister of Health announced details of the six pilot projects in July 1995. Speaking at the Institute for Health Service Management's Practice Manager's conference, he said:

> *The main aim of the Maternity Services Charter, backed up by the recommendations in the Changing Childbirth report of the Expert Maternity Group, is to tailor maternity care to meet the needs of individual women. As general practitioner fundholders are at the forefront of improving services to patients through innovative developments in purchasing, they are ideally suited to respond to the maternity care needs of their patients. The six pilot sites will give general practitioner fundholders an opportunity to explore the feasibility of including maternity services among the health services which standard fundholders can purchase on behalf of their patients.*

Subsequent notification of the success of their applications and the length of the pilot, to the projects took some time, and preparations for purchasing in 1996/7 began at different stages in each of the six sites. Thus the extended fundholders started the formal pilot of purchasing maternity care one year later than the total purchasing pilots, in April 1996 (although preparatory work had already started in most sites before that date).

A feature associated with the introduction of both total purchasing and extended fundholding was their pilot status, and the commissioning of independent evaluations. The National Evaluation of Total Purchasing Pilot Schemes was commissioned from a consortium led by the King's Fund (TP-NET). The National Evaluation of General Practice-Based Purchasing of Maternity Care, was commissioned from another consortium of researchers, some of whom were members of TP-NET, and some of whom were expert in the evaluation of maternity services. This consortium is led by the Department of General Practice, University of Edinburgh, and the research includes both extended fundholders and total purchasing pilots as

general practice-based purchasers of maternity care. The evaluation started in April 1996, and is funded until September 1998.

1.3 The potential of general practitioners' involvement in commissioning or purchasing to achieve the objectives of *Changing Childbirth*

In the area of maternity care as well as in continuing and community care (Myles *et al*, 1998), there is a consensus that general practitioners have an obligation to be involved in delivering high quality co-ordinated care through both provision (Royal College of General Practitioners, 1995) and playing a part in commissioning and planning services (Audit Commission, 1997). This is likely to continue with the present Labour Government's continued commitment to devolved commissioning.

Many of the potential pitfalls of increasing purchaser plurality in the NHS, cogently outlined by Mays and Dixon (1996), are also relevant in planning and developing general practitioner led locality commissioning. However, as with continuing and community care (Myles *et al*, 1998), general practice involvement in commissioning or purchasing maternity care may actually provide the 'bite' necessary to move reluctant provider Trusts more quickly towards services which meet the aims of *Changing Childbirth* than Health Authorities have been able to do. Thus it is important to learn what lessons we can from the experience of practices actively trying to purchase maternity care in their first (extended fundholders) or second (total purchasing pilots) year of the pilot. This paper will therefore:

- describe some selected characteristics of the general practice-based purchasers involved in this evaluation;
- describe their motivations and aims of taking part in the pilot and initial assessment of progress by 1997;
- describe the characteristics of maternity care experienced by some women registered with the general practice-based purchasers in comparison to those registered with practices not purchasing maternity care;
- describe contracting for maternity care in the study sites;
- describe influences on the development of general practice-based purchasing and how changes are brought about.

2 Methods

The National Evaluation of General Practice-based Purchasing of Maternity Care is funded by the Department of Health and is due to report in September 1998 by which time the extended fundholders will have been through two purchasing and contracting cycles (1996/7 and 1997/8) and the total purchasing pilots through three rounds (1995/6, 1996/7 and 1997/8). The study's aims, objectives, design and methods are described in detail in an interim report available from Department of General Practice, University of Edinburgh (McCourt and Page, 1996).

2.1 Design and aims

The overall aim of the study is:

To investigate whether general practitioners, either as extended fundholders or as total purchasing pilots, can purchase maternity care more effectively (in terms of choice, continuity and control) or more efficiently (in terms of resource utilisation and transactions costs) than their local Health Authorities.

The design of the study involves a non-randomised comparison of two models of purchasing maternity services. Comparisons will be made along two dimensions: the purchaser dimension (Health Authority purchasing compared to general practice-based purchasing); and the general practice dimension (fundholders (both extended fundholders and standard fundholders), total purchasing pilots, and general practices with a special interest in maternity care who may be standard fundholders or not.) Figure 1 illustrates the comparisons which will be made between models of purchasing and between types of general practice.

Figure 1. Models of purchasing maternity services in relation to different types of general practice

		Type of general practice (number in group)		
		Total purchasing pilot	*Fundholders*	*Special Interest*
Type of Purchaser	*HA*		5 standard fundholders	5
	General Practice	6	**5* extended fundholders**	

* 6 extended fundholding pilot practices were specified in the research brief. One subsequently pulled out and was not replaced.

The five practices with a special interest in maternity care are important to include, because it is possible that innovative practices may have other ways to influence the configuration of services than through purchasing maternity care. Since the 5 extended fundholding practices are likely to be enthusiastic about maternity care in order to have considered purchasing it, the inclusion of the special interest practices will help the research to distinguish between the impact of holding a budget and simply being enthusiastic about maternity care on the pattern of care women receive and how it is experienced.

2.2 The participating practices

The Interim Report describes the rationale for identification, and matching of practices to take part in the study in detail (Wyke *et al*, 1997). The six total purchasing pilots, 5 standard fundholders and five practices with a special interest in maternity care participating in the study as comparators for the 5 extended fundholding practices were matched, as far as possible, according to 4 principles:

1. comparison practices should not have the same principal providers of maternity services;
2. comparison practices should have similar Rural Practice Payments;
3. comparison practices should have similar Deprivation Payments;
4. comparison practices would, ideally, be in the same Region.

None of the practices use the same providers of maternity care and matched sets were achieved in all but two cases. However, getting standard fundholding practices to take part

was particularly difficult and it is important to consider the nature of the sample of practices when considering the data that has been produced about their approaches to maternity care. As we have stated, the extended fundholders can all be expected to be interested in maternity care, or they would not have volunteered to hold a budget to purchase it. The special interest practices were explicitly asked to take part in the research on the basis of their interest in maternity care. The total purchasing pilots might be expected to have at least some interest in maternity care given that they had chosen to focus on changes in this service in their first year of total purchasing (and 25 total purchasing pilots decided not to focus on maternity care). The standard fundholding practices were explicitly asked to take part because we did not expect them to take a particular interest in maternity care, but as might have been expected, some difficulty in recruiting suitable standard fundholding practices was experienced. It is likely that they had more interest in maternity care or in fundholding than other practices in the area for the very reason that they agreed to take part in the study. Therefore we are not researching a representative group of general practices, rather a group of general practices which have a particular interest in maternity care. This is an important point in considering the potential to 'roll out' the lessons we might learn from them about general practice-based purchasing or commissioning.

2.3 Data Collection

For the purposes of the overall evaluation, data are being collected from a variety of sources using a range of methods, described in detail in the Interim Report (Wyke *et al*, 1997). Data described in this paper are drawn from two parts of the study.

2.3.1 Characteristics of the practices and their approaches to influencing provision of maternity care

Descriptive data on the structure of the 21 practices and total purchasing pilots in terms of staff and their experience has been gathered through a self-completion questionnaire to practice managers or general practitioners.

Semi-structured interviews with seven key informants associated with the general practice-based purchasers and five informants associated with other practices have been interviewed between May 1996 and January 1997. Panel 1 lists the key informants interviewed at each of the practice types.

Panel 1

Key Informants at Practices Participating in the Study

Total purchasing pilots and extended fundholding Practices	**Special interest practices and standard fundholding Practices**
Lead General Practitioner for maternity care	General practitioner consenting to interview
Practice fund manager	
Trust	***Trust***
Director of Midwifery (DM) or equivalent	Director of Midwifery (DM) or equivalent
CMW associated with practice	CMW associated with practice
Obstetrician	Obstetrician
Contracts Manager	
HA	***HA***
Director of contracting or total purchasing pilot/extended fundholder lead	Director of contracting

A range of information has been elicited through these interviews, including:

- motivation for general practitioners undertaking the purchasing, or having a special interest in maternity care;
- what general practitioners hope to achieve;
- how ideas will be operationalised;
- perceived success criteria;
- perceived obstacles to success;
- views of other key informants as to the feasibility and desirability of general practice-based purchasing of maternity care;
- availability of costs and activity data;
- organisational arrangements;
- relationships between HAs, general practice or total purchasing pilot and providers;
- level of funding;
- methods by which women's views of services will be incorporated into the purchasing process;

- initial data on non-service costs in terms of the tasks and time involved in the process of negotiation of contracts;
- training needs;
- understanding of the principles of *Changing Childbirth* and methods by which these principles will be incorporated into practice.

Telephone interviews with lead general practitioners at each of the general practice-based purchasers have also been conducted and have provided an update on progress to date.

2.3.2 Contracts, planned structure of services and planned resource distribution

Participating general practitioners and their HAs were asked to send maternity contracts and service specifications for the practices' main provider. Data was extracted from these documents using a detailed proforma which covered contract format (contract type, currency, activity levels, rules for under and over trading, monitoring information requirements, penalties and incentives) and service specifications (service agreement type, aims and objectives, description of service and standards, clinical quality indicators, *Changing Childbirth* 10 indicators of success, monitoring arrangements and measures to involve local women).

Specific (local) changes to the planned structure of services to meet contract specifications (in terms of what patterns of service delivery are proposed) have been elicited through telephone interviews with directors of midwifery. Particular attention has been paid to activity at the study practices compared to the Trust's other activity, whether the practice receives more resources that other practices the Trust deals with, whether general practitioners are actively involved in care, lead professionals for high and low risk women, and whether *Changing Childbirth* objectives are being met.

3 Purchasing and providing maternity care

3.1 Characteristics of general practice-based purchasers

Most extended fundholders and total purchasing pilots participating in this study are single practice projects, although 1 extended fundholder consists of 2 practices operating as one purchaser, and 2 of the 6 participating total purchasing pilots are multi-practice projects. Although total purchasing pilots were originally envisaged as consortia of practices, in the event 27 out of 62 total purchasing pilot sites consist of a single practice* so the total purchasing pilots participating in this study are not necessarily unusual.

Table 3.1 summarises some basic characteristics of the practices taking part in the study, whilst Table 3.2 summarises some characteristics of participating total purchasing pilots in their first year of purchasing (1995/6).

Table 3.1 Practice characteristics by type of practice

	Extended fundholder[1] (6)	Total purchasing pilots[2] (6)	Special interest practice (5)	Standard fundholders (5)
Mean number of principals per practice	6.6	7.0[2]	4.4	5.0
Average list size per principal	1961	2148	1728	1937
Receive some rural practice payments	2	3	1	1
Receive some deprivation payments	1	1	2	1
Members of association for community based maternity care	2	0	5	0
General practitioners do IP care in an obstetric/General Practice/Community unit	3	3	3	1
General practitioners support home deliveries	4	3	5	2

1 One extended fundholder site includes 2 practices whose characteristics are both included here.
2 Only one practice in each total purchasing pilot completed a practice structure questionnaire (the 'maternity lead's' practice). Thus only these practices' principals were used to calculate the mean number of principals per practice.

Both extended fundholder and total purchasing pilot practices have slightly higher numbers of principals than either standard fundholder or special interest practices, whilst extended fundholding, total purchasing pilot and standard fundholding practices have slightly higher mean list size per principal than special interest practices. Extended fundholding practices are

* A number of the 53 TPP projects were multi practice projects which did not act as a single purchasing unit: rather they acted as more or less independent *sites* within the project, with separate budgets and purchasing plans. Thus the first wave TPPs included 53 *projects* but 62 *sites*.

more likely than total purchasing pilot or standard fundholding practices to show their interest in maternity care through membership of the Association for Community Based Maternity care (special interest practices were identified through the Association), but also through their support of home deliveries (4 out of 5 extended fundholders compared to 3 out of 6 total purchasing pilots and 2 out of 5 standard fundholders). However, the relatively high involvement of general practitioners in all types of practice in some form of intrapartum care (in a general practitioner unit or through supporting home births) shows that practices participating in the study are likely to have a greater interest in maternity care than other practices.

Table 3.2 Selected Total Purchasing Pilot Characteristics

	Total purchasing $pilot_1$	Total purchasing $pilot_2$	Total purchasing $pilot_3$	Total purchasing $pilot_4$	Total purchasing $pilot_5$	Total purchasing $pilot_6$
Number of practices	1	3	1	1	5	1
Number of principals	4	15	6	12	23	17
Total population	12000	27949	12310	21250	38113	33000
Service areas of focus 95/96	maternity A&E community care	maternity mental health continuing care	maternity A&E prescribing	maternity A&E mental health primary care	maternity A&E mental health community care	maternity A&E mental health primary care

The relatively limited areas of focus for the 6 total purchasing pilots in 1995/6 illustrates that total purchasing simply has the *potential* for general practices to purchase all hospital and community health services. In effect, the experience of the first year of preparation for purchasing (1995/6) showed that projects were permitted to choose which of the range of services purchased previously by the HA they wished to take on. A more appropriate term for TP at present might be 'selective purchasing' (Mays *et al*, 1997). The total purchasing pilot with 5 practices had reduced in size to 3 practices by April 1997.

3.2 Motivations for and aims of taking part in general practice-based purchasing or for special interest in maternity care

3.2.1 Early motivations and aims

During interviews with lead general practitioners, practice fund managers, directors of midwifery and community midwives associated with each of the practices participating in the study, informants were asked what were their motivations for undertaking general practice-based purchasing of maternity care, or in the case of the special interest practices, their reason for having a 'special interest'. Not surprisingly, few of the special interest practice informants could articulate motivations or aims. Their interest in maternity care was often long held, and their often active participation in the provision of maternity care (or in the support of community midwives' provision of maternity care) routine and everyday. Only one special interest practice general practitioner articulated his concern that if the practice general practitioners did not continue their support of intrapartum care in the local unit, it might close down. Thus their active participation in maternity care was motivated by a desire to support the maintenance of local people's choice of location of care.

Table 3.3 summarise the motivations and aims of informants at extended fundholding and total purchasing pilot practices for the purchasing of maternity care.

Table 3.3 Motivations and aims of general practice-based purchasers

	Number of extended fundholders (N=5)	*Number of total purchasing pilots (N=6)*
Changing Childbirth *type aims*		
To implement *Changing Childbirth*	4	4
To improve continuity of care	1	5
To support/implement team midwifery	2	
To make maternity services more responsive to women's needs	4	2
Developing contracting type aims		
To develop better contracts for maternity services	2	1
To get information on the costs of maternity care	4	2
General aims		
A 'new challenge' - the next step from standard fundholding	4	
To influence the way care is provided	1	3
To maintain/support the local general practitioner maternity unit		2
General Practitioners mentioned having little influence on maternity care prior to becoming a purchaser	4	1

The main aims of both types of general practitioner purchaser were related to *Changing Childbirth* policy. Improving continuity of care was mentioned at more of the total purchasing pilots than the extended fundholders, although this did not necessarily imply continuity between antenatal and intra partum care. At least one of the total purchasing pilots, practice-based staff were dissatisfied with team midwifery which they felt had been thrust upon them by the local Trust. The team midwifery approach was designed to try to achieve the *Changing Childbirth* indicator that 75% of women should be delivered by a midwife known to her. Practice staff felt that antenatal and postnatal continuity were being sacrificed for supposed continuity between antenatal and intra partum care (this was a common theme running throughout the interviews in relation to team midwifery, regardless of type of general practitioner practice). Staff at this total purchasing pilot were keen to 'go back' to having practice attached community midwives who at least offered women continuity antenatally and postnatally, although they would not move their contract to do so, as they were keen to support their local provider.

Informants from two of the extended fundholders and one of the total purchasing pilots mentioned their general aim of developing better contracting mechanisms for maternity care, although four of the extended fundholders were more specific, and said that one of their main aims was to develop systems to gather information to support contacting through better estimation of costs.

For extended fundholding practices taking on the purchasing of maternity care was an obvious next step from standard fundholding, and one practice at least expected to become a total purchasing pilot.

Informants at one extended fundholder and three total purchasing pilots said that their motivation was wanting to influence maternity care. All informants were also asked whether they felt that general practitioners had an influence on the way the HA purchased care or on the way the provider organised care. General practitioner-based purchasers answered this question in relation to their perceived influence now in comparison to before they purchased care. Informants from four of the five extended fundholding practices and four of the six total purchasing pilots felt that they had had no influence on care provision or purchase before becoming a purchaser. Similarly, informants at three of the five special interest practices and four of the five standard fundholding practices felt they had no influence with either the Trust on the Health Authority. Some expressed dissatisfaction with this, but some only wanted influence if they were unhappy about the services women received.

3.2.2 How had they progressed by summer 1997?

By summer 1997, when lead general practitioner purchasers and/or their fund managers were contacted by telephone to discuss progress with the pilots, progress had been made in a number of areas. Extended fundholders and total purchasing pilots who wanted to support or implement team midwifery, or who saw team midwifery, or practice attached 'group midwifery practice' as a way to achieve continuity of care, had on the whole succeeded in its implementation. Even the total purchasing pilot which had been unhappy with geographically based team midwifery had negotiated changes in team practice so that general practitioners provide more of women's antenatal care and antenatal care is provided in the practice rather than in women's homes, unless women specifically choose to have care at home.

Whether there had been progress with some of the loftier *Changing Childbirth* aims, such as increasing women's choice or providing better information is harder to assess on the basis of telephone calls with the lead general practitioners. However, one of the extended fundholding practices had developed and piloted an information leaflet about 'Choices' and two total purchasing pilots felt they had maintained choice by negotiating the continued existence of general practitioner units with the local HAs. Progress had also been made on some of the contracting type aims. Two extended fundholders and one total purchasing pilot had got all information they wanted. These and some others had costed packages of care. Two extended fundholders and two total purchasers developed more sensitive contracting, through changing contracting currency.

However, progress in other pilots seemed modest, and based on maintenance of patterns of organisation of maternity care the pilots valued. Two total purchasers were happy that their local general practice maternity units were still open and not under current threat of closure, two extended fundholders were relatively happy that team midwifery or group practice had been set up. As we discuss in more detail later, the aims and developments were locally based. Extended fundholding and total purchasing were often seen as a means to achieve a long desired end relating to service provision, and slotted into a purchasing framework. In these pilots, no progress had been made in contracting, improving efficiency, or even in changing patterns of care within the organisation they had been seeking to protect.

3.3 Characteristics of maternity care in the study practices

At the time of interviews in 1996/early 1997, all informants who were involved in providing care to women registered with the study practices were asked to describe the pattern of care women currently receive, whether this pattern had recently changed, and whether further changes were planned. Informants highlighted different aspects of the pattern of care, and from their accounts it was possible to build up a detailed picture of the pattern of care before the practices started purchasing. Thus the patterns of care described provide a baseline assessment of what it is that the practices were or were not changing from. Table 3.4 highlights two aspects of the structure of care provided and five aspects of care which might indicate whether practices and associated trusts are likely to meet some of the objectives of *Changing Childbirth*. Although the telephone interviews undertaken in Summer 1997 did not focus on patterns of care, few clear differences were apparent over the time period, emphasising that valued patterns of care were being developed over a period of time, or were being maintained, rather than being initiated by general practice purchasing.

Table 3.4 Characteristics of maternity care at each type of practice

Characteristic	Extend fundholder (N=5)	Total purchasing pilot (N=6)	Special interest practice (N=5)	Standard fundholder (N=5)
General Practitioner Unit available and used	1	2	3	0
Organisation of midwifery care				
Team midwifery	4	2	2	1
'Integrated midwifery'		1	1	
Practice-based CMWs	1	3	2	4
Continuity				
Continuity of carer between antenatal and intrapartum periods prioritised or achieved	4	4	4	1
Antenatal/Postnatal continuity achieved	1	4	5	4
Choices				
2 or more choices of place of delivery	2	4	4	0
Other choices highlighted	3	3	4	2
Care community based	5	6	5	5
Informants highlighted that antenatal care reviewed and flexible (or soon will be)	2	4	4	3
Informants highlighted that postnatal care flexible	3	4	3	1
General Practitioner routinely involved in providing care				
antenatal care	5	4	3	4
intrapartum care	1	2	5	0
Practice ***women formally consulted*** about experience of care, or consulted in the planning process	5	2	1	3

3.3.1 General practitioner units

It is clear from the table that the availability and use of a general practitioner unit for intrapartum care differs between the practices involved in the study. Three out of five of the special interest practices and two out of six of the total purchasing pilot practices used local general practitioner units for intrapartum care. Although most care at these units is

undertaken by midwives, with general practitioners unlikely to attend normal births, general practitioners do offer emergency medical care for deliveries at the Units.

3.3.2 Team or 'integrated' midwifery

It is also clear from the table that team midwifery is the most popular approach to the organisation of midwifery care at extended fundholding practices: four out of five of the extended fundholders are covered by a midwifery team, which is usually trying to achieve continuity of carer through the intrapartum period. Three of the six total purchasing pilots and three of the five special interest practices have a form of team or 'integrated' midwifery (in which midwives who are usually community or hospital based work in groups and 'take turns' in the other setting, and may be more likely therefore to have met women when they go into labour). However, there was varying satisfaction with the team midwifery approaches at these practices, with staff from one total purchasing pilot and two special interest practices critical of the way that team midwifery can act to reduce rather than enhance overall continuity of care. Midwifery care at the standard fundholding practices tended to be more 'traditional', with four out of five practices working with community midwives who offered antenatal and postnatal care to women who were usually delivered by hospital midwives, although the community midwives would always deliver home births and may offer some domino deliveries.

3.3.3 Continuity of carer

The table suggests that team midwifery is not the only way to achieve continuity of care through the intrapartum period. Four of the extended fundholding practices have either achieved, or are trying to achieve this goal, but continuity of care through antenatal and postnatal periods is perceived to be compromised. One of the total purchasing pilots on the other hand achieves continuity through antenatal, intrapartum and postnatal care through the use of a local general practitioner unit staffed by both hospital based and community midwives. Three of the special interest practices also use general practitioner units and/or community midwives attached to their practice to achieve intrapartum continuity of care. All of the special interest practices ensure that women experience continuity of care from midwives between antenatal and postnatal care. Women registered with the standard fundholding practices are less likely to have both team midwifery and continuity of care in the intrapartum period. However, most achieve continuity of care between antenatal and postnatal periods by working with practice-attached community midwives.

3.3.4 Choices and flexibility

Four of the six total purchasing pilots, and four of the five special interest practices are able to offer two or more choices for place of delivery. In the case of total purchasing pilots this is usually because of the availability of more than one hospital in which women are able to deliver. In the case of special interest practices it is usually because of the availability of the extra choice of the general practitioner unit as well as consultant unit and home birth. However, at three of the five extended fundholders, three of the six total purchasing pilots and four of the five special interest practices, staff highlighted another element of choice. For example the provision of information on which women could make informed choices about the care she would receive, or careful discussion of all of the options for care by the general practitioner or midwife. Choice was less clearly highlighted at the five standard fundholding practices in the study.

One of the impacts of *Changing Childbirth* on the provision of maternity care is clearly seen, as all of the practices in the study offered care which was primarily based in the community. However, total purchasing pilots and special interest practices were more likely than other groups of practices to have reviewed or be offering flexible patterns of antenatal care, and similarly, the extended fundholding, total purchasing pilot and special interest practices were more likely than standard fundholding practices to offer flexible postnatal care. Whereas most of the general practitioners were involved in the provision of antenatal care (the exceptions tended to be where general practitioners felt it right to leave care to community midwives, rather than lack of interest), only a few were involved in intrapartum care. Those that were tended to support general practitioner units for emergency cover, or in the case of special interest practice general practitioners to value home births as an interesting part of their work and attend most of them. At one special interest practice , the general practitioner saw himself as a midwife.

3.3.5 Listening to women's views

One of the most important aspects of *Changing Childbirth* was its emphasis on shaping services through listening to women's views, and on the importance of including local women in the purchasing process. All of the extended fundholding practices, or trusts working with them, were actively seeking women's views on care; four were using surveys of women's experience of care (in addition to the survey being undertaken for this study), whilst one was using focus group discussions to help them understand women's experiences and to help them to shape information leaflets. Only two of the six total purchasing pilots and one of the five

special interest practices and their associated trusts were actively seeking women's views, whereas three Health Authorities or Trusts working with standard fundholding practices had sought women's views on care in the recent past.

At the undertaking of the practice attached community midwife and the fund manager; one of the extended fundholding practices undertook a comprehensive survey of women's views of care before undertaking big service changes. They used financial support form the Executive to do this, and were helped by a local University. They used the report, which emphasised that women like practice-based care and that some aspects of community care were important, as the basis of a workshop with the HA and Trust and have negotiated some service change as a result.

3.4 Summary

In summary, this section has shown that the main motivations for, and aims of, general practices purchasing maternity services focused around achieving *Changing Childbirth* objectives and developing better information on which to base contracting. Some progress had been made in some areas, but was modest in others.

In terms of characteristics of maternity care, the extended fundholding practices seem to be using team midwifery approaches to care to achieve intrapartum continuity of carer, whereas the total purchasing pilots are using more varied approaches. The structure and organisation of care provided to women registered with most of the extended fundholders, total purchasing pilot and special interest practices may be likely to achieve at least some of the *Changing Childbirth* objectives; this may be less likely in the standard fundholding practices. All extended fundholding practices were actively seeking women's views of care and was the basis of service development in one; this was less likely to be the case at other types of practice.

4 How are developments brought about?

4.1 Contracting for maternity care

When this research was designed, it was assumed that provider service developments would be driven by purchasing plans, contracts and service specifications. However, developing these documents takes time, so we would have expected total purchasing pilots to be further advanced than extended fundholders, given that they had an additional year to develop their plans. An analysis of 1996/7 contracts for each of the extended fundholder and total purchasing pilot practices shows that this was indeed the case. Three of the six total purchasing pilots had maternity contracts whereas only one of the five extended fundholders had.

The fact that only four of the eleven general practice-based purchasers had maternity contracts, even though six of them were in their second purchasing cycle having been through one preparatory year, illustrates that in the early stages of purchasing maternity care the formal aspects of contract development followed, and was shaped by, service development rather than driving it. However, the processes linking service development with contracting may become two-way with time, as six of the eleven general practice-based purchasers stated their motivation to get better cost and activity information on which to base maternity contracts, and as we have seen, by summer 1997, two extended fundholders and two total purchasers had gathered sufficient information to cost services and one extended fundholder and two total purchasers had changed contract currencies.

All of the Health Authority purchasers have block or cost and volume contracts with a single provider Trust. On the other hand, two of the four purchasing general practitioner sites have (or are moving towards) cost per case contracts. This is an interesting observation which is, at first sight, counterintuitive. A cost per case contract makes it more difficult for a purchaser to predict total expenditure at the beginning of the contracting period because expenditure is ultimately determined by the actual level of activity (which is difficult to predict with certainty). However, where anticipated activity levels are relatively low, and particularly where the purchaser intends to ensure a choice of provider, a cost per case contract may be more efficient because it avoids some of the transaction costs involved in establishing indicative volumes in block or cost and volume contracts. This type of contract also has the effect of eliminating the risk that expenditures will prove to be greater than is necessary if activity is lower than anticipated.

4.2 Who and what is important in shaping developments?

Changing Childbirth promotes the independent role of the midwifery profession in the delivery of women-centred, accessible, efficient maternity care. There was real concern in policy and practice circles that general practitioners purchasing maternity care may not fully value midwives' role or the centrality of *Changing Childbirth* objectives in guiding purchasing. This might be especially the case with total purchasing pilots, as they had not been hand picked for their ability to purchase in accordance with *Changing Childbirth*. However, examination of the stated motivations of all general practitioner purchasers (see Section 3.2) shows that *Changing Childbirth* type of motivations were most prevalent. Detailed questioning of the history of the development of general practice-based purchasing of each interview respondent also made it clear that general practitioners were working in association with midwifery staff and midwifery managers in the development of their plans. Indeed, in the majority of cases the initial impetus for change had come from either trust directors of midwifery or from community midwives working with general practitioners to provide maternity care as part of the Primary Health Care Team. In a typical purchasing practice, midwives may have had plans or changes they wanted to enact in order to implement *Changing Childbirth* type objectives, and saw total purchasing pilot or extended fundholding as a means to this end. They discussed their ideas with general practitioners, and possibly with fund managers, who then became key players in subsequent developments. Discussion was initiated at a strategic level with midwifery managers and other Trust staff, and often with Health Authority staff. Thus alliances between general practice staff, trust midwifery staff, Trust management and often Health Authority management staff were forged to bring about change. These developing relationships may be an integral part of developing contracting, acting to reduce transaction costs in the longer term, but they certainly precede formal contracting as a mechanism to shape service development.

The situations in special interest practices tended to be rather different. The general practitioners involved were very supportive of, or involved in, maternity care (because of the way in which they were selected for the study). However, in most cases their involvement in service development was at practice or general practitioner unit level. They influenced care by working directly with midwives and other practitioners rather than through Trust or HA management and policy makers. In standard fundholding practices general practitioners tended to be more passive in the development of maternity care. In some cases general practitioners were happy with this situation; they felt that they could influence care if they

wanted to, but felt no need. In other cases general practitioners were less happy, and would have liked active consultation on the development of maternity services for their patients.

Table 4.1 emphasises these points by highlighting key players in the design and development of maternity care at each type of practice.

Table 4.1 Key players in designing maternity care for practice women

	Extended fundholder (N=5)	Total purchasing pilot (N=6)	Special interest practice (N=5)	Standard fundholder (N=5)
Director of Midwifery	5	3	5	5
Midwives working with General Practitioners	5	4	3	0
Obstetricians (maybe clinical directors)	0	0	0	2
General practitioners	5	5	3	0
Practice Fund Managers	2	0	0	0
HA staff	1	2	1	2

The table shows that directors of midwifery and midwives working with general practitioners were always involved in the development of services at extended fundholder practices, along with general practitioners. Similarly, directors of midwifery and midwives working with total purchasing pilots were usually involved in developments.

In special interest and standard fundholding practices the directors of midwifery saw themselves as in overall control of developments in the areas generally, and detailed interaction between general practitioners and directors of midwifery concerning the development of services was less common (indeed directors of midwifery did not interact with general practitioners in the standard fundholding practices). None of the standard fundholding general practitioners felt that they were actively involved in the design or development of maternity care in their practices.

The point that general practice-based purchasing was likely to be associated with negotiation at strategic level between Trust midwifery managers (particularly directors of midwifery) and general practitioners is further supported by Tables 4.2 and 4.3.

Table 4.2 How are changes implemented?

	Extended fundholder (N=5)	Total purchasing pilot (N=6)	Special interest practice (N=5)	Standard fundholder (N=5)
Using ***women's views*** of care to inform change	3	2	1	0
Negotiation between General Practitioners and Trust management	4	4	1	1
Negotiation between General Practitioners and Health Authority	4	4	2	0
Discussion between General Practitioners and CMWs	1	1	3	0
Discussion within the Trust	0	0	0	3
Liaison with Trust to develop ***contracting***	0	2	0	0
Through ***training*** midwives	0	0	1	2
Extra resources available	1	0	0	0
Gathering information	1	0	0	0

Table 4.2 shows that at four of the five extended fundholders and four of the six total purchasing pilots negotiation between general practitioners and Trust and between general practitioners and Health Authority staff were mentioned as ways in which changes were implemented. Discussion between general practitioners and midwives was the main way in which changes were brought about at special interest practices, whereas discussion within the Trust itself, without discussion with general practitioners or Health Authority staff, was mentioned most often at standard fundholding practices. It is worth noting that three of the five extended fundholder practices explicitly said that women's views were being used to develop services and inform change. This accords with the finding that all of the extended fundholders were actively seeking women's views on the changes they are trying to enact.

Table 4.3 Enabling factors for developing services

	Extended fundholder (N=5)	Total purchasing pilot (N=6)	Special interest practice (N=5)	Standard fundholder (N=5)
No enabling factors given	0	0	1	3
Good relationships between practice and Trust	4	6	2	2
Good relationships between practice and HA	4	4	1	0
Good relationships between General Practitioners and midwives	0	0	3	2
Enthusiasm for maternity care	2	3	2	0
Pilot Status	1	0	0	0

Table 4.3 reinforces the view that changes are brought about by joint working and co-operation between staff at different agencies at general practice-based purchasers. When asked what enabling factors there were for the development of maternity care, the majority of informants associated with extended fundholders and total purchasing pilots mentioned good relationships both between general practitioners and Trust staff and between general practitioners and Health Authority staff. This was more rarely mentioned at special interest and standard fundholding practices. At special interest practices, good relationships on the ground between general practitioners and midwives were the most frequently mentioned enabling factor, whilst three of the standard fundholders could identify no enabling factors - because they were less likely to be engaged in active change, the issue seemed less salient for them.

When we telephoned general practice-based purchasers in summer 1997, the relational rather than contracting or purchasing approach was once again stressed by respondents. In describing their views of the progress of the pilot, one lead general practitioner at an extended fundholding practice said:

> *The process has not really improved purchasing but the commissioning aspect has been very successful. We've taken the lead on changing clinical attitudes and ideas and the organisation of care.*
> lead GP, extended fundholding practice

A fund manager at an extended fundholding practice said something similar when asked what had been enabling factors in their project's development:

> *Recognition by the provider unit that they can enact change through negotiation and discussion - it wasn't necessarily due to holding the budget, we have not used the budget as a threat.*
> practice manager, extended fundholding practice

Finally, it was clear from talking to staff associated with general practitioner purchasers that their projects were being resourced through the devotion of more community midwives to provide care to women registered with them. The negotiations around this allocation of resource were explicitly described at some of the practices. Directors of Midwifery were asked whether study practices had a different ratio of midwives to women than other practices in the area, and if this was the case and the ratio was lower, who funded the extra resource provided. Table 4.4 shows that four of the five extended fundholders and four of the five total purchasing pilots (for which data are available) had more generous allocations of community midwives per patient than other practices in the area. Trusts themselves funded the extra allocation in most of the cases, usually after lengthy negotiation with the practice or total purchasing pilot. Reports of these negotiations emphasised that Trusts were prepared to invest in this way because of the pilot status of the practice to 'see if it works'. The practices may be being resourced as a 'vanguard' for change; it is typical of many pilot projects that even in constrained circumstances, they tend to attract resources. However, this means that beneficial results will be more difficult to roll-out in the absence of equal funding for service support. Considerations of equity are also important in terms of extra resources for the pilot projects. It is notable that some general practitioner purchasers explicitly mentioned concern from other local practices about equity implications as a constraining factor in their developments, and in response to questioning about working with general practitioners, some directors of Midwifery discussed the difficulty of ensuring equitable provision of services to all practices.

It should be noted that two of the special interest and two of the standard fundholder practices taking part in the study also experience more favourable ratios of midwives to women than practices in the surrounding area. In two of these cases, the directors of Midwifery reported that the practices themselves funded the midwives (possibly through fundholding budgets, though this is not clear from the Directors of Midwiferys' responses). In the case of one of the special interest practices, this was due to their negotiation with the employing Trusts. One

of the Directors of Midwifery said that she had to choose community midwives to work with the carefully, because they had to be enthusiastic and independent. Where standard fundholding practices got more resources, this was either because it was geographically isolated and midwifery care could not be shared with local practices or because the practice was participating in a pilot of team midwifery.

Table 4.4 Resources for developing service - number of study practices having a lower ratio of women to midwives compared to other practices in area?

	Extended fundholder (N=5)	Total purchasing pilot (N=5)[1]	Special interest practice (N=5)	Standard fundholder (N=5)
Study practices have ***lower ratio of women to midwives*** than other practices in area	4	4	2	2
Funding through:				
Trust	2	4	1	1
Practice	1	0	1	1
Part HA, part Practice	1			

[1] Data only available from 5 total purchasing pilots

4.3 Summary

This section has shown that contracting for maternity care is not far advanced amongst many of the general practice-based purchasers; contracts are following service development, informed by the gathering of better information, rather than driving change itself.

It has also shown that the developments are often midwifery led, and motivated by a desire to achieve *Changing Childbirth* objectives. The opportunity to purchase care was often used as a catalyst for changes already planned or desired by staff, and acted as an impetus to detailed negotiation at strategic management level between Trust management and midwives, general practitioners and Health Authority staff. This meeting and negotiation was associated with, and may have resulted in, good relationships between those involved.

At special interest and standard fundholding practices change was usually brought about at practice rather than at strategic level, and standard fundholding general practitioners were more likely to be enforced or willingly passive participants in the development of maternity

care. Thus general practice-based purchasing is associated with the active participation, at a strategic level, of general practitioners in the design and development of maternity care.

General practitioner purchasers' projects were being resourced through the devotion of more community midwives per women than other practices in the area. This has equity implications and implications for roll-out of beneficial results in the absence of further funding for service support.

The particular confluence of factors seen in general practitioner purchasers: the potential for general practitioners to purchasing maternity care; community midwives or directors of midwifery with plans for change; enthusiastic fundholding general practitioners with an interest in maternity care; support from Trust and Health Authority management; and resources to develop services, may be more difficult to achieve in other areas.

5 Conclusions

This paper has drawn on the interim report of the general practice-based purchasing of maternity care to present preliminary findings about general practitioners motivations and aims for purchasing or having a special interest in maternity care and described some ways in which changes in maternity care are brought about.

5.1 Selection of the study sites

In assessing these preliminary findings it is important to bear in mind that all of the 21 practices taking part in the study are likely to be particularly interested in maternity care, in general practitioner fundholding, or in both. The extended fundholder practices were selected on the basis of their likely ability to purchase in accordance with the principles of *Changing Childbirth*. The total purchasing pilot practices must have some interest in maternity care as they selected it as an area in which to focus their efforts as total purchasers; this interest was subsequently confirmed when it became clear that they were motivated by a desire to implement *Changing Childbirth's* recommendations. The special interest practices were explicitly chosen because of their interest in maternity care, whilst difficulty in recruiting standard fundholding practices means that the five who did agree to take part are likely to be more interested in maternity care and fundholding than other similar practices. This means that it is particularly important to consider the local circumstances in which general practices were purchasing maternity care in assessing the potential to 'roll-out' this approach to service development. Its success cannot be assumed in less favourable circumstances and with less interested general practitioners.

5.2 National policy versus cost effectiveness as motivating factors

Preliminary assessment of the data on reasons why general practitioners decided to take part in the pilots of purchasing maternity care made it clear that most of the practices were motivated by a desire to achieve the objectives of *Changing Childbirth*. This would be expected of the extended fundholder practices who were chosen as pilot sites on the basis of their ability to purchase according to *Changing Childbirth*, but was also true for total purchasing pilots. This means that initial concern in policy and professional circles that general practitioners purchasing maternity care might not fully value midwives' role, or the centrality of *Changing Childbirth* objectives in guiding purchasing, may have been unfounded. General practitioners at purchasing projects were aware of the policies and objectives outlined in *Changing Childbirth*, and wholly supportive of the kind of services they would develop for their patients. Considerations of cost, efficiency or cost-effectiveness of local services were not mentioned when general practitioner purchasers discussed either their motivations to purchase maternity care or the service developments they were planning. This suggests that *Changing*

Childbirth's philosophy and prescription for service development was a stronger influence on general practice-based purchasers than the identification of problems in the local delivery of services. A key issue in this evaluation will be to examine which type of purchaser gets furthest in implementing the national strategy outlined in *Changing Childbirth*.

5.3 Provider dominance and the midwifery agenda

Changing Childbirth promotes the independent role of the midwifery profession in the delivery of women-centred, accessible and efficient maternity care. It is a powerful document which has been enthusiastically taken up by midwives and their managers throughout the country. It is interesting that much of the impetus for taking part in the purchasing pilots came from midwifery staff - both community midwives and directors of midwifery - who saw total purchasing pilot or extended fundholder as a vehicle through which *Changing Childbirth* type service changes could be driven. This means that changes in general practice involvement in planning and purchasing services was *initially* dominated by the providers of care rather than by general practice itself (although the general practitioners became enthusiastic supporters of change). New alliances were forged between community midwifery and primary care which resulted in pressure on other areas of the Trust management and on local Health Authorities to invest in the pilot sites to develop services in the way the midwifery profession wanted. Without the enthusiasm of local midwifery staff and their managers to work with general practitioners the pilots may not have been initiated and may not have developed as quickly. This is an important point in considering the potential of devolved commissioning of maternity care. It may not be successful without the enthusiasm of midwifery staff and/or managers.

5.4 Resources for care

Most general practice purchaser's plans for maternity care received more generous resources for delivering care (in terms of the ratio of community midwives to women) than other practices in their local area. This was financed from Trust resources (presumably to the detriment of other practices) or through extra funds from the Health Authority. In only one case was the practice part funding the extra resource from its own budget. Although it is very common for pilot projects, even in constrained circumstances, to attract resources, this point is worth considering for its implication for the equitable provision of maternity care and because of the potential to 'roll-out' the model in the absence of equal funding for service support. Where extra investment in community based care in a few practices side by side traditional care, costs savings are unlikely due to diseconomies of scale. These diseconomies may be removed if similar investment is made across the board at the same time as disinvestment from

hospital based care (McCourt and Page, 1996) (although change on this scale might be very difficult to implement).

5.5 General practice-based contracting for maternity care

It is clear that developing a contracting process takes longer than anticipated. Indeed, in the area of maternity care, service developments seem to precede and drive contracting in maternity care rather than the other way round. This may be partly because information requirements are a problem for general practitioner purchasers, who because they are exposed to greater risk in terms of fluctuating numbers of pregnancies within the practice, need more detailed information than Health Authorities, and need to reduce the transaction costs of contracting. Some of the general practitioner based purchasers were motivated by a desire to gain better information for maternity contracting, which will help Health Authority contracting in the long term as well. This is partly because there is a feeling that existing maternity contracts focus resources in hospital rather than in community based care, and that more resources should shift to the community in order to fund *Changing Childbirth* type initiatives. Early contract analysis, and experience with standard fundholding, suggests that contracts, if continued to be developed, would become more sophisticated in time, this was indeed the case with one extended fundholder and two total purchasing pilots having changed contract currency, and two total purchasers had made savings on their maternity budget by summer 1997.

5.6 Listening to women's views

A key feature of *Changing Childbirth* is that women should be involved in the planning and monitoring of maternity services and the recent Audit Commission report (Audit Commission, 1997) on maternity care charges service commissioners (in that case Health Authorities) with the responsibility to investigate local women's views and use them to shape local services. All of the extended fundholder practices were actively seeking women's participation in planning services through undertaking surveys of their views, or through discussion groups, with a view to using this information to reconsider service planning and provision; one had made great progress in doing so. It is difficult to ascertain whether this feature of good practice is down to their enthusiasm for maternity care (shared by the special interest practices) or to their purchaser status (shared by the total purchasing pilots). Neither the special interest nor the total purchasing pilot practices were as likely to be involved in actively seeking local women's views. It is possible that the extended fundholders' high activity in this area is down to their pilot status, that hey were hand picked to purchase according to *Changing Childbirth* aims by NHSE staff, and to the funding of local evaluations through the NHSE. If so, this has important implications for the ways in which devolved commissioning organisations may seek

to incorporate women's views. As is the case with continuing and community care (Myles *et al*, 1998), we cannot automatically expect general practitioners to be aware of the importance of seeking women's views on service plans without strong policy endorsement and guidance.

5.7 Purchasing and general practitioners' participation in planning care

Both extended fundholder and total purchasing pilot general practitioners were more likely to be involved at a strategic level in planning maternity services than general practitioners in special interest or standard fundholding practices, who more often had a passive or no role in the planning of services. As we have seen, this active participation may have been initiated by midwifery staff, but it meant that general practitioners and fund managers held regular meetings with directors of midwifery and community midwives in particular, and often with clinical directors or Trust contract managers. The regular meetings often brought an atmosphere of trust; it became clear to Trust staff that general practitioners were motivated by a desire to achieve *Changing Childbirth* objectives and practice-based staff began to understand the difficulties faced by Trusts in the provision of high quality services in the face of shrinking resources. Health Authority staff were also often involved in these meetings, and partnerships developed between general practice, Trusts and Health Authorities, which are likely to facilitate the pilot projects' success.

Since few of the extended fundholders or total purchasing pilots are actively contracting for maternity care, it may not be the **actual** purchasing that is important in developing general practitioners' participation and encouraging Trust and Health Authority staff to listen to them, but the **ability** to purchase, even at some point in the future. This is another important issue to consider in the light of plans for devolved commissioning. Without incentives to discuss service plans with general practitioners the productive alliances between Trust and primary care staff seen in this study may not develop.

The particular confluence of factors present in most of the general practice purchasing sites (the perceived ability to purchase, enthusiastic midwifery staff, the ability to negotiate extra resources, general practitioners enthusiastic for maternity care and for fundholding) may have resulted in an ability for general practitioners to influence the strategic development of the organisation of care, or to ask for detailed information on which future purchasing could be based. The potential ability to purchase may have catalysed change and ensured that Trust management met with and listened to, general practice and other community staff (community midwives in particular). Without exception, general practitioners wanted to be involved in the

planning of maternity care for their patients. The Audit Commission also recommend that general practitioners should be involved in developing strategy and in improving the effectiveness of clinical care (1997). Whether their active participation results in services which are more likely to be effective and efficient will become clear as this evaluation progresses.

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