King's Fund

National Evaluation of Total Purchasing Pilot Projects
Working Paper

Profile of Second Wave Total Purchasing Pilots: Lessons Learned from the First Wave

Gill Malbon
Nicholas Mays
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Amanda Killoran
Nick Goodwin
King's Fund
London

For further information on this part of the national evaluation contact Gill Malbon (tel 0171 307 2542/fax 0171 307 2807/email G.Malbon@kehf.org.uk).
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This report has been produced to disseminate research findings and promote good practice in health and social care. It has not been professionally copy-edited or proof-read.

The Total Purchasing National Evaluation Team (TP-NET)

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

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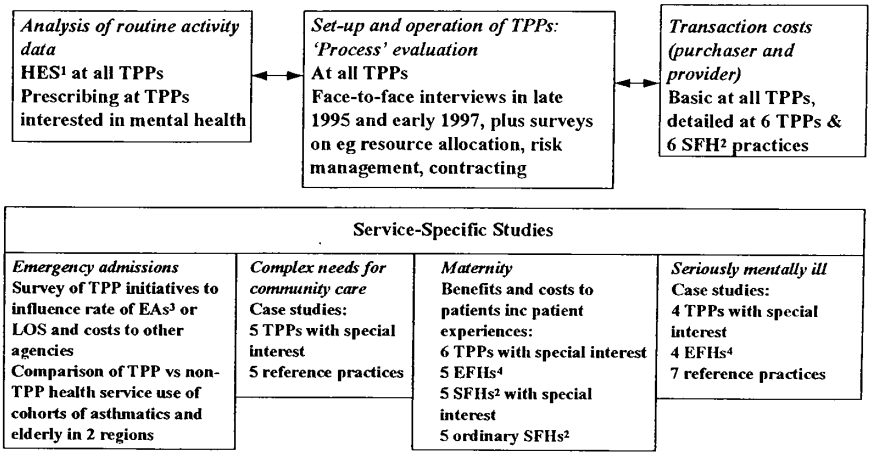
Contents

Preface: The National Evaluation of Total Purchasing Pilot Projects

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

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

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



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

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

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

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

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

Title and Authors	*ISBN*
Main Reports	
Nicholas Mays, Nick Goodwin, Gwyn Bevan, Sally Wyke on behalf of the Total Purchasing National Evaluation Team (1997). *Total purchasing: a profile of the national pilot projects*	1 85717 138 1
Nicholas Mays, Nick Goodwin, Amanda Killoran, Gill Malbon on behalf of the Total Purchasing National Evaluation Team (1998). *Total purchasing: a step towards primary care groups*	1 85717 187 X
Working Papers	
The interim report of the evaluation, *Total purchasing: a step towards primary care groups*, is supported by a series of more detailed Working Papers available during the first half of 1998, as follows:	
Nicholas Mays, Nick Goodwin, Gill Malbon, Brenda Leese, Ann Mahon, Sally Wyke *What were the achievements of total purchasing pilots in their first year and how can they be explained?*	1 85717 188 8
Gwyn Bevan *Resource Allocation within health authorities: lessons from total purchasing pilots*	1 85717 176 4
Ann Mahon, Brenda Leese, Kate Baxter, Nick Goodwin, Judith Scott *Developing success criteria for total purchasing pilot projects*	1 85717 191 8
Ray Robinson, Judy Robison, James Raftery *Contracting by total purchasing pilot projects, 1996-97*	1 85717 189 6
Kate Baxter, Max Bachmann, Gwyn Bevan *Survey of budgetary and risk management of total purchasing pilot projects, 1996-97*	1 85717 190 X
Ann Mahon, Helen Stoddart, Brenda Leese, Kate Baxter *How do total purchasing projects inform themselves for purchasing?*	1 85717 197 7
John Posnett, Nick Goodwin, Jenny Griffiths, Amanda Killoran, Gill Malbon, Nicholas Mays, Michael Place, Andrew Street *The transaction costs of total purchasing*	1 85717 193 4
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Sally Wyke, Jenny Hewison, James Piercy, John Posnett, Linda Macleod, Lesley Page, Gavin Young
National evaluation of general practice-based purchasing of maternity care: preliminary findings.
1 85717 198 5

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

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

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

1 Introduction

Purpose of the report

The aim of this working paper is to present a profile of the thirty-five second wave Total Purchasing Pilots (TPPs) in England and Scotland as part of the national evaluation of TPPs. The projects were established in April 1996 and joined the fifty-three first wave TPPs as part of the national Total Purchasing (TP) pilot scheme a year later than their predecessors.

The objectives of the report are:

- to describe the basic characteristics of the second wave TPPs, and particularly, highlight similarities and differences between first and second wave projects;
- to report the experience of the second wave TPPs in setting up their projects including aspects of organisation and management, management costs, relationship building, budget setting, financial and risk management;
- to document and analyse the purchasing intentions of the second wave TPPs and compare them with the purchasing intentions of the first wave;
- to comment on the position and prospects of the second wave TPPs in the light of the progress of the first wave TPPs in their first live year of purchasing (1996/ 97), the factors which appear to be associated with more and less successful first wave TPPs and the implications for the implementation of the White Paper: *the New NHS: Modern-Dependable* especially the creation of Primary Care Groups (PCGs)

The report is based on the experience of the projects during their preparatory year (i.e. the information was collected January-April 1997 as projects were preparing for their first live year of purchasing). The report, therefore, documents a 'baseline' position before the projects went into their first 'live' purchasing cycle. The follow up evaluation of the projects is planned to take place in April-May 1998 and will assess the extent to which projects have been able to implement their purchasing intentions, and the factors that have helped or hindered progress, their management costs and their transition towards PCGs.

A similar baseline profile report was produced for the first wave TPPs (TP-NET, 1997).

Policy Context

The White Paper *The New NHS* sets out a new context for the development of primary care commissioning. Primary Care Groups of around 100,000 population are to be established in all parts of the country by April 1999. Groups will have a comprehensive range of

responsibilities. They are to commission virtually all health care, but also be concerned with promoting the health of the populations they serve and developing primary care. It is envisaged that PCGs will 'grow out' of the existing range of commissioning models (fundholding, multi-funds, total purchasing, locality and general practitioner commissioning).

Box 1.1: Options for Primary Care Groups

Primary care groups will:

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

Level 2: take devolved responsibility for managing the budget for healthcare in their area, formally as part of the Health Authority.

Level 3: become established as free-standing bodies accountable to the Health Authority for commissioning care.

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

Although originally introduced as an extension of fundholding, TP is perhaps the closest form of general practitioner involvement in commissioning to that envisaged in the White Paper. TP involves fundholding general practices being delegated a budget to purchase potentially all the hospital and community health services (HCHS) for their populations.

Method

The study was based on three distinct phases outlined below. Data collection was undertaken between November 1996 and April 1997, i.e. towards the end of the projects' preparatory year. It therefore provides information on projects' setting up activities and purchasing intentions for 1997/ 98.

Phase 1

A form was sent to the named project manager of each project. This requested basic details such as number of practices; number of general practitioners and general practitioner codes; project population; providers and key contact names (lead general practitioners, Health Authority (HA) contact, main providers, social services contact). A 100% response rate was achieved.

Phase 2

A detailed postal questionnaire was sent to each project manager in January-February 1997. This covered a wide range of topics including the objectives of projects in becoming a TPP, aspects of organisation and management, areas of business planning, TPPs' relationships with other organisations, management costs, budget setting, and purchasing intentions . Thirty two (out of 35) questionnaires were returned. One TPP was interviewed as part of a separate Regional study, one TPP had dropped out of the scheme and the final TPP required a slightly different approach as it included all the practices in the district. A 100% response rate was achieved.

Phase 3

Thirty two structured telephone interviews with the lead general practitioner of each TPP were undertaken in March - April 1997. This covered similar topics to the project manager questionnaire, therefore, enabling corroboration of findings. Particular emphasis was given to investigating the relationships between general practitioners in each of the projects and purchasing intentions. Interviews were taped. Subsequently, responses to pre-coded questions were entered into SPSS for analysis and responses to open-ended questions were recorded verbatim and coding systems developed for analysis.

Reasons for TPPs dropping out of the scheme

The reasons given for dropping out of the TP scheme by second wave TPPs were similar to those given by first wave TPPs (Mays, Goodwin, Malbon, et al, 1998). Both of the second wave TPPs which withdrew were small inner city projects which found that the level of work and time required for TP was more than the lead general practitioner and other practice staff were able to provide.

2 Profile of first and second wave TPPs

Comparison of 'first and second' wave TPPs

There are a number of basic differences between first and second wave TPPs as shown in Table 2.1:

- Generally, the TPPs that make up the second wave are much more varied in size. For example, population size ranges from 8,500-319,280, compared with 8,100-84,700 in the first wave, suggesting a continuing level of uncertainty about the optimum size of a TPP. One second wave TPP contained a number of unofficial non-fundholding practices which boosted the variation in population size.
- There are more single practice TPPs in the second wave than the first wave - 40% compared with 36% - which is interesting in view of the Labour government's policy shift towards more collective forms of general practitioner commissioning.
- Second wave TPPs are on average (taking the median, rather than the mean due to the enormous variation amongst the TPPs) smaller than their first wave counterparts, with fewer practices per TPP on average, fewer general practitioners per TPP, smaller populations and a smaller proportion of the HA population overall.
- Second wave TPPs have substantially less experience of fundholding than first wave TPPs. For example, nearly three-quarters of first wave TPPs contained practices which were first or second wave fundholders, compared with less than half of the second wave TPPs (see Table 2.2).
- Second wave TPPs also reported lower direct management costs per patient in their preparatory year than first wave TPPs
- Finally, second wave TPPs were more likely to be found in major towns or cities (i.e. urban settings) than first wave TPPs.

The 35 projects were located in each of the eight NHS Regions in England and in one of the Scottish health boards. There are 32 District Health Authorities and one Scottish health board which contain second wave TPPs. Three of these have more than one second wave project (per HA) and ten HAs contain both first and second wave TPPs. The average size of second wave TPPs varies by Region. The Anglia and Oxford and South and West Regions have a high proportion of single-practice TPPs and the Northern and Yorkshire and the North West Regions have a higher proportion of larger, multi-practice projects.

Table 2.1: Summary table of basic characteristics for first and second wave TPPs: April 1997

	First wave	Second wave	All
Basic features			
Number of projects	56[1]	35[2]	91
Number of single-practice TPPs	36%	40%	37%
Number of multi-practice TPPs	64%	60%	63%
Size			
Mean number of practices	3	4	4
Median number of practices	3	2	3
Mean number of general practitioners	17	20	18
Median number of general practitioners	16	10	12
TPP patient population			
Range of population	8,100-84,700	8,500-319,280	8,100-319,280
Mean TPP patient population	31,300	34,900	32,700
Median TPP patient population	28,200	18,000	23,000
HA patient population			
Mean percentage of HA-population served by the TPPs	6%	10%	7%
Median percentage of HA-population served by the TPPs	6%	4%	5%
Mid-range (25%-75%) of HA population served by the TPPs	3%-8%	3%-9%	3%-9%
Organisational features			
Proportion of TPPs with a dedicated Project Manager	66%	43%	59%
Proportion of TPPs with a complex organisational structure	38%	40%	39%
Proportion of TPPs with a simple organisational structure	30%	11%	24%
Experience of fundholding			
Percentage of TPPs with first or second wave fundholders	73%	40%	60%
Percentage of TPPs without first or second wave fundholders (i.e. third-sixth wave fundholders)	27%	60%	40%
Management costs in the preparatory year			
Mean per capita cost in the preparatory year, wave 1 (n=51): 1995/96 adjusted to 1996-97 prices and wave 2 (n=29): 1996/97	£2.79	£2.40	£2.65
Median per capita cost in the preparatory year, wave 1: 1995/96 adjusted to 1996/97 prices and wave 2: 1996/97	£2.71	£2.09	£2.48
Management costs in the first 'live' year of purchasing: first wave			
Mean per capita cost in the first live year (wave 1 data only) 1996/97 (n=50)	£2.90	-	£2.90
Median per capita cost in the first live year (wave 1 data only) 1996/97	£2.78	-	£2.78
Future ambition			
Percentage of TPPs whose future ambition lie in TP-specific areas	77%	-	77%

[1] Four first wave TPPs withdrew from the scheme before the end of their first 'live' year of purchasing
[2] Two second wave TPPs withdrew from the scheme before the end of their first 'live' year of purchasing

Table 2.2: Breakdown of TPP practices by fundholding wave, first and second wave TPPs, April 1997

First wave	*Wave 1 April '91*	*Wave 2 April '92*	*Wave 3 April '93*	*Wave 4 April '94*	*Wave 5 April '95*	*Wave 6 April '96*	*Wave 7 April '97*	*TOTAL*
Single-practice sites	12	7	6	2	0	0	0	27
Multi-practice sites	37	42	30	25	7	23	0	164
TOTAL	**49**	**49**	**36**	**27**	**7**	**23**	**0**	**191**
Second wave	*Wave 1 April '91*	*Wave 2 April '92*	*Wave 3 April '93*	*Wave 4 April '94*	*Wave 5 April '95*	*Wave 6 April '96*	*Wave 7 April '97*	*TOTAL*
Single-practice sites	3	2	6	1	1	0	0	13
Multi-practice sites	9	5	19	21	12	17	3	86
TOTAL*	**12**	**7**	**25**	**22**	**13**	**17**	**3**	**99**

*One second wave TPP has 9 non-funfholding practices

2 second wave TPPs are missing

Table 2.3: Regional distribution of First and Second Wave TPPs, April 1997

Region	*First wave* *Number of projects*	*Second wave* *Number of projects*	*First wave* *No. of authorities with a project*	*Second wave* *No. of authorities with a project*	*First wave* *Number of practices covered*	*Second wave* *Number of practices covered*	*First wave* *Mean (ave.) no. of practices per project*	*Second wave* *Mean (ave.) no. of practices per project*	*First wave* *Patient population**	*Second wave* *Patient population**
South and West	6	3	6	3	15	5	2.5	1.7	182,951	37,639
South Thames	6	3	6	3	26	29	4.3	9.7	244,634	264,587
North Thames	6	5	3	5	31	10	5.2	2.0	285,501	96,214
Anglia and Oxford	3	3	3	3	6	4	2.0	1.3	94,400	44,752
West Midlands	6	6	5	5	11	16	1.8	2.7	128,527	109,193
Trent	8	5	7	4	24	20	3.0	4.0	213,999	124,958
North West	7	3	5	3	39	15	5.6	5.0	261,576	86,224
Northern and Yorkshire	5	6	5	5	19	53	3.8	8.8	163,948	91,690
Scotland	6	1	5	1	20	3	3.3	3.0	185,249	21,460
TOTAL	**53**	**35**	**45**	**32**	**191**	**155**	**3.6**	**4.4**	**1,760,785**	**876,717**

*2 second wave TPPs are missing

3 Organisation and management of second wave TPPs

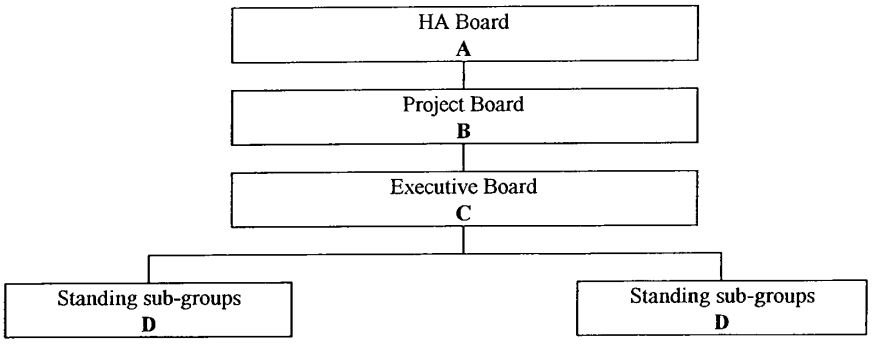
The ability to define what organisational arrangements are effective and cost effective in different local contexts is a critical issue for the future of general practitioner commissioning and the development of PCGs. Certain aspects of management and organisational development of TPPs appear to be important factors influencing the nature and scale of service changes TPPs are able to make and over what time scale. For example, the degree of organisational maturity and cohesive working between practices appears to be important from the experience of first wave TPPs (Mays, Goodwin, Malbon, et al, 1998).

This section outlines the formal management arrangements of TPPs and identities of the participants on the executive board or decision making group of the project, together with an account of which groups make the key decisions. It also looks at the background of the project mangers, project management tasks and the Information Technology (IT) required in the preparatory year.

The formal organisational structure of TPPs

TPPs have been crudely classified into levels of organisational complexity based on their formal organisational structures. The approach is presented in Figure 3.1, below.

Figure 3.1: Formal organisational structure of a hypothetical TPP



Codes for organisational structure:

1 = Most complex/ mature	Hierarchy A to D exists, formal sub-groups developed and a high degree of participation or involvement from external stakeholders.
2 = Intermediate	Hierarchy A to D exists, possible merger of B and C, some formal subgroups developed, low degree of participation from stakeholders - not formally part of committee structure but kept informed more casually.
3 = Least complex	Least bureaucratic/ mature. Few/ no formal sub-groups outside of main executive board. Few links with external organisations.

Table 3.1 indicates that over two-thirds of TPPs operated with the involvement of the HA Board, a Project Board and an Executive Board and about a quarter had merged their Project and Executive Board. In addition, nearly three-quarters of second wave TPPs had formed formal sub-groups. The work undertaken by Posnett *et al.* on first wave TPPs' transaction costs (Posnett, Goodwin, Killoran, *et al.*, 1998) identifies three levels of management meetings: 'Level 1' represented the formal mechanism by which the HA discharges its responsibility to monitor and in some cases to guide the development of the TPP (this could equate to the HA board indicated above); 'Level 2' represented the policy board of the TPP itself, responsible for strategic direction and decision-making (Project board level); and 'Level 3' reflected the day-to-day running of the project (Executive Board). This work showed that the frequency of meetings held varied across TPPs, although members of a TPP usually had at least one meeting per week at 'Level 3' which were supplemented by monthly and quarterly meetings at the other two levels. This suggests quite a high level of activity within sites which is crucial to consider in view of the amount of time required to manage total purchasing (increased pressure on general practitioner workload), the level of commitment involved, the extra costs incurred in attending frequent and regular meetings and the future sustainability of projects. Table 3.2 shows the regularity of project, executive and merged project and executive board meetings held by the second wave TPPs. The majority of TPPs held their Project and Executive (or combined) board meetings on a monthly basis. Project Boards were often held less frequently, and on a more sporadic basis, whereas approximately 80% of projects had either an executive or combined board meeting at least once a month.

Table 3.1: Organisational groups involved in the TPP

Organisational Groups	*Number (n=31)*	*% of responses*	*% of cases*
Health Authority Board	21	22.1	67.7
Project Board	24	25.3	77.4
Executive Board	20	21.1	64.5
Combined Project and Executive Board	8	8.4	25.8
Formal Sub groups (ad hoc, standing/ permanent)	22	23.2	71.0
TOTAL*	**95**	**100.0**	

*Total number adds to more than 30 because TPPs may have more than one different organisational body
4 TPPs are missing

A. The Health Authority Board

The Health Authority Board is attended purely by health authority staff and discusses health authority policy towards the TPP and gives strategic guidance to the project.

B. The Project Board

The Project Board acts as the steering group to the TPP Project and is most likely to be a sub committee of the health authority. The project board gives strategic guidance to the executive board and often holds full delegated power over the project on behalf of the health authority. The project board tends to be a mixed group of health authority and TPP personnel. Membership may also be extended to representatives from other organisations such as providers, social services, other fundholding groups and Community Health Councils (CHCs)

C. The Executive Board

The Executive Board can be described as the 'decision making' group of the project since it develops and proposes the objectives and purchasing intentions of the project. The executive board is most likely to comprise the TPP project manager and/or fundholding managers and lead general practitioners.

B/C. The Combined Board

The functions of the project board and executive board are often combined into a single decision-making body - the Combined Board. This is particularly true of single practice projects.

D. Ad Hoc Groups and Standing/ Permanent Sub Groups

These can be both standing groups with specific roles, such as dealing with IT issues, contracting, finance, clinical priorities etc, or ad hoc groups which disband when their task is accomplished. The membership of ad hoc and sub groups varies but often comprises lead general practitioners with a special interest, project managers and health authority managers seconded to help the project in that specific area.

Table 3.2: Regularity of Project and Executive Board Meetings

Regularity of meetings	*Project Board Meeting* (n=29)	%	*Executive Board Meeting* (n=24)	%	*Merged board meeting* (n=10)	%
Weekly	0	*0*	2	*10*	1	*10*
Fortnightly	0	*0*	5	*25*	1	*10*
Monthly	9	*38*	9	*45*	6	*60*
4-8 weeks	0	*0*	2	*10*	0	*0*
6-8 weeks	8	*33*	0	*0*	1	*10*
Quarterly	0	*0*	0	*0*	1	*10*
Other (including ad hoc)	7	*29*	2	*10*	0	*0*
TOTAL*	**24**	***100***	**20**	***100***	**10**	***100***

*Respondent could give more than one answer

Table 3.3 shows the level of organisational complexity by the number of practices per TPP for first and second wave TPPs. One might have expected second wave TPPs to have had less complex arrangements than first wave TPPs for managing TP, due to their relatively smaller size. However, at first glance it seems that second wave TPP were in fact more highly organised than the first wave TPPs. This was because more second wave TPPs had already established formal links with their host HA, more had set-up sub-groups including organisations like the Community Health Council (CHC) and Local Medical Committee (LMC) and more had started talking to their patients about TP during the preparatory year. When first wave TPPs organisational structures were considered in connection with their level of achievement during the first live year of purchasing, single practice TPPs with 'simple' organisational structures appeared to find it easier to make early progress on objectives than larger, more 'complex' projects. This is explicable principally in terms of the fact that the single practice TPPs did not require to establish a completely new organisation to undertake TP. Smaller projects, however, are likely to be encouraged to join other organisations in line with the new policy shift towards larger groupings of practices, or PCGs with patient lists of around 100,000 (Secretary of State for Health, 1997).

Table 3.3: Organisational complexity of the TPP projects by number of practices in the TPP

Number of practices	*First wave*	*Second wave*	*First wave*	*Second wave*	*First wave*	*Second wave*
	Most Complex/ Mature		***Intermediate***		***Least Complex***	
One	4	2	3	9	13	2
Two	1	3	1	4	1	0
Three	2	2	6	0	1	1
Four	2	0	4	1	2	0
Five	6	2	1	0	0	1
Six	0	1	1	0	0	0
Seven	1	1	1	0	0	0
Eight	4	2	0	0	0	0
Nine	1	0	0	0	0	0
More than ten	0	0	1	1	0	0
TOTAL	**21**	**13**	**18**	**15**	**17**	**4**

3 second wave TPPs are missing

Management arrangements

Table 3.4 shows the participants on the decision making board (i.e. the executive board) for first and second wave TPPs. Nearly all first and second wave TPPs had a general practitioner representative on the executive board (96%), however, there was a larger proportion of dedicated TP project managers, HA representatives, public health staff, and CHC representatives and social services staff on the executive boards in the second wave than the first wave. The number of people from the CHC and the social services department was still very small (11% and 7% of the participants in the second wave). General practitioners were more likely to attend meetings when the TPP was intending to promote service development than when discussions on contracting were being held. This may be relevant to Level 1 PCGs whose primary role will be in advising the HA in commissioning care for its population (Secretary of State for Health, 1997) as opposed to being involved in managing the budget for healthcare as in Levels 2-3. Thus general practitioners will be expected to play quite a significant role in PCGs even at Level 1 status.

One potential influence on the ability of TPPs to succeed is the degree to which external organisations are involved with projects during the decision-making process.

Table 3.4: Participants on the executive boards of projects, April 1997

Participant	*First wave*	*Second wave*	*First wave*	*Second wave*
	% of projects including participant		*% of projects excluding participant*	
General practitioner	96%	96%	4%	4%
Dedicated TP manager	62%	82%	38%	18%
Health Authority representative	62%	71%	38%	29%
Fundholding manager	66%	64%	34%	36%
Other representative*	38%	39%	62%	61%
Public health representative	17%	29%	73%	71%
Provider representative	13%	14%	77%	86%
Community Health Council representatives	4%	11%	96%	89%
Social services representative	4%	7%	96%	93%
	n=53	*n=28*	*n=53*	*n=28*

* Other representative includes local medical committee, local authority councillor, GP commissioning group, etc.

4 second wave TPPs are missing

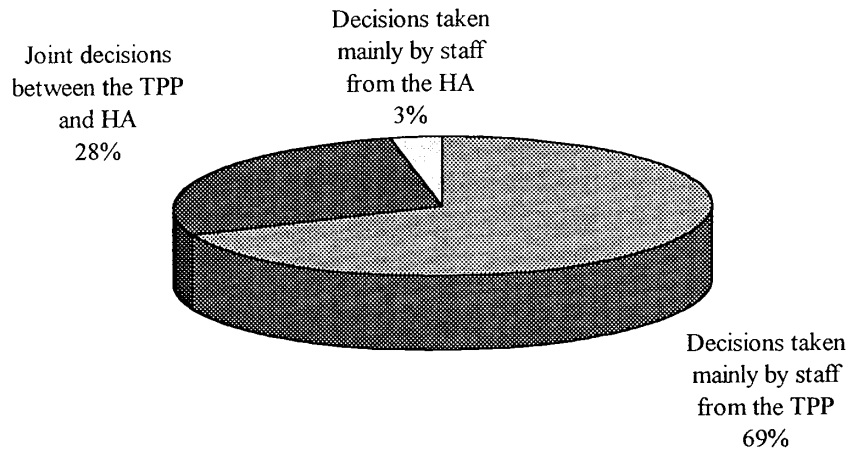
3 TPPs did not have an 'executive board'

Despite these formal arrangements outlined above , the majority of TPPs reported that most decisions were taken by members of staff from the TPP rather than decisions being taken mainly by members of the HA or jointly between the HA and TPP. This is likely to change with the introduction of PCGs which will require more formal managerial arrangements (for example, health needs assessment, patient participation, performance management and accountability frameworks which were largely absent in first and second wave TPPs) within the framework of the local Health Improvement Programme (HIPs) developed by the HA.

Table 3.5: Who takes decisions about the development of the project

Decision making group	*Number*	*%*
Decisions taken mainly by staff from the TPP	22	69
Joint decisions between the TPP and HA	9	28
Decisions taken mainly by staff from the HA	1	3
TOTAL	**32**	**100**

Figure 3.2: How decisions about the development of the project are taken



Project Managers and Project Management

As Table 3.6 suggests, single practice TPPs were more likely than multi-practice TPPs to use their existing fund/ practice manager as the TP project manager, whereas multi-practice TPPs in the main tended to employ a dedicated TP project manager. This is to be expected in multi-practice TPPs (and by implication in the still larger PCGs in the future) given their likely greater need for coordination.

Table 3.6: Management arrangements by type of TPP project (n=32)

Management arrangements	*Single-practice projects*		*Multi-practice projects*	
	n	*%*	*n*	*%*
Previous Fund/ Practice manager	8	61.5	6	31.6
Specialist TP Manager	3	23.1	12	63.2
Other	2	15.4	1	5.3
TOTAL	**13**	**100.0**	**19**	**100.0**

3 TPPs are missing

Nearly half of all second wave TP project managers came from an NHS management background (Table 3.7), with a quarter having previously worked as a fundholding/ practice manager. Forty per cent of TP project mangers came from either a nursing, public (non-NHS) or private sector background or some other professional area (10% in each group), with one TPP employing a retired general practitioner. At this stage of the evaluation, it is not possible to say whether any particular type of background is more suitable to manage a TPP than any other. However this will be an important issue when PCGs begin to recruit project managers for their organisations and it may be possible to cast some light on this when the second wave TPPs are followed up at the end of their first 'live' year to see which have progressed.

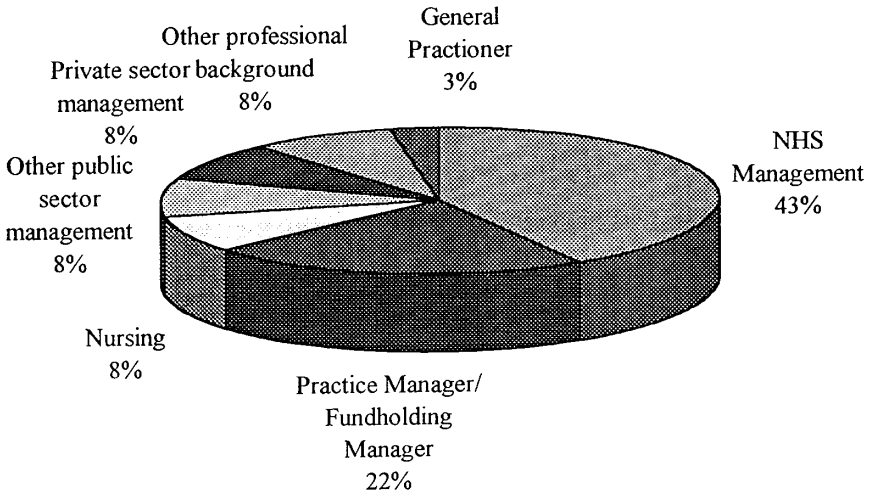
Table 3.7: Background of the 'second-wave' TP Project Managers

TP Manager's background	Number of responses	*% of responses*	*% of TPPs*
NHS Management	15	*41.7*	*46.9*
Practice Manager/ Fundholding Manager	8	*22.2*	*25.0*
Nursing	3	*8.3*	*9.4*
Other public sector management	3	*8.3*	*9.4*
Private sector management	3	*8.3*	*9.4*
Other professional background	3	*8.3*	*9.4*
General Practitioner	1	*2.8*	*3.1*
TOTAL*	**36**	***100.0***	

*Respondent could give more than one answer

3 TPPs are missing

Figure 3.3: TP Manager's background



Project Management Tasks

The most frequently reported task in the preparatory year was, deciding what to purchase and what to 'block back' to the HA. This is not surprising given that the aim of TP is to expand general practitioner purchasing into new service areas. The second and third most commonly cited tasks since becoming a TPP were setting up the information and financial monitoring systems in conjunction with the HA and developing the budget setting method and agreeing an allocation. Similar areas were identified by first wave TPPs as key tasks in the preparatory year. Overall the TP project manager and HA lead took part in the most key tasks, with the lead general practitioner being the third most dominant player.

Previous experience of purchasing/ commissioning, working together and the role of general practitioners

Table 3.8 shows the proportion of practices which had had experience of commissioning *other than* single practice standard fundholding before becoming involved in a TPP. Findings from the first wave suggested that TPPs with more experience of fundholding were better able to progress than those without (Mays, Goodwin, Malbon, *et al.*, 1998). Single practice TPPs in

the second wave were almost twice as likely as multi-practice TPPs *not* to have had experience of any collective fundholding or commissioning models: 80% compared with 44%. Just over two-fifths of multi-practice TPPs contained practices with experience of locality commissioning, being part of a SFH consortium or being in a multi-fund. This may suggest that there are different types of practices: those which choose to work with other practices and those which prefer to operate alone. This will be significant for the development of PCGs in terms of involving practices which in the past have intentionally maintained a single practice identity.

Table 3.8: TPP's experience of fundholding, other than single practice SFH by whether a single or multi-practice TPP

Type of fundholding	Single practice TPP	Multi-practice TPP	*Single practice TPP*	*Multi-practice TPP*
	number of responses		*% of responses*	
SFH consortium	1	3	*7.7*	*13.0*
SFH multi-fund	0	2	*0.0*	*8.7*
HA generated scheme, such as Locality Commissioning	1	5	*7.7*	*21.7*
GP-led or practice-led commissioning scheme	0	1	*0.0*	*4.3*
Never previously purchased/ commissioned, other SFH	10	10	*76.9*	*43.5*
Other type of scheme	1	2	*7.7*	*8.7*
TOTAL*	**13**	**23**	***100.0***	***100.0***

*Respondent could give more than one answer

3 TPPs are missing

In addition, practices in the second wave of TPPs tended to have joined the SFH scheme later than practices in the first wave (see Table 2.2). It will be interesting to see if their shorter experience of purchasing influences their ability to implement their objectives compared to first wave TPPs.

The extent to which the TPP is run as a top-down or bottom-up organisation is important in terms of motivation and HA support. Exactly half the second wave TPPs reported that they had actively volunteered to take part (i.e. a bottom-up approach). About a third reported that TP was a result of both them and the HA coming together and formulating a plan, and only a small minority suggested that it was entirely the result of an enthusiastic HA. As shown elsewhere (Mays, Goodwin, Malbon, *et al.*, 1998), first wave TPPs which had received a

higher level of HA support were more likely to achieve their objectives in their first 'live' year of purchasing compared with those which did not.

Table 3.9: Whether practices involvement in TP was driven from the bottom-up (i.e. practices) or whether the impetus came from the HA

Motivation to become a (part of) TPP	(n)	%
The practices actively volunteered to join TP: BOTTOM-UP	16	*50.0*
Mixture of both practice(s) and HA	11	*34.4*
The practices were approached by the HA: TOP-DOWN	4	*12.5*
Other	1	*3.1*
TOTAL	**32**	***100.0***

3 TPPs are missing

Finally, the role of the lead general practitioner within the TPP is considered. Lead general practitioners appear to have distinct views about their main roles as internal and external coordinators and facilitators, ensuring communication between, and participation of, their colleagues, and as providers of clinical expertise in the purchasing process (Table 3.10).

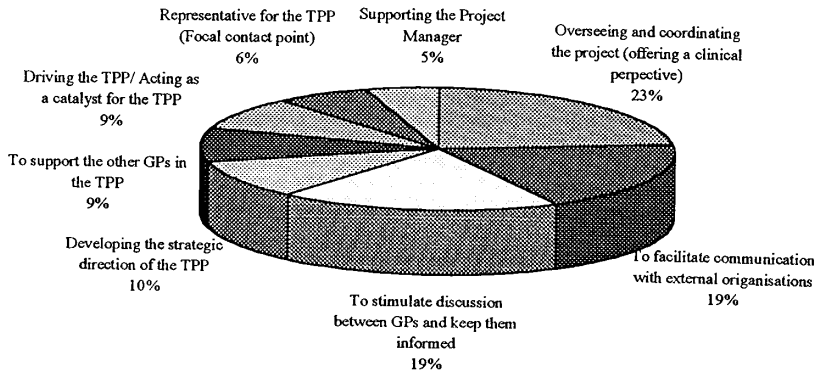
Table 3.10: What the lead GP thought their role should be in the TPP

Lead GP's role	*Number**	*% of responses*
Overseeing and coordinating the project (offering a clinical perspective)	18	22.8
To facilitate communication with external organisations	15	19.0
To stimulate discussion between GPs and keep them informed	15	19.0
Developing the strategic direction of the TPP	8	10.1
To support the other GPs in the TPP	7	8.9
Driving the TPP/ Acting as a catalyst for the TPP	7	8.9
Representative for the TPP (Focal contact point)	5	6.3
Supporting the Project Manager	4	5.1
TOTAL*	79	**100.0**

* Respondents could give more than one answer

3 TPPs are missing

Figure 3.4: Role of the lead GP in the TPP: lead GP's perspective



The majority (91%) of lead general practitioners said that they were happy with the way that the TPP was currently organised and managed (Table 3.11), although over a third of lead general practitioners said that they would like more support from the HA (36%). Others mentioned how time-consuming TP had been in the preparatory year (18%). This was corroborated by the TP project manager who suggested that approximately half of all lead general practitioners were working longer hours to sustain their TPP than they had previously. It is clear that TP places extra demands on general practitioners, especially lead general practitioners, both in terms of time and workload. Early findings from the first wave suggest that the majority of the additional transaction costs generated by TP are borne by the projects, especially by the lead general practitioners (Posnett, Goodwin, Killoran, *et al.*, 1998). A considerable proportion of the second wave general practitioners expressed fear over the sustainability of TP which will need to be addressed very carefully by policy makers as they widen TP to commissioning for all general practitioners. For example, extra reimbursement may be necessary on a larger scale than was available for enthusiastic volunteer TPP general practitioners.

Table 3.11: How happy are the lead GPs with the way the TPP is organised and managed at present

Happy with the organisation and management of the TPP	*Number*	*%*
Very happy	8	25.0
Fairly happy	21	65.6
Neutral	1	3.1
Not very happy	2	6.3
Not at all happy	0	0.0
TOTAL	**32**	**100.0**

3 TPPs are missing

Table 3.12: Reasons why the 'lead GP' would like to see changes in current management arrangements

Reasons for wanting to see some changes in the management arrangements	*Number*	*% of responses*
More support from the HA	10	35.7
Too time consuming for the key players	5	17.9
Disappointed that a budget has not yet been set	5	17.9
Too much central guidance, i.e. from the HA	3	10.7
Poor relations between the practices/ GPs within the TPP	3	10.7
Unable to employ locums (despite receiving mgt. costs)	1	3.6
Other *	1	3.6
TOTAL**	**28**	**100.0**

*Other includes lack of experience of project manager

** Respondents could give more than one answer

3 TPPs are missing

Non-lead general practitioners in the second wave also contributed to running the TPP. Sixty-three per cent were given responsibilities which contributed to the running of the TPP. Of those TPPs which did involve non-lead general practitioners, most were involved in developing specific clinical (service) areas with a view to purchasing or providing services within the practices, usually where they had expressed an interest. Experience from the first wave TPPs shows that progress is more likely to be made when a range of individuals is involved in specific tasks rather than one or two isolated general practitioners taking the lead. All too often, first and second wave TPPs have tended to rely on one or two key individuals.

Occasionally, the non-lead general practitioner developed non-clinical areas like IT or premises in second wave TPPs. In one TPP, there was a rotating lead general practitioner - thus all general practitioners were fairly actively involved in the running of the TPP. It is important to involve so-called, non-lead general practitioners for a number of reasons: firstly because it lightens the load for one or two general practitioners; secondly, it promotes commitment to TP amongst the general practitioners; thirdly, it provides more general practitioners with commissioning experience, which will be of real importance in the near future; and fourthly, collaborative working between general practitioners and a 'corporate' approach in areas such as clinical policy and budgetary management is likely to be important in

securing service improvements and staying within budget (Bevan, Baxter and Bachmann, 1998). Therefore, the role of general practitioners in encouraging intra- and inter-practice collaboration appears especially critical and challenging.

Tables 3.13 and 3.14 show the varying levels of commitment towards TP amongst the general practitioners in multi-practice TPPs. Table 3.13 shows that over half of the lead general practitioners suggested that commitment towards TP varied from practice to practice, and the main reasons cited were the concern about the amount of work involved (91%) and the uncertainty as to the benefits of TP (55%). These issues concerning workload and commitment will have to be addressed in the run up to PCGs.

Table 3.13: Whether the practices were equally committed to TP: multi practice TPPs only

Equal commitment	(n)	*%*
Yes	8	*42.1*
No	11	*57.9*
TOTAL	**19**	***100.0***

2 TPPs are missing

Table 3.14: Reasons why some practices were less committed than other: multi practice TPPs only (n=19)

Less commitment	(n)	*% of responses*	*% of TPPs*
Concerned about the amount of work involved	10	*41.7*	*90.9*
Uncertain about advantages of TP over SFH	6	*25.0*	*54.5*
Other	5	*20.8*	*45.5*
Have just recently joined SFH and feel unsure about what it's all about	3	*12.5*	*27.3*
TOTAL*	**24**	***100.0***	

* Respondents could give more than one answer

2 TPPs are missing

Lead general practitioners were asked whether they thought they were adequately trained for the management aspects of total purchasing. Most thought they probably were, but would like more information on issues concerning the wider NHS; for example, quicker access to Executive Letters (ELs), Health Service Guidance (HSGs), Health Service Circulars (HSCs) needs assessment and the application of ' Evidence Based Medicine'. Clearly TP requires general practitioners to take on significantly different and new areas of responsibilities beyond SFH which raises important questions about future training and career development opportunities, particularly with the establishment of PCGs. Despite the fact that the practices involved were all fundholders, TP represented an increase in responsibilities and required a deeper knowledge of the wider NHS. It is, therefore, interesting that 10 out of 35 lead general practitioners did not consider themselves to be managers at all. Rather, lead general practitioners regarded themselves solely as clinicians and than management and managers belonged to a certain type of person or role to which they did not relate. Management or being a manager was not considered to be a set of skills which they could acquire.

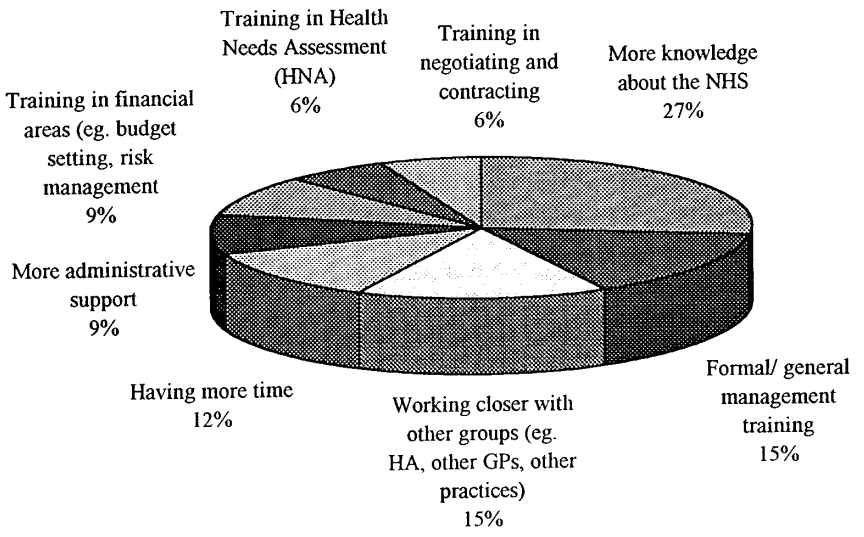
Table 3.15: Types of things the lead GP said might improve his/ her ability as a good manager

Areas which might improve the lead GP as a manager	*Number*	*% of responses*
More knowledge about the NHS, e.g. ELs, HSGs	9	27.3
Formal/ general management training	5	15.2
Working closer with other groups (eg. HA, other GPs, other practices)	5	15.2
Having more time	4	12.1
More administrative support	3	9.1
Training in financial areas (eg. budget setting, risk management	3	9.1
Training in Health Needs Assessment (HNA)	2	6.1
Training in negotiating and contracting	2	6.1
TOTAL*	**33**	**100.0**
Non-response (Nothing - doesn't consider themselves to be a manager	10	

* Respondents could give more than one answer

3 TPPs are missing

Figure 3.5: Things which might improve the lead GP's ability to manage the TPP



Information Management and Technology

Investment in, and the setting up of information systems as indicated above is essential in developing a TPP. Existing fundholding software packages are inadequate for TP and most first wave TPPs invested in developing new systems or modifying current ones. Projects are,in effect, acting as 'catalysts' for change in alerting practices, trusts and HAs to the information requirements of primary care organisations as providers and purchasers of care, and, therefore, represent a considerable source of experience for wider application (Mahon, Stoddart, Leese *et al.*, 1998). For example, TPPs were asking for information that had not previously been collected by HAs, or data that had been collected, but not in a manner which enabled monitoring or validation.

The majority of second wave TPPs (21 out of 32) were engaged in undertaking similar investments in developing new systems or modifying or extending their existing arrangements for SFH (Table 3.16). Overall, they seemed seem fairly or very happy with their IT arrangements for TP. According to Mahon, Stoddart, Leese *et al.* (1998) 51% of first wave TPPs (23 out of 45) had felt that their current IT arrangements were inadequate during their preparatory year, compared with only 13% of second wave TPPs (3 out of 23) which were

unhappy with their current IT arrangements. This is likely to be related to the fact that much of the software and hardware required for TP was still being developed during the first wave TPPs' preparatory year (Table 3.17). Equally, second wave TPPs were more likely to have had experience of seeing these newer systems in action, either at exhibitions or in operation at first wave TPPs. For example, two second wave projects were invited by two first wave TPPs to have a look at the system they were operating for TP. This provided the second wave TPPs with an opportunity to explore their IT requirements for TP which the first wave TPPs would not have had. However, this type of information sharing between waves was the exception rather than the norm and little was made of the first wave TPPs' experience of IT by the second wave TPPs.

Table 3.16: Information Technology (IT) arrangements for total purchasing

IT TP system	(n)	*%*
Developing a brand new system (ITS)	11	*34.4*
Using current SFH system **with** modifications	10	*31.3*
Using current SFH system **with no** modification	5	*15.6*
Not yet decided	6	*18.8*
TOTAL	**32**	***100.0***

3 TPPs are missing

Table 3.17: Whether happy with the current IT system or not

Happy with IT	*Number*	*%*
Very happy	1	4.3
Fairly happy	11	47.8
Neutral	8	34.8
Fairly unhappy	1	4.3
Very unhappy	2	8.7
TOTAL	**23**	**100.0**

12 TPPs are missing

4 External Relationships

Section four examines the relationships second wave TPPs have with other stakeholders (e.g. host HA, local providers, social services, etc.) and the nature of their relationships. First wave TPPs which had successfully managed to secure effective external links were also more likely to meet their own achievements in their first 'live' year of purchasing (Mays, Goodwin, Malbon, *et al.*, 1998).

Relations with the TPP's host HA

Tables 4.1-4.3 show that the majority of TPPs considered their HA to be 'fairly' or 'very' accessible (over three-quarters) and reliable (over half). Similarly about a third described their TPP's relationship with the HA as 'collaborative'. Only two lead general practitioners described the relationship as 'dictatorial' or 'hostile'. TP project managers were more likely to complain about specific departments in the HA, for example, the finance or contracting department. For the first wave TPPs (Mays, Goodwin, Malbon, *et al.*, 1998), the extent to which the relationship 'between the TPP and the HA' was supportive was a reasonable predictor of levels of progress in the first year of purchasing. Those TPPs with a supportive HA were able to achieve more of their own objectives than those with less good support from the HA. The next stage of the national evaluation will see how much HA support influences success and the cost of such HA input.

Table 4.1: TPP's perception of the accessibility of the host HA: TP Project Manager and lead GP

Accessibility of host HA	*TP Project Manager* *(n)*	*lead GP* *(n)*	*TP Project Manager* *%*	*lead GP* *%*
Very accessible	12	18	37.5	56.3
Fairly accessible	12	12	37.5	37.5
Neutral	5	1	15.6	3.1
Fairly inaccessible	2	0	6.3	0.0
Very inaccessible	1	1	3.1	3.1
TOTAL	**32**	**32**	**100.0**	**100.0**

3 TPPs are missing

Table 4.2: TPP's perception of how reliable the host HA has been so far: TP Project Manager and lead GP

Reliability of host HA	*TP Project Manager* *(n)*	*lead GP* *(n)*	*TP Project Manager* *%*	*lead GP* *%*
Very reliable	11	11	34.4	34.4
Fairly reliable	9	11	28.1	34.4
Neutral	5	8	15.6	25.0
Fairly unreliable	5	1	15.6	3.1
Very unreliable	2	1	6.3	3.1
TOTAL	**32**	**32**	**100.0**	**100.0**

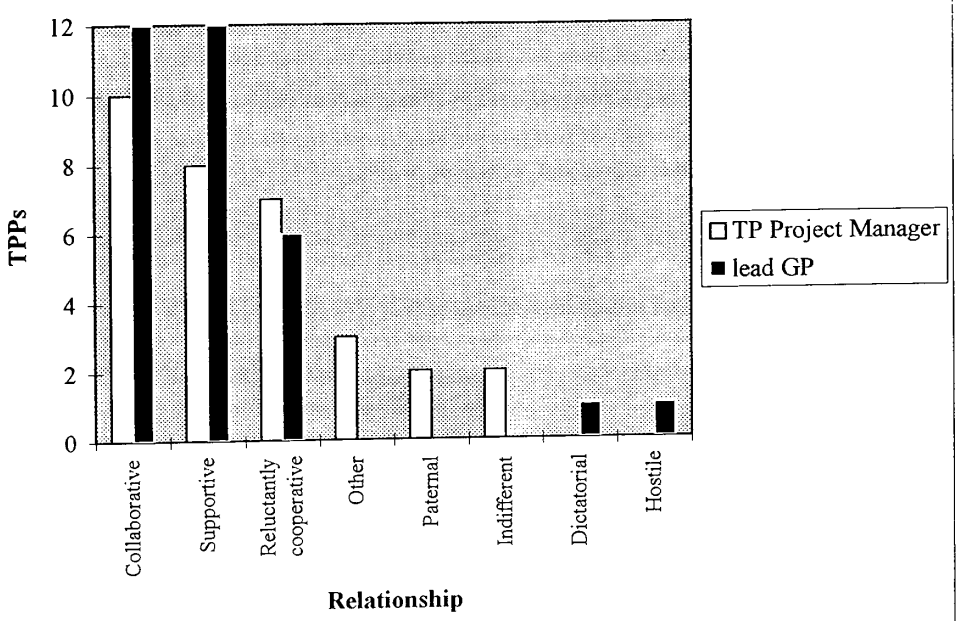
3 TPPs are missing

Table 4.3: TPP's relationship with the host HA: TP Project Manager and lead GP

Relationship with host HA	*TP Project Manager* *(n)*	*lead GP* *(n)*	*TP Project Manager* *%*	*lead GP* *%*
Collaborative	10	12	31.3	37.5
Supportive	8	12	25.0	37.5
Reluctantly cooperative	7	6	21.9	18.8
Other	3	0	9.4	0.0
Paternal	2	0	6.3	0.0
Indifferent	2	0	6.3	0.0
Dictatorial	0	1	0.0	3.1
Hostile	0	1	0.0	3.1
TOTAL	**32**	**32**	**100**	**100**

3 TPPs are missing

Figure 4.1: TPP's relationship with host HA



Relations with TPP's main provider

Almost all second wave TPPs had access to two or more providers. Only two projects said there was only one main provider to which they referred. Overall, about three-quarters of TPPs said they had a fairly or very good relationship with their providers (obviously this varied across trusts, but they were asked to give an overall judgement). When asked whether relations could be improved about two-thirds of the TPPs said they could for both their main and second main provider. This increased to nearly 80% when asked about their third main provider which for a number of TPPs was the community hospital. In addition, about one in five projects reported the relationship between themselves and the providers as indifferent: i.e. neither good nor bad, (this may have reflected a lack of contact due to the timing of the interviews early in the preparatory and purchasing cycle). These findings are similar to those for first wave TPPs in their preparatory year. However, the proportion of first wave TPPs which described their relationship with the provider as poor increased from 10% to 20% in the first live year of purchasing. It will be interesting to see whether the perceived relationship between the two organisations will improve over time as contact increases. The relationship

between acute trusts, GP commissioning groups and fundholders can be adversarial. With the introduction of the New White Paper and the development of much larger commissioning organisations, the relationship between general practitioners and acute providers will require even more sensitive handling. One method currently being tried out by a second wave TPP is 'tripartite meetings' where the general practitioners, HA representatives and managers from the acute trust meet monthly to discuss the TPP's strategic plans. This may well be one of the approaches adopted by PCGs as they begin planning for the future since the White Paper encourages a more collaborative approach to commissioning.

Table 4.4: Relationship with TPP's main provider

Relation with main provider	*Main provider** (n)	%	*Second main provider*** (n)	%
Very good	11	35.5	6	22.2
Fairly good	14	45.2	12	44.4
Neutral	5	16.1	7	25.9
Fairly bad	1	3.2	1	3.7
Very bad	0	0.0	1	3.7
TOTAL	**31**	**100.0**	**27**	**100.0**

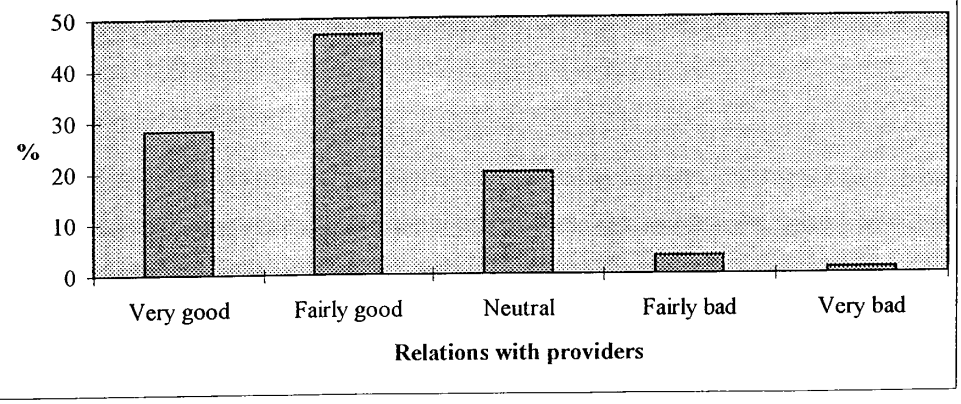
* 4 TPPs are missing

** 8 TPPs are missing

Table 4.5: Whether relations with provider(s) could be improved

Improvement in relations with MAIN	*n*	*%*
Yes	21	67.7
No	10	32.3
TOTAL	**31**	**100.0**
Second MAIN provider	*n*	*%*
Yes	17	65.4
No	9	34.6
TOTAL	**26**	**100.0**
Third MAIN provider (e.g. community hospital)	*n*	*%*
Yes	11	78.6
No	3	21.4
TOTAL	**14**	**100.0**

Figure 4.2: Overall relations between TPP and main providers



Relations with social services

Exactly three-quarters of second wave TPPs (24 out of 32) had already made contact with social services by the end February 1997 (at the time of interview, i.e. towards the end of the preparatory year). Contacts were usually made with senior managers in the social services department, such as the deputy director or director, principal officer, area or county manager or a senior person in a specific department, for example, the mental health services manager if the TPP had decided this was an area which they were considering tackling. Contact with senior staff in the social services department (SSD) seemed to be critical in terms of the SSD accepting the presence of the TPP as legitimate. This was shown in the study conducted at the Bromsgrove TPP (Bromsgrove Total Purchasing Project, 1997) where the project staff maintained that progress only began to occur after the general practitioners had contacted the director of social services and they had sat down to map out areas of common interest. Of the remaining 25% of second wave TPPs (8 out of 32) which had not contacted the local social services department, most said they were planning to make contact as soon as they could. Many of the second wave TPPs expressed interests relevant to social services. These are discussed at length in chapter seven.

Table 4.6: Contacts made by second wave TPPs in the Social Services Department, February 1997

Social Services Contact	(n=24)
Deputy Director	5
Principal Officer	4
Area/ County Manager	4
Director of SSD	3
Adult Commissioning Manager/ Assistant	3
Service Manager, Mental Health	2
Customer Services Manager	2
Assessment and Purchasing Manager	2
Partnership Coordinator	2
Home Care Manager	1
Primary Care Development Officer	1
Group Manager at Management Board Meetings	1
Social Services representative for the TPP	1
Care of the Elderly Lead	1
Learning Difficulties Coordinator	1
Assistant head - Adult Provider	1
Chief Housing Officer	1
Voluntary Association of Voluntary Service	1
Director of Performance and Planning	1
Locality Managers in the SSD	1
Senior Officers	1
TOTAL*	**39**

*The TPP could have made more than one contact

Contact with other TPPs

The majority of TPPs (88%) said they were in contact with other TPPs. This contact was generally made during workshops for second wave TPPs organised by the Region. Very few follow-up, formal meetings had taken place amongst the TPPs, although lead general practitioners might talk to other lead general practitioners about TP when they met at other meetings. TP project managers who had met up during these regional workshops would sometimes discuss TP issues over the telephone with other second wave project managers. There was also the occasional visit to a well known 'pioneer' TPP, or an invite from a

geographically close first wave TPP to look at their new IT systems. This inter-TPP contact is significantly greater than was reported in the first wave, where very few had contact with other TPPs. Possibly one of the learning points from the first wave was the benefit of information sharing. It may also suggest a gradual change in culture as general practitioners become more used to the idea of working collaboratively.

5 Direct management costs

A standard data collection form was sent to second wave TP project managers in January 1997 with a request for information on the direct management costs of each TPP for 1996/ 97 (the preparatory year). If the TPP did not have a management allocation, but instead had a budget against which actual expenditure had to be claimed, staff were asked to estimate the likely year-end expenditure. Respondents were asked to itemise non-recurrent and recurrent costs. Direct management costs were defined as costs identified explicitly with the operation of the project. Therefore, if a member of HA staff was seconded to the TPP, or a specific proportion of his/ her time was set aside for TPP work, these costs would be included in the *direct* management costs of the project. However, estimates of other HA staff time are excluded from direct management costs. Direct management costs, typically, include the salary of the TP project manager and clerical help, office expenses, costs of general practitioner time, computing and Information Technology costs, etc. The costs exclude the management costs of fundholding. Evidence so far suggests a wide variation, both in absolute and per capita terms in the direct management costs in the preparatory year (1996/ 97) reported by the second wave TPPs. This supports findings from the first wave TPPs in their preparatory year (TP-NET, 1997). As noted at the beginning of section 2, second wave TPPs' direct management costs were slightly lower than those of first wave TPPs. In order to make sensible comparisons, the first wave TPPs' preparatory year costs (1995/ 96) have been inflated to 1996/ 97 prices, using the GDP inflator.

First and second wave management costs in the preparatory year

Data are available for 29 second wave TPPs and 50 first wave TPPs. Data from one district wide TPP have been excluded since it covers an entire district of 45 practices organised into five separate localities. Money has been allocated using a variety of methods (e.g. a distinction has often been made between set-up costs for the first year and running costs for future years).

Table 5.1 indicates that the larger TPPs spent more in absolute direct management costs in the preparatory years than single practice TPPs: this was true for both waves of TP. This is largely attributable to the fact that TP requires the development of a more corporate form of organisation in many of the multi-practice TPPs than previous practice-based fundholding (Mays, Goodwin, Killoran, *et al.* 1997). Table 5.2 presents the same data as Table 5.1, but in per capita terms. This shows that the second wave projects had lower costs in their preparatory period both in absolute and per capita terms than the first wave. The difference between first and second wave TPPs' management costs is, in part, related to their different characteristics (Mays, Goodwin, Killoran, *et al.* 1997). While the mean population of the second wave TPPs is little different from the first wave (35,000 compared with 31,000,

respectively) and the median substantially lower, the principal difference in the basic features of the two waves relates to the distribution of multi-practice projects between the two. The second wave has more two-practice TPPs, fewer three-, four- and five-practice TPPs, which tend to be among the more costly, and one TPP (excluding the district wide TPP) which is substantially larger than any TPP in the first wave, with 15 practices.

Table 5.1: Direct management costs in the preparatory year for first and second wave TPPs, by size of TPP

Size of the TPP	*Mean*	*Median*	*Range*	*(n)*
First wave TPPs (1995-96*)				
Single practice TPP	£39,765.00	£37,504.00	£7,528-£84,077	*18*
Two-four practices	£81,320.00	£68,886.00	£20,880-£224,817	*18*
Five-nine practices	£155,772.00	£144,877.00	£5,137-£339,075	*13*
Ten or more practices	£94,530.00	£94,530.00	-	*1*
TOTAL	**£85,980.00**	**£64,230.00**	**£5,137-£339,075**	***50***
Second wave TPPs (1996-97)				
Single practice TPP	£39,536.50	£34,494.50	£5,000-£86,571	*12*
Two-four practices	£43,377.00	£39,000.00	£9,300-£94,750	*11*
Five-nine practices	£71,839.00	£41,698.00	£34,000-£127,500	*5*
Ten or more practices	£132,560.00	£132,560.00	£132,560-£132,560	*1*
TOTAL	**£49,770.00**	**£39,000.00**	**£5,000-£132,560**	**29**

* The first wave TPPs' preparatory year costs have been inflated to 1996-97 using the GDP inflator

Table 5.2: Direct management cost per patient in the preparatory year for first and second wave TPPs, by size of TPP

Size of the TPP	*Mean*	*Median*	*Range*	*(n)*
First wave TPPs (1995-96*)				
Single practice TPP	£2.63	£2.60	£0.51-£5.46	*18*
Two-four practices	£2.80	£2.82	£0.73-£7.49	*18*
Five-nine practices	£3.11	£2.81	£0.11-£6.14	*13*
Ten or more practices	£1.42	-	£1.42-£1.42	*1*
TOTAL	**£2.79**	**£2.71**	**£0.11-£7.49**	**50**
Second wave TPP (1996-97)				
Single practice TPP	£3.03	£2.17	£0.59-£7.53	*12*
Two-four practices	£2.20	£1.51	£0.72-£4.42	*11*
Five-nine practices	£1.62	£1.48	£0.48-£3.32	*5*
Ten or more practices	£0.97	-	£0.97-£0.97	*1*
TOTAL	**£2.40**	**£2.09**	**£0.48-£7.53**	**29**

* The first wave TPPs' preparatory year costs have been inflated to 1996-97 using the GDP inflator

Another way of exploring the ways in which costs of the TPP differ is to look in more detail at their activities and also at the composition of their management costs. Features identified as affecting the level of management costs in the first wave were: whether the TPP employed a specialist TP project manager; how complex the organisation was; method of finance; and whether individual general practitioners/ practices were reimbursed for their management input (Mays, Goodwin, Killoran, *et al.*, 1997).

Whether a dedicated project manager was employed in second wave TPPs appears to relate to the amount of *absolute* direct management costs. However, when analysing by management cost *per capita* (i.e. taking into account the size of the TPP's practice population), the relationship between whether a TPP employed a specialist TP project manager and management costs seems to go in the opposite direction (i.e. the more costly TPPs did not employ a dedicated TP project manager). This is likely to be related to the fact that a number of single practice TPPs with small practice populations who did not recruit a dedicated project manager to work on TP were also among those with fairly high management costs.

Table 5.3: Direct management cost (absolute and per patient) in the preparatory year for first and second wave TPPs, by whether a dedicated TP Project Manager was employed

TP Project Manager	*Mean*	*Median*	*Range*	*(n)*
First wave TPPs (1995-96 absolute*)				
Dedicated Manager	£102,985	£84,077	£5,137-£339,075	*35*
Using existing staff	£46,308	£39,045	£7,528-£129,465	*15*
First wave TPPs (1995-96 per capita*)				
Dedicated Manager	£2.74	£2.55	£0.11-£7.49	*35*
Using existing staff	£2.90	£2.83	£0.51-£5.46	*15*
Second wave TPPs (1996-97 absolute)				
Dedicated Manager	£62,698	£50,697	£9,300-£132,560	*14*
Using existing staff	£37,705	£35,330	£5,000-£86,571	*15*
Second wave TPPs (1996-97 per capita)				
Dedicated Manager	£2.31	£1.69	£0.48-£6.62	*14*
Using existing staff	£2.49	£2.14	£0.59-£7.53	15

* The first wave TPPs' preparatory year costs have been inflated to 1996-97 using the GDP inflator

Table 5.4 shows that TPPs coded as having an 'intermediate' level of organisational complexity in both the first and second wave (£2.34 and £2.00 per capita, respectively) appeared to have lower costs per patient than either a 'simple' or 'complex' structure. This may reflect the possibility of there being an optimum size of TPP (Posnett, Goodwin, Killoran, *et al.*, 1998) as those TPPs with smaller populations (i.e. single practice and simply structured TPPs) and larger TPPs with more practices (i.e. demanding more resources and 'complex' TPPs) tend to be more costly than TPPs with 'intermediate' levels of complexity (i.e. mid-range in size of population and number of practices). This relates to the point made in the previous paragraph.

Table 5.4: Total direct cost of managing TP per capita in the preparatory years by level of organisational complexity

Organisational complexity	*Mean*	*Median*	*Range*	*n*
First wave TPPs (1995-96*)				
Most complex/ mature	£3.30	£3.05	£0.11-£6.14	19
Intermediate	£2.34	£2.37	£0.51-£7.49	17
Least complex	£2.64	£2.73	£0.92-£5.46	14
TOTAL	**£2.79**	**£2.71**	**£0.11-£7.49**	**50**
Second wave TPPs (1996-97)				
Most complex/ mature	£2.55	£2.19	£0.48-£6.62	11
Intermediate	£2.00	£1.74	£0.59-£3.83	14
Least complex	£3.41	£2.70	£0.72-£7.53	4
TOTAL	**£2.40**	**£2.09**	**£0.48-£7.53**	**29**

* The first wave TPPs' preparatory year costs have been inflated to 1996-97 using the GDP inflator

Data from first wave TPPs suggest that direct management in the preparatory year were also dependent on whether the lead general practitioner was reimbursed for the extra time s/he spent on TP over and above locum costs. About half of the second wave lead general practitioners stated that they were reimbursed financially for the time spent on total purchasing, and when median costs per patient were examined, they showed that the TPPs which were not paying for general practitioner time had slightly lower costs than those which did. However, the difference was very small: £2.14 per patient at TPPs where general practitioners were reimbursed, compared with £2.03 per patient where the TPPs were not reimbursing general practitioner time. From a sample of 24 first wave TPPs, the proportions that received reimbursement to the lead general practitioner/ practices was 58%. Those which did receive payment for general practitioner time spent on TP were more likely to be higher achievers than those that did not (Mays, Goodwin, Malbon, *et al.*, 1998). This has major implications for PCGs, particularly as the White Paper stipulates that management costs will be capped for the new PCGs (Secretary of State for Health, 1997).

The most common source of non-recurrent costs was the purchase and installation of computer hardware and software and staff IT training; this ranged from zero to £50,000 for a completely new system. Other sources of non-recurrent costs were management consultancy fees, building work, new furniture and the expense of staff training and courses.

Management budgets

This next section looks at the TPP's method of finance and level of reimbursement to individual general practitioners/ practices. As with the first wave of TPPs, each second wave TPP had to negotiate a management budget with its local HA to help with the set up and running costs of TP. The first wave TPPs all received a one-off payment of £20,000 from their Region. However, not all second wave TPPs received this: 26 out of the 32 TPPs did, and six appeared not to. Of those TPPs which did receive an allocation from the Region, five were also given a top-up (from the Region). Thirteen TPPs (out of 32) were allocated an HA management budget from which the TPP had to claim actual expenses and seven received a simple cash allocation.

Table 5.5: Methods of financing the TPP (n=32)

Method of payment	Number*	% of responses	% of TPPs
£20,000 from the Region	21	36.2	65.6
£20,000 from the Region, plus a top-up	5	8.6	15.6
Cash allocation from the Local Health Authority	7	12.1	21.9
Management budget from the Local Health Authority	13	22.4	40.6
Financed from SFH savings	5	8.6	15.6
Other	7	12.1	21.9
TOTAL*	**58**	**100.0**	**181.3**

*Respondents may have more than one method of being financed
3 TPPs are missing

Findings from the first wave suggest that TPPs which were given a cash allocation were more likely to be lower spenders than those TPPs who received a budget against which they had to claim actual expenses (Mays, Goodwin, Killoran, *et al.*, 1997). Similar findings can be seen in Table 5.6. This shows that those second wave TPPs which were given a cash allocation were lower median spenders (per capita) on average, than TPPs which were given a budget: £1.30 per capita compared with £2.17. The mean showed very different results. However this is likely to be due to the massive variation in size of the second wave TPPs.

Table 5.6: Method of financing the TPP by cost per patient (96/97) (n=29)

Method of payment	Median per capita	Mean per capita	Range per capita
£20,000 from the Region	£2.17	£2.53	£0.60-£6.62
£20,000 from the Region, plus a top-up	£0.73	£1.45	£0.48-£3.90
Cash allocation from the Local Health Authority	£1.30	£3.06	£0.73-£7.52
Management budget from the Local Health Authority	£2.17	£2.74	£0.72-£7.53
Financed from SFH savings	£3.72	£4.12	£2.15-£7.53
Other	£1.49	£1.76	£0.48-£4.41
TOTAL	**£2.09**	**£2.40**	**£0.48-£7.53**

6 TPPs are missing

6 Budgets, risk and financial management

This section outlines how the purchasing budgets for second wave TPPs were being determined and issues of budgetary management. These areas are potentially problematic. The difficulties relating to setting budgets for first wave TPPs proved to be a major obstacle to making early process with contracting (Bevan, 1997). While most first wave projects were able to keep within budget, single practice projects appeared better able to do this than multi-practice projects. Due to the timing of the interviews (i.e. January-February, 1997, at the end of the preparatory year), only one second wave TPP had received a budget. It was, therefore, impossible to predict whether or not second wave TPPs would be able to stay within budget, make savings or overspend during 1997/ 98.

Budget setting method

Almost three-quarters of second wave TPPs said a method for resource allocation had been agreed with the HA by the end of the preparatory year. When first wave TPPs were asked the same question during their preparatory year (1995/ 96) far fewer had managed to agree a method of resource allocation with the HA. One possible explanation may be that calculating resource allocation for TPPs in 1995/ 96 was a relatively new task for HAs, whereas by the time the second wave TPPs came along most HAs were relatively familiar with the procedure and some had systems in place that were able to make calculations based on existing information from first wave TPPs. In addition, most HAs also had the experience of setting indicative budgets for locality commissioning groups.

The majority of the TPP budgets included some element of capitation in the calculation. Table 6.1 shows the proportion of TPPs with a capitation-based allocation only, and the proportion which had agreed a method which included both capitation and historical expenditure. These findings compare almost exactly with those reported in the first wave, suggesting no trend towards fairer methods in allocating resources. However, 70% had received a method of resource allocation which included some element of capitation (i.e. 13% used capitation alone and 57% calculated the allocation using a mixture of both capitation and historical elements).

Table 6.1: Method of resource allocation: TP Project Managers

Method of RA	*Number* First wave	*%* First wave	*Number* Second wave	*%* Second wave
Historic activity only	9	30.0	7	30.4
Weighted capitation	4	13.3	4	17.4
Mixture of capitation and historic activity	17	56.7	12	52.2
TOTAL (who said a method had been set)	**30**	**100.0**	**23**	**100.0**

3 TPPs are missing

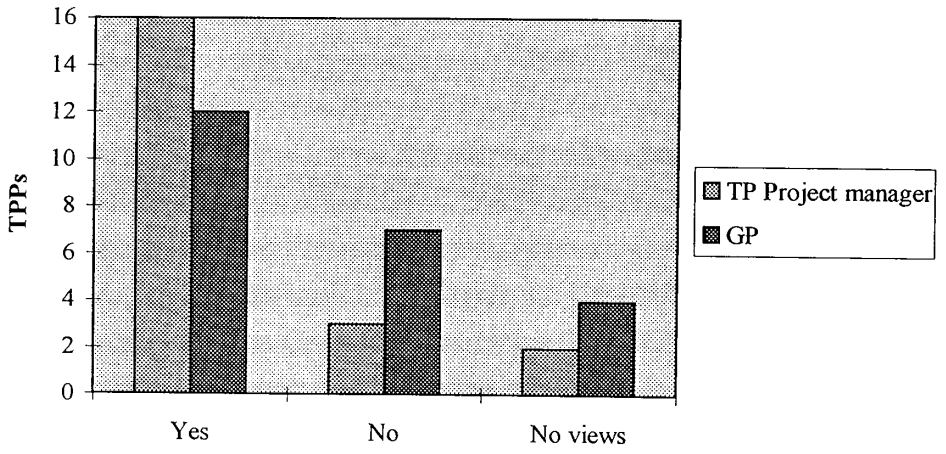
Not everybody in the TPP was satisfied with the way the resource allocation method had been calculated. Only half the lead general practitioners questioned considered the method of resource allocation to be fair, suggesting a continuing problem area for HAs and TPPs. The lead general practitioner was less likely than the TP project manager to agree that the method being used was fair. These findings are similar to those reported by the first wave TPPs.

Table 6.2: Whether the Project Manager and lead GP considered the RA method a fair one

Was RA method considered fair?	*TP Project manager Number*	*TP Project manager %*	*GP Number*	*GP %*
Yes	16	76.2	12	52.2
No	3	14.3	7	30.4
No views	2	9.5	4	17.4
TOTAL (who said a method had been set)	**21**	**100.0**	**23**	**100.0**

Project Manager's questionnaires were sent out between January '97-March '97, while interviews with the lead GPs were held between March '97-April '97: this may account for some of the differences
2 TPPs are missing

Figure 6.1: Whether the TP Project Manager and the lead GP considered the RA method fair



Receipt of an allocation

TPPs were asked between February and April 1997 if they had agreed and received a budget with the HA. Only one out of 32 TPPs said they had. Some of the reasons given were that the TPPs were either waiting to receive a budget offer from the HA, after having agreed the details, or the TPPs were deciding amongst themselves whether to accept an offer received, or details concerning activity data were still being investigated, or the TPP had decided to shadow the HA in 1997/ 98 and thus would not be allocated a real budget. Budget setting was perceived as less of a problem for second wave TPPs than first wave TPPs. However, this did not mean that they received their budgets any sooner than the first wave TPPs.

Table 6.3: Reasons why the final amount for the budget has not yet been agreed between the TPP and HA: (asked where the TPP indicated not yet having received a budget)

Reasons for not having received a budget	*Number (n=30)*	*% of responses*
Method of resource allocation accepted, either awaiting a budget offer from the HA, or currently negotiating over an offer received	12	36.4
Problems with the available resources (HA limited resources)	7	21.2
Final activity not yet agreed between HA and TPP	3	9.1
Shadowing the HA (1997-98): thus no budget	3	9.1
Fallen behind (e.g. practice withdrawn, only just received RA method)	3	9.1
Still undergoing discussion on the RA method	2	6.1
Investigating activity data at the community trust	1	3.0
Financial framework still under debate at the HA level	1	3.0
Still working out risk sharing agreements at TP-level	1	3.0
TOTAL*	**33**	**100.0**

*Respondents could give more than one answer

5 TPPs are missing

Risk Management arrangements

Table 6.4 details some of the methods TPPs were planning to use to cope with expensive cases. The most commonly cited were to define purchasing strategies clearly and to have drafted a formal risk sharing agreement between the TPP and HA. A minority of TPPs (7 out of 31) said they were considering pooling their budgets with the HA, and only one TPP suggested they would be pooling their budget with another TPP. The lack of sharing budgets between TPPs is likely to result from the lack of contact they have had with one another. However, it will be interesting to assess how quickly groups of practices within PCGs start to formulate risk sharing policies which involve pooling budgets, within and between PCGs.

When asked how confident they were that such policies would protect the TPP from overspends (due to very expensive cases) the majority of TP project managers and lead general practitioners (65% and 75%, respectively) said they were 'fairly' or 'very confident'. However, almost a fifth (17%) of the lead general practitioner respondents and the TP project

managers said they were not very or not at all confident that their spending policies would help protect the TPP from an overspend due to expensive cases.

Table 6.4: Methods for dealing with expensive cases

Types of policies agreed	*Number*	*% of responses*	*% of TPPs*
Defining purchasing strategies clearly	14	38.9	45.2
Drafting a formal risk sharing agreement between the TPP and HA	11	30.6	35.5
Pooling budgets with the HA	7	19.4	22.6
Flexible system, where HA reserves would be used in the case of TPP overspends, and any TPP 'savings' would be handed back to the HA	2	5.6	6.5
Pooling budgets within the TPP or with other TPPs	1	2.8	3.2
Managing the budget over a 3-5 year period	1	2.8	3.2
TOTAL*	**36**	**100.0**	**116.1**
None yet agreed	13		

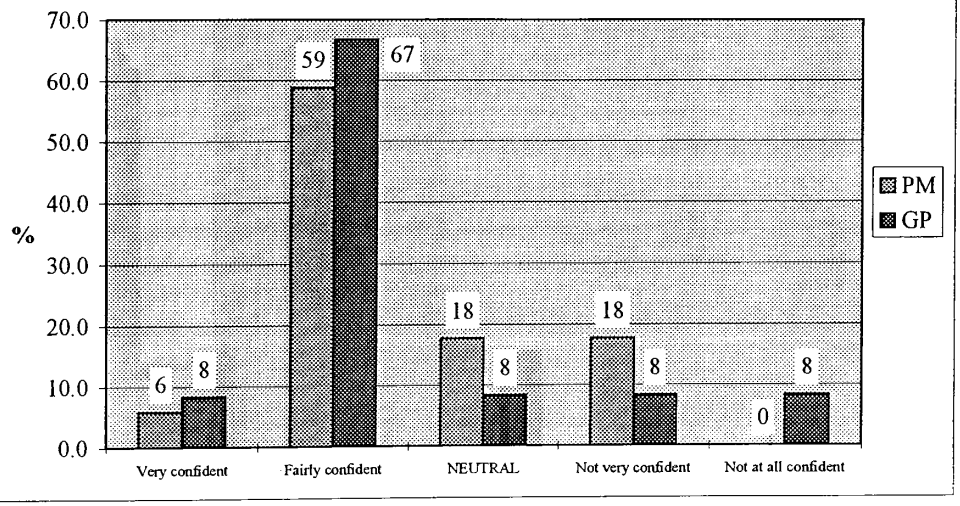
* Total number adds to more than 31 because respondents may have more than one method of financing expensive cases
4 TPPs are missing

Table 6.5: Whether confident that spending policies arranged in advance would protect the TPP from very expensive cases

Confident about arrangements	*PM* Number (n=29)	*PM* %	*GP* Number (n=24)	*GP* %
Very confident	1	5.9	1	8.3
Fairly confident	10	58.8	8	66.7
NEUTRAL	3	17.6	1	8.3
Not very confident	3	17.6	1	8.3
Not at all confident	0	0.0	1	8.3
TOTAL	**17**	**100**	**12**	**100**

N.B. 12 TPPs did not have any specific spending policies for dealing with expensive cases

Figure 6.2: Level of confidence of TP Project Manager and lead GP of policies for dealing with expensive cases (n=17, 12)



In terms of whether the TPP had arranged any policies for keeping savings or coping with overspends, only a minority of TPPs had done so despite the fact that they were only two-three months away from going into their first 'live' year. Similar findings were reported for first wave TPPs. Table 6.6 outlines some of these. For example, four TPPs were able to reinvest savings in purchasing health services for the following financial year only; one TPP had maintained that all savings would revert to the HA; and another was being allowed to retain 1% of its savings, handing the rest back to the HA. Of those TPPs which had policies to cover overspends, three said any overspends would be recovered from the forthcoming budget, two TPPs said they had been explicitly told no overspends were allowed and another was intending to use its SFH budgets to compensate in the eventuality of a TPP overspend.

Table 6.6: Policies agreed between the HA and the TPP on 'savings' and 'overspends'

Saving / Overspend Policies	*Number*	*% of responses*
SAVINGS		
Savings available for reinvestment in purchase of health services, in the following financial year (only)	4	28.6
TPP should not make savings: savings revert back to the HA	1	7.1
Savings credited to the locality	1	7.1
1% of savings to be retained by the TPP	1	7.1
OVERSPENDS		
Overspends will be dealt with (recovered) from the following years budget	3	21.4
No overspends allowed	2	14.3
Overspends to be met by savings in the SFH budget	1	7.1
Nominal budget, thus lessening the impact of any overspends (if they occur)	1	7.1
TOTAL*	**14**	**100.0**
No policies agreed	22	

*TPP may have agreed to more than one policy on savings and overspends with the HA
6 TPPs are missing

Budgetary management

The main objectives of budgetary management for second wave TPPs tended to be strategic rather than short-term. For example, the majority of TPPs (22 out of 32) said their main aim was to change the service as part of a plan or vision for the future, compared with only five TPPs which identified wanting to make savings as their main budgetary objective. In addition, a number of second wave TPPs indicated that avoiding overspends was a key objective of budgetary management in the first year. This is more likely to preoccupy and affect those TPPs in HAs which have a deficit. The impact of this must be considered when setting up PCGs.

Table 6.7: Main objectives of budgetary management during the financial year (1997-98)

Main objectives	*Number*	*% of responses*	*% of TPPs*
To change the service as part of a plan or vision of the future	22	43.1	68.8
To avoid overspending	18	35.3	56.3
To make 'savings'	5	9.8	15.6
To minimise interference to the clinical decisions of GPs	3	5.9	9.4
To inform the capitation weighting calculation	1	2.0	3.1
To understand the budget	1	2.0	3.1
Not receiving a budget for the first year ('96-'97)	1	2.0	3.1
TOTAL*	**51**	**100.0**	

* Respondents may have more than one method of budgetary management
3 TPPs are missing

An important finding from first wave TPPs concerning budgetary management was that 80% of projects with their own budgets reported that contracts were very or quite important in bringing about service changes. Those which did not hold a budget or contract independently were not as able to progress as quickly as those that did (Mays, Goodwin, Malbon, *et al.*, 1998). Nearly two-thirds of first wave TPPs purchased directly (i.e. had independent contracts). In the majority of cases the decision not to hold contracts was the result of factors beyond their control. How the less 'competitive' NHS will affect the ability of TPPs to hold budgets and contracts to purchase services directly and achieve what they set out to do will be keenly monitored in the coming months.

7 Needs assessment and purchasing objectives

Needs assessment

Over half of the second wave TPPs (57%) had been involved in some form of health needs assessment (HNA) since becoming a TPP. The majority of these were at practice level, occasionally with HA input. A couple of TPPs had also arranged regular meetings with their local CHC and another had commissioned a local university to conduct a survey of local people's health needs. One second wave TPP had also established two HNA working groups which examined locally available information and public health reports, as well as carrying out small studies on particular areas of interest. Other TPPs also wanted to expand HNA and develop care protocols. Similar findings were recorded for first wave TPPs, where just under half said they were undertaking HNA (Mahon, Stoddart, Leese and Baxter, 1998).

Most first and second wave TPPs recognised that they needed to do more HNA, and it was mentioned by second wave lead general practitioners as an area which they specifically wanted to develop. This issue is likely to become increasingly important as PCGs start to tackle the public health agenda.

Table 7.1: Whether second wave TPPs involved in Health Needs Assessment

HNA	*Number (n=23)*	*% of TPPs*
Yes, has been involved	13	56.5
In the process of undertaking a HNA	1	4.3
Have very close links with the Public Health dept.	2	8.7
Meet regularly with the CHC	1	4.3
Are planning to in the future	1	4.3
Yes, but prior to becoming a TPP	4	17.4
Not yet	1	4.3
TOTAL*	**23**	**100.0**

* Respondents may give more than one answer
12 TPPs are missing

Over three-quarters of TPPs said they had consulted a database or formal information source when deciding which services to purchase. Most of the databases consulted by second wave TPPs were a combination of data provided by the HA, their own practice-based database and provider information systems. Two TPPs said they relied solely on data they had collected themselves (i.e. with no input from the HA or providers) and nearly a third of TPPs had not

considered looking at data produced by their local provider (i.e. second wave TPPs tended not to use 'Evidence Based Medicine'). Obtaining routine NHS data did not appear to be particularly problematic for second wave TPPs with 60% saying it was fairly or very easy to do so. This is an encouraging sign for the future.

Table 7.2: TPPs which had consulted a database or formal information source

Whether consulted database	*Number*	*% of TPPs*
Yes	25	78.1
No	6	18.8
Don't know	1	3.1
TOTAL	**32**	**100.0**

3 TPPs are missing

Table 7.3: Main source of database consulted

Data source	*Number*	*% of TPPs*
Practice-based, HA and provider database	17	68.0
Practice-based and HA database	3	12.0
Data provided by the HA	3	12.0
Practice-based	2	8.0
TOTAL	**25**	**100.0**

Table 7.4: Whether TPP found it easy to obtain data

Obtaining data	*Number*	*% of TPPs*
Very easy	2	8.0
Fairly easy	13	52.0
Neutral	7	28.0
Fairly difficult	2	8.0
Very difficult	1	4.0
TOTAL	**25**	**100.0**

Relevance of local and national targets to TPP purchasing

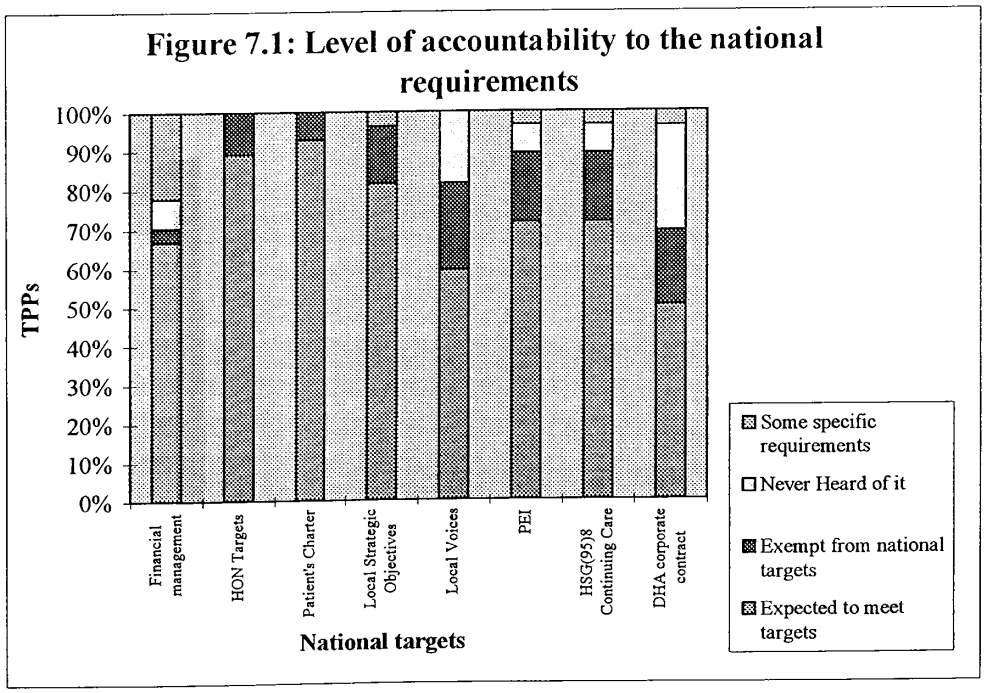
Table 7.5 lists a number of national targets and records the number of TPPs which were: expected by their host HA to meet these targets with no local requirements; to meet them with special requirements specified; were exempt from them; or those where the TPP staff had never heard of them. Overall, about two-thirds said they would most likely have to meet the same requirements as were set out for the HA by the Region. There were very few TP-specific requirements mentioned except in financial management. Here six TPPs stated that the HA had set down specific requirements. TPPs appear to hold the view that they have some degree of responsibility in contributing to national priorities and targets, although this may well not be well defined (Dixon, Mays and Goodwin, 1998). These findings are similar to those reported by the first wave TPPs.

At the time of interview (February-April 1997), 13 TPPs had a completed Purchasing Intentions Document; 14 said they had not yet finished writing it; and five admitted to not having begun one. It is likely that a more thorough approach to documentation will be required in the form of business plans when PCGs come into existence.

Table 7.5: What the expectations of the LHA or Region were for the TPP in specific national areas: data from the Project Manager

Any specific requirements	Financial management	HON Targets	Patient's Charter	Local Strategic Objectives	Local Voices	PEI	HSG(95)8 Continuing Care	DHA corporate contract
Expected to meet the national targets, no specific requirements	18	25	26	22	16	20	20	13
No, exempt from the national targets	1	3	2	4	6	5	5	5
Never Heard of it	2	0	0	0	5	2	2	7
TP mentioned some specific requirements	6	0	0	1	0	1	1	1
TOTAL (n=32)	**27**	**28**	**28**	**27**	**27**	**28**	**28**	**26**

3 TPPs are missing



Approach to purchasing

During the interviews with general practitioners and TP project managers in January-April 1997, TPPs were asked to identify their purchasing intentions/ priorities for the 1997/ 98

contracting year - the year that most second wave TPPs would be going 'live'. The data proved difficult to analyse because of the variation in number of purchasing objectives and the extent to which these intentions varied. As for the first wave analysis which examined the *'main purchasing intentions of TPPs'* a judgement was made from the interviews and documents produced in order to derive priorities as they stood at the end of the preparatory year. Furthermore, since these accounts are statements of intention, the following analysis should be seen as a guide to the main ideas of TPPs rather than as a definitive list of what the TPPs would eventually purchase in 1997/ 98. Unlike the data collected from the first wave, second wave TPPs were not restricted to outlining their four main purchasing objectives. Instead, second wave TPPs were asked to indicate which areas were priorities for change through TP without an upper limit.

Most TPPs did not intend to purchase the full range of the services potentially available to them. Instead, as shown by the first wave, TP could be renamed '*selective purchasing*' since it is clear that most TPPs selected certain service areas to influence. In many cases, TPPs intended to purchase services in subsequent years which they were not considering in 1997/ 98, but this was by no means the case for all TPPs.

There appear to be four main approaches to the purchasing of services that potentially fall within the scope of TP:

Exclusion: This is where the TPP considers certain services inappropriate to buy, thus does not hold any part of the budget for that service, e.g. services that require specialist treatment: HIV/ AIDS services where resources have been ringfenced and cannot be used alternately, GUM services where patients cannot be identified, etc.
Blocking back: This is where the TPP holds an indicative budget for the service but 'blocks back' all contracting responsibilities to the HA
Copurchasing: This is co-operative or joint commissioning with the HA. The final contract is negotiated by the HA
TPP purchasing: This is where the TPP holds a delegated budget from the HA for a service and negotiates contracts to purchase the service largely independently of the HA

As with the first wave TPPs, second wave TPPs had a wide range of ambition for purchasing. Most TPPs have concentrated on areas where they have a specific interest or in areas of local concern.

In terms of the range of services which second wave TPPs were intending to purchase in their first live year, analysis shows that on average second wave TPPs had identified four service areas where they would like to make changes in 1997/ 98. This ranged from two service areas in one TPP, to seven specific areas selected by three TPPs.

Analysis of services not being purchased, blocked back or copurchased

In most TPPs, certain services that could potentially be purchased have been wholly excluded. These generally include high cost/ low volume services and regional specialties. Such services carry potential problems and risks to TPPs given their high cost and largely unpredictable nature. They are assumed to present a high risk to the budget of TPPs, however, Bevan *et al.*, showed in their work on risk management that problems relating to specialised services are unlikely to occur as often as the TPP anticipates (Bevan, Baxter, Bachmann, 1998). Perhaps more importantly, many TPPs have highlighted the lack of sufficient expertise in general practice for understanding such services, thus making effective purchasing impossible. Consequently, budgets generally exclude allocations to buy such services, or there is a mechanism by which the funding allocated for such services is automatically returned to the authority.

Among the services that many TPPs considered inappropriate to purchase were things like paediatric oncology and bone marrow transplantation.

Common areas that were 'blocked back' to the HA by second wave TPPs were patient transport (although one or two TPPs did say they would contract for ambulances), forensic psychiatry (although this was often wholly excluded as well) and renal dialysis. Inevitably, there is some overlap between types of services which are excluded and others that are blocked back. The variety of services the TPPs identified as suitable for blocking back differed between TPPs and reflected a lack of confidence in dealing with these specific service areas. One solution to this was to copurchase new or relatively specialised services with the HA. This is what some TPPs decided to do at least for their first year. Palliative care, school nursing, health promotion, and, occasionally, forensic psychiatry, were all examples of service areas where TPPs entered into copurchasing arrangements with the HA. Here the general

practitioners had more input (compared with blocking back services) into the nature and content of the contract with the provider, but left the detailed contract negotiating to the HA.

Analysis of purchasing intentions by service area

Choices and priorities for purchasing and service development among first wave TPPs appeared to have been based primarily on general practitioners' own experiences and awareness of specific local service issues with little use of formal evidence (TP-NET, 1997). Second wave TPPs also adopted a practical approach in which they concentrated on a few service areas where the need for change was clear, where the general practitioners and project managers could cope with the work and where the probability of success was high. However, as noted earlier, some formal needs assessment activities did take place (e.g. one second wave TPP had established two HNA working groups which examined locally available information and public health reports, as well as carrying out small studies on particular areas of interest).

Each TPP was asked to outline what they were planning to do in each area selected for purchasing and any changes they hoped to see as a result of TP. They were also asked to indicate which areas constituted their main priorities. The findings presented here are based on those areas identified as a priority and mentioned by both the lead general practitioner and project manager. From 33 second wave TPPs, over 180 responses were collected which identified areas the TPPs intended to influence in 1997/ 98.

Table 7.6 shows the frequency with which broad service areas were included in the purchasing intentions of the 33 second wave projects compared with first wave TPPs. Table 7.7 shows the 'non-service specific' (i.e. information gathering and monitoring of services to inform future purchasing, developing protocols and clinical guidelines, changing contract currency, and needs assessment to inform purchasing in the future, etc.) priority areas identified by second wave TPPs. Appendix I explains the classification of purchasing intentions which was the basis for Tables 7.6-7.7 and provides a more detailed breakdown of second wave purchasing intentions.

Some TPPs did not have more than four purchasing objectives, and, in other cases, one purchasing objective impinged on two service areas. For example, 15 TPPs wished to reduce length of stay in hospitals which was also linked to objectives such as purchasing services for respite care in local community hospitals, purchasing nursing home beds, or employing a discharge liaison nurse. As noted in the earlier study of first wave TPPs (TP-NET, 1997) there is likely to be irreducible overlap between some of the categories such as emergency

admissions and elderly care, depending on how the project expressed its purchasing intentions. In addition, when first wave TPPs were analysed after their first year of purchasing, a number of additional service changes had been made which had not been mentioned in their four main purchasing intentions before they started their 'live' purchasing.

The frequency count of purchasing intentions reveals that the most popular service areas for change in the second wave have been mental health (26), maternity (19) and emergency admissions and accident and emergency (A & E) attendances (18). Table 7.6 shows the similarity in ranking of service areas in the two waves. The six most popular service areas identified as priorities in the first and second wave were identical (although the ordering was slightly different). The service areas mentioned were: mental health; maternity; emergency admissions and A & E attendances; community and continuing care; early discharge and reduced length of stay; and care of the elderly. First wave TPPs were more likely to consider emergency admissions, A & E attendances and community and continuing care as areas to tackle in their first 'live' purchasing cycle. Whereas the majority of second wave TPPs concentrated on mental health and maternity services. Evidence from the first wave suggests that managing emergency services and mental health were the two service areas in which first wave TPPs found it most difficult to achieve their objectives (Mays, Goodwin, Malbon, *et al.*, 1998). It is too soon to know how well second wave TPPs will fare in different service areas. The most popular service areas identified as priorities by second wave TPPs are discussed below along with comparisons with first wave TPPs, where relevant.

Table 7.6: Priority service areas for purchasing by the TPPs: first (1995/96) and second wave (1996/97)

Service areas	*First wave (1995/96)* (n=51)	*% of responses*	*% of TPPs*	*Second wave (1996/97)* (n=32)	*% of responses*	*% of TPPs*
Mental health	29	*16.2*	*56.9*	26	*19.5*	*81.3*
Maternity	28	*15.6*	*54.9*	19	*14.3*	*59.4*
Emergency admissions and A & E attendances	33	*18.4*	*64.7*	18	*13.5*	*56.3*
Community/ continuing care	32	*17.9*	*62.7*	16	*12.0*	*50.0*
Early discharge and reduced LOS	12	*6.7*	*23.5*	15	*11.3*	*46.9*
Care of the elderly	14	*7.8*	*27.5*	6	*4.5*	*18.8*
Other A & E	12	*6.7*	*23.5*	6	*4.5*	*18.8*
Cardiology	2	*1.1*	*3.9*	3	*2.3*	*9.4*
Palliative & terminal care	3	*1.7*	*5.9*	3	*2.3*	*9.4*
Oncology	5	*2.8*	*9.8*	1	*0.8*	*3.1*
Other priority service areas	9	*5.0*	*17.6*	20	*15.0*	*62.5*

Table 7.7: Non-specific priorities for the TPPs: second wave TPPs (1996/97)

Non-specific service areas	(n=32)	*% of responses*	*% of TPPs*
Information gathering and monitoring of services to inform future purchasing	14	*25.5*	*43.8*
Developing protocols and clinical guidelines	9	*16.4*	*28.1*
Changing contract currency	7	*12.7*	*21.9*
Needs assessment to inform purchasing in the future	6	*10.9*	*18.8*
Developing the PHCT	5	*9.1*	*15.6*
Developing the MIU	3	*5.5*	*9.4*
Protection or enhancement of the local hospital	3	*5.5*	*9.4*
Health promotion	3	*5.5*	*9.4*
Examining evidence based medicine	3	*5.5*	*9.4*
Building new premises for PHCT	1	*1.8*	*3.1*
Moving services from secondary to primary care	1	*1.8*	*3.1*

Mental health

Twenty six projects expressed an interest in tackling some form of mental health care beyond the services included in SFH. By far the most popular method of influencing mental health provision was to recruit practice-based Community Psychiatric Nurses (CPN) and also to enhance the role of the Community Mental Health Team (CMHT), for example, by appointing an attached social worker to the practice or realigning the CMHT to clusters of practices rather than hospital catchments. Another area identified by two TPPs was drug and alcohol abuse. The approach here was to establish a drug and alcohol abuse counselling service based in or near the practice, coordinated by the general practitioners. A number of TPPs suggested setting up a mental health register so they could monitor patients with mental health problems and thus liaise more effectively with social services and the mental health specialist providers. A key element identified by a significant proportion of TPPs wanting to improve mental health services was to increase the links between practices, social services, the CMHT and the local mental health trust. This demonstrates an awareness of wider services in the local area and a commitment to liaising with otherwise unfamiliar groups. However, the majority of initiatives for mental health in the second wave were not concerned with making changes in the acute mental health sector, instead they concentrated upon enhancing mental health care provision in primary care, thus emphasising the providing role that TPPs have as well as their commissioning role. A noticeably higher proportion of second wave TPPs compared with first wave TPPs considered tackling mental health: 80 per cent of second wave TPPs mentioned it as a priority area, compared with just over half of first wave TPPs. The differences in the proportion of first and second wave TPPs attempting to influence mental health services might be explained by looking at the types of objectives each wave set themselves. For example, second wave TPPs were more likely to consider employing an attached CPN, than changing their mental health provider. Perhaps the second wave was more realistic in specifying changes that could be made in the first 'live' year, or perhaps they were simply less ambitious than the first wave. Exhibit 7.1 shows some of their purchasing intentions.

Exhibit 7.1: Example of second wave TPPs' purchasing intentions for mental health services

- Develop practice-based mental health services through appointment of CPN and counsellor, particularly to reduce waiting times for referral to the CMHT.
- Encourage more in-house assessments so as to look after the majority of patients locally
- Develop child and adolescent mental health services through appointment of social worker/ mental health worker to liaise between patients, general practitioners, social services and schools.
- Undertake in-house monitoring of patients with mental health problems; improve team work between general practitioner, CPN and psychiatrist; appoint two psychologists to work in the practice, and a Community Care Assistant/ CPN to ensure patients are integrated back into the community after specialist treatment.
- Establish a register of 'at risk' patients and systems to monitor and coordinate care for the severely mentally ill, including appointment of a practice-based team coordinator (CPN), to ensure patients receive complete care and are tracked successfully through primary and secondary care and supported in the community.
- Align the CMHT to clusters of practices rather than the hospital and strengthen links between the practice and the CMHT. Appoint a liaison worker to investigate methods of referral and ways of improving management of those who are mentally ill.
- Consider using alternative providers.
- Work with the mental health trust on future mental health service developments to ensure appropriate care in appropriate settings for patients.

Maternity care

This was the second most commonly cited area for change. Nineteen TPPs expressed an interest in developing and improving the quality of maternity care which their patients received. A number of mechanisms were suggested, but the main emphasis was to bring maternity services into the community and to enhance patient choice in line with the *Changing Childbirth* programme (Expert Maternity Group, 1993) (See Exhibit 7.2). Improving maternity services was also a popular area identified by first wave TPPs and one in which more than half managed to meet their own objectives (Mays, Goodwin, Malbon, *et al.*, 1998).

Exhibit 7.2: Example of second wave TPPs' purchasing intentions for maternity services and the implementation of *Changing Childbirth*

- Increase patient involvement and establish a more integrated antenatal and postnatal service linking both midwives and general practitioners.
- Establish an obstetric day unit at the community hospital to bring services closer to patients.
- Move towards more community based maternity care for low risk pregnancies including involvement of patients in shaping the service, and agreement of protocols by general practitioners, midwives and the trust and their introduction into the practice.
- Establish a more practice based comprehensive midwifery service, including targeting and coordinating services to those mothers who are most vulnerable.
- Monitor the new midwifery service set up in line with *Changing Childbirth* and attach two midwives attached to the practice to follow women through all stages of pregnancy.

Reducing emergency admissions

Fourteen second wave TPPs identified a number of strategies to reduce emergency admissions, some of which included trying to develop a minor injuries unit (MIU), developing the role of nurses and nurse-practitioners at the practice, promoting community hospital facilities and altering the way patients were seen and admitted to hospital through the use of protocols, such as defining a category of 'immediate necessary referrals'. As mentioned above, findings from the first wave TPPs suggested that emergency admissions were one of the more difficult areas to influence (Mays, Goodwin, Malbon, *et al.*, 1998). None of the first wave TPPs was successful in setting up a MIU and most of their effort was concentrated on ensuring that adequate data were available from the provider(s) in order to plan more effectively for the following year.

Two second wave TPPs had tried to enlist the help of their local ambulance service by drawing up a contract based on protocols for the ambulance staff which meant that patients with a manageable condition would always be driven to the community hospital instead of the acute trust. However, one TPP remarked that this had caused some controversy because acute hospital staff and some patients were concerned over a number of issues: firstly, that the ambulance staff might not be sufficiently trained to diagnose a condition; secondly, that the procedure might slow the process of getting emergencies to the acute hospital; and thirdly, that patients might not receive the care they needed in the local community hospital compared with the level of expertise perceived to be available at the main acute trust. This contract was under negotiation at the time of interview.

Reducing Accident and Emergency attendances

TPPs had begun to investigate and monitor the use of their local A & E department, to educate patients about the proper use of A & E and to develop and strengthen the links between A & E departments and general practices (See Exhibit 7.3).

Exhibit 7.3: Example of second wave TPPs' purchasing intentions for accident and emergency attendances/ emergency admissions

- Reduce unplanned acute admissions through effective use of the MIU at the local hospital.
- Develop the role of nurses in the practice-based MIU, including use of nurse practitioners, agreement of clinical protocols and training of nurses in their use.
- Establish a system of 'immediate necessary referrals', enabling patients to be seen and treated more efficiently within the day, avoiding unnecessary admission.
- Investigate and monitor use of A&E, and agree management protocols between clinicians and general practitioners.
- Educate patients in appropriate use of A&E and practice-based services.
- Develop the A&E information system and strengthen links between the A&E department and general practitioners, including increased use of computerised data links.

Care of the elderly, continuing care and reduction in the length of stay

Taken as a group (since many of the intended changes overlap), 37 TPPs prioritised these three areas. For example, 16 TPPs reported that they were interested in community and continuing care, 15 were aiming to reduce length of stay and six second wave TPPs mentioned care of the elderly as a priority service area (See Exhibit 7.4). A discharge liaison nurse had been appointed to reduce length of stay and also to anticipate discharge arrangements by ensuring that patients had suitable surroundings when they left hospital. This required coordination between the trust, general practitioners and social services. 'Care pathways' and integrating services, encouraging closer working between trusts and community nurses was also on the agenda for some TPPs, which is an important area for the future given the push towards greater contact and cooperation between all local providers within Health Improvement Programmes (Secretary of State for Health, 1997). Other TPPs intended to purchase nursing home beds to provide new forms of convalescent care.

One second wave TPP introduced an imaginative, if risky, pricing system in which differential prices were negotiated over the length of stay: 8-10 day admissions were paid for in a lump

sum and from then on a price per bed day was paid for subsequent days. The aim was to help reduce unnecessary costs by only paying for those days when the patient was in hospital. Other TPPs tried to encourage providers to categorise admissions into Healthcare Resource Groups (HRGs) and to cost on the basis of HRGs to assist in the reduction of inappropriate length of stay.

Exhibit 7.4: Example of second wave TPPs' purchasing intentions for care of the elderly/ continuing care/ reduction of length of stay

- Encourage providers to categorise admissions by HRGs and costs on this basis to assist in the reduction of inappropriate length of stay.
- Appoint liaison nurse to assess admissions and anticipate discharge arrangements to prevent 'bed blocking' and enable early and efficient discharge of patients.
- Buy nursing home beds for convalescence to enable early discharge and prevent 'bed blocking'.
- Introduce use of 'care pathways' to enable a more integrated service and closer working between hospital nurses and community nurses together with more effective use of the community hospital and shorter length of stay at the acute hospital.
- Provide a family centre, jointly run by social services and general practitioners to provide a comprehensive approach to social and medical care, avoiding duplication or gaps.
- To set up a pre admission assessment clinic for elderly patients.
- Establish an 'at-risk' register of over 75s, linked to the practices' register of over 75s, and to investigate/ follow-up needs identified in order to reduce future crises.
- Establish alternative pricing structures for admissions, whereby 8-10 day admissions are paid as a lump sum and subsequent days on a per diem basis.

Non-service priorities

As outlined in Appendix I, a number of generic objectives were identified by the TPPs which did not apply to specific services. These are listed in Table 7.7 and include information gathering and monitoring of services to inform future purchasing, developing protocols, needs assessment to inform purchasing, developing the Primary Health Care Team (PHCT), health promotion, examining 'evidence-based medicine' and building new premises for the PHCT.

8 Conclusions

So what are the similarities and differences between the first and second wave TPPs? And are the second wave TPPs more or less likely to report achievements in their first 'live' year (1997/ 98) than the first wave TPPs?

Like first wave TPPs, none of the second wave TPPs was planning to undertake 'total' purchasing, instead they preferred to purchase a *selective* range of services. The range and goals of their purchasing were broadly similar between the first and second waves, although second wave TPPs placed more emphasis on primary health care development than first wave TPPs.

There were, however, a number of structural and organisational differences between the first and second wave TPPs. The second wave contained more single practice projects, but had developed more elaborate forms of organisation than had been seen in the first wave at the same stage. Second wave TPPs also incurred lower management costs; had less fundholding experience than the first wave; and were less likely to employ a dedicated TP project manager. They were also more likely to have made links with external agencies, such as the Community Health Council (CHC) or social services than first wave TPPs at the same stage of their development (See Exhibit 7.5).

Exhibit 7.5: A typical first and second wave TPP

A typical first wave TPP	A typical second wave TPP
• Three practices	• Two practices
• 30,000 patients	• 20,000 patients
• 15 general practitioners	• 10 general practitioners
• Range of organisational complexity, varying from 'simple' to 'complex'	• 'Intermediate' level of organisational complexity (influenced by having a formal HA board, and sub-groups including CHCs, voluntary services, providers and social services)
• Employed a dedicated TP project manager	• Using former fundholding manager as TP project manager
• Were likely to be first or second wave SFH practices	• Joined SFH in the third wave (1993/ 94)
• Interested in trying to influence secondary health care provision, e.g. employing a discharge liaison nurse, setting up a minor injuries unit	• Interested in developing the primary health care team (PHCT) and emphasising the providing role of the TPP practices

Perhaps the most important and indisputable difference between first and second wave TPPs was that the second wave started a year later in 1996/ 97 when a General Election was looming. Political uncertainly was influential in terms of levels of commitment from the general practitioners, HA leads and local provider representatives, etc. Particularly since Labour was intending to abolish fundholding and therefore placing TP under threat. It may also have prevented second wave TPPs from planning too far ahead for their first 'live' year thus inhibiting their development. The HA and the participants will have been disinclined to invest in a project which might be withdrawn before it had the opportunity to progress. This was commented upon by a number of the general practitioners interviewed in April 1997.

According to the findings from first wave TPPs, achievement in the first 'live' year was associated with smaller TPPs (i.e. those with fewer general practitioners, fewer than five practices and smaller populations); a 'fair' to 'good' level of support from the HA; holding a budget; having at least some independent contracts; good inter-agency co-operation; and effective leadership (Mays, Goodwin, Malbon, et al, 1998). Second wave TPPs exhibit most, if not all, of the above attributes and, therefore, it could be argued that second wave TPPs are well placed to achieve their objectives in their first 'live' year of purchasing. In addition, second wave TPPs may be more likely to achieve their own objectives because they are less ambitious than first wave TPPs and are more likely to have primary care-related service objectives, which were shown in the first wave to be easier to achieve than objectives involving altering secondary care.

Other variables associated with success (dedicated TP project manager; higher management costs and 'simple' organisational structure) in first wave TPPs were absent from the second wave. Fewer second wave TPPs had employed a dedicated TP project manager; second wave TPPs had lower management costs than first wave TPPs; and thirdly, they were more likely to have an 'intermediate' or 'complex' organisational structure. However, since second wave TPPs are on average smaller then first wave TPPs, these factors may not prove to be so significant in achieving one's own objectives.

Both first and second wave TPPs are now well placed to become involved in larger PCGs. A lot of their preparation in the last couple of years will be extremely useful, particularly in the areas of commissioning, relations with external organisations and, most importantly, working across practice boundaries. In some ways, the first wave are slightly better placed, as more of them are part of multi-practice projects and have more experience of purchasing and commissioning. On the other hand, the second wave TPPs appeared to have created quite sophisticated organisations, were well advanced in communicating with social services, CHCs

and other voluntary bodies, had better prepared IT systems and had begun to investigate health needs assessment and patient involvement. The biggest hurdle facing both first and second wave TPPs will be how well they manage to work with larger groups of fundholding and non-fundholding general practitioners. This will be a major test of the feasibility of PCGs.

Appendix 1: Classification of Purchasing Intentions

Classification Number	Service area	(n of TPPs)
1	Community MH	21
1	Inpatient MH	5
2	Maternity	19
3	Reduce emergency admissions	14
3	Reduce A & E attendances	4
4	Community/ continuing care	16
5	Care of the elderly	6
6	Reduce LOS	15
7	Improve A & E data	3
7	Patient transport	3
8	Cardiology	3
9	Palliative & terminal care	3
10	Oncology	1
11	Sexual Health	6
11	Employing Liaison Nurse	4
11	Child health	2
11	Controlling ECRs	2
11	HON targets	2
11	Epilepsy	1
11	Community pharmacist	1
11	Prescribing	1
11	Dermatology	1
11	Orthopaedics	1
12	Data collection	14
13	Protocols & clinical procedures (EBM)	9
13	Evidence Based Medicine	2
14	Changing contract currency	7
15	Needs assessment	6
16	Developing PHCT	5
16	Developing new building for the PHCT	1
17	Develop MIU	3
18	Protecting/ enhancing Community Trust	3
19	Health promotion	3
20	Moving from 2 to 1 care	1
		188

The second wave purchasing intentions have been categorised in order to make comparative analysis possible between first and second wave TPPs . However, other classifications could be created.

There are a number of overlapping areas and it is clear that some TPPs described an intention using the process or mechanism of change (i.e. the 'how' of purchasing), whereas others preferred to use the service area (i.e. the 'what' of purchasing'). It is this variation which makes classification difficult.

Some overlapping areas included 'care of the elderly' (6 TPPs) and 'community and continuing care' (16 TPPs) which appears above as two separate groups.

The following list could all relate to the intention of reducing length of stay (15 TPPs): changing contract currency (7 TPPs); employing a liaison nurse (4 TPPs); developing a MIU (3 TPPs) (which could fit in with reducing emergency admissions and A & E attendances); and developing the community hospital (3 TPPs). This suggests that 31 TPPs were interested in influencing length of stay for their patients, if classified in this fashion.

Data collection, improving data and health needs assessment could also be grouped together.

Working with a community pharmacist could be put with developing the PHCT.

A further potential grouping would be to put health promotion and health of the nation targets into the same group.

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Total Purchasing National Evaluation Team (TP-NET)

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

KING'S FUND 11–13 Cavendish Square, London, W1M 0AN T: 0171 307 2400 F: 0171 307 2807 ***Lead:*** Nicholas Mays ***Other members:*** Nick Goodwin, Gill Malbon, Julian Le Grand, Jennifer Dixon, Amanda Killoran, Jo-Ann Mulligan	***Project Responsibilities:*** Hertford, Hemel Hempstead, Hillingdon, New River, St Albans, Stevenage, Attleborough, South Bucks, Belper, Keyworth, Long Eaton, Melton Mowbray, Wakefield. ***Other Main Responsibilities:*** Process evaluation co-ordination (Mays, Goodwin); A&E services and emergency admissions (Dixon, Mays, Mulligan); monitoring at all TPPs (Mays and Malbon); case studies (Mays, Goodwin, Killoran, Malbon).
NATIONAL PRIMARY CARE R&D CENTRE **Manchester:** University of Manchester, 5th Floor, Williamson Building, Oxford Road, Manchester, M13 9PL T: 0161 275 7600 F: 0161 275 7601 **Salford:** PHRRC, University of Salford, Davenport House, 4th Floor, Hulme Place, The Crescent, Salford, M5 4QA T: 0161 743 0023 F: 0161 743 1173 **York:** YHEC, University of York, YO15 4DD T: 01904 433620 F: 01904 433628 CHE, University of York, York, YO1 5DD T: 01904 433669 F: 01904 433644 ***Leads:*** Brenda Leese (Manchester and CHE), Linda Gask (Manchester), Jennie Popay (Salford), John Posnett (YHEC) ***Other members:*** Ann Mahon, Martin Roland, Stuart Donnan, John Lee, Andrew Street	***Project Responsibilities:*** High Peak, North Lincolnshire, Rotherham, Sheffield South, Ellesmere Port, Knutsford, Liverpool Neighbourhood, Newton le Willows, Wilmslow, Ribblesdale, Southbank, North Bradford, York. ***Other Main Responsibilities:*** Transaction costs (Posnett and Street); service provision for the seriously mentally ill (Gask, Roland, Donnan and Lee); service provision for people with complex needs for community care services (Popay); relations with health authorities (Leese and Mahon); maternity (Posnett).
DEPARTMENT OF SOCIAL MEDICINE, UNIVERSITY OF BRISTOL Canynge Hall, Whiteladies Road, Bristol, BS8 2PR T: 0117 928 7348 F: 0117 928 7339 ***Lead:*** Kate Baxter ***Other members:*** Max Bachmann, Helen Stoddart	***Project Responsibilities:*** Bewdley, Birmingham, Bridgnorth, Coventry, Solihull, Worcester, Saltash, South West Devon, Thatcham. ***Other Main Responsibilities:*** Budgetary management (Baxter); risk management (Bachmann); use of evidence in purchasing (Stoddart); case studies (Baxter).
DEPARTMENT OF GENERAL PRACTICE, UNIVERSITY OF EDINBURGH 20 West Richmond Street, Edinburgh, EH8 9DX T: 0131 650 2680 F: 0131 650 2681 ***Lead:*** Sally Wyke ***Other members:*** Judith Scott, John Howie, Susan Myles	***Project Responsibilities:*** Durham, Newcastle, Tynedale, Aberdeen West, Ardersier & Nairn, Grampian Counties, Lothian, Strathkelvin ***Other Main Responsibilities:*** Maternity (Wyke); monitoring of participants' views (Wyke); prescribing (Howie); community care (Wyke and Scott).
INSTITUTE FOR HEALTH POLICY STUDIES, UNIVERSITY OF SOUTHAMPTON 129 University Road, Highfield, Southampton, SO17 1BJ T: 01703 593176 F: 01703 593177 ***Lead:*** Ray Robinson ***Other members:*** Philippa Hayter, Judy Robison, David Evans	***Project Responsibilities:*** Dorset, Romsey, Trowbridge Bath & Frome, Winchester, Bexhill, East Grinstead, Epsom, Kingston & Richmond, Merton Sutton & Wandsworth, West Byfleet. ***Other Main Responsibilities:*** Contracting methods (Robinson, Raftery, HSMC and Robison; case studies (Evans).
HEALTH ECONOMICS FACILITY, HSMC, UNIVERSITY OF BIRMINGHAM 40 Edgbaston Park Road, Birmingham, B15 2RT T: 0121 414 6215 F: 0121 414 7051 ***Lead:*** James Raftery ***Other member:*** Hugh McLeod	***Main Responsibilities:*** Activity changes in inpatient services; contracting methods (with Robinson and Robison, IHPS); service costs and purchaser efficiency (with Le Grand).
HEALTH SERVICES RESEARCH UNIT, LONDON SCHOOL OF HYGIENE AND TROPICAL MEDICINE Keppel Street, London, WC1E 7HT T: 0171 927 2231 F: 0171 580 8183 ***Lead:*** Colin Sanderson with Jennifer Dixon, Nicholas Mays and Jo-Ann Mulligan (King's Fund), James Raftery (HSMC) ***Other member:*** Peter Walls	***Main Responsibility:*** A&E services and emergency admissions.
LSE HEALTH, LONDON SCHOOL OF ECONOMICS AND POLITICAL SCIENCE Houghton Street, London, WC2A 2AE T: 0171 955 7540 F: 0171 955 6803 ***Lead:*** Gwyn Bevan	***Main Responsibilities:*** Resource allocation methods.

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