King's Fund

National Evaluation of Total Purchasing Pilot Projects Working Paper

Contracting by total purchasing pilot projects 1997 - 1998

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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

1 85717 249 3

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

Further copies of this report can be obtained 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 Research and Development Centre at Manchester, Salford and York Universities, together with researchers from the Universities of Edinburgh, Bristol, Southampton, York and Birmingham; the London School of Hygiene and Tropical Medicine; and the London School of Economics and Political Science. More information about the evaluation as a whole is available from: Gill Malbon, King's Fund, 11-13 Cavendish Square, London W1M 0AN.

Acknowledgements

The national evaluation of total purchasing pilots is funded by the Department of Health in England and the Scottish Office Department of Health. The views expressed in this report are those of the researchers involved and not those of the two Health Departments.

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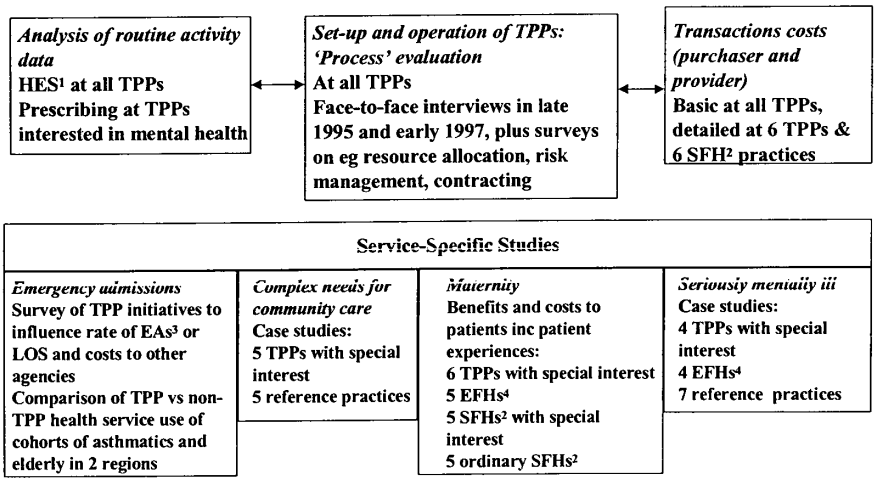
Preface: The National Evaluation of Total Purchasing Pilot Projects

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

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

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



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

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

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

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King's Fund, London
January 1999

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

Title and Authors	*ISBN*
Main Reports	
Nicholas Mays, Nick Goodwin, Gwyn Bevan, Sally Wyke on behalf of the Total Purchasing National Evaluation Team (1997). *Total purchasing: a profile of the national pilot projects*	1 85717 138 1
Nicholas Mays, Nick Goodwin, Amanda Killoran, Gill Malbon on behalf of the Total Purchasing National Evaluation Team (1998). *Total purchasing: a step towards primary care groups*	1 85717 187 X
Working Papers	
The interim report of the evaluation, *Total purchasing: a step towards primary care groups*, is supported by a series of more detailed Working Papers available during the first half of 1998, as follows:	
Nicholas Mays, Nick Goodwin, Gill Malbon, Brenda Leese, Ann Mahon, Sally Wyke *What were the achievements of total purchasing pilots in their first year and how can they be explained?*	1 85717 188 8
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An analysis of the transactions costs of total purchasing pilots. Final report

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Contracting by total purchasing pilot projects 1997-98

1. INTRODUCTION

1.1 Background

In a previous Working Paper we reported the results of a survey of the contracting arrangements of the 53 first-wave total purchasing pilot (TPP) projects during 1996-97 (Robinson, Robison and Raftery, 1998). In this working paper we report the results of a follow-up survey carried out for the 1997-98 contracting round.

1.2 Scope and methodology of the 1997-98 study

The 1997-98 study was designed to take account of what had been learned from the 1996-97 survey. The TPPs were placed in one of two broad categories - those who had some independent contracts in 1996-97 and would, presumably be developing these in 1997-98; and those who for a variety of reasons had not contracted independently in 1996-97 and might or might not be going on to do so in 1997-98. As we had a clearer idea about the topics of interest and the likely range of responses to our questions than we had at the design stage of the 1996-97 survey, we decided to use a semi-structured postal questionnaire to collect basic data, in preference to a telephone interview survey, allowing for the possibility of some follow up work on a selective basis. A separate questionnaire was designed for each of the two categories of TPPs and each questionnaire was piloted with one TPP.

By this time the Scottish sites were excluded from the scope of the project, as were the four sites that had formally withdrawn from total purchasing, whilst one multi practice TPP was excluded because it was operating as four separate sites and was not able to provide data on a comparable basis to the other sites. This gave us 45 first wave sites for the 1997-98 study.

We requested information from the 45 sites as follows:
Questionnaires were mailed to

- 17 (38%) in group 1 (NO independent contracts last year)
- 28 (62%) in group 2 (SOME independent contracts last year)

The 45 questionnaires were mailed in December 1997 and a reminder letter was sent to 19 non-responders, immediately following the specified return date of 16 January 1998. After follow-up telephone calls to non-responders, the following response rates were achieved:

- 13/17 (76%) in group 1 (no independent contracts in 1996-97)
- 26/28 (93%) in group 2 (some independent contracts in 1996-97)
- 39/45 (87%) overall

The design of the survey questionnaires was closely structured, to request details of contracts and also to elicit details of the experience or opinions of respondents regarding aspects of the contracting process. Most questions offered precoded response options which were developed with the benefit of the experience of the 1996-97 interviews which had necessarily been more exploratory in nature. Respondents were invited to elaborate or comment where applicable. The quantitative data have been analysed using the computer software package SPSS. Qualitative data, comprising respondents additional written comments, have been analysed by grouping them according to identified themes.

1.3 Scope for comparative analysis using the 1996-97 and 1997-98 data sets

The main purpose of this paper is to report on the findings of the 1997-98 survey, focusing on TPPs with independent contracts but also examining the circumstances of those who have not contracted independently. The intention, however, is to examine how contracting has developed in the second year of TPP rather than to present a straightforward snapshot of the position at one point in time. Interpretation and presentation of the 1997-98 data therefore frequently requires reference to the 1996-97 data.

The 1996-97 data set on which our previous analysis took place comprised 45 TPPs. Although the 1997-98 survey was conceived as follow-up to the 1996-97 survey, the two sets of data do not derive from identical TPPs. The 1997-98 data set is smaller, consisting of 39 cases. Attrition, resulting from the exclusion of the Scottish sites and from non-response in the second year, is partly offset, however, by the appearance in 1997-98 of three TPPs for whom data were either excluded from analysis or not available in 1996-7. Thirty six TPPs appear in both sets of data. In the remainder of the paper - when comparative analysis of two sets of data is necessary - we have endeavoured to identify and focus on selected groups of TPPs as appropriate.

2. OVERVIEW OF INDEPENDENT CONTRACTS

2.1 How many TPPs contracted independently in 1997-98?

In 1997-98 27/39 (69%) TPPs had one or more independent contracts. Table 1 shows that there were three TPPs who had independent contracts for the first time in 1997-98 and two who had contracted independently in 1996-97 but were no longer doing so in 1997-98. (The circumstances and experience of those TPPs without independent contracts will be discussed in a later section of this report.)

Table 1 TPPS contracting independently in 1996-97 and 1997-98

'Any independent contracts?'	some in 1997-98	none in 1997-98	*total*
some in 1996-97	24	2	26
none in 1996-97	3	10	13
Total	27	12	**39**

2.2 TPPs new to independent contracting in 1997-98

It was a somewhat unexpected finding of the 1996-97 contracting survey that a significant minority (38%) of TPPs had not fulfilled what seemed to be the *raison d'etre* of total purchasing by taking advantage of the freedom to contract independently. We had not expected that individual TPPs would be contracting independently for *all* services within the scope of the total fund; 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 and would also depend on their readiness to contract independently. We had expected, however, that most, if not all TPPs, would have made plans during their preparatory year to *'go live'*, by contracting independently for some services at least.

In an attempt to identify general TPP characteristics that might have been associated with the decision to contract independently in 1996-97, we examined site size, organisational complexity and length of experience with fundholding. On the basis of these findings, our tentative conclusion was that single practice sites with less complex organisational structures (and, presumably, fewer problems of inter practice coordination) 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. At the same time we drew attention to other findings from the study which suggested that whilst a few TPPs had *chosen* to contract jointly with their HA as their preferred model, the reasons why many TPPs did *not* contract independently were often perceived as being beyond their control, e.g. HA opposition.

When interviewed for the 1996-7 survey, mid way through the contracting year, respondents from TPPs who had not contracted independently varied in their intentions and predictions for the following year. The survey findings suggested that, in order to 'catch up' in 1997-98 with others who had started to contract independently in 1996-97, these TPPs would need a strong commitment to the principle of holding and spending a budget in order to achieve the necessary organisational development and/or overcome active resistance from the HA.

Of 13 TPPs taking part in the 1997-98 survey, who had *not* had independent contracts in 1996-97, only three had moved to independent contracting in 1997-98. Box 1 sets out details of the circumstances of these TPPs in 1996-97; their stated intentions at that time for 1997-98; and the actual outcome in 1997-98.

In case one, the TPP had encountered considerable HA opposition in the face of their own determination and apparent self confidence. The TPP proceeded to negotiate an extensive range of independent contracts in 1997-98, but was hampered by problems with the budget allocation process and quite heavily constrained by restrictions imposed by the HA on the scope and style of their contracting.

In case two, the TPP also faced HA opposition in 1996-97, which served to compound the TPPs own doubts about their readiness to engage in the contracting process. Budget setting was also problematic and unresolved mid way through the financial year. A subsequent change of heart by both parties meant that the TPP proceeded to contract independently in 1997-98, albeit with some regrets that they could not make up for the lost time within the timescale of the project.

In case three, the TPP had felt unprepared for independent contracting in 1996-97, recognising the need to improve collaboration between the practices. The HA, although not apparently particularly supportive, was not perceived in this case to be obstructive to the ambitions of the TPP and the TPP was able to proceed to contract independently in 1997-98.

Details of the contracts and the experience of these three TPPs, contracting independently for the first time in 1997-98 will be identified and discussed separately, where relevant, in the following sections of this report.

Box 1 TPPs who started to contract independently in 1997-98

Circumstances in 1996-97	Intentions for 1997-98	Circumstances in 1997-98
Case one (ref CD) two practices, no pioneer fundholders, complex organisational structure		
All contracts as subsets of HA contracts (2 HAs) . Had wished to contract separately but *'not allowed'* by HA. Budget allocation was problematic - due to the *'complexity of disentanglement and the tardiness of the accountants'* -over the course of the year had 6 different budget figures on system. TPP had no involvement with 1996-97 contract negotiations - HA didn't permit. During 95-96 TPP asked to join formal contract monitoring meetings with provider - but HA excluded them and continued to do so in 1996-97. TPP reported huge problems with data from providers - set up their own tracking systems in areas where they wished to make service developments. Expressed the belief that they were managing to develop services through positive relations with the Trusts, in spite of being excluded from the contracting process.	TPP stated wish to contract separately - anticipated that they *'may have a fight'* to do so. Determined to view the right to the whole budget and stated intention to have contracts with main providers.	Achieved independent contracts with 3 main local providers of acute, community and mental health services and 11 cost per case contracts for acute services from other providers. However, had a major problem with TP budget allocation and were heavily constrained by HA(s) e.g. obliged by HA to enter into block contracts for main providers against wishes ; not permitted to contract for certain services; and blocked in attempts to move providers.
Case two (ref CC) four practices; includes pioneer fundholder, intermediate organisational complexity		
TP manager appointed in Sept 95 and project intended to go live for 1996-97. TPP found HA obstructive and GPs had concerns re the TP contracting process. Had expected that TP contracting would be similar to GPFH - with prices and budgets in advance BUT perceived that the HA simply gave money back to providers for agreed levels of activity leaving providers to work out prices to fit the budget (- *'retrospective rather than prospective purchasing'*). TPP *'had cold feet'* so agreed not to go live in 1996-97 but 'shadowed' the HA contracts to gather data to inform contracting for 1997-98. TPP budget not agreed before Dec 1996. Tried to manage their ECR budget. Received some activity data from providers but not patient specific. Set up independent contract monitoring system.	Believed that HA attitude was changing and becoming supportive. Stated intention to go live in 1997-98 and have contracts with main providers. Expected some areas to be blocked back to HA. Practices were also planning to have one contract for GPFH in 1997-98.	Achieved independent contracts with 3 main local providers of acute, community and mental health services but contracted jointly with more peripheral providers. Regret the years delay in going live - had they done so they could have *'moved forward'* in 1997-98 with other providers.
Case three* (ref BG) six practices, one pioneer fundholder, complex organisational structure		
TPP opted for joint contracting with 5 main providers in 1996-97 because it was *'too late to get involved'* in independent contracting at the beginning of the year. Increased collaboration and integration between the practices was a main priority for the project. The HA was not seen as particularly supportive. Had HA contracts for regional services and A&E (*'didn't want to take the risk'*) Also 'blocked back' the ECR budget but monitored the small amount of activity.	Unclear from interview data but purchasing intentions suggested that 'joint' purchasing would continue in spirit of 'locality commissioning.'	Achieved independent contracts with 4 main local providers of acute, community and mental health services.

*** Contract survey data is supplemented by information derived from core evaluation interviews with the site manager**

2.3 Independent contracts and services covered

In the 1997-98 survey respondents were asked to list their independent contracts, noting in each case the name of the provider; whether the contract had been signed off by 31/10/97; the broad categories of services covered; and the contract value for each of the service categories and/or for the contract as a whole.

The 1997-98 survey found that 27 TPPs had between 2 and 17 independent contracts; the total number of contracts was 154 - the mean was 5.7. Two TPPs noted that, in addition to the contracts they itemised, they had an unspecified number of small cost per case contracts with various providers.

As Table 2 shows, straightforward acute contracts dominated in 1997-98, accounting for 59% of the total, although TPPs were also contracting for a range of other services including nursing home, hospice and intermediate care services, as well as community and mental health services.

Table 2 Overall numbers of independent contracts by service type for 1997-98

Services covered:	(N= 27 TPPs)
Acute Services	92
Mental Health Services	14
Community Services	12
Combination - Mental Health / Community	11
Combination – Acute / Community	4
Combination – Acute / Mental Health	2
Combination – Acute / Community/ M. Health	3
Ambulance Services	2
Nursing Home	7
Hospice	2
Other e.g. intermediate care services	5
Column total	155

Some idea of the change in number and service type of independent contracts between 1996-97 to 1997-98 can be obtained by examining the data for 23 TPPs who had independent contracts *and* took part in the contracting surveys in both years. For these 23 TPPs a

comparison between the two data sets suggests that the range has narrowed with a small increase in the overall number of contracts (see Tables 3 and 4).

Table 3	**Number of independent contracts held – comparison between 1996-97 and 1997-98 (summary statistics)** *N=23 TPPs where two sets of data are available*	
	1996-97	1997-98
Range	1-22	2-17
Sum	121	126
Mean	5.26	5.48

Comparison of the grouped frequency distributions shows a decrease in the number of TPPs having between one and three contracts with a corresponding increase in the number having between four and nine contracts.

Table 4	**Number of independent contracts held - comparison between 1996-97 and 1997-98** *N=23 TPPs where two sets of data are available*	
number of contracts	No.TPPs in 1996-97	No TPPs in 1997-98
1-3	11	7
4-6	9	11
7-9	-	2
10-12	1	1
13+	2	2
total	23	23

A comparison of the data at the level of individual TPPs shows that ten TPPs reported contracting with exactly the same number of providers in 1997-98, whilst eight appear to show a net increase and five a net decrease in the number of contracts they held.

Some understanding of the nature of these changes may be derived from Table 5 which shows the overall numbers of contracts by service type in both 1996-97 and 1997-98. On the face of it this table suggests a decrease in the number of straightforward acute contracts and an increase in the number of contracts for non- acute services, including community, nursing home, hospice and intermediate care.

Scrutiny of the raw questionnaire data for individual TPPs sheds further light on this change. In most cases where TPPs showed an apparent increase in the number of contracts held, it was possible to identify that they had actually taken on new independent contracts in accordance with their service objectives. The new contracts for nursing home, hospice and intermediate care signify that TPPs made progress in achieving increased provision of community based care for their patients. Two TPPs started to contract independently for community/mental health services in 1997-98 and three for acute services from specialist providers. As an example of the latter, one TPP signed cost and volume contracts with four acute Trusts for small volumes of activity that they had purchased in 1996-97 on an ECR or cost per case basis.

The apparent decrease in the number of acute contracts held by several TPPs seems to stem from inconsistent reporting. For example, one TPP reported having 22 contracts in 1996-97, most of which were for acute services, yet itemised only 5 contracts in the 1997-98 survey, noting that it purchased additional services to a value of under £200,000 on an ECR or cost per case basis without specifying a number of cost per case contracts. In other words, the apparent reduction in number of acute contracts does not for the most part seem to mean that TPPs have ceased to purchase from particular providers.

Table 5 Overall numbers of contracts by service type - comparison between 1996-97 and 1997-98
N=23 TPPs where two sets of data are available

Services covered:	1996-97	1997-98
Acute Services	83	71
Mental Health Services	11	11
Community Services	11	13
Combination - Mental Health / Community	7	8
Combination - Acute / Community	1	4
Combination - Acute / Mental Health	2	2
Combination - Acute / Community/ M. Health	2	2
Ambulance Services	1	2
Nursing Home	3	7
Hospice	0	2
Other e.g. intermediate care	0	3
Column total	121	125

2.4 The total value of contracts

In the 1997-98 survey respondents were asked to list all contracts identifying the value of each (with a breakdown of separate values for different types of services where relevant). The total contract spend for individual TPPs in 1997-98 ranged from £1,284,000 to £15,741,000. As Table 6 shows the value was between £1million and £3 million in 50% cases. The total value of all independent contracts held by the 26 TPPs with independent contracts was £126,097,531.

Table 6 Total value of TPP contracts in 1997-98
N=26 TPPs*

total contract spend	*no. of TPPs*
£1-2 million	5
£2-3 million	8
£3-4 million	2
£4-5 million	3
£5-6 million	1
£6-7 million	2
over £7 million	5
Total	26

** data missing in one case where TPP did not supply information.*
Note: One TPP had all joint TPP/GPFH contracts and cited only the overall value for each contract. The figure for total contract spend included in this tabulation was derived from an additional document supplied by the TPP. Three TPPs provided details of the values of all contracts with the exception of a small number of cost per case contracts. The figure for total contract spend included in this tabulation does not take account of this anticipated cost per case expenditure.

3. TPP MAIN CONTRACTS FOR ACUTE SERVICES

3.1 How successful was last years main independent acute contract?

We were able to investigate how successful contracting had been for 24 respondents. who had contracted independently with their main acute provider in 1996-97. The general picture is a positive one with 20/24 (83%) rating the contract as an overall success. A more detailed assessment of contract performance was elicited by asking respondents if specific outcomes had been achieved. The data reveal that, whilst each these outcomes was said to have been achieved in the majority of cases (where it was deemed relevant), for a significant minority things did not turn out as expected (see Table 7).

Table 7 How successful was last years main independent acute contract?

N=24 TPP respondents in 1997-98 survey who had contract in 1996-97	Yes	no	n/a to TPP	total
activity as predicted	16	8	-	24
unit costs as predicted	21	2	-	23*
cost savings as predicted	12	7	4	23*
Service quality improved	14	5	3	22*
Successful in other respects**	5	-	19	24
Successful overall	20	4	-	24

**response to this item omitted by respondent(s)*

Note. The five respondents who noted 'other' ** ways in which the 1996-97 contract with main acute provider was successful mentioned: significant improvements in the quality of information obtained from the Trust; development of trust between provider and the project; improved dialogue with the Trust with more clinical input (but tempered by inability of Trust staff to accept that financial resources are finite); good management of the risk of over activity; and the value of the learning experience.

3.2 The value of the main acute contract

The 1996-97 survey established that the main acute contract is an important part of the TPP's contracting business. For all but two of the 27 TPPs with independent contracts for acute services in 1996-97 the main contract was said to represent more than 50% of the TPP's spending on acute services. The importance of the main contract, thus established, was seen to justify our *a priori* decision to concentrate on this contract on the grounds that it often dominates contracting activity.

In 1997-98 the value of the main acute contracts ranged from £420,000 to £6,700,000 with a total value of £52,610,000 and a mean value of £2,391,363, (data for 22 out of 26 cases).

One TPP had a contract with an integrated trust which also included acute mental health services, and had a higher value, by a considerable margin, at £11,700,000. The distribution of acute contract values is shown in Table 8.

Table 8 Value for main acute contract 1997-98

Value of contract	No. of TPPs (N=26)
Up to £1 million	4
£1-2 million	8
£2-3 million	6
£3-4 million	0
£4-5 million	1
£5-6 million	2
over £6 million	1
total	22**

** *Data missing in 4 cases*
Case 1 - TPP gave no contract values
Case 2 - TPP gave value for combined TPP and GPFH contract
Cases 3&4 - Contract with integrated trust - value for acute services was not identified.

As TPPs had provided details of the values of all 1997-98 contracts it was possible to compute the value of the main acute contract as a percentage of total acute contract expenditure. This reveals that, as in 1996-97, for all but two of the TPPs the main contract represented more than 50% of the TPP's spending on acute services. In fact in 11 (50%) cases the main acute contract represented more than 90% of the TPPs spending on acute services and in six (27%) cases the TPP's main acute contract was their only acute contract which therefore represented 100% of acute spending.

3.3 Characteristics of main acute contracts.

In the 1996-97 survey 27 TPPs who were contracting independently with their main acute provider gave details of contract type, currency and specifications. Respondents were also asked to comment on the extent to which the 1996-97 TPP contract specifications differed from those in previous HA contracts. The intention was to gauge how far the TPP contract had been based on the previous host purchaser contract and to identify any particular differences or innovations in the TPP contract. Fifteen respondents indicated that the TPP contract was *largely based* on the HA contract. Ten suggested that the TPP contract was *significantly different from* the HA contract while two did not comment.

In the 1997-98 survey, 23 TPPs, who were contracting independently with the same main acute provider for the second year, supplied details of changes or additions that had been made to the contract. All but two TPPs recorded at least one change. The remaining 21 TPPs reported making between one and eight changes to the contract.

Table 9 provides an overview of the numbers of TPPs reporting changes or additions in relation to specified contract features. Each of these features is discussed in more detail below in light of two years' data.

Table 9 Changes made to TPPs main independent acute contract for 1997-98?	
Item	Number of TPPs (N=23 TPPs)
change in contract type	3
FINANCE	
change in contract currency	5
Arrangements for pricing under/over runs	4
penalties associated with information requirements	2
penalties associated with quality standards	1
prices (excluding inflation)	6
inflation adjustment	5
ACTIVITY	
projected levels	11
Management of admissions	7
Management of discharge	7
Accounting for length of stay	6
additional services	5
SERVICE SPECIFICATIONS	
Service quality standards	3
Use of clinical guidelines/protocols	5
Information requirements	4
Clinical audit requirements	4
Total changes reported	78

3.3.1 Contract Type

In 1996-97 respondents were asked to indicate the contract type of their main acute contract by reference to definitions supplied in the interview guide. Table 10 shows that TPPs opted

for a variety of contract types with sophisticated block being the most popular. This pattern reflects a similar pattern found in an earlier study of HA contracting.

Table 10 Main TPP contracts for acute services by type (in 1996-97)	
Type	TPPs
Simple block	4
Sophisticated block	10
Cost and volume	5
Cost per case	1
Combination	7
	27

The seven contracts described as *'combinations'* comprised a number of sub-contracts of different types . In these cases the TPP appeared to be contracting differentially for certain services according to perceptions of risk as in the example given in Table 11.

Table 11 Example of 'combination contract' (in 1996-97)	
Contract types	*Services included*
Simple block	A&E General surgery Non-elective admissions
Cost and Volume	Maternity
Cost per case	General medicine Care of the elderly

In 1997-98 three TPPs reported changes to the contract type. One had changed from sophisticated block to cost and volume; the second had made changes to the composition of a 'combination' contract to comprise fewer cost per case elements and more sophisticated blocks; whilst the third reported that TPP and GPFH activity was included in a single cash limited contract with agreement to manage waiting lists. In the second of these examples, it seems that the TPP had experimented with cost per case purchasing for some high cost low volume elective activity in 1996-97 but had concluded that the potential saving did not justify the additional cost in terms of managing the activity.

3.3.2 Finance - contract currencies

In the 1996-97 survey respondents were asked how activity was measured for the purposes of establishing the contract value. In particular, they were asked for details of contract currencies used and prompted to indicate whether there was any differentiation according to length of stay. The data are summarised in Table 12 which shows that the most common practice was for the value to be based on Finished Consultant Episodes (FCEs) at average specialty costs.

Table 12 Measurement of activity in main acute contracts (in 1996-97)

	% contracts to which this applies:				
	for all specialties	for most specialties	for some specialties	not at all	N
Value based on FCEs at average specialty cost	59%	26%	15%	-	27
Value based on FCEs at HRG cost	4%	4%	4%	88%	27
Differentiation according to length of stay	-	-	32%	68%	25*
Day cases separately specified	32%	8%	20%	37%	25*
Use of other contract currencies	-	-	22%	78%	27

**Data missing in 2 cases*

Specialties mentioned as examples of those where the contract value was based on HRGs were cardiology, rheumatology, surgical specialties and burns plastic surgery (where the main acute provider was a regional centre.). The specialties most frequently mentioned as examples of those in which there was differentiation by length of stay were general medicine and care of the elderly. Examples of 'other' contract currencies used in the main acute contract were attendances for A&E; admissions for geriatrics; and births or deliveries for maternity.

A number of respondents to the 1996-97 survey commented that they had hoped to move away from contracting on the basis of FCEs, echoing sentiments and intentions expressed in 1996-97 purchasing intentions documents but that their expectations had not been fulfilled. Whilst some respondents perceived that Trusts were reluctant to accommodate their wishes, others pointed out that was a lot of work involved and were more optimistic that changes would be made in the future.

In 1997-98 five (22%) TPPs reported a change in contract currency. Whilst, somewhat unexpectedly, one TPP was reverting to *more* use of the FCE and less use of *'cost per day'*,

four had made a change to a more refined contract currency, each in a different way. The four cases were: a change from FCEs to *'cost per delivery'* in obstetrics; a change to HRGs in *'some specialties'*; a change from *'cycles of treatment'* to *'individual patients treated'* for fertility treatment; and a change from FCE to *'per diem'* rate for medicine and care of the elderly'.

Two respondents noted that they had sought to change from FCEs to LOS costings in some specialties but had still not succeeded. In one further case a bed day rate was to be run in parallel to the FCE rate in the specialties of GP medicine and elderly care in order to assess the benefits of change.

3.3.3 Activity and cost variances specified in contracts

With *sophisticated block* contracts purchasers paid providers a fixed contract sum for access to a defined range of services or facilities. Indicative patient activity levels were included as well as agreed mechanisms if targets were exceeded. Thus sophisticated block contracts specified variances which triggered action. In the 1996-97 survey, the activity variances or tolerance limits specified in TPP main acute contracts which are of this type were found to range from 0 to 5%. In the majority of cases over performance beyond the margin of tolerance was said to trigger payment at agreed marginal costs up to an agreed ceiling;

With *cost and volume* contracts purchasers did not purchase fixed volumes but developed 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. The 1996-97 survey found that the five TPPs with main acute contracts of this type had agreed a variety of arrangements for paying for activity beyond the fixed contract baseline.

In the 1997-98 survey four TPPs indicated that their arrangements had changed. One TPP had agreed an absolute cash limit for the 1997-98 contract so that there would in effect be no payment for excess activity. In another case the TPP noted that, for 1997-98, the costs of activity above contract were negotiated when the contract was set whereas in 1996-97 they had agreed 80% of the contract sum and monitored bed days for final agreement on the remaining 20%.

3.3.4 Penalties associated with information requirements

The 1996-97 survey found that one third of TPPs with independent main acute contracts had secured an agreement that an element of payment was dependent upon compliance with information requirements or quality standards specified in the contract. In most of these cases the TPP could withhold some or all payment if clinical letters and/or discharge summaries

were not received, although not all of the TPPs concerned expected to invoke the penalty. It was not clear whether the principal concern was to validate activity data or improve clinical practice; respondents comments tended to give emphasis to the former. The comments made by respondents from TPPs whose contracts did *not* include such financial penalties revealed a range of views about the desirability of such arrangements, varying degrees of success in attempts to negotiate them with providers and some different intentions for the future.

Three TPPs reported changes to their contract for 1997-98 with respect to financial penalties. One TPP, that was concerned in 1996-97 to validate the accuracy of data from a provider who would *'not allow'* financial penalties, had succeeded in inserting a penalty clause in the 1997-98 contract stating that payment would be witheld for lack of information on attendances at A&E. In contrast, the other two TPPs had *removed* penalties for non provision of clinical information from their 1997-98 contracts. In one case, having achieved the desired improvement in information provision through rigorously invoking the penalty, the requirement for timely clinical discharge letters had become a quality standard without penalties. In the second case the TPP agreed to remove the penalty for 1997-98 due to the Trust's difficult financial situation.

3.3.5 Prices

Six TPPs noted that there had been a change to their main acute contract associated with prices (excluding inflation), and five noted a change associated with an inflation adjustment, which varied from 2% - 2.73% where specified. Five respondents gave details of the price related changes they had noted. In one case all prices had simply risen above inflation, but in the remaining four cases there had been either been changes to the provider's price structure, for example *'recosting of emergency/elective work which resulted in a significant hike in emergency prices'(ref EE)* , or refining of pricing, for example *'price changed to reflect change in case mix' (ref AH)* or *'HRG outliers priced on a daily banding'(ref DC).*[1]

3.3.6 Activity - projected levels

Just over 50% (11/23) TPPs reported that they made adjustments to activity levels for their 97-8 main acute contract. Nine gave details of the adjustments (both upwards and downwards for different types of activity) which were typically said to have been made to match or more closely emulate the 1996-97 outturn. In two cases the change was made in anticipation of service developments that were expected to impact on activity levels, such as the introduction

[1]When the survey respondent's own words are used to illustrate a point, we cite a reference number for the TPP concerned, which has been anonymised to preserve confidentiality.

of an intermediate care service and an initiative to increase admissions to GP beds. In one case a reduction in activity levels had been necessary to offset a price rise above inflation.

3.3.7 Management of admissions and discharge

The management of admissions and discharges are closely related and have been the focus of service developments initiated by a number of TPPs. Seven TPPs noted that a change or addition had been made to their 1997-98 main acute contract in relation to the management of admissions and seven noted a change in relation to the management of discharge.There was considerable overlap with six TPPs noting a change or addition in both categories.

As far as admissions were concerned, there was one case where there had been a switch of some acute geriatric admissions to GP managed beds, and in two cases the TPPs had set up 'avoidance of admissions schemes', one of which involved the use of observation beds in A&E. Two TPPs reported the appointment of 'liaison staff' whose role encompassed the management of admissions in addition to taking a proactive role with respect to discharge; one TPP reported a new requirement for a weekly list of hospital admissions; and one TPP described having helped to set up a medical assessment unit. In an apparently similar case one TPP noted *no change* to the contract but commented - *'medical assessment unit is open ; part of ongoing dialogue, not part of contracting' (ref AH).*

In relation to the management of discharges, six of the seven TPPs noting a change in this respect referred to initiatives, variously described as *coordinating* or *promoting* early discharge through the activity of additional members of staff. In five of these cases the initiatives had previously been noted in the 1996-97 survey and had presumably developed in 1997-98. One respondent, for example, noted - *'arrangements for early transfer of appropriate patients to community hospital for rehab care have tightened' (ref EE).* The sixth of the seven TPPs noted that work had been done to establish the *need* for a discharge coordinator. It is not clear if such a response can justifiably be counted as a contract alteration. In apparently similar circumstances, another TPP noted that there had been *no change* to the contract but commented that a joint survey of discharge had been undertaken *'as part of ongoing dialogue with the provider' (ref AH).*

3.3.8 Accounting for length of stay

A notable feature of TPP initiatives to promote early discharge from acute hospital to home or to community based care has been a quest for a means of releasing the resources from the acute contract to fund the alternative services. A number of TPPs have sought to change, within an activity related contract, from FCEs to a length of stay sensitive contract currency, in the hope of making financial savings when length of stay is reduced. The 1996-97 survey

found, however, that some TPPs were unsuccesssful in attempts to change contract currency owing to reluctance on the part of providers who perceived the threat to their income as an unacceptable financial risk.

One of the six TPPs, recording a change to their main acute contract for 1997-98 in relation to accounting for length of stay, had succeeded, in 1996-97, in contracting for general medicine and elderly care on the basis of occupied bed days at varying daily rates, whilst employing a liaison nurse to promote early discharge to home or nursing home beds. This TPP noted that in their 1997-98 contract there had been price adjustments on daily costs.

Another TPP, whose lead GP had in 1996 bemoaned failure to move away from FCEs, noted a change to a *per diem* currency in 1997-98 in the specialties of elderly care and general medicine, linked to the TPP intitiative of employing a nurse and clinical assistant to monitor lengths of stay, manage admission and discharge pro-actively, in liaison with primary health care teams and local authority social services departments.

We have noted that some TPPs were unsuccesssful in attempts to change contract currency in 1996-97 and that such a change continued to elude them in 1997-98. One respondent commented *'We are still working on this issue. The Trust is most reluctant to release funds for work transferred to primary care'(ref EE).* Nevertheless some TPPs persisted in their attempts to achieve more flexibility in contracts and it seems that, in certain cases, providers were prepared to make concessions or to consider the possibility of doing so in the future. One TPP reported that their main acute provider had agreed to limited discounts for patients discharged early; another had been discussing the possibility of a retrospective discount in recognition of reduction in LOS; and two reported that whilst the contract was based on FCEs, a bed day rate was also being used on a shadow basis to provide information about the implications of making such a change in the future.

3.3.9 Additional services

Five TPPs noted that they were purchasing additional services from their main acute provider in 1997-98. In three cases the TPP was investing additional resources to expand the scope of services already included in their contract with their main provider. The first was investing in a specialist cardiology nurse whilst in the second case the list of expanded services included *'investment in adult mental health services; a second consultant cardiologist; additional neurology sessions; cancer services; a second chest physician' (ref ED).* In the third case the TPP was extending the range of service associated with the day hospital to include domiciliary occupational therapy. The remaining two TPPs noting the purchase of additional services in 1997-98 had taken over the independent purchase of services which they had formerly purchased jointly with the health authority. In one case maternity services and clinical audit had been added to the independent contract with their main acute provider and

in the second case the services concerned were direct access to endoscopy, echo cardiography and ambulatory blood pressure testing.

3.3.10 Quality standards, clinical guidelines and protocols

Three TPPs noted a change to their contract in relation to quality standards. Two referred in a general way to revision of existing standards but did not note specific areas or aspects of clinical care. The third case involved increased monitoring of quality of obstetric care.

Five TPPs reported a change associated with the use of clinical guidelines or protocols. Three of these referred to joint projects between primary and secondary care clinicians to develop protocols, in relation to, for example, prescribing and cancer treatment.

3.3.11 Information requirements

Four TPPs noted a change to their contract information requirements. In one case the change related to the format of the contract minimum data set and a new requirement for the information to be provided on disc rather than on paper. In the remaining three cases the new information requirements were clearly linked to issues of service development and to activity management of priority to the TPPs concerned. The first required more information in relation to A&E activity; the second had asked for information on emergency admissions to be faxed daily and length-of-stay analysis to be supplied. The third required a weekly list of hospital admissions. One further TPP noted *no change* to the contract but commented that there was ongoing dialogue addressing information issues as they arise.

3.3.12 Clinical audit requirements

The 1996-97 survey found that there was typically a broad requirement in a TPP contract that the provider should undertake a programme of audit with reference to local HA guidelines or strategy. There were few references to specific TPP priority issues. In the 1997-98 survey, four TPPs noted a change or addition to their main acute contract in this respect. In one case, the TPP noted that the change had been *'as per the host HA' (ref EB)* but in the remaining three cases, the audit requirement was linked to the TPPs service development initiatives and priorities. Two TPPs had instigated an audit of emergency admissions, which in one case also encompassed the work of staff employed to manage admission and discharges, and the third TPP had initiated an audit of care of patients with fractured neck of femur and myocardial infarction against evidence based protocols. One further TPP noted that there had been no change to the contract but commented that there was an audit programme which had been jointly agreed with the HA and Trust in relation to nutrition of elderly people and joint replacements.

3.4 Comment on the development of contracting

As we pointed out earlier, all but two TPPs reported at least one change to their main acute contract for 1997-98 and four TPPs had made as many as seven or eight changes. Not every change stemmed from a TPP initiative; alterations to prices, for example, were outside the TPPs control. In other cases the change represented the TPPs reaction to such external factors; for example, significant price rises meant that several TPPs had to respond by reducing activity levels; and in other cases the TPP responded to providers' concerns or financial difficulties by removing financial penalties that had previously been inserted in the contract. Such changes suggest a capacity to respond appropriately to external factors. Some TPPs purchased additional services in 1997-98 indicating increased confidence, and, by adjusting activity levels and refining information requirements, TPPs also demonstrated that they had learned from the experience of the previous year.

Two brief examples (given in Box 2) illustrate, at the level of individual TPPs, how contract changes reflected a balance of TPP initiative and response to external factors, and also how TPPs built on the experience of the 1996-97. These TPPs were amongst those reporting more than five changes to their main acute contract. Data from the contracting surveys are supplemented by data from interviews with representatives of the acute trusts conducted in summer 1997 and updated by reference to data from interviews conducted in summer 1998 as part of the third year core evaluation. These two TPPs share a common interest in influencing discharge from the acute hospital and developing community based intermediate care, but the contract changes they report are not solely related to these areas.

Box 2 Examples of development in contracting
Example one: (Ref EE) four practices, 35,400 patient population. This TPP had an interest in the development of rehabilitation services based at the community hospital, an initiative which involved promoting early discharge and hence reducing length of stay in the acute hospital. The new service was funded in 1996-97 from TPP growth money and a contribution from the community trust, but the TPP was to fund it in full in 1997-98. Hence the TPP had a strong desire to change contract currency from FCEs to reflect reduction in LOS and to secure release of funds to invest in community contract.
The 1996-97 contract was described by the TPP as significantly different from previous HA contract in terms of information requirements and quality standards- informed by their experience as standard fundholders. The trust representative described those changes as *'minor tinkering'* emphasising the similarities in terms of indicative baseline activity and prices paid. Another change involved the TPP switching from the block contract, historically favoured by the HA, to purchase maternity services on a cost per case basis, in order to get an accurate picture of activity levels to inform future budget setting. Non-fundholding elective activity was also purchased on a cost per case basis.

The 1997-98 contract incorporated several changes. Having obtained information and in order to reduce the administrative load, the TPP reverted to a sophisticated block contract for some of the activity they had purchased on a cost per case basis; they reduced baseline emergency activity levels in line with previous years outturn; and they *'tightened'* their standards for waiting times, information requirements, and arrangements for the transfer of appropriate patients to rehabilitation. At the same time the trusts financial situation led to significant price increases in some areas and the need to remove financial penalties associated with quality standards. The TPP reported with regret that they were still working on a change to length of stay costings in some specialties but found the Trust reluctant to release funds for work transferred to the community sector. The Trust agreed however to investigate the costing structure and the possibility of giving a retrospective discount to reflect the savings that might be accrued when patients are discharged early. The TPP was satisfied that their service objectives were reflected satisfactorily in the contract for 1997-98 and perceived the contract as a very important mechanism for achieving their objectives. Speaking of this TPP as *'a unique pilot'*, the Trust representative described their approach to contracting and administration as excellent, being *'high level, simplistic and built on trust'*, and said he would recommend this approach to all purchasers.
Core evaluation interviews conducted in summer 1998 found that major difficulties had continued in negotiating LOS sensitive contracts. The TPP continues to pay both the acute trust and the community trust per admission regardless of length of stay. When a patient transfers to the community hospital for rehabilitation there is a small rebate from the acute trust but essentially the TPP pays twice. This *double charging* is perceived as a major barrier to developing the scheme. Resolution would require both trusts to revise their system wide pricing structures.

Example two: (ref EH) eight practices, patient population 81,000.
This TPP had a strong interest in the development of intermediate care services associated with admission avoidance, active discharge planning and reduced length of stay in the acute hospital. A scheme started in early 1997.
The 1996-97 contract was described by the TPP as largely based on the previous HA contract. There were separate invoicing arrangements but it was considered appropriate that all other standards were as the host purchaser contract. It was not considered necessary to incorporate agreements to service changes into contracts.

The 1997-98 contract incorporated several changes. For the first time TP and GP fundholding activity was included in a single cash limited contract with an agreement to manage waiting lists. In the view of the Trust representative, the TPP had risen well to the challenge of purchasing the range of emergency as well as elective services, by recognising that for emergency activity to be sustained it is sometimes appropriate to reduce elective activity. As the provider's prices rose by more than inflation it was necessary to offset this by reducing activity. There was no change to contract currency - the Trust expressed concerns that contracting for bed days could have a destabilising effect on their income-but for the first time the contract was allowing a rebate for patients discharged early. Otherwise the intermediate care/discharge planning scheme was funded using growth money and from the HCHS acute service budget through capping expenditure of the acute unit.
Whilst the TPP acknowledged that it benefited from the budgetary leverage associated with independent contracting (core evaluation interviews - Summer 1998), they maintained the view that a contract formalises service developments that have been agreed and is not in itself the important mechanism for achieving change.

3.5 Were service objectives for 1997-98 adequately reflected in contracts?

Nineteen TPPs (73%) contracting independently for acute services said that their service objectives were adequately reflected in contracts. This included the three TPPs contracting independently with their main acute provider for the first time in 1997-98. Four TPPs considered that their service objectives were not adequately reflected in contracts, while one TPP said that some, but not all, objectives were adequately reflected in contracts. Two TPPs said that the question was not relevant as contracts were not used to achieve service objectives. One explained that *'...dialogue for service delivery and quality continues all year- contracts are used to agree finance and activity.' (ref AH)*

Supporting comments (given in Box 3) provide examples of the ways in which TPPs felt their service objectives had been reflected in contracts.

Box 3 Examples of service objectives adequately reflected.....

'Our main concern was risk management and discharge - both issues were covered satisfactorily' (ref BE)
'Contract activity was more accurate with early transfer of patients occurring more readily' (ref CI)
' We were able to secure threatened service from acute trust by providing financial support' (ref EG)
'Yes - developments were introduced in maternity services' (ref AG)

(All respondents contracting for the second time)

As for the four TPPs who considered that their service objectives had not been adequately reflected in contracts, it was clear that they had been frustrated in their desire to change to a method of determining the contract value which was sensitive to activity variations, such as admissions and length of stay. This would have increased the potential of the TPP to control the flow of resources in accordance with their priorities (see Box 4).

Box 4 Examples of service objectives not adequately reflected....

'We need to move from FCE currency. No progress can be made until this happens' (ref EI)
'Unable to realise savings through reductions in length of stay achieved by discharge nurses.' (ref AG)

(All respondents contracting for the second time)

3.6 Contract monitoring - TPP views on the adequacy of provider data

In the 1996-97 survey TPPs were asked if they experienced any inadequacies in the quality of the data on activity and costs that they received from their main acute provider. At that time, 17 (63%) TPPs with independent main acute contracts said that there were currently inadequacies in the quality of data from the acute provider. It was noted, however, that 11 (41%) commented spontaneously that the data quality had improved recently. These comprised four who currently regarded the quality of data as adequate and seven who said that inadequacies persisted despite the improvements.

The 17 TPPs who reported inadequacies with data in 1996-97 identified a total of 42 different problems in six different categories, as shown in the following table. Table 13 shows that the main problems in 1996-97 were with *activity* data, and that respondents were particularly concerned about the quality of the data with regard to coverage and accuracy.

Table 13 Problems with quality of data from main provider by type in 1996-97

	% TPPs who mentioned (n=17)
Problems with ***activity data*** in relation to :	
Coverage	59%
Timeliness	41%
Accuracy	71%
Problems with ***costs data*** in relation to:	
Coverage	18%
Timeliness	12%
Accuracy	47%

Comments made by respondents in the 1996-97 survey revealed differences in the way that they perceived the consequences of data inadequacies, depending on the purpose to which it was to be put. Thus, in the 1997-98 survey respondents were asked to rate the adequacy of the data they received from the main acute provider for different contract monitoring purposes. Table 14 presents the data for the 26 TPPs with an independent main acute contract in 1997-98. This group of 26 TPPs comprises 23 TPPs contracting independently with their main acute provider for the second time in 1997-98 and three contracting independently for the first time. The table presents the data for the whole group and also (in parentheses) the data for the subset of three TPPs with independent contract for the first time.

The data suggest that improvements, which were noted to be underway during 1996-97, continued into 1997-98, so that only a small number of TPPs were experiencing major difficulties with monitoring activity and expenditure. It seems that the quality of data on activity and costs improved as a result of widespread investment by HAs and Trusts in the development of information systems, in response to the demands of TPPs, as the pioneers of primary care based purchasing, seeking the information they needed to manage activity and costs.

Table 14 TPP rating of the adequacy of data from the main acute provider for contract monitoring purposes in 1997-98
(N=26 TPPs)

	totally adequate	largely adequate	Largely inadequate	totally inadequate	*row total*
For monitoring activity	7 *(-)*	17 *(3)*	2 *(-)*	- *(-)*	26 *(3)*
For monitoring expenditure	7 *(-)*	15 *(2)*	3 *(1)*	1 *(-)*	26 *(3)*
For monitoring service quality	3 *(-)*	10 *(1)*	7 *(1)*	6 *(1)*	26 *(3)*

In contrast almost 50 % respondents regarded the routinely supplied data as inadequate for the purpose of monitoring service quality. It might be argued that the data supplied was not specifically intended for this purpose - and that service quality could more appropriately be monitored through other means, such as clinical audit or through TPP led evaluations of specific service developments. At the same time, it needs to be emphasised that, if primary care based purchasers are in future to be less preoccupied with counting activity and more concerned with the characteristics and quality of service provided, then there will need to be even more investment in information systems to cope with their changing information needs.

3.7 TPPs contracting for acute services for the first time in 1997-98

The 1997-98 survey was designed to treat TPPs that were contracting independently for the first time separately from those who were contracting independently for the second time. The questionnaire requested details of the new independent contracts, comparable to those obtained via the 1996-97 survey about 'first time' independent TPP contracts with main acute providers .

As we reported earlier the survey found that three TPPs started to contract independently in 1997-98. Some details of the general circumstances of these three TPPs have been presented in Box 1. Turning attention now to their main acute contracts, Box 5 summarises the 1997-

98 contract details. The table sets these data alongside any information that was provided in the course of the 1996-97 survey about the joint or HA contract that existed then, and the plans or aspirations for the future expressed by TPP respondents at the time.

All three TPPs succeeded in agreeing an independent contract which, in their opinion, adequately accommodated and reflected their service objectives. In two cases the TPPs reported experiencing no problems agreeing the contract although they did not achieve the changes they had hoped for with respect to contract currency. In one case the TPP maintained a separate sub contract for maternity services - initiated in the context of the previous years joint contract - to facilitate service developments in that area. All three had established systems for monitoring contract activity during the non-live year- in one case in the context of serious inadequacies with available data - and were continuing to do so in 1997-98. They all rated the quality of data received as largely adequate for monitoring activity in 1997-98 but were divided in their views about its adequacy for monitoring expenditure and service quality.

The fact that only three TPPs started contracting independently for acute services in 1997-98 compared to a much larger group of 27 TPPs in 1996-97 restricts the scope for comparative analysis but, nevertheless, some observations may be made. Two of the three new TPP contracts were sophisticated block contracts, in common with the majority of TPP contracts for acute services in both 1996-97 and 1997-98. The arrangements for managing activity and cost variances within the contracts were similar: indicative patient activity levels were specified and a tolerance range of up to five per cent of indicative volume was allowed beyond which additional activity tended to be priced on an agreed marginal cost basis, up to a specified ceiling. The third contract was an example of the 'combination' type identified in the 1996-97 survey as the choice of seven TPPs (see Table 11). Whilst in the case of the newly contracting TPP, this particular contract was a combination of two blocks, rather than a mix of contract types, the arrangement fulfilled a similar function in that it facilitated a selective focus on a particular service area. Two of the three TPPs hoped to adopt a length-of-stay sensitive contract currency. However, in common with many TPPs in both their first and second year of independent contracting, they failed to achieve this aim.

Assessment by these three TPPs of the quality of data from the main provider is similar to that of other independently contracting TPPs in 1997-98. Whilst all three were satisfied with the adequacy of data for the purposes of monitoring activity, one reported problems with monitoring expenditure and two rated the data as inadequate for the purpose of monitoring service quality. Overall, it seems clear that the quality of data has improved generally in the NHS, in response to the demands of purchasers as well as in specific areas where TPPs have made particular demands.

Box 5 TPPs contracting with their main acute provider for the first time in 1997-98	
Case One (ref CC) four practices **1996-97** No independent contracts so shadowed HA contract with main acute provider – budget approx £5m. HA contract was sophisticated block with FCE prices based on average specialty costs. TPP planned to have independent cost and volume contract for 1997-98, holding back a % for contingency with marginal cost payment for over activity. Believed that issue of contract currency was *'open to discussion'* but difficult to negotiate. Set up independent contract monitoring system, gathering referral data from practices + activity data from providers on monthly basis . TPP hoped to be able to incorporate GPFH in 1997-98 contract.	**1997-98** Agreed independent sophisticated block contract with main acute provider - value of £2,581,000. No problems noted re. negotiation. Contract based on FCEs at average specialty cost for most specialties + attendances for A&E. Contract schedule distinguished elective and non-elective activity in some specialties. Contract did *not* differ from previous years HA contract with regard to information requirements; quality standards; management of admission or discharge; or clinical management through protocols etc. TPP satisfied that service objectives were reflected satisfactorily in the contract. Financial and activity ceilings applied with threshold of + or - 5%. Over/under performance measured with marginal costs. Quality of data rated as largely adequate for monitoring activity and expenditure and largely inadequate for monitoring service quality.
Case two (ref CD) two practices **1996-97** No independent contracts so operated as a subset of HA cost and volume contract with TPP activity treated and monitored as a block (i.e. HA responsible for managing activity). Generally no TPP involvement in contract negotiations or service specification but had separate sub-contract for maternity with service specification, expected activity and value. Quality of data *'absolutely dreadful'* – with problems disentangling TP activity from GPFH and HA activity, so set up own systems for tracking patients to guide planning decisions in priority areas.	**1997-98** TPP proceeded to contract independently with main local acute provider (value £1,721,287). All acute services in block contract. Maternity services in separate block with additional pressures payments. List of contract exceptions agreed and paid for on 'case by case' basis. Contract based on FCEs at average specialty cost for all specialties except for maternity where value was equivalent to cost of midwives. Contract schedule distinguished elective and non-elective activity in all specialties and activity also split by two HAs. TPP introduced new information requirements (named patient detail) and protocols for maternity services but contract did not differ from previous years HA contract with regard to quality standards or management of admission or discharge. TPP satisfied that service objectives have been reflected satisfactorily in the contract, but finance aspect of contract negotiation proved hugely problematic due to budget setting pressures. TPP monitored activity/cost as if it were cost per case contract for discussion at quarterly contract meetings. Quality of data rated as largely adequate for monitoring activity; largely inadequate for monitoring expenditure and totally inadequate for monitoring service quality.

Case Three (ref BG) six practices **1996-97** No independent contracts so contracted jointly with HA with main acute provider. Intended to move to independent contracts in 1997-98 . Contract value for TPP was £6.5m . Cost and volume contract based on average specialty cost for all specialties; TPP expressed wish to have Length-of-stay sensitive contract in future. Quality of data from provider and TPP facility to interrogate this was rated as satisfactory.	**1997-98** TPP proceeded to contract independently with main local acute provider. No problems noted re contract negotiation. Sophisticated block contract based on FCEs at HRG cost. TPP contract value did not take account of LOS but TPP still hoping that contract may be set on LOS in 1998-99. TPP contract differed from 1996-97 joint contract as it included TPP information requirements (with linked financial penalties) and quality standards with clinical management influenced by joint work between TPP and provider clinicians. TPP satisfied that service objectives have been reflected satisfactorily in the contract with developments linked to specifications. TPP monitors activity closely and hold monthly meetings to assess position and manage fluctuations. Outside threshold of +or- 5% of target payment negotiated at marginal cost. Quality of data rated as largely adequate for monitoring activity, expenditure and service quality.

4. TPP CONTRACTS FOR COMMUNITY AND MENTAL HEALTH SERVICES

The 1997-98 survey found (see Table 15) that 25 of the 39 respondent TPPs (64%) had an independent contract for community services which was either a straightforward contract with a community trust or a component of a contract with a combined trust. (In ten of the 25 cases, the particular contract identified by the TPP as the main independent contract for community services was with a combined trust and was also identified as the TPPs main contract for mental health services.) Of the 14 TPPs without an independent contract for community services, five were actively co-purchasing with their HA, whilst in the remaining nine cases the HA contracted on behalf of the TPP.

Table 15 TPP contracting for community services in 1997-98

Contracting arrangement:	N and (%) TPPs	
Independent TPP contract	25	(64)
Joint contract with HA	5	(13)
HA contracted on TPP behalf	9	(23)
Total	39	100

The group of 25 TPPs with an independent contract for community services comprised : 20 TPPs contracting for community services for their second time in 1997-98 ; three TPPs new to contracting for community services in 1997-98 having held no independent contracts at all in 1996-97; and two TPPs new to contracting for community services in 1997-98 whilst having held independent contracts for other types of services in 1996-97.

Only 13 of 25 TPPs contracting independently for community services in 1997-98 were able to give a discrete contract value for community services. The values given by these 13 TPPs ranged from £300,000 to £2,808,000. As Table 16 shows, the value was less than £1 million in 70% cases. When considering these values, it is important to bear in mind that there are considerable variations in the range of services provided by 'community' trusts: contracts may cover in-patient (e.g. community hospital) as well as community services and so wide variations in contract value are to be expected.

Table 16 Value of TPP contracts for community services 1997-98	
	TPPs N=13
up to £500,000	5
£500,0001 - £1,000,000	4
£1,000,001 - £2,000,000	3
£2,000,001 - £3,000,000	1

In the case of mental health services, the 1997-98 survey found that 23 of the 39 respondent TPPs (59%) had independent contracts which were either a straightforward contract with a mental health trust or a component of a contract with a combined trust (see Table 17).

Table 17 TPP contracting for mental health services in 1997-98		
Contracting arrangement:	N and (%) TPPs	
Independent TPP contract	23	(59)
Joint contract with HA	4	(10)
HA has contracted on TPP behalf	12	(31)
Total	39	100

The group of 23 TPPs with an independent contract comprised: 19 TPPs contracting for mental health services for their second time in 1997-98; three TPPs new to contracting for mental health services in 1997-98 having held no independent contracts in 1996-97; and one TPPs new to contracting for mental health services in 1997-98 whilst having held independent contracts for other types of services in 1996-97.

Of the 15 TPPs without an independent contract, four were actively co-purchasing with their HA, whilst in the remaining twelve cases the HA contracted on behalf of the TPP.

Only 12 of 23 TPPs contracting independently for mental health services in 1997-98 were able to give a discrete main contract value for mental health services. The values given by these 12 TPPs ranged from £138,000 to £1,066,392, with a value of less than £500,000 in 9 cases (see Table 18).

Table 18 Value of TPP Contracts for mental health services 1997-98	
	TPPs N=12
up to £250,000	4
£250,0001 - £500,000	5
£500,0001 - £1,000,000	2
£1,000,001 - £2,000,000	1

Six TPPs gave the overall value of a contract covering a combination of community and mental health services, without identifying the separate values for the component services. In these cases the value ranged from £900,000 to £3,800,000 with 50% having a value of less than £1,000,000.

4.1 Changes made to contracts for 1997-98

The 1996-97 survey found that the majority of contracts for community and mental health services were either simple block contracts or were described as 'combinations' comprising a number of sub- contracts of different types . The combination typically contained a cost & volume and/ or cost per case element for specific services, such as in- patient mental health, with the remaining elements in a simple block contract.

The majority of mental health services which come within the scope of the total fund are provided in secondary care. Hence most contracts were based on FCEs or occupied bed days with the latter being used in more than half the contracts. Similarly , with community services, contracts for in patient activity in GP beds or community hospitals showed a preference for use of occupied bed days rather than FCEs as contract currency.

Patient contacts or attendances were found to be the most commonly used currencies for community services; attendances were also used as contract currency for mental health outpatient or day care.

Most TPPs reported that they were experiencing some difficulty in monitoring their contracts for community services in 1996-97. At that time 78% of TPPs with an independent contract for community services, were either receiving no data at all from the provider (13%) or identified inadequacies in the quality of the data (65%). Coverage was the most significant problem referred to by 80% of those respondents who identified inadequacies in the data. Moreover, concerns about the accuracy of the data were voiced by 59% of respondents who

identified problems. In addition, respondents voiced concerns about their ability to purchase effectively and promote service developments through the vehicle of a simple block contract which was largely based on a meaningless currency (contacts) and with little accurate information about the nature and quality of service provided. At the same time, TPPs revealed an awareness of the difficulties faced by community providers in recording and supplying meaningful information and also expressed some optimism that investment in new information systems would produce improvements for the medium term future if not in the short term.

In contrast, only a minority of TPPs (33%) identified data quality as a concern in relation to mental health services in 1996-97. Respondents were more likely to be preoccupied with operational issues, such as problems of poor communication between professionals or the challenge of developing locality community based mental health services.

TPPs contracting independently for community/mental health services for the second time in 1997-98 were asked to indicate if they had made any changes to their main contracts for these services. Fourteen of the 20 TPPs contracting for community services for a second time noted between one and eight changes to the contract and 14 of the 19 TPPs contracting for a second time for mental health services noted between one and twelve changes. The numbers of TPPs noting each type of change presented in Table 19.

Few TPPs provided detailed information on the nature of the changes that had been made although some information was forthcoming. One TPP reported that they had increased the number of community services which were included in their contract with the community trust for 1997-98. They had decided to include learning disability and school nursing services - which had previously been blocked back to the HA - to enable them to obtain information about activity etc on a patient specific basis. The HA was unable to do this.

A second TPP reported a series of changes to their main contract for both community and mental health service with a combined provider. The changes related to the cost and volume element of the contract for the purchase of in-patient mental health services, based on occupied bed days. In 1996-97 the TPP had noted inaccuracies in the provider data and suspected over counting of activity because patients had been wrongly ascribed to the TPP. It also expressed concerns about the rigidity of the provider view, with psychiatrists wielding power and resisting change. In 1997-98 the TPP revised the contract with projected activity levels adjusted downwards and with revised marginal rates to be paid for additional activity. In addition, the TPP reported that there had also been a revision in arrangements for referral to a second consultant.

The three TPPs who noted the greatest number of changes (either seven or eight) in their contracts for community services were actively involved in initiatives to develop services at their local/community hospital, as an alternative to acute hospital care, and especially in the case of rehabilitation. At the same time they were seeking to influence the throughput of patients in both sectors through the intervention of a discharge liaison nurse and use of nursing home beds.

Table 19 Changes made to community and mental health contracts for 1997-98
data for TPPs contracting for the second time in 1997-98

Item	*Community N=20 TPPs*	*Mental health* N=19 TPPs
Change to contract type	4	6
FINANCE		
Change in contract currency	3	2
arrangements for pricing under/over runs	6	6
penalties associated with information requirements	2	3
penalties associated with quality standards	1	2
prices (excluding inflation)	4	3
inflation adjustment	3	3
ACTIVITY		
projected levels	7	7
management of admissions	3	4
management of discharge	5	3
accounting for length of stay	4	3
Additional services	2	3
SERVICE SPECIFICATIONS		
Service quality standards	2	4
Use of clinical guidelines/protocols	4	4
Information requirements	4	3
Clinical audit requirements	1	0
OTHER	1	2

4.2 Were service objectives for 1997-98 adequately reflected in contracts?

In the case of community services, eighteen (72%) of the 25 TPPs contracting independently said that their service objectives were adequately reflected in contracts. This number included four of the five TPPs contracting independently with their main community provider for the first time in 1997-98. Four TPPs considered that their service objectives were not adequately reflected in contracts. One TPP said that some but not all objectives were adequately reflected in contracts. Two TPPs said that the question was not relevant as contracts were not used to achieve service objectives. One explained that *'...dialogue for service delivery and quality continues all year- contracts are used to agree finance and activity.' (ref AH)*

Some explanatory comments revealed that the service objectives that TPPs had succeeded in addressing in their second round of independent contracting ranged from securing increased provision of one minor service to making a radical change by switching provider (see Box 6)

Box 6 Comments and examples where 'service objectives adequately reflected.....'

'Additional chiropodist secured.' (ref BE)
'Improvement to the primary health care team has been enabled by the TPP contract with greater use of the community hospital.' (ref CJ)
'We don't generally use contracts to achieve service objectives but for 1997-98 we tendered all services (£2m per annum x 3 years)' (ref EH)

(TPPs contracting for the second time in 1997-98)

The comments made by those TPPs who felt that their service objectives had not been adequately reflected in their contracts revealed that inadequacies with provider data, identified in the 1996-97 survey, persisted in relation to community services in 1997-98 and that this was still regarded as an obstacle to service development by some TPPs (see Box 7).

Box 7 Comments and examples where 'service objectives not adequately reflected...'

'Development of health park at local community hospital remains an important objective.' (ref AE)
'Data remains patchy' (ref DB)
'We failed to achieve improved contract monitoring data - still addressing this.' (ref EB)

(TPPs contracting for the second time in 1997-98)

As far as mental health services were concerned, fourteen (61%) of the 23 TPPs contracting independently for mental health services said that their service objectives were adequately reflected in contracts. This included two of the four TPPs contracting independently with their main mental health provider for the first time in 1997-98. Seven TPPs considered that their service objectives were not adequately reflected in contracts; another TPP said that the question was not relevant as contracts were not used to achieve service objectives; and one TPP did not respond directly to the question but noted that the Trust had been *'incentivised'* as a result of *'taking on the management of mental health ECRs and potential savings'.*

Only one TPP (contracting for mental health services for the second time in 1997-98) gave precise details of the service objective achieved through the contract, noting that the services of an additional psychologist had been secured.

The explanatory details noted by some of the TPPs whose service objectives were not considered to be adequately reflected in contracts suggest that TPPs and HAs had been engaged in, or wished to see, some major service reconfigurations and also had concerns about persistent inadequacies with the quality of provider data in some areas (see Box 8).

Box 8 Comments and examples where 'service objectives not adequately reflected....'

'Data remains patchy.'(ref DB)
'Failed to achieve improved contract monitoring data and did not achieve new drug & alcohol service'. (ref EB)
' A change of provider will be made during 1998/99 .... to provide an integrated service for this area' (ref AE)
'The review of mental health services in ..... (HA area) has taken longer than we anticipated' (ref CJ)

(respondents contracting for the second time in 1997-98)

4.3 TPPs contracting for the first time in 1997-98

Five TPPS who contracted independently for *community* services were doing so for the first time in 1997-98, having copurchased through a joint contract with the HA or blocked the budget back to the HA in 1996-97. Four of these five TPPs were also contracting independently for *mental health* services for the first time. Three of this group of five were altogether new to independent contracting in 1997-98.

The circumstances of these five TPPs in 1996-97 and details of the contracts they agreed in 1997-98 are set out in Box 9. Similarities can be seen between the concerns that they expressed in 1996-97, when they did not hold independent contracts, and those of the TPPs who had held independent contracts at that time. Three suggested that they had been hampered in their decision making by the poor quality of data available to them about the different elements of community services, and three indicated that major changes were called for in the structure and organisation of mental health services. In 1997-98, four out of five were satisfied that their objectives for community services had been adequately reflected in contracts whilst three out of four were satisfied that this was the case with respect to their contracts for mental health services.

Box 9 Circumstances of TPPs contracting independently for community/mental health services for the first time in 1997-98

Case One (ref EB) 12 practices **1996-97** Contracted jointly with the HA, for both community and mental health services because of difficulties disaggregating activity data, but always intended to move to independent contracts in 1997-98. Both contracts were simple block and the TPP expressed strong concerns about the quality of activity data. Received data re face to face contacts only from the community provider and no data at all from the mental health provider but were optimistic that the situation would improve.	**1997-98.** Agreed independent contracts with values similar to those in 1996-97. The value of the mental health contract rose from £775,100 to £776,200 whilst the contract for community services (includes both TP and GPFH) increased from £1,238,200 to £1,298,200 (representing adjustment for inflation. The independent contract specified new information requirements but TPP stated that contracts did not reflect service objectives because they failed to achieve improved contract monitoring data.
Case two (ref CI) 4 practices **1996-97** 'Blocked back' the budget for community services (whilst contracting independently for mental health) as part of a deliberate strategy to take on only as much as they felt they could confidently cope with in year 1. Noted that they received good data from the HA re their activity and indicated that they might consider contracting independently in areas where they felt *'they could make a difference in the future.'*	**1997-98** Proceeded to contract independently with local community trust. Contract value £301,834. Stated that service objectives were adequately reflected in the contract.

Box 9 Circumstances of TPPs contracting independently for community/mental health services for the first time in 1997-98	
Case three (ref BG) **1996-97** TPP had no independent contracts. Had joint, simple block contract with main comm/mh provider. TPP received activity data but rated it, and the information system as a whole as useless. Mental health services said to be a major cause for concern - structural problems with the service following 're-sectorisation' and difficulties with resources allocation . Saw no point in changing provider - *'the problem is that there is infinite demand for finite resources'.*	**1997-98** Proceeded to contract independently with main comm/mh provider. TPP considered that service objectives had been reflected satisfactorily in the contract with respect to community services but that problems remained with mental health service provision.
Case four (ref CD) 2 practices **1996-97** Had joint contracts for all services because independent contracts were *'not permitted by HA'* but always intended to move to independent contracts in 1997-98. Contracts for both community and mental health services were simple block contracts. TPP manager expressed concerns about the adequacy of 'contacts' as the currency for the *community* contract: *'What good is a contact? The HA may be happy with a block contract and lists of contacts but the TPP wants patient based longitudinal information. It won't improve because the systems aren't there - it needs massive investment'* Also expressed concerns about usefulness and quality of data from the mental health contract; TPP had experienced difficulty putting together a patient register for SMI. Noted that mental health was a service priority and that TPP intended to change the service specification dramatically. Admitted to worrying about how the Trust could deliver this new service to just one part of the population and whether it would destabilise the Trust.	**1997-98** TPP reported that they had negotiated independent contracts with difficulty. They had agreed the service changes they wished for in the context of a block contract but were ' *struggling with arguments over finance in terms of poor budget setting, financial pressures and additional service costs.'* These problems were said to apply to all contracts.
Case five (ref CC) 4 practices **1996-97** Did not have any independent contracts because of the 'obstructive' attitude of the HA but had clear plans about the contracts they hoped to enter into in 1997-98. Re. community: (budget £2m) mentioned aspirations to develop the local community/day hospital and long term plans for a PHC resource centre. Re .mental health: said they were planning a community based service model and also hoping to contract with a single provider for the whole service rather than with the two trust that were currently service providers.	**1997-98** Went on to contract independently with community trust (value: £2,808,000) and for mental health services as part of contract with main acute/ mh provider (value £400,000). Sophisticated block contracts in each case. Stated that service objectives had been satisfactorily reflected in contracts but no details.

5. ASPECTS OF CONTRACTING

5.1 TPP's experience of negotiating independent contracts

The 1997-98 survey found that 125/156 (80%) contracts were signed off at the specified date i.e. 31/10/97. This compared with the 1996-97 survey results which found that 104/151 (69%) contracts were signed off at the time of interview (November 1996 - January 1997).

Respondents to the 1996-97 survey indicated that, for the most part, signing off was a formality which may be delayed for some time after the contract has been agreed, the inference being that too much significance should not be attached to the fact that a contract is not signed off. Nevertheless the fact that fewer contracts remained unsigned at the mid point of the year suggests that contract negotiation may have been more straightforward in 1997-98 than in 1996-97. This supposition is confirmed by respondents to the 1997-98 survey, 50% of whom said that they had found the process of agreeing independent contracts easier in 1997-98.

In both surveys respondents were asked if they had encountered any problems in obtaining agreement on contracts at the beginning of the financial year and, if so, how may contracts had been problematic. While in 1996-97 82% (n=22) of those TPPs who had independent contracts had experienced problems in getting agreement, by 1997-98 this proportion had fallen to 41% (n=11). In 1996-97, 22 TPPs had had problems with a total of 73 contracts, whilst in 1997-98 only 11 TPPs had difficulties with a total of 33 contracts. Moreover, the 22 TPPs who had problems agreeing contracts in 1996-97 were equally divided between those who had problems agreeing *all* their contracts and those who had problems agreeing one or more particular contracts only. In 1997-98, of the 11 TPPs who had problems agreeing contracts, only 3 experienced problems with *all* contracts, the remaining 8 having problems with specific contracts only. Thus in 1997-98 fewer TPPs experienced problems agreeing contracts and those that did so had problems with fewer contracts.

In both 1996-97 and in 1997-98 TPPs were asked to give up to three examples of contracts that were problematic identifying the provider and the nature of the problem. In the 1997-98 survey, 11 TPPs cited 48 examples of problems associated with 20 different contracts. Tables 20 and 21 show the types of provider with whom the TPPs had difficulties agreeing contracts and the types of problems they cited in relation to these contracts. These data should be regarded as illustrative of the problems experienced rather than an exhaustive audit. As the first of the tables shows, the contracts they chose to cite as examples are, in almost every case, significant contracts with all types of main provider.

Table 20	**Types of provider with whom TPPs who had difficulties agreeing contracts in 1997-98** (11 TPPs cited 48 examples of problems associated with 20 different contracts)
main acute provider	6
main community provider	3
main mental health provider	1
main provider - combined acute/community/mental health	2
main provider - combined acute/community	1
main provider - combined community/mental health	3
main provider - combined acute/mental health	2
specialist provider	1
other acute provider	1
	20

Table 21 presents the types of difficulties experienced by the 11 TPPs who had problems with contract negotiations in 1997-98. These 11 TPPs actually cited 48 examples of problems associated with 20 different contracts. The table simply shows how many TPPs experienced each type of difficulty in relation to at least one contract. The most frequently cited factors were: delays or difficulties in agreeing the budget allocation with the HA; delays or difficulties in contract negotiations between HA and the provider which impacted on the TPP negotiations; and difficulties agreeing activity levels with the providers. Only one TPP had found that a main provider (community/mental health service) was reluctant to enter negotiations in the second year of TPP contracting .

Table 21	**Types of problems experienced by TPPs who had difficulties agreeing contracts in 1997-8** (N=11)
Problem Type *Contract negotiations with the provider were delayed or influenced by:*	No. (and %) of TPPs who cited
Delays or difficulties in agreeing TPP budget allocation with HA	6 (55%)
Delays or difficulties in contract negotiations between HA and this provider	6 (55%)
Reluctance on the part of the provider to enter into or take seriously negotiations with TPP	1 (9%)
Disagreement with the provider over prices	4 (36%)
Difficulty agreeing activity levels with the provider	6 (55%)
Difficulty or disagreement with the provider over contract specifications e.g. quality standards or penalty clauses	2 (18%)
Other e.g. HA wide service review	4 (36%)

Table 22 presents findings concerning the outcomes of negotiations in the cases of the 20 contracts that TPPs had chosen to cite as problematic. Resolution was achieved in thirteen cases overall. However, in five cases the problems were *'yet to be resolved'*; and in two cases the contract had been abandoned. In a further two cases the resolution had depended on extreme measures (namely a threat to change providers in one case and a one-off payment to bridge a 'contract gap' in the other). These findings suggests that whilst fewer TPPs experienced problems in agreeing contracts in 1997-98, and those that did so had problems with fewer contracts, the difficulties were not always easy to overcome.

Table 22 Resolution of problems experienced by TPPs who had difficulties agreeing contracts in 1997-98
N= 20 (contracts)

resolved after discussion between parties	9
concluded after discussion and resolution of HA contract difficulties	2
yet to be resolved	5
other outcome*	4
total	20

** the outcomes in cases coded as other are as follows:*

case 1 When negotiations with a minor acute provider reached an impasse the TPP felt obliged to block the budget back to the HA so the provider *'got a contract with the HA after all.'* (ref BF)

case 2 The outcome of contract negotiations with a combined acute/community /mental health provider was that some difficulties were resolved after discussion; some were resolved after threat to change providers but others were yet to be resolved (ref CD)

case 3 A problem with the main community/mental health provider was resolved after the 'contract gap ' was bridged by a non-recurring one-off payment. The HA was involved in facilitating the agreement. It was not an option for the TPP to change provider as there was no realistic alternative. The respondent commented: *'the difficulties experienced described above are against the backdrop of financial pressure throughout the Authority and the Trust which has resulted in two years of disinvestment, particularly by the above trust.'* (ref AG)

case 4 The TPPs attempt to agree contract with a specialist provider of oncology services was unsuccessful so an extra contract referral arrangement was retained. (ref EG)

Some further understanding of how the experience of agreeing contracts may have changed over time can be gained from examining the responses of the 23 TPPs who contracted independently and took part in our survey in both 1996-97 and 1997-98. Of these 23 TPPS with two years experience, the number reporting difficulties decreased by one third from 15 in 1996-97 to 10 in 1997-98. The number of contracts which were problematic decreased from 48 (mean =3.2) to 19 (mean =1.9).

5.2 The significance of contracting as a mechanism for achieving change.

In the 1996-97 survey respondents were asked to assess the importance of the contracting process to the achievement of change and the development to services. Of 28 TPPs with independent contracts: 11 (39%) said contracting was 'very important', 13 (47%) said it was 'of some importance' and 4 (14%) said it was 'unimportant'

Respondents who perceived the contracting process to be *very important* said they valued the opportunities it afforded them to communicate with clinicians and to negotiate from a position of strength with financial leverage over providers. They emphasised the need to save money from existing contracts to fund service development. The comments of those who said they thought the contracting process was of some importance tended to echo these sentiments, however they also revealed some ambivalence and a recognition that an effective commissioning process must go beyond a narrow focus on contracting. The minority of respondents who saw the contracting process as *unimportant* were even more convinced that having constructive relationships with providers was the key to achieving service development.

In the 1997-98 survey respondents were also asked to rate the significance of their independent contracts as a mechanism for achieving their objectives. The responses indicated a slight weakening of the emphasis on contracting. Of the 27 TPPs with independent contracts eight (30%) said it was 'very important', 13 (48%) felt it was 'important' and six (22%) saw it as 'unimportant'.

Through their comments, those who rated their 1997-98 contracts as *'very important'* emphasised the leverage afforded by the contract mechanism in enabling them to influence providers (see Box 10). Of those who rated their contracts as *'important'*, some emphasised the value of the contract, and in a wider sense, the contracting process, as a focus for discussion about services whilst, for others, the significance clearly derived from their success in exploiting the contract mechanism to achieve savings or shift resources in order to fund service developments (see Box 11). As in 1996-97, some respondents acknowledged the significance of their contracts but at the same time recognised the limitations. The comments of those TPPs who rated their contracts as unimportant as a mechanism for achieving their objectives refer to a process of working together with providers to agree service improvements which is merely formalised by a contract after the event (see Box 12).

Box 10 'Contracts are very important...'

(also had independent contracts in 1996-97)

'(the contract) provides targets for trusts to aim for and levers for the TPP to apply if targets are not achieved' (ref EE)

'..to achieve early discharge and obtain a better pricing structure for obstetrics' (ref AI)

(did not have independent contracts in 1996-97)
'service developments are linked to contract specifications' (ref BG)

Box 11 'Contracts are important...'

as a focus for discussion about services...

'They act as a good means of understanding and detail for the commissioning process and as a focal point for discussion on future service objectives' (ref AE)

'...important as a focus, not as a piece of paper. We try to maintain dialogue throughout the year to keep abreast of changes' (ref AH)

'...but more important is the contracting process which enables the process of setting service objectives ' (ref CJ)

as mechanism for directing the flow of resources...

'Daily costs must be as accurate as possible to make savings to pay for nursing home' (ref BC)

'Bed day rate acts as lever to facilitate transfer back to community beds from acute provider' (ref EG)

'Objectives in terms of service developments are separate from contracts. However, in the absence of development funds or growth monies, we aim to fund them from contracts, through reduced admissions and reductions in length of stay' (ref AG)

but there are limitations..

'...but change is brought about outside the contracting process. Contracts are a little like nuclear bombs - hopefully only used rarely.' (ref BE)

'...but only with regard to budget management, one of our objectives being to balance the budget in 1997-98 and recoup last year's overspend. They do not play any 'real' role in ensuring quality of care.' (ref CH)

Box 12 'Contracts are not important...'

(had independent contracts last year too)

'Work continues all year long to improve services, establish new services, improve contract monitoring information, move to different contract currencies etc. Contracts are seen as end points of the work, not mechanisms for achieving objectives (ref EB)

'Contracts reflect agreements reached after service developments are agreed' (ref EH)

'The nature of relationships/communication with providers is far more important.' (ref EJ)

(did not have independent contracts last year)

'The changes have been negotiated on the back of service development and collaboration, the agreed block contract was just the funding following the service development.' (ref CD)

5.3 Did TPPs change their minds over time?

A comparison between the snapshots of 1996-97 and 1997-98 presented in the previous section suggests that TPPs continued to hold a wide spectrum of views about the significance of contracting to the achievement of their service objectives. It is likely that each TPP's view was coloured by the nature of the service objectives they held, the financial implications of the changes they wished to make, and the context in which they operated in terms of the quality of the relationship they enjoyed with the provider in question. However, as we pointed out above, it seems that overall TPPs rated the significance of contracting to a slightly lesser extent in 1997-98 compared with 1996-97.

To ensure that the picture is not confounded by the fact that the two data sets do not comprise exactly the same TPPs, and to answer the question *'did TPPs change their minds?'* it is necessary to focus on the views of those TPPs included in both data sets. The following table compares the 1996-97 view with the 1997-98 view for 23 TPPs who had independent contracts and took part in the survey in both years. From this its seems that there was some considerable shift of opinion. Six of the ten TPPs who rated contracting as *'very important'* in 1996-97 moderated their view and in 1997-98 rated it as *'important'* , whilst four of the ten TPPs who rated contracting as *'important'* in 1996-97 had by 1997-98 formed the view that it was *'unimportant'*. In contrast three TPPs rated contracting as *more* important in 1997-98 than they had done in 1996-97 (see Table 23).

Table 23	**Views about the importance of contracting - 1996-97 by 1997-98**			
	views in 1997-98			
views in 1996-7	very important	important	not important	*row total*
very important	4	6		10
of some importance	1	5	4	10
not important		2	1	3
column total	5	13	5	**23**

In the cases where TPPs added to their response with supporting comments in both 1996-97 and 1997-98, it is interesting to examine these comments and to try and assess whether the substance of their views changed or merely the strength of feeling or emphasis. Further items of data from the questionnaire may aid understanding of the reasons for the apparent change. Some examples are set out in Box 13.

In example one the TPP's rating changed from *'very important'* to *'important'*. The respondent's verbatim comments from each survey are juxtaposed in the box. Both comments stress the TPP's concern to exploit the contract mechanism in order to achieve savings to fund service developments and yet the respondent's choice of words in 1997-98 hints at slightly less conviction than that expressed in 1996-97. Elsewhere in the 1997-98 questionnaire the respondent noted that the TPP had been unable to achieve savings through reduced length-of-stay in 1997-98 so perhaps this disappointment may account for the slight change of opinion. This respondent also registered anticipation of *'the dismantling of the internal market'* as a inevitable consequence of the change of government and it is possible that the changed policy context may had a bearing on the views expressed.

In example two, the rating also changed from *'very important'* to *'important'*. The respondent's comments in 1996-97 referred to the leverage the TPP possesses by virtue of being a budget holder and a party to the contracting process. In 1997-98 the respondent acknowledged the role of the contract mechanism as a means of controlling the flow of resources to support service development. However, when reflecting on the success of the 1996-97 main acute contract, this respondent highlighted the achievement of *' improved trust between TPP and provider'*. The indication is that the TPP may have adopted a less confrontational / more collaborative stance and become less concerned about the balance of power in relationships with providers.

In example three the rating changed from 'important' to 'unimportant' yet it is hard to detect a change in the substance of the respondents view as elaborated in comments . This respondent seemed to take a narrow view of the contract as something separate from and less important than the *'joint work'* achieved by the parties to the contract.

In example four the rating changed from *'unimportant'* to *'important'*. The respondent continued to emphasise the importance of the ongoing relationship between the parties concerned but seemed to have become less dismissive of the contracting process, recognising the value of the contract as a focus.

Box 13 Illustrations of changing TPP views of the importance of contracting

	1996-97	1997-98
1.	Rated as 'very important' *'Its absolutely critical. There is no new money so you have to make money from within contracts to fund new developments.' (ref AG)*	rated as 'important' *'Objectives in terms of service developments are separate from contracts. However, in the absence of development funds or growth monies, we aim to fund them from contracts, through reduced admissions and reductions in length of stay' (ref AG)*
2.	'rated as 'very important' *'Money certainly gives you the power to make change (ref EG)*	'rated as 'important' *'Bed day rate acts as lever to facilitate transfer back to community beds from acute provider' (ref EG)*
3.	Rated as 'important' *'Contracting is important but you also need to undertake joint work throughout the year: contracting is the culmination of this work. (ref EB)*	'rated as 'unimportant' *'Work continues all year long to improve services, establish new services, improve contract monitoring information, move to different contract currencies etc. Contracts are seen as end points of the work, not mechanisms for achieving objectives (ref EB)*
4.	'rated as 'unimportant' *'The contracting process is only an exercise- the all year round relationship and power that the GP has is important.' (ref AH)*	'rated as 'important' *' the contract is important as a focus, not as a piece of paper. We try to maintain dialogue throughout the year to keep abreast of changes' (ref AH)*

6. ALTERNATIVES TO INDEPENDENT CONTRACTING

TPPs used a variety of expressions to describe purchasing arrangements that do not involve independent contracts. In reporting on the 1996-97 contracting survey we noted the distinction between 'joint' contracts and the 'blocking-back' of services. A joint contract involves the specification of the TPP contract as an identified 'subset' of the overall HA contract. Blocking-back, on the other hand, refers to an arrangement where the TPP returns its allocated budget for the service(s) to the HA, or the budget may be ring fenced by the HA, and the HA contracts on the TPP's behalf. The terminology implies that there is some kind of participation on the part of the TPP in the setting and/or monitoring of a joint contract whereas there may be little TPP involvement in the purchasing process when services have been blocked back. In practice the distinction between these two types of arrangements was somewhat blurred and when TPPs used phrases such as *'buy into'* or *'piggy back on'* or *'shadow'* HA contracts the precise meaning of the term may have varied from one TPP to another.

In discussing the alternatives to independent contracting a distinction may be made between those TPPs with some independent contracts, who use these alternatives for selected services only and those TPPs without independent contracts for whom these alternatives apply across the board.

As far as joint contracting by TPPs who also had some independent contracts was concerned, 14 of the 27 TPPs with some independent contracts said that they had also contracted jointly with the HA for some services in 1997-99. Two respondents were unable to provide details of the number of contracts concerned but the remaining 12 of these TPPs were said to have between 1 and 70 joint contracts. The total number of joint contracts was 180.

The 1996-97 survey found that TPPs had a number of reasons for opting to contract jointly. The most frequently mentioned reason was that the volume of activity concerned was too small to justify the negotiation of a separate contract for the TPP. In the case of specialist and high cost/low volume services, some TPPs also felt that they lacked the necessary expertise to purchase effectively, or the capacity to manage the financial risk. The 1996-97 survey examined the characteristics of joint contracting arrangements and found that those TPPs who had been directing their energies and resources to contracting independently with their main providers had typically been quite passive partners in the joint contracting process. Fewer than one third had taken part in any of the contract negotiations or in setting the service specifications. However, two thirds were receiving activity data for the purpose of monitoring at least some if not all of the joint contracts.

In the 1997-98 survey TPPs with joint contracts were asked to say if there had been any changes to joint contracting arrangements. In response, of the 14 TPPs with joint contracts, four said the number of providers had changed; one said that the range of services covered had changed; three said that there had been a change to the level of TPP input to contract setting; and three said that there had been a change to the level of TPP input to contract monitoring.

The details provided suggested that only three TPPs had made a change in order to extend the scope of independent purchasing. One TPP had started to contract independently for clinical audit and maternity services (midwifery and obstetrics), family planning and school nursing services, which they had previously co-purchased, and a second TPP had changed from joint to independent contracts with two specialist providers. A third TPP had changed from joint to independent contracts with six providers, including the main providers of community and mental health services, and minor providers of small volumes of acute services. In the latter case, the TPP had intended to have independent contracts in 1996-97 but, in response to data disaggregation problems in some areas, and in the absence of the TP manager due to ill health, these contracts were signed by the HA and run 'back to back' as an administrative convenience. The change to independent contracts in 1997-98 therefore seemed more like a formal consolidation of the 1996-97 position than a new extension to the scope of the TPPs purchasing.

A fourth TPP said that the number of joint contracts had increased by two but noted that these contracts had been agreed as an alternative to previous extra contractual referral arrangements. In a similar vein, a fifth TPP, that reported having 36 joint contracts with low volumes of activity, noted that the HA may have reduced or increased the number of contracts versus ECR arrangements *'taking account of the total 1996-97 contract performance and ECR budget' (ref AH)*

It seems that, from 1996-97 to 1997-98, little changed with respect to TPP levels of involvement in the setting or monitoring of joint contracts. In acknowledging the *status quo* one TPP noted *'all contracts are of very low activity for the TPP and service delivery is not targeted for change as TPP objective' (ref AH).* In contrast, another TPP whose independent contracting was limited to one provider and whose joint contracts therefore assumed more significance, also noted that co-purchasing arrangements had not changed but emphasised that a full range of services was commissioned in both years. It also pointed out that there was total involvement in contract negotiations and noted that all activity was monitored against targets at both project and practice level. Three TPPs reported a slight increase in their involvement in contracts setting. In one case the TPP had participated in setting specialist contracts which were part of a consortium arrangement whilst in the second the TPP had been *' invited to join one meeting at the HA' (ref EB).* The third TPP expressed the view that as a general rule their involvement was *'totally inadequate'* and noted that they had

only succeeded in becoming involved and obtaining information *'after problems arose' (ref AI).*

In the case of HA contracting on behalf of TPPs who also had independent contracts, the 1996-97 contracting survey found that no TPP contracted independently for all services and that with one or two exceptions all TPPs said that they had opted to, or been obliged by their HA, to block back some service budgets to the HA to purchase on their behalf. For some TPPs blocking back was the only alternative to independent contracting whilst others had some joint contracts as well. The 1996-97 contracting survey asked about services that TPPs had seriously considered contracting for, but then decided to block-back. This revealed that services broadly categorised as specialist (such as regional cancer services, renal services, cardiac services and head injury rehabilitation services) had posed most dilemmas for TPPs. TPPs were most likely to have decided against independent contracts for these services because they perceived their high cost/low volume nature to represent an unacceptable financial risk. Lack of information on which to base contracts or lack of expertise in a specialist area were other reasons given for deciding to block back services. Some TPPs had encountered temporary local difficulties associated with trying to purchase services such as community, mental health or maternity services independently in the context of ongoing wider service reconfiguration.

Despite the widespread blocking-back of services, TPPs were not necessarily content with this arrangement and approximately half of those TPPs who had done so said that they had plans to start contracting independently in 1997-98 for some of the services concerned. It was clear however that, in some cases, TPPs differed from their HA in their opinions concerning what was an appropriate contracting arrangement for particular services.

In the light of these stated intentions, the 1997-98 survey aimed to find out if TPPs had proceeded to make the changes they had planned and if they were in agreement with their HA about which services should be purchased by the HA on the TPPs' behalf. Examination of the data for TPPs who took part in both surveys reveals that only two of the 12 TPPs who stated in 1996-97 that they had plans to contract independently in 1997-98 for particular services that were hitherto blocked back, actually went on to do so.

In the first case the TPP had changed to independent contracts as (tentatively) planned for some specialist services including haemophilia, and neo-natal intensive care. The respondent noted *'HA contracts were inappropriate, expensive and too restrictive with inappropriate level of cover' (ref CH)* . In the 1996-97 survey the TPP also noted that they had been obliged to block back the budget for maternity services with one provider because changes in service configuration had made it too complex to proceed independently. The plan was to

proceed to include maternity services in the independent contract with the provider concerned with effect from 1997-98. As the block-back schedule supplied by the TPP in 1997-98 makes no reference to maternity services, it seems likely that the TPP had realised this aim.

In the second case the TPP had proceeded, in accordance with plans agreed with the HA for their second year of operation, to expand independent contracts to cover: special health authorities; A and E contracts with two main acute providers; extra contractual referrals for both acute and mental health; and specialist services including renal medicine, special care baby units and neonatal high dependency services. In addition, beyond the intentions they stated in the 1996-97 survey, they had extended independent contracts to cover hospices and a range of services from the community trusts including various forms of self referral such as - wheelchairs, family planning, speech and language therapy. This TPP noted that they were considering extending the scope of independent contracting still further in the future to include some elements of continuing care.

In a third case, a TPP had extended the scope of their independent purchasing but not in the service areas they had identified in response to the 1996-97 survey. The expressed intention had been to contract independently in 1997-98 for maternity services; these were blocked back in 1996-97 because of problems with HA data and *'disagreements over true activity levels' (ref CJ).* It seems that in the event, however, the TPP decided against the move in 1997-98 because of *'problems contracting with multiple providers and the potential for high cost ECRs.'* On the other hand, however, they extended the scope of their independent contract with their main provider of community services by including learning disability and school nursing services which had formerly been blocked back to the HA. The stated reason for doing so was to enable the TPP to obtain information about activity on a patient specific basis which the HA was unable to do.

In addition to asking if TPPs had expanded the scope of independent contracting in 1997-98, the survey also sought details of any services that TPPs had previously contracted for but had decided to block back to the HA. There were three instances of such a change.

In one case the TPP had decided to block back the budget for terminal care noting that *'the split between terminal care and continuing care is artificial and difficult to administer and changes to criteria are not a 'TPP only' debate.' (ref AH)* In the second case the TPP decided to block back the budget for genito-urinary medicine services because of problems with *'data integrity' (ref BF)* and were also obliged to block back the budget for acute and regional services with one provider when contract negotiations broke down. In the third case the TPP blocked back funding for learning disability services (previously co-purchased) as part of an overall settlement with the relevant provider.

Notwithstanding the fact that only three out of 12 TPPs had realised their stated hopes of contracting independently in 1997-98 for services that had been purchased on their behalf by the HA in 1996-97, only three TPPs said that they were *not* in agreement with the HA about which services were purchased by the HA on the TPP's behalf in 1997-98. Two TPPs noted that they still had hopes of extending direct contracts further in 1998/99. In one case the TPP ascribed their lack of success in this respect in 1997-98 to *'provider indifference'* rather than HA interference *(ref AG).*

6.1 TPPs who did not contract independently in 1997-98.

Twelve of the 39 TPPs taking part in the 1997-98 contracting survey reported that they had no independent contracts in 1997-98. Of these 12 TPPs, two had been contracting independently in 1996-97 whilst the other ten had no contracts in that year either.

Of the two TPPs who reported that they had ceased to contract independently, one had expanded to become a HA wide TPP in 5 localities co-purchasing with the HA. This TPP is subject of a separate detailed case study as part of the core evaluation of TPP. In the second case the TPP reported that having had independent contracts in 1996-97 they were unable to place contracts in 1997-98 as they had not received a budget (as at 31/12/97).

Five TPPs described themselves as purchasing jointly with their HAs and they gave details about joint contracts with main local providers which they had opted for *instead of* independent contracts. Boxes 14 and 15 draw on data from the 1996-97 and 1997-98 contracting surveys and present details of circumstances surrounding the decisions to contract jointly in 1996-97, their stated intentions for 1997-98 and the eventual outcome in 1997-98. Details of the contracts they held are presented in the next section of this report.

As Box 14 shows, three of the five 'copurchasing TPPs' said that joint contracting was their *'preferred'* model and they indicated that they were satisfied overall with the balance of their contracting arrangements, although in Case 3 the TPP experience had clearly led the respondent to raise the possibility of switching to independent contracts in the future in order to respond more effectively to local concerns.

The remaining two of the 'copurchasing' TPPs seemed to have been obliged to settle for joint contracting although they expressed continuing dissatisfaction with their contracting arrangements (see Box 15). They had both recognised the potential benefits of dealing independently with providers and expressed regret that their own aspirations had been overtaken by events they perceived to be beyond their control.

Box 14 Circumstances of TPPs contracting jointly with the HA

TPPs who stated that joint contracting was the preferred model.....

Case one (ref CB) Seven practices, one pioneer fundholder, complex organisational structure

Circumstances in 1996-97	Intention for 1997-98	Circumstances in 1997-98
Not interested in contracting independently- good relationship with HA – happy to be involved in HA contracts in areas of interest. Initially had 3 areas of interest for developing services but in the end decided to contract jointly for only one area - mental health.	No desire for change. Respondent said TPP happy to continue to exert influence over services with status of TPP giving them the right to access to the debate.	TPP has continued with same arrangement. *'Although only one (joint) contract is held* (and all other services are purchased by the HA) *the TPP considers that a partnership with the Health Authority was and is the most effective way of obtaining the re-configuration of the mental health services that the GPs required'*

Case two (ref DA) Three practices, all pioneer fundholders, simple organisational structure

Circumstances in 1996-97	Intention for 1997-98	Circumstances in 1997-98
TPP obliged to *'settle for'* joint contracts with main acute and community providers (all else 'blocked back'). GPs had wanted to contract independently on a 'cost per case' basis. They entered negotiations with the provider who was not happy with this proposal. The HA intervened and imposed a compromise arrangement whereby the TPP have cpc arrangement, with indicative activity targets, as subset of HA (c and v) contracts. Contract includes TPP info and monitoring requirements.	Same arrangement will apply next year.	TPP has continued with joint contracting arrangement - *' trying to reduce bureaucracy involved in too may different contracting arrangements'* TPP is now satisfied with arrangement but notes *' should have had better monitoring systems earlier'*

Case three (ref EF) Three practices , no pioneer fundholders, intermediate organisational structure

Circumstances in 1996-97	Intention for 1997-98	Circumstances in 1997-98
All contracts were a subset of HA contracts. TPP saw clear distinction between 6 main contracts which they negotiated and signed jointly (with adjustments made *'to meet TPP concerns')* and 16 small contracts for one off or specialist care which they 'fed into'. Managed their own ECR budget	Stated intention to continue working in close collaboration with HA - stated belief that joint contracting was the best arrangement. Philosophy is that *'TPP tries something out and HA picks it up.'*	Continuing with joint contracting and satisfied with the arrangement. Commented however : *'The main problem for the future will be where a TPP problem which is not shared with the HA exists. A separate contract and/or appendix to the main contract may be required. This is likely to be needed for the 98/99 contracts and may need a change from joint to independent contracts.'*

Box 15 Circumstances of TPPs contracting jointly with the HA

TPPs who stated that joint contracting was not necessarily the preferred model.....

Case Four (ref CF) Ten practices, one pioneer fundholder, intermediate organisational structure

Circumstances in 1996-97	Intention for 1997-98	Circumstances in 1997-98
TPP decided to *'shadow'* HA contracts for 97-97 on the basis that information was poor. HA also seemed reluctant to *'let go reins'*.	TPP expressed uncertainty about the future and ambivalence about independent contracts. Did not believe it was absolutely necessary for TPP to negotiate face to face with providers; the HA could do so, informed by GPs views. Yet, anticipated that HA would simply contract again on last years activity levels which would not be acceptable to GPs. They would be required to monitor activity and control referrals without influence....	TPP continued with previous arrangement, partly because it was the preferred model but *'there was also lack of clarity regarding the budget arrangements'* Expressed some disatisfaction with the arrangement. *'In the light of changes in the NHS the TPP have agreed to continue (in 1997-98) with the 1996-97 contract arrangements. In the next months we will agree future strategy. The TPP view is that we will contract independently for all mainstream activity (in 98/99) and block back to DHA to commission the low volume/ high cost specialties. All GPFH activity is done jointly by the TPP.'*

Case five (ref FB) Five practices, one pioneer fundholder, intermediate organisational structure

Circumstances in 1996-97	Intention for 1997-98	Circumstances in 1997-98
TPP agreed to accept 'shadow budget' in 1996-97 because of difficult position of HA. Also lacked capacity in preparatory year to monitor expenditure against a nominal budget and get any idea of activity trends. Therefore operated in 1996-97 *'with slice of HA contracts'*. Were involved in negotiations with providers for whom they are the host purchaser. TPP had separate line of data in HA contract management system and got data from HA.	TPP expressed the belief that the value of GP involvement in the commissioning process had been demonstrated but also sought a more active contracting role. Expected to have some independent contracts in 1997-98 for acute, community and mental health services . Acute purchasing was to be provider specific rather than service specific so they would purchase everything from local providers	Joint contracting has continued with main local provider of acute services and main local provider of community and mental health services . TPP expressed disatisfaction with the balance of contracting arrangements. *'We would have wished to have a more independent relationship with our providers but have been hampered by variable data and a dire local financial position.'*

There were five TPPs where it seems that, in 1997-98, the HA purchased all services on the TPPs behalf (including one site which decided to withdraw completely from TP during the course of the year). Details of the circumstances of these TPPs are set out in Box 16. Being new to fundholding at the same time as becoming total purchasers, problems with budget allocation, and ambivalence about the need for independent contracts as a means of influencing service development were clearly important factors in determining the course of events for these TPPs. The final example shows the vulnerability of small sites, typically most successful in achieving independent contracts, when faced with a resistant monopoly provider.

Box 16 TPPs for whom the HA purchased all services.....

Case Six (ref CE) three practices, all sixth wave fundholders, intermediate organisational complexity

Circumstances in 1996-97	Intention for 1997-98	Circumstances in 1997-98
Decided to *'buy into'* all HA contracts in 1996-97 whilst consolidating SFH.	TPP said they would continue to contract jointly, except perhaps for maternity which they might take on independently. *'The GPs just want to have influence on services with contracting muscle rather than set up their own bureaucracy.'* Pre TPP the practices were a locality commissioning pilot and made some change through negotiating but aware that *'when push came to shove it lacked the bite of the contract.'*	Said they had no independent contracts as joint contracting is preferred model BUT also said that *'due to local circumstances all non fundholding contracts were blocked back to HA'* Described themselves as satisfied with this. - *' the current arrangement has suited the GPs as they have developed their joint purchasing for fundholding.'*

Case seven (ref CG) Four practices, one pioneer fundholder, intermediate organisational complexity

Circumstances in 1996-97	Intention for 1997-98	Circumstances in 1997-98
TPP *'bought into'* HA contracts having identified level of usage by TPP. Separately monitored as sub set of HA contracts .	TPP expressed the belief that they would be capable of contracting independently because they would have the necessary robust information system in place. However, GPs had signed up to TPP. not for the money but to change services and would rather put effort into that area - so would only contract independently for a small number of services	Said they had no independent contracts in 1997-98 as they did not feel ready for independent contracting. Neither did they have any joint contracts i.e. everything was blocked back. Said they were in agreement with the HA about which services the HA purchases but were not satisfied with current arrangement in terms of balance of contracts.

Case eight (ref CA) Eight practices, all sixth wave fundholder, complex organisational structure		
Circumstances in 1996-97	Intention for 1997-98	Circumstances in 1997-98
Weren't fundholders prior to becoming TPP so had no *'contracting set-up'* in place. Took on GPFH in 1996-97 so decided that for TP they would 'piggy back' on HA contracts. Also, the GPs were not entirely happy with the budget allocation and so thought it 'safer' to go with the HA. Were not involved in contract negotiations etc but received Good data via HA on all contracts.	TPP stated that they planned to take on some independent contracts in 1997-98 and had started setting up the necessary mechanisms to manage TPP contracts. HA contact said GPs saw themselves as a purchasing group, interested in service issues and change - not in replicating transaction based processes. Hence TPP would in 1997-98 only get budget for independent commissioning in identified priority areas . Said '*budget allocation needs to be soundly based - not carved up in a cavalier manner - must be acceptable to providers.'*	Did not proceed to contract independently . During 1997-98 major developments affected progress towards devolved budgets, which led to change of focus for the project: a) major city wide review of health services was judged likely to affect many of the core projects the TPP intended to tackle. Having no wish to work at a tangent to the rest of the city TPP decided to await results of the review. A consideration was that key managers in the HA were fully committed in supporting service review. b) exercise to establish weighted capitation targets for the whole city made significant demands on corporate services and the Project, and resulted in progress towards a fair shares allocation mechanism c) white paper caused TPP to change their focus for 1998-99. Intend to return full HCHS allocation to the HA who will then act as agents on the TPP's behalf.
Case Nine (ref FC) Single site, simple organisational structure		
Circumstances in 1996-97	Intention for 1997-98	Circumstances in 1997-98
No agreed budget allocation. TPP rejected budget based on historic activity as it was far less than a capitation based figure. HA perceived to be reluctant to yield control to TPP. Also TPP opted not to contract independently when they realised the hassles + bureaucracy involved. Worked with HA on service specifications e.g. cancer services, and have informed HA contracting process.	Uncertain about the future. Believes TPP status brought independence and they achieved service developments working with trusts and avoiding protracted debates on budget and contracts. Would really only wish to contract on a completely different basis - for packages of care across organisations etc.	TPP did not receive budget in 1997-98 and has had no involvement in contracting. HA can identify TPP activity in contracts and is monitoring this but TPP is not involved. Lead GP recognises that the TPP *modus operandi* does not *'actually fulfil the TP concept'*.Two primary care based projects (in Cancer services and School health) funded over and above HCHS more in line with the PCAP model.

Case ten (ref BJ) Single practice site, pioneer fundholder, simple organisational structure		
Circumstances in 1996-97	Intention for 1997-98	Circumstances in 1997-98
HA negotiated contract with monopoly provider (combined trust) with intention of identifying and removing activity/budget for TPP so TPP could negotiate independently. However, HA had problems setting TPP budget and the provider refused to talk to the TPP until the 'defund' was agreed. Thus, TPP had no budget and, by default, the HA contracted on their behalf without TPP input or agreement about activity levels. Monitoring activity proved problematic due to poor data quality. TPP claimed to have negotiated 2 changes in service provision - with clinicians rather than though contracting. Have secured their own team of midwives and a linked CPN arrangement.	TPP uncertain about the future. It had been their intention to contract independently in 1996-97 for most services, blocking back only high cost/low volume services. Site manager noted that TPP was single practice - covering 8% of city population - not a definitive geographical patch. Said the TPP felt quite powerless.	TPP reports *'As we had no contracts or budgets in place by the end of the summer we decided, with NYHA, to abandon the project. We will be in a commissioning group next year or the year after,'*

6.2 Joint contracting by TPPs who did not have independent contracts.

As discussed in the previous section, the 1997-98 survey identified five TPPs, without any independent contracts, who had opted instead to contract jointly with their HA for the purchase of services from some or all of their main local providers. The survey also included one HA wide TPP in 5 localities co-purchasing with the HA. One of the TPPs had a joint contract for mental health services only, but typically these TPPs held contracts with their main local providers of acute, community and mental health services. As they had no independent contracts, all services not covered by joint contracts were purchased by the HA on the TPPs behalf (blocked back). Two of the TPPs had a more extensive range of joint contracts covering, for example, acute services from lesser providers or regional specialties.

The 1996-97 contracting survey investigated the level of TPP activity and involvement typical of 'joint' contracting arrangements for TPPs without any independent contracts and found that those TPPs typically had a greater level of involvement in the joint contracting process than TPPs for whom joint contracts were supplementary to independently negotiated

contracts. The majority took part in the contract negotiations or in setting the service specifications for at least some of their joint contracts. All but one received activity data for the purpose of monitoring some if not all contracts and the majority perceived that the TPP had a responsibility for keeping activity levels within specified limits. The fact that, not withstanding a considerable level of involvement in other aspects of the contracting process, only one TPP had been a signatory to joint contracts in 1996-97, led us to conclude that such a formality was regarded as unnecessary.

The 1997-98 questionnaire sought once again to establish what level of TPP activity and involvement was typical of joint contracting arrangements in relation to contracts for different types of services. Survey respondents were offered a list of statements which sought to describe a TPP actively participating with the HA in the contracting process and were asked to say if these applied with respect to their main joint contracts for acute, community or mental health services. The composition of the statements was informed by the experience of the 96 -97 survey. Where TPPs had contracted for mental health and community services with the same provider they made a separate response for each of the two parts of the contract. For each of the three types of contract the questions were applicable to five TPPs. The data are summarised in Table 24.

Table 24 Characteristics of joint contracting arrangements for TPPs without independent contracts in 1997-98

	acute contract (N=5 TPPs)	community (N=5 TPPs)	mental health (N=5 TPPs)
TPP and HA are signatories to contract	2	2	3
TPP receives activity data for monitoring purposes	5	5	5
TPP is invoiced by providers prior to payments being made by the HA	2	2	1
TPP activity and costs are identified in the contract	5	4 cost only 1	4 cost only 1
TPP pays for TPP activity overruns	2	1	1
TPP input to finance negotiations was....	*none* - *minimal* - *modest* 2 *substantial* 3	*none* - *minimal* - *modest* 2 *substantial* 3	*none* - *minimal* 1 *modest* 2 *substantial* 2
TPP input to setting service specifications was.....	*none* 1 *minimal* 1 *modest* - *substantial* 3	*none* - *minimal* 1 *modest* 2 *substantial* 2	*none* - *minimal* 1 *modest* 2 *substantial* 2

The table shows that in all but one case TPP activity and costs are both clearly distinguished in joint contracts and activity data is received for monitoring purposes in all cases. The TPPs typically had substantial or modest levels of input to finance negotiations, although administrative procedures were such that TPPs did not typically receive separate invoices prior to payment. Levels of input to setting service specifications were also often substantial or modest but responses showed rather more variation. The data suggested that the nature of joint contracting had not changed substantially since 1996-97.

With respect to the management of activity, the 1996-97 survey found that the majority of TPPs who contracted jointly with main providers considered that they had a responsibility to keep activity within given limits. In other words they did not perceive that contracting jointly insulated them from responsibilities to manage activity within budgetary limits. The 1997-98 survey addressed this issue in slightly different terms by asking if the TPP paid for activity overruns. In fact the responses indicated that TPPs paid for activity overruns in only two out of five cases with respect to acute contracts and in only one out of five cases with respect to community and mental health contracts.

6.3 Monitoring of joint contracts - TPP views on the adequacy of provider data

As Table 25 shows, TPPs who had a joint contract with their HA for services from their main acute provider were typically satisfied with the adequacy of the data they received from the provider for all contract monitoring purposes. In 1996-97 two of these TPPs had identified some problems with accuracy of data.

Table 25 TPP rating of the adequacy of data from the main acute provider for contract monitoring purposes in 1997-98 - joint contracts
(N=5 TPPs)

	totally adequate	largely adequate	largely inadequate	totally inadequate	*row total*
for monitoring activity	1	4			5
for monitoring expenditure	1	4			5
for monitoring service quality	1	3		1	5

6.4 The experience of agreeing joint contracts

Only one TPP reported having experienced any major problems in getting joint HA/TPP contracts with main providers agreed at the beginning of the financial year. The TPP concerned had tried but failed to move to contracting on a length of stay basis by changing to the use of occupied bed days as the contract currency in respect of the TPP component of the contract. It appeared that it had proved impossible to get the necessary information to support this change for the 1997-98 contract but the TPP reported that they still hope to contract on LOS in 1998-99 and they noted that *'any reductions would save money' (ref DA).* (This TPP had employed a case manager to look at admissions and facilitate discharge and thereby promote a shift from secondary to primary care - *source 1996-97 contracting survey*)

6.5 Service changes achieved through joint contracting

All but one of the six TPPs who contracted jointly with main providers in 1997-98 stated that the TPP had succeeded in bringing about change to services that were co- purchased . The exception was the HA wide TPP where the respondent pointed out that it was too soon to make such claims as 1997-98 was the first year of the project, but noted that changes were likely in 98/99 on opthalmology services.

Two TPPs claimed to have achieved changes to the organisation and delivery of local mental health services. In one case the respondent explained *' the role and functions of a community mental health team have been determined with substantial input from GPs' (ref CB)*

Three TPPs claimed to achieved developments in a range of community services. The first noted the introduction of in-house chiropody and shared care for patients with chronic obstructive pulmonary disease; the second claimed to have had a *'minor influence'* on developments to physiotherapy services ; whilst the third claimed to have taken the lead on major changes to family planning services and community medical officer services. In this last case the TPP led a review of family planning services which resulted in a *'reduction of the former community service and an increase in primary care based provision with the service specification rewritten from a primary care perspective'*. The TPP also led a review of the community medical officer service which resulted in the *'refocusing of the service to provide a specialist service not available in primary care '(ref FB).*

One TPP claimed changes to maternity services achieving the criteria of 'Changing childbirth' and one TPP claimed to have had a minor influence on developments in acute urology services.

These data suggest that the achievements of TPPs who have opted to contract jointly have related almost exclusively to developments in community and primary care based services rather than influencing secondary care. At least two of the co-purchasing TPPs, however, gave indications that they had some interest in the latter. As previously noted, one had sought to change to a length of stay sensitive contract currency to achieve savings associated with early discharge whilst another reported that their 1997-98 contract differed from the 1996-97 contract with the same provider in that there had been *' a change in emphasis on a range of standards e.g. pressure sores; analysis of emergency admissions; and a move to a patient centred discharge policy which accounts for needs and is multi agency. Standards for drugs and continuing care arrangements are included' (ref EF).*

To add to this account of joint contracting, it is relevant to refer to details of a further TPP having a joint contract with the main local provider of acute services. The TPP in question was not placed in the same category as the others discussed in this section because, unlike them, the TPP had also contracted independently, but for community services only. This TPP was an active co-purchaser, however, and claimed to have had major influences on services covered by joint contracts, including secondary care. The TPP claimed that, as a consequence of TPP led analysis of contract minimum data set (CMDS) data, the contract currency for the main acute provider was changed from finished consultant episodes to admissions for non-elective activity. The TPP also claims credit for working with consultant medical staff to obtain a better understanding of the use of the A&E service and the reasons why some patients use the service rather than consulting a GP; encouraging an acute provider to develop an assessment ward, with differential pricing; and obtaining more competitive prices from an acute provider where the TPP was a major stakeholder.

7. TPP FINAL REFLECTIONS

As a final reflection TPPs were asked - in the latter half of the third year of TPP, which was intended to be the second year of live purchasing- if they were satisfied with the current combination of contracting arrangement in terms of the balance between independent, joint, and HA contracts.

34 of the 39 TPPs who took part in the survey gave a response. As Table 26 indicates, the TPPs who had independent contracts were more likely to be satisfied overall than those who had no independent contracts.

Table 26 TPP contracting status by satisfaction with overall combination of contracting arrangements 1997-98

	satisfied	not satisfied	total
had independent contracts	19	6	25
had no independent contracts	6	3	9
total	25	9	34

Just over half of these TPP elaborated on their response with additional comments. In many cases these comments refer to opinions or aspects of the TPP experience that had already been explored in the survey questionnaire and have been referred to elsewhere in this report. These comments reveal a diversity of opinion amongst TPPs, and between TPPs and their HAs, about the appropriate scope of total purchasing.

The circumstances of TPPs without independent contracts were presented in a previous section of this report in which a distinction was made between those TPPs who had opted for joint contracts as their preferred model and those who had been frustrated in their ambitions to purchase independently. As the majority of TPPs without independent contracts in 1997-98 fall into the latter category it is not surprising that the majority who responded directly to this question said that they were not satisfied with the overall balance of their contracting arrangements. Comments such as the following reveal that they perceive their experience as a missed opportunity;

> *'We would have wished to move to a more independent relationship with our providers but have been hampered by variable data and a dire local financial position' (ref FB)*

As far as TPPs with some independent contracts were concerned, two of them - who expressed satisfaction with their current balance of contracting arrangements - indicated that they hoped to extend the scope of independent purchasing even further in the future and both mentioned continuing care as an example of services they might wish to take on. A third TPP qualified their expression of satisfaction by noting that they had been frustrated by the HA in their wishes to have an independent contract for mental health services alongside their other independent contracts. A further TPP expressed a similar commitment to purchasing as many services as possible independently:

> *'My feeling is that only minimal services e.g. clinical audit, health promotion, public health etc. should be blocked back to the HA. A risk management strategy for supra-regional services and high cost/low volume activity should be established (ref DC)*

In contrast, two TPPs with some independent contracts linked their expression of satisfaction to the fact that they did *not* have the responsibility of purchasing *all* services:

> *'Joint contracting was done on grounds that duplication of effort would not gain benefits for the TPP and its population' (ref AH)*

> *' We have freedom to deal with all of the local trusts but are no longer concerned with the concern and administration of the ECR process and consequent financial risk (ref BE)*

The six TPPs who had some independent contracts but claimed to be *dissatisfied* with the overall balance of their contracting arrangements had been frustrated in a variety of ways in their efforts to extend the scope of their endeavours. In one case the TPP noted a lack of success in extending direct contracts further in 1997-98 *'due to provider indifference*' and voiced uncertainty about how much independence the TPP would retain *' in the current climate under which the internal market is being dismantled and whole authority service and financial framework introduced'(ref AG).* A second TPP, also noted that the TPP would not continue in its present form beyond the end of March 1998 in consequence of the government white paper, and in retrospect judged its decision to opt for a joint contract with the main acute provider as a *'missed opportunity' (ref BD).*

Three TPPs, whilst satisfied with the independent contracts they had, were dissatisfied overall because they would have wished to contract independently for additional services. In the case of one TPP who expressed the wish to *'take on or have more influence in the regional*

specialties budget' (ref DB), it is not clear how they had been prevented from doing so. In the remaining two cases, it was clear that they had been frustrated by disagreement and lack of support on the part of the HA. The first had disagreed with the HA in respect of a number of *'block backs'* whilst the second had wished to contract independently for ambulance services and noted *'we acknowledge HA concerns, but have yet to be convinced that it is a 'non-starter' (ref EE).* Unlike those referred to in the previous paragraph, this TPP clearly did not assume that changes to government policy spelt an end to their ambitions because the respondent noted *'Perhaps when we move to a Primary Care Group.....!'*

In the final case of a TPP expressing dissatisfaction with the overall balance of their contracting arrangements, 1997-98 was the first year in which they had independent contracts. The respondent perceived that the TPPs independence had been curtailed by HA insistence that block contracts be retained and no changes of provider be made.

8. CONCLUSIONS

When we reported the results of our survey of TPP contracting for 1996/97 we were very aware that we had data for only one live year of contracting. While we were able to highlight a number of significant developments, it was clear that these were early developments which could be expected to be subject to change as total purchasing evolved. The survey findings in this report have enabled us to follow developments through the second year of contracting. They reveal that that total purchasing has indeed evolved but not always in ways that might have been expected.

Comparing TPP contracting in 1997/98 with that undertaken in 1996/97, some of the key findings are as follows:

- There was not a major expansion in the scale of independent contracting in 1997/98 as TPPs which had not contracted independently in 1996/97 caught-up. Thus of the 13 TPPs who had no independent contracts in 1996/97, only three moved to independent contracting in 1997/98. Nonetheless, independent contracting was widespread: 27 of the 39 (69%) TPPs included in the 1997/98 survey had one or more independent contracts.

- There was little change between 1996/97 and 1997/98 in TPPs level of involvement in setting or monitoring joint contracts held with their DHAs. Twelve TPPs holding joint contracts when they were interviewed in 1996/97 indicated that they intended to move to independent contracts in 1997/98. In the event, only two did so.

- There were no major changes in the number and size of contracts between the two years, but there were several examples of new independent contracts being used to achieve specific service objectives, e.g. new contracts for nursing home, hospice and intermediate care.

- Twenty out of 24 respondents (83%) rated their first years main acute contract as "successful" in terms of predicted activity and costs, cost savings and service quality improvements. Extensive learning-by-doing was suggested by the fact that 21 TPPs made changes to their 1997/98 contracts on the basis of their experience during the first year of contracting. A total of 78 changes were reported covering finance, activity and service specifications. More effective contractual arrangements for managing admissions to and discharges from hospitals were an important focus of change for a number of sites.

- The perceived "success" of contracting was further emphasised by 19 TPPs (73%) who reported that their service objectives were adequately reflected in their contracts.

- Improvements in data on activity and costs - which were identified in 1996/97 - continued in 1997/98, so that only a small number of TPPs were experiencing difficulties in monitoring activity and expenditure. In contrast, 50% of respondents said that routinely supplied data was inadequate for purposes of monitoring service quality. This suggests that if, in the future, primary care based purchasers are to be less concerned with monitoring activity and more concerned with the quality of care, there will need to be major investments in information systems to provide them with the necessary data.

- Twenty-five out of 39 respondents (64%) had independent contracts for community services in 1997/98. Many of these TPPs had revised their contracts on the basis of their first year's experience. Thus 14 out of 20 respondents reported between one and eight changes to their 1996/97 contracts on aspects such as finance, activity and service specifications. The majority of respondents (72%) said that their service objectives were now reflected in their contracts.

- Taking all contracts together, it is noticeable that the process of negotiating them was far less difficult in the second year compared with the first year. In 1996/97, 82% of TPPs with independent contracts reported difficulties in reaching agreement; by 1997/98 the proportion reporting difficulties had fallen to 41%.

- A major finding of the 1996/97 survey was that 86% of respondents described their contracts as either "very important" (39%) or "of some importance" (47%) in achieving change and in the development of services. The 1997/98 findings indicated a slight weakening in this emphasis with 78% of respondents rating contracting "very important" or "important".

Our interpretation of these findings is that independent contracting continued to be an important aspect of total purchasing for the majority of sites in 1997/98. Most of them considered their contracts to have been successfully managed in terms of achieving planned levels of activity and costs, making cost savings and bringing about service quality improvements. There had been considerable learning-by-doing as contracts were adjusted in the light of the first year's experience. Contract negotiations had proved less difficult in the second year and a majority of TPPs still considered the contracting process to be an important lever for bringing about service changes.

The main defect of the contracting process expressed by those TPPs undertaking independent contracting seemed to be the poor quality of data available for monitoring service quality.

Set against the achievements outlined above was the fact that independent contracting had not spread more widely among TPPs as might have been expected. TPPs who had announced their intentions of moving to independent contracting had, on the whole, not done so.

What conclusions can be drawn from these findings for the future development of primary care based purchasing, especially as it is likely to be undertaken by PCGs? Certainly TPPs with independent contracts bear many similarities with level 2 PCGs. In our last report we pointed to the success of smaller, less organisationally complex TPPs in relation to contracting. This tendency was confirmed in other parts of the TP-NET study. The second year results of the main TP-NET study have suggested that the advantages of smaller, less complex sites were less apparent as larger sites caught up. The second year results on contracting do not throw any additional light on this subject, but it is important to emphasise that even the largest TPPs (with patient populations up to 80 thousand) are considerably smaller than most PCGs. Beyond this, we continue to emphasise the importance of the contracting mechanism as an important part of the commissioning package designed to bring about change. Finally, we would emphasise the need to improve information systems dealing with service quality if this aspect of care is to receive the deserved priority it merits in the future.

References

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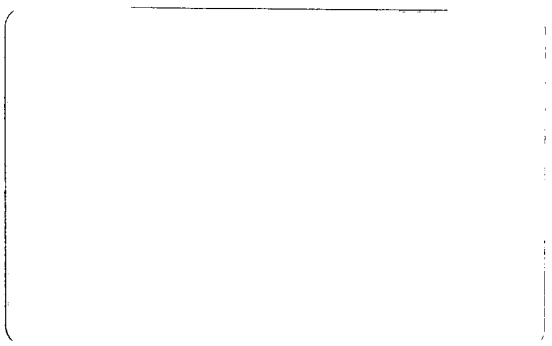

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ISBN 1-85717-249-3