King's Fund

National Evaluation of Total Purchasing Pilot Projects Working Paper

How Do Total Purchasing Projects Inform Themselves For Purchasing?

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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.

Acknowledgements

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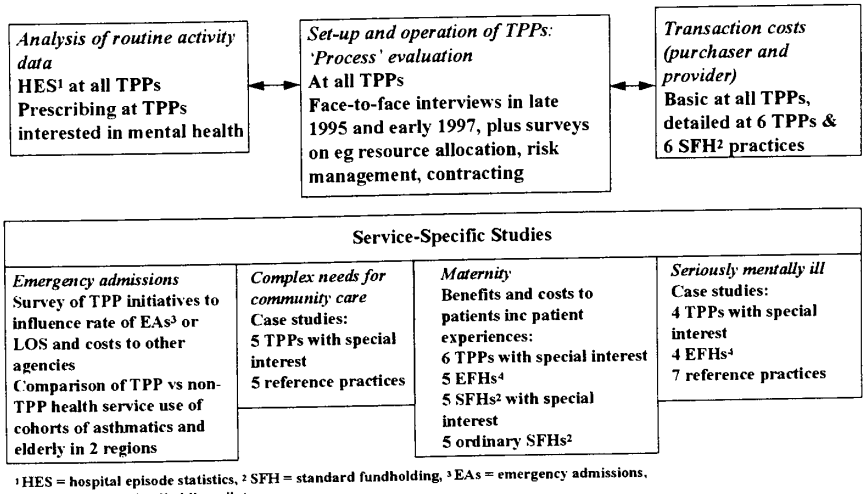
CONTENTS

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, Amanda Killoran, Gill Malbon, Nicholas Mays, Michael Place, Andrew Street
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Linda Gask, John Lee, Stuart Donnan, Martin Roland
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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, Amanda Killoran, Nicholas Mays, Nick Goodwin
A profile of second wave total purchasing pilots: lessons learned from the first wave
1 85717 195 0

Abstract

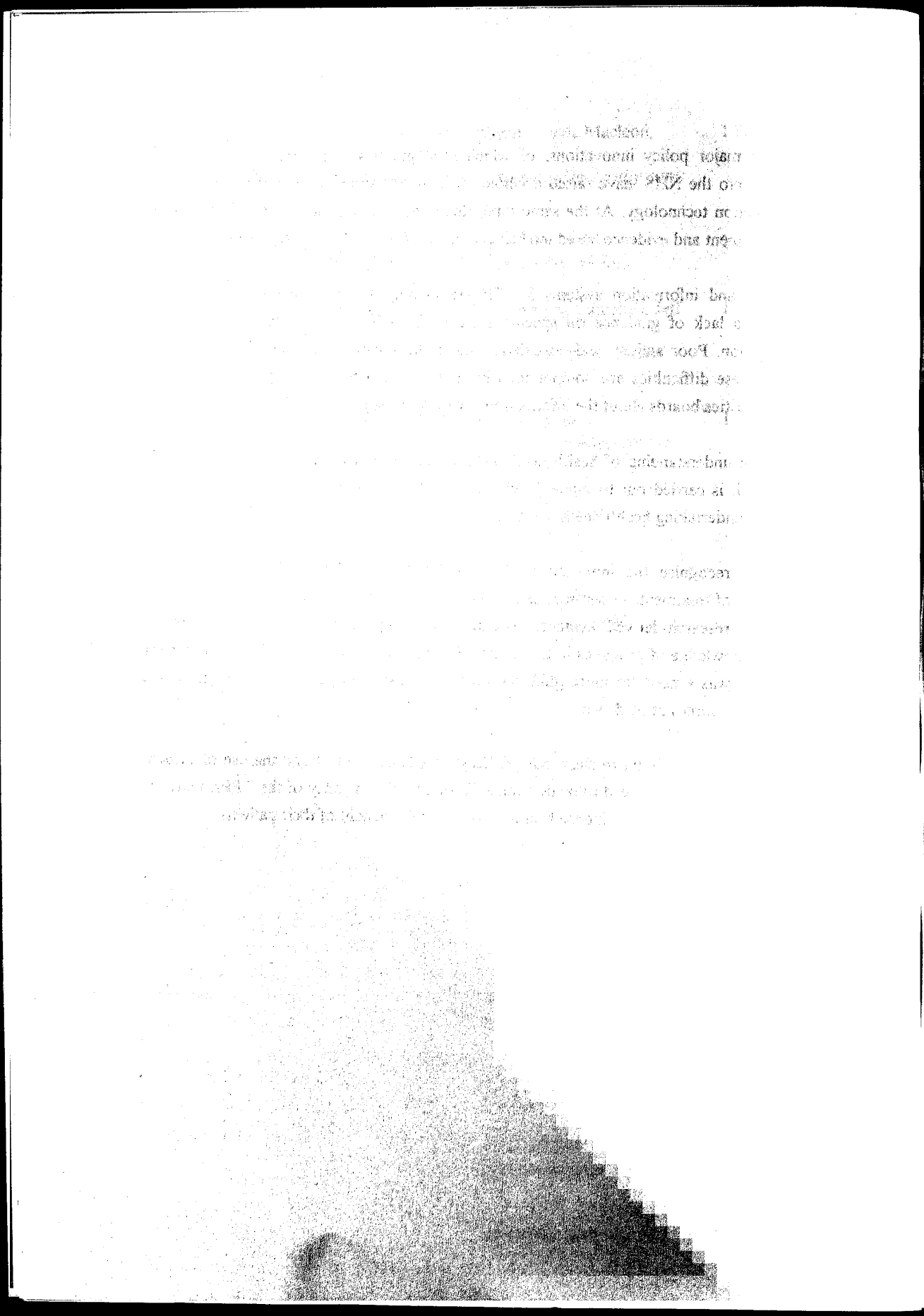
The recent major policy innovations, of which total purchasing is one, which have been introduced into the NHS, have raised a whole set of issues about information requirements and information technology. At the same time, there has been increasing emphasis on health needs assessment and evidence based medicine, stimulated by the health service reforms.

Information and information systems for TP are inadequate, with major problems being centred on a lack of guidance on specific systems for TPPs and an absence of software standardisation. Poor activity and cost data hamper the attempts of many TPPs to change services. These difficulties are compounded by a lack of understanding between TPPs and health authorities/boards about the information necessary to support devolved purchasing.

The level of understanding of health needs assessment varies widely, as does the frequency with which it is carried out to guide purchasing. TPPs want more support and guidance in methods of undertaking health needs assessment.

Most TPPs recognise the importance of using 'evidence' of the effectiveness or cost effectiveness of treatments or services as a guide to their purchasing decisions. However, few currently use research-derived 'evidence' as a main input to purchasing decisions as compared with local knowledge of problems in the health care system affecting the TPP's own patients. Again, there was a need for more guidance on what constitutes good evidence and how to access usable sources of evidence.

The results of this study make clear that IT, health needs assessment and the use of evidence to inform purchasing will need to be developed further by the majority of the TPPs. Only then will they have the ability to influence health services for the benefit of their patients.



1 Introduction

Since the late 1980s the NHS has given 'abundant license'(Meads, 1996) to numerous local and national innovations in primary care (Department of Health, 1989; Holliday, 1992), perhaps the most significant of which was the introduction of fundholding from April 1991 (Department of Health, 1989).

Fundholding was one of a series of policy changes introduced following the publication of the NHS White Paper *Working for Patients* (Department of Health, 1989), subsequently enshrined in legislation by the 1990 NHS and Community Care Act (HMSO, 1990). These major policy innovations raised a whole set of issues about information requirements and availability for purchasers and providers, and about information technology in the NHS. At the same time there has been an increasing emphasis on health needs assessment and evidence based medicine stimulated by the health service reforms. A key task for health authorities (HAs) has been the systematic assessment of the health needs of their local populations. There have, however, been few studies detailing how topics for HNA are chosen or what effect they have on purchasing (Fulop, 1997). Evidence based medicine is the conscientious, explicit, and judicious use of current best available external evidence about medical care (Sackett, 1996). The aim is an evidence-based service that provides the best quality health care for the population. Over the last few years, however, there has been a realisation that a great deal of evidence that would be helpful has been ignored and the NHS Executive (NHSE) is trying to promote clinical effectiveness by a variety of methods (NHSE, 1996). The TPPs have not been exempt from these issues and have provided an environment in which to test the appropriateness of IT, health needs assessment and the use of evidence in these new primary care organisations.

Total purchasing was introduced in 1994 (NHSE, 1994). 'First wave' total purchasing projects (TPPs), numbering 53 initially, are subject to evaluation by a consortium (TP-NET) led by the King's Fund and including researchers from the Universities of Manchester, York, Bristol, Southampton and Edinburgh (TP-NET, 1997). The TPPs entered their preparatory year in April 1995 and went 'live' in April 1996.

Some regard total purchasing as a 'natural progression' from standard fundholding, but in reality it is quite different. Standard fundholding has a 'top down' framework which practices have to work within. Total purchasing, by contrast, is subject to few regulations, and was to

be implemented locally. Although fundholders hold their own budgets, TPPs have no direct purchasing power since the budget remains the responsibility of the local health authority (HA), and the TPPs are sub-committees of that health authority.

The national evaluation

The national evaluation is composed of a series of studies designed to assess and evaluate total purchasing from a range of perspectives. This paper is based on findings from the process evaluation which aims to describe the local implementation of total purchasing and to identify more and less successful projects. It includes an assessment of how projects have identified their information needs, developed information technology and the extent to which evidence has informed their purchasing plans and priority setting, including their approach and use of health needs assessment. This involved in depth interviews with key personnel at each project as well as collection of relevant documentation, for example purchasing and business plans. This paper reports on the findings from the first two years of total purchasing. It draws on data obtained during two rounds of interviews, at the end of the preparatory year and at the end of the first year of 'live' purchasing'. The interviews were held with TPP managers, lead general practitioners (GPs), and representatives from the health authorities and the main provider organisations (preparatory year only).

Some of the questions asked enabled an assessment to be made about the information and information technology requirements of the TPPs during their preparatory year and how these progressed during the course of the first live year. They also allowed an assessment of the views of health authorities and providers about how TPP might impact on their respective organisations. The interview data were further analysed to assess the TPPs involvement with health needs assessment (HNA) and the role evidence played in the activities of the TPP, including the nature and the extent of the relationship between the TPP and the public health department of the host health authority.

Defining total purchasing

A working definition of total purchasing was set out in the first report of the Total Purchasing National Evaluation Team (TP-NET) as;

> *Where either one general practitioner practice, or a consortium of practices are delegated money by the relevant health authority to purchase potentially all of the community, secondary and tertiary care not included in standard fundholding for patients on their lists.* (TP-NET, 1997).

Sixteen (30%) TPPs are single practices. The mean number of practices per site is 3.1 and the mean patient population is 28,500, ranging from 12,310 to 84,700. Since it is a requirement of fundholding that practices should be computerised, and TPPs had to be fundholders, all practices should have been computerised but their preparedness for total purchasing varied. In effect some practices had taken up community fundholding at the same time as total purchasing and were still developing their computer systems.

2 Methods

The data presented in this paper are from the component of the evaluation which focuses on the establishment and operation of the 'first wave' TPPs. Data were collected from face to face semi-structured interviews with representatives of the main parties involved in each TP (for this paper these were the lead GP, project manager, HA lead and provider contacts). Each interview comprised a set of pre-determined questions supported by a range of supplementary questions and interviewer prompts. The interview guide was thus semi-structured to allow for flexibility. Interviews were tape recorded and researchers prepared written summaries in a structured format for analysis. The first set of site visit interviews were carried out between October 1995 and January 1996 for all four types of respondent given above; the second set of interview visits were carried out towards the end of the first live year for all but the provider contacts. Providers were contacted by telephone at a later date but these data are not included here. Documents such as business plans and purchasing intentions were also collected.

For the information technology (IT) section of this paper, interviews with lead GPs, HA contacts and project managers were analysed for details of their perceptions of the information and IT needs of TP. This was carried out for both the preparatory and first live year. In addition, provider interviews from the preparatory year were analysed to determine the expected impact on providers of TP information requirements.

Similarly, HA/Board contacts, lead GP and project manager interviews were examined to determine the level of understanding and involvement of TPs with health needs assessments (HNA), and the level of support provided by public health departments. This was carried out using both the first and second sets of site interviews for each of the respondents.

To determine the extent to which purchasing decisions were based on evidence, and the type of evidence used, TPs identified the four main changes they wished to make through becoming total purchasing. Providers in the preparatory year and HA leads in the live year were then asked what kind of evidence, if any, TPs had used to support these changes.

3 Results

The main tasks facing TPPs during the preparatory year included obtaining information to allow priorities to be set and purchasing decisions to be made. Information was also required to inform budget setting, to prepare documentation e.g. purchasing and business plans, and to carry out contracting and monitoring functions.

The TPP managers and GPs stressed that they needed to identify their inherited activity before they could progress to purchasing health care related to the health needs of a population and that accurate data is the essential basis of undertaking health needs assessment. They reported that all projects needed a morbidity profile of their population. Some health authorities, however, had only done some very basic HNAs and practices had been using historical data, amended by GP perceptions of patient need and input from the public health medicine (PHM) department. The data collection had enabled them to identify trends in historic activity but they felt it needed to be further developed to enable projections to be made.

The projects also recognised that whilst they needed to ask public health medicine to produce information and statistics, they also needed to do searches of their own data. Lack of computerisation of clinical data was felt to be the main barrier to further HNA. GP information systems need to communicate with hospital systems and they need to access a national HNA database. It was also recognised that some information is not available from routine statistics e.g. on the health needs of some client groups such as holiday makers/temporary patients.

Surprisingly, requests for information about clinical effectiveness were not mentioned by projects in relation to HNAs, other than by one project which wanted information about the effectiveness of health promotion activities.

For 28 out of 52 (54%) projects, collecting information was identified as a key task during the preparatory year. Three main sources of information were used by TPPs; practices within the TPP, local trusts and health authorities. Whilst 16 (31%) TPPs obtained (or requested) some information from all three sources or were unable to identify a main source, typically they relied on a single main information source. Fourteen (27%) identified their local health authority as a main source compared with 11 (21%) who identified their local trust or trusts. Perhaps surprisingly, 11 (21%) projects identified practices within the TPPs as the main source for information relating to their total purchasing function.

The different areas of information need will now be looked at in more detail under three main headings;

(1) information technology
(2) health needs assessment
(3) the use of evidence.

Information Technology

Total purchaser views about IT

The problems TPPs encountered in obtaining information related to quality, usability and accessibility and are summarised in Table 1.

Table 1: Problems with information experienced by TPPs (N=52), during the preparatory year, by source

Problem	Source of Information		
	Health Authority	Providers	Practices
Quality	16 (31%)	13 (25%)	2 (4%)
Usability	6 (11.5%)	5 (10%)	1 (2%)
Access	9 (17%)	9 (17%)	3 (6%)

Many TPPs were critical of health authority and provider information but GPs were largely uncritical of practice based data; indeed this was often commented on as being the most accurate and, not surprisingly, the most relevant to their needs. Although TPPs could often obtain data from several sources it may not have been in a form that could be used to inform practical decision making. As one GP noted 'it's difficult to get information but lots of data are supplied'. For one TPP manager 'getting information was like putting together pieces of a jigsaw', and, given the different sources of information, this was not an uncommon experience. Sometimes, though, pieces of the jigsaw were missing and despite often repeated requests for information, this was not forthcoming from health authorities and providers. Some TPP managers and GPs interpreted this as lack of co-operation whilst others felt the providers and

health authorities simply did not have the information. The involvement in total purchasing of non-fundholding practices and those that were not computerised was often the cause of difficulties in accessing practice based information. Access to data varied according to hospital specialty and appears to have been particularly problematic in the case of A&E and emergency admissions.

Table 2 shows the information technology systems in place during the preparatory year and the first live year.

Table 2: Information technology systems for total purchasing - managers' views

IT System	Preparatory year (n=49)		First live year (n=43)	
Modifying new or existing	29	(59%)	17	(39.5%)
New system (not fundholding)	3	(6.1%)	10	(23.3%)
Not yet decided	9	(18.3%)	0	(0.0%)
Link with/rely on provider or HA	4	(8.1%)	7	(16.3%)
Other (manual, database)	4	(8.1%)	3	(7.0%)

During the preparatory year most projects reported some modification or extension to their existing arrangements for standard fundholding, or modifications to newly acquired fundholding software. Others preferred to rely on, or link with, their local providers or health authority for the information required for total purchasing. Nine (18%) were still exploring the options available at the time of the interviews. Three TPP managers referred specifically to a system designed exclusively for total purchasing. As the projects developed they adopted different approaches to IT so that by the first live year fewer were depending on modified standard fundholding packages (which had caused enormous problems for many) and more had adopted entirely new systems specifically for total purchasing or were developing more systematic links with their health authorities and providers.

Forty five project managers expressed an opinion about the adequacy of their IT systems. Sixteen (36%) felt that the IT arrangements in the TPPs would meet their requirements as total purchasers. Of these, 12 had some reservations about their systems; for example the legal requirement to keep fundholding and total purchasing separate was seen as a definite

limitation for some TPPs. Twenty three (51%) felt that current IT arrangements were inadequate, the most common problem encountered being the existence of different software systems for fundholding in practices within the TPP, and the failure of current systems to meet their requirements as total purchasers. Six (13%) TPP managers were still in the process of identifying their IT requirements.

Satisfaction with IT arrangements had not improved by the time projects were live as they were becoming increasingly aware of their IT requirements and the limitations of their existing systems. Indeed only 16.6% of TPPs were entirely happy with the way their project was managing IT, although a further 36% were happy, with reservations. A third (31%) felt the management of IT within their projects remained inadequate.

Health authority views about IT

IT was not such a major issue for health authorities since they were pre-occupied with other issues such as budget setting and contracting, particularly during the preparatory year when difficulties with data relating to resource allocation and budgetary management were expressed by 13 (24%) health authority leads. HAs found a general lack of reliable historical data. Twenty six (47%) commented on the additional workload generated by IT but only three on the need to rethink their systems, processes and information flows and the need to re-focus to practice level. Individual health authorities noted problems with sorting out data disagreements with practices, the fact that IT systems tended to be inflexible and that there was no co-ordination of IT amongst practices within a project. Two health authority leads were positive, one feeling that the IT links with the practices would improve data access, and a second welcomed the opportunity to test out its 'sophisticated IT system' for purchasing on the TPP.

From interviews conducted during the live year, only 7 health authority interviewees mentioned IT, four referring to having provided their TPP with assistance and a further two commenting on the good IT knowledge of the TPP. One HA lead commented that the HA and TPP IT systems were not linked, which had caused difficulties and the TPP were requesting information without being clear why it was needed. Finally, one interviewee observed that the HA could not sustain IT resources if TP were to be rolled out to all practices.

Provider views about IT during the preparatory year

Many trusts had very limited contact with their TPPs and consequently had little information on which to make plans or anticipate the impact on themselves. Some heard about very specific information requirements second hand. Responses to questions put to trusts are consequently largely impressionistic and reflect anticipated development rather than actual experiences. However, many trusts had dealt with some or all of the practices within TPPs as standard fundholders and often drew on this experience when describing or anticipating the impact of the TPP on the trust. One respondent summed up the view of many by saying that estimating the extra work brought about by TPP was like 'groping in the dark' . Nevertheless, many trusts did express a view about how their organisation would be affected by their local TPPs.

The impact of TPPs on trusts had been, or was anticipated to be, greatest in the following areas; data collection, data analysis and interpretation, contract monitoring and negotiation, and to a lesser extent, validation and dealing with invoicing queries. These are summarised in Table 3.

Table 3: Provider views of the impact of total purchasing during the preparatory year

Nature of Impact	Type of Provider: Integrated (n=8)	Acute (n=43)	Community (n=39)	Mental Health (n=2)	All (n=92)
Data Collection	3 (38%)	18 (42%)	22 (56%)	0 (0%)	43 (47%)
Data Analysis	5 (63%)	34 (79%)	26 (66%)	2(100%)	68 (74%)
Contract Negotiations	4 (50%)	32 (74%)	23 (59%)	2(100%)	61 (66%)
Validation Requests	3 (38%)	6 (14%)	2 (5%)	0 (0%)	11 (12%)
No additional work	0 (0%)	1 (2%)	2 (5%)	0 (0%)	3 (3%)
Less work	1 (13%)	0 (0%)	2 (5%)	0 (0%)	3 (3%)

Community trusts were more concerned than acute trusts about the additional data they would need to collect, since they recognised that there were considerable gaps in their computerised and manual systems. For all trusts the additional analysis, interpretation and report writing as a consequence of the TPP was perceived to generate the greatest new work. Trusts expected contracting and monitoring to be more complex, detailed and sophisticated compared with health authority contracting and similar to fundholding with a greater emphasis on cost per case contracts as opposed to block contracts.

Despite these problems, total purchasing was seen as a catalyst for change by some trust managers; some initiatives, such as changes to contract currencies, had been expedited, some had reconfigured their internal structures in anticipation of total purchasing and some expected a greater role for directorate staff. Few trusts had employed new staff and most reported that additional work had been or would have to be absorbed within the existing system. Ironically, whilst the experience of dealing with standard fundholders was considered to be advantageous in dealing with TPPs, many recognised that the improvements made to cope with standard fundholding were now routine, and a new problem was how to reconfigure current systems to cope with standard fundholding and total purchasing running in parallel.

Health Needs Assessment (HNA)

Involvement of the projects with health needs assessment

The preparatory year

Of the 53 projects, no information about HNA was recorded for 12. The rest (41) mentioned needs assessment in a variety of ways (Table 4).

Table 4: Involvement of the projects with HNA

Involvement in HNA	Number (% of those responding)
Project is doing HNA	20 (49)
Project plans to do HNA in the future	12 (29)
Project is not undertaking any HNA / no plans to do any HNA	5 (12)
Informant unaware of any HNA	4 (10)

Twenty projects (49% of those responding) were currently undertaking HNAs and a further 12 (29%) indicated that they had plans to do HNAs in the future. Five (12%) reported they were not undertaking any HNA and had no plans to do so in the future. One respondent said they had 'talked a lot about it but it is difficult to pin down' and another admitted that 'work on needs assessment has been pretty limited'.

Generally, more projects were starting to think about HNA or stated simply that they were doing it, than gave specific details. Many recognised that they needed to do more needs assessments in the following year. The importance of the concept of HNA was, however, mentioned by many of the projects. Several projects commented that needs assessment, giving a better picture of patient needs, was one of their key tasks as a TPP. Similar comments include 'we are especially interested in health needs assessments' and HNAs 'would provide a fairer allocation of resources to patients'.

Although many projects report that they had done HNAs there was little detail about what had been done. The following statements and quotes highlight a variety of ways in which HNAs had been interpreted and undertaken by the projects:

- practice profiles are described as being needs assessments
- 'GPs have a good handle on the needs of the population because they do it all the time'.
- the knowledge and experience gained by GPs in their every day clinical work is felt to be the most important factor in the assessment of health needs by some GPs.
- 'needs assessment is bound to be partly subjective and cannot be done with great accuracy'.

- it initially consisted of understanding better the past and present pattern of services used.
- 'our needs assessment was done by identifying historic activity'.

Only a few projects referred to the analysis of statistics, epidemiological data, comparative and effectiveness data and local opinion as part of a HNA process. Some projects did however now recognise that HNAs were previously based on local opinion rather than 'statistical information', that they were undertaken in an unstructured way, relying on the 'gut feelings of GPs, in particular in relation to those services which they feel are under provided' and they now want to move away from demand to need. They recognised that a structured approach is needed and one project described HNA as being 'a focus for care through response to hard facts and figures about local population ... rather than by anecdote through local knowledge of patients'.

There were a few examples of HNA being well established. One project had a HNA working group, headed by a consultant in public health medicine. This group had examined locally available information, public health reports on statistics, and learning experiences from regular fortnightly meetings with the primary health care team and a group of a wide variety of people from health promotion, social services, Joint HA-LA post and other GP health needs assessment groups. Another project wanted to expand HNA and develop care protocols. An organisational structure for undertaking HNAs had been developed by another project - this followed difficulties the health authority had pulling out local data.

The first live year

When asked what approaches had been undertaken to assess the health needs of TPP populations for defining purchasing priorities, the lead GPs often mentioned specific areas as being the subject of some form of needs assessment, but gave fewer details about the approaches actually used. Some form of response was given by 26 (52%) TPPs. The general approaches used to inform purchasing were; using chronic disease registers, EBM/cost-effectiveness of services, linking a 'morbidity coding project' with the TPP, practice based needs/database of 'soft areas', patient views/complaints, using public health skills for informing ECR policy.

A number of these approaches used quantitative information and data sources, whilst others are more oriented towards learning from other's experiences, either from patients using the

services or professionals with appropriate training. The local public health departments had been used for some of the above, although in many cases the projects had undertaken the work themselves, often health visitors and district or practice nurses took a lead role. Public health doctors appeared to play a greater role in discussing the use of evidence (e.g. reviewing the EBM literature and discussing the policy for extra contractual referrals (ECRs)) rather than carrying out needs assessments.

Service areas in which health needs assessment was carried out

During the preparatory year specific topics or conditions for which HNAs had been undertaken were mentioned only by a few projects. Also, the need for local (project/practice level) needs assessments was becoming apparent in some projects. Although some needs assessment work had been done in the past it had not always been relevant to the project's area and had arisen from national or health authority priorities. The needs of the project's population may differ from that of the health authority and similarly, there may be differing needs and characteristics of populations within a TPP. How such topics were prioritised is unknown although one project stated that they were focusing on the high cost areas for HNAs.

HNAs had been undertaken in the preparatory year for a range of conditions, people or services as follows; learning disability, mental illness, holiday makers, health visitors, maternity services, asthma, emergency admissions, community nurses.

During the live year the service areas specifically mentioned by GPs as being the subject of some form of needs assessment were broadly similar to those undertaken in the preparatory year; elderly/geriatric services, cardiology/cardiovascular services, monitoring/development of local community unit, health needs of terminally ill patients, health visitor/district nurse contacts, mental health services, drug addiction/CPN/social services use, A&E attendance's, asthma and diabetes.

Support for health needs assessment

The preparatory year

As well as requiring information support many projects recognised that they lacked the skills to do HNAs and they needed public health medicine support from the health authority. Many who recorded that they were doing HNAs were involved with the local public health medicine department, often following initiatives led by public health medicine. Several had a public health medicine trainee or consultant attached to the project who was taking a lead and offering assistance. Others, not yet involved directly with HNA, had been offered public health medicine advice. The projects expected the involvement of public health medicine to be provided free of charge and believed that the local health authority would receive reciprocal benefit from this joint working as 'we have the data, they don't'. The TPPs usually want this public health help from the local public health medicine department, but comment that public health medicine in turn needs help and further training as they are not skilled using GP information systems.

Other projects had limited support and only a few members of staff involved with the HNAs - for example, a former health visitor who was undertaking community based needs assessment for one project and a single GP from another. Some mentioned they would buy help if it was needed. Indeed, one project had utilised the skills of the local university (as Consultancy), another external consultants. These were financed from special project grants.

Many projects did, however, recognise the need to collaborate with other purchasers for HNA activities, both locally and nationally.

Others projects highlighted the following about support needed for HNA: more resources are needed; the lack of primary care development hinders the HNA process; there should be joint learning on health needs by primary care and the health authority and HNA should be supported by primary care development funds.

The first live year

The main HA/B contacts were asked questions in the second round of interviews about the role of public health and needs assessment. The HA/B's were asked specifically about the

training and support they had provided over the first year of purchasing, in particular, support with needs assessments. Responses about HNA or public health medicine support from the HA/B lead for the remaining 50 projects were given by 28 (56%).

Responses about HNA or public health medicine support from the HA/B contact in interviews conducted during the first live year are given in Table 5.

Table 5: Support Received by the TPPs for HNA *(responses by HA/B Lead)*

Support given by public health medicine at HA/B	**Number (% of respondents)**
Some support	20 (71%)
No Support	6 (21%)
Other (non-HA/B) support	2 (7%)

* percentages do not add to 100 due to rounding.

The majority of the TPPs (71%) were given support from the local public health medicine department. The degree of support was variable - one had a full time public health specialist for the project, others had public health medicine trainees seconded to work with them and other stated simply that the public health department had *'links'* with the project.

However, some (21%) of TPPs were given no support from the health authority. Comments about this included '... but you can only give people support if they are prepared to accept it...' and 'instead of public health working along the TPP in identifying health needs and priorities, the relationship has been quite confrontational ...'. It was also reported that one TPP did not need any such support as the necessary skills were available in-house. For another project the public health medicine department was co-ordinating a local evaluation of clinical projects by an outside body.

Relationship with public health medicine

Some difficulties with the relationship with public health medicine were discussed in the preparatory year, although their involvement in HNA was generally welcomed by the projects.

One project admitted they initially felt unsure of public health medicines motives. This was described in one interview 'X 'appeared' at one meeting and no-one was sure of his role at first since we did not know his motives - was it as an advisor/director/colleague? In the end he has become most useful ...'. Another problem noted was that the involvement of public health medicine had led to many HNAs being at the authority/board rather than project level. The public health medicine department may 'take over' the HNA 'public health medicine has done the HNA, not us' and the projects were thus passively involved with HNA. There were some comments that public health medicine support had not been forthcoming and one did not want any local public health medicine support - in the long term they wanted to purchase public health support from outside the health authority because they were concerned about health authority access to GP data.

Two questions were asked of the lead GPs which gave information about relations with the HA/B public health department and how useful was the input from public health physicians. Table 6 gives numbers (%) of TPPs reporting on relations with HA/B public health departments.

Table 6: Working relations between TPPs and HA/B public health department (lead GP views)

Type of relations with HA/B public health dept	Number (% of respondents)
Very good/full collaboration	5 (18%)
Good/improving	11 (39%)
No links	11 (39%)
Deteriorated over year	1 (4%)

Of those TPPs that gave a response, 16 (57%) indicated that relations with the HA/B public health department were good or very good. Examples given of such relations were having a senior registrar or registrar in public health medicine seconded to the project, although long term secondments were considered of greatest use. Also a GP from one TPP was working one session a week in the public health department.

Comments from the GPs that illustrate their feelings about the lack of public health links ranged from the fairly general 'Public health is just useless' to more specific 'Up until 18

months ago I was unaware of what they actually did. Know I know, actually not very much'. Three projects, two who stated no links with public health at the local HA/B and the one claiming deteriorating relations, had already or planned in 1997/8 to employ external public health support (i.e. through local Consultancy).

Table 7 shows the perceived usefulness of public health input as it was given from the HA/Bs.

Table 7: Usefulness of HA/B public health department input(lead GP views)

Usefulness of public health input	Number (% of respondents)
Very useful	5 (23%)
Useful	6 (27%)
Moderate	2 (9%)
Not useful/no input	8 (36%)
Unsure	1 (5%)

The number of practices reporting public health input as at least moderately useful was 13 (59% of respondents). Those projects reporting public health input as very useful were usually the same projects reporting full collaboration from the HA/B or having a member of the department seconded to the project.

Projects reporting no use or input in some cases found a gap in the cultures of the two organisations, with the HA/B still being very top down in their approach and very secondary care orientated, as well as being out of touch with developments in primary care over recent years. One project described trying to undertake needs assessments with the HA/B as 'like trying to stir thick heavy dough'. Another thought 'public health have been a bit backwards in coming forward'. The department of public health was willing to answer questions but as neither public health nor the GPs knew what question to ask, the process had gone no further.

Use of Evidence by TPPs

The use of evidence in identifying priorities during the preparatory year

The four main changes introduced by the TPPs

The four main changes that lead GP and TPP managers in the preparatory year stated that they intended to make through becoming a total purchaser are given in Table 8.

Table 8: The 4 Main Changes Classified by Speciality, Secondary-Primary Shift or Other Change

Specialities		Secondary/Primary shift		Other Change	
Maternity	24	Community care (e.g.		Quality (e.g. efficiency	
Mental Health	14	CPN/nurses, care at home,		services, patient choice,	
A/E	8	community care package,		quality/local service,	
Stroke care/rehab.	7	link with social services,		communication)	17
Elderly	8	development of a		Contracting/Funding	12
Community care	6	community hospital and		Needs Assessment /	
CV disease	3	nursing homes beds)	39	Evidence	10
General medicine	2	Emergency admissions	20	Better information	4
Breast cancer	2	A/E sec-prim/ shift	19	Developing Primary	
Teenage services;		More power to primary		Care	2
Acute services;		care	18	New hospital (DGH)	1
General surgery;		Services moving from			
Palliative care; Back		secondary to prim care	8		
pain;		Transfer care to primary			
Ophthalmology;	1	from secondary	2		
Oncology; Leg ulcers	each				
Other	4				
Total	***86***		***106***		***46***

A total of 238 changes were recorded by 63 sites. Two projects had withdrawn from the scheme by the end of the preparatory and they have not been included in the analysis. The main changes are classified into whether a speciality was noted, whether a shift to primary care

was indicated, or whether there were other changes. An assessment was later given by providers and HA contacts about the extent to which evidence had informed these changes.

Eighty six main changes highlighted a particular medical speciality or group of specialities e.g. general medicine. The most common speciality was maternity and within this implementing *Changing Childbirth* was a predominant theme.

Other specialities highlighted included those which were currently topical nationally and locally (community care, oncology, accident and emergency) and others which had a particular local significance or day-to-day priority e.g. teenage pregnancies. A&E was a topical area which was often cited as an area of change. Assessing the current position and the contracting currency and reducing inappropriate utilisation were the main themes for A&E.

Many sites were planning a 'shift to primary care' - mentioned on 106 occasions. This shift was across the spectrum of services and includes buildings, staff, services, resources, power and control.

Supporting and developing the local community hospital was the single most commonly mentioned change. A&E attendance's and emergency admissions was another common theme as was the development of alternative services in the community / primary care, the development of beds in the local community hospital or nursing home and the devolution of power to primary care.

On 46 occasions, other developmental changes were stated as being one of the four aims. Some sites recorded their main changes in terms of long term plans to improve the quality of care (17) or other developmental areas like generating information (4) or developing primary care (2).

Ten sites did however record changes of approach in general terms which are based on or driven by evidence. These included the development of needs assessment and needs led purchasing, the promotion of evidence based medicine and the development of protocols and guidelines.

The Views of Providers

All types of providers were asked before the beginning of the first live year if TPPs had produced any evidence to support the changes they wished to make, and what kind of evidence. The results are given in Table 9.

Table 9: Provider views of evidence given by TPPs

	Acute	Community	Combined	Totals
Yes - specific evidence/data	10 (45%)	2 (13%)	4 (19%)	16 (28%)
Yes - GP perceptions of need	2 (9%)	8 (53%)	6 (29%)	16 (28%)
None	4 (18%)	1 (7%)	3 (14%)	8 (14%)
Too early/no changes	1 (5%)	2 (13%)	2 (10%)	5 (9%)
Don't know	5 (23%)	2 (13%)	6 (29%)	13 (22%)
Totals	22 (100%)	15 (100%)*	21 (100%)*	58 (100%)*

* percentages do not add to 100 due to rounding.

At least one provider (usually two, an acute and a community trust) for each of the 53 original TPPs was approached. However, due to missing interview data, the total number of providers for which data are available is only 58. The information given therefore is representative of TPs purchasing from these 58 providers only.

It appears that acute providers were offered more 'hard' evidence than community or combined acute /community providers (45% v. 13% and 19% respectively). In secondary care, evidence may be available in more 'hard' forms (e.g. specific service changes mentioned were the use of aspirin after MI and specialist care after a stroke). Services changes proposed with community providers were often about developing local community hospitals or the working patterns of community nurses where national or published evidence may not be available for such developments. GPs often wanted change because they perceived the need for it from their

own local experiences. The sources of evidence put forward and numbers of providers mentioning are historic/practice data (4); HNA (4); health outcomes data (2); patient groups/views (2); academic links (2); written report/guidelines (4); Cochrane database (1). These sources were given by all types of providers and relate to responses in the first line of Table 9.

The use of evidence in identifying priorities during the first year

Health authority leads were asked at the end of the first live year about the use of evidence. Data were available from 42 interviewees. They reported that 23 projects (55%), were using clinical effectiveness information and 5 (12%) were not. Fourteen informants (33%) were unaware of any clinical effectiveness information being used. The detail given for those using clinical effectiveness information varies.

Some respondents highlighted specific conditions or services where clinical effectiveness information had been used to inform purchasing decisions. These conditions and the number of times they were mentioned are; cardiovascular disease (4); maternity services (2); diabetes (1); stroke rehabilitation unit (1); nurse triage (1); ENT (1); asthma protocols (1); lipids (1); falls in the elderly (1); mental health (2); adolescent health project(2); protocols for dyspepsia (1) and clinical protocols for early discharge (1).

Other respondents gave more general information about the type of evidence used, where it was found and less specific uses. Some of the sources of evidence are very similar to evidence that providers claimed to have been given in the previous year, namely public health medicine, disinvestment of resources, developing managed care; prescribing; reading journals; developing clinical indicators; Cochrane database and using own funds to get 'evidence information'.

Most of the projects using clinical effectiveness information were using national initiatives rather than responding to particular local problems - hence its use in areas like cardiovascular disease, maternity services, and issues like ENT referrals and falls in the elderly.

There were clearly some projects who had used clinical effectiveness information for new areas and issues. One has introduced a software package to all practices in the TPP about clinical effectiveness and this information has been used promote the development of a stoke rehabilitation unit at the local trust, in managing ECRs and in developing nurse triage.

Cardiovascular disease was the topic which they had used clinical effectiveness information for the most. Other projects responded more generally stating that clinical effectiveness information had been used when working with public health medicine, with prescribing or simply that they had been using the Cochrane Database or had been reading the journals.

4 Discussion

Total purchasing and the 'learn by doing' (Meads, 1996) approach, typical of many primary care innovations, represents a double edged sword. On the one hand local interpretation encourages innovation and builds on local strengths. On the other hand, with respect to the information requirements of TPPs and the strategic development of information and IT systems for a primary care led NHS (Ferguson, 1996; DH, 1996), it appears to represent a missed opportunity.

The absence of a blueprint, emphasis on local interpretation, the fluid nature of priorities and the immature relations with providers and health authorities were inevitable given the manner with which TPP was introduced into the NHS (NHSE, 1994). Whilst it would not to be totally accurate to say that 'muddle and chaos' predominated, it was certainly the case that trusts experienced considerable difficulty in assessing the impact of total purchasing on their organisation. Opportunities to engage with trusts from the start and, indeed, prior to the introduction of TPP, were missed by both the NHS Executive and the TPPs themselves. Many TPPs were not sure what information they required and in what format. Priorities were fluid and the nature of their contracting and commissioning relationship with the health authority was developing and had not been tested. Negative attitudes to health authority and provider data may be a reflection of suspicion and confusion relating to respective roles and responsibilities, and, indeed, information requirements. As projects develop, priorities may crystallise and relations with health authorities mature so that information requirements will be clarified.

Many practices within TPPs were modifying current software systems which varied enormously, not just between TPPs, but between practices within TPPs. This raises questions about the lack of compatibility between IT systems and the feasibility of modifying computer systems whilst projects are evolving and priorities are still emerging. Important precepts for collaboration are, *inter alia*, mutual understanding of roles and agreements concerning shared information (Allsop and May, 1996). It may be that as organisations evolve the collaborative structures and mutual understanding of roles and information requirements will evolve too. Only then can information and IT requirements be properly assessed and appropriate systems installed.

Purchasers and providers need timely and accurate information on activity and costs with which to make informed decisions about contracting, and much progress has yet to be made in the development of information systems which would allow TPP staff to tap into compatible provider and health authority data. At present, the information is best for acute services, whilst that for community and mental health services is poor. Arguably, progress is being made through the government's IM&T strategy (Ferguson, 1996) although the findings from this study suggest there is a considerable way to go to achieve the aims set out in 'A Service with Ambitions'(DH, 1996). There are however a number of policy initiatives in place that will help move towards the 'best case scenarios' set out in this document. These include the establishment of an NHS wide network which will ultimately enable all organisations in the NHS to share information, and the development of a common language to describe clinical activity. The evidence from this study suggests that TPPs may be acting as a catalyst for change in alerting practices, trusts and health authorities to the information requirements of primary care organisations as providers and purchasers of care. This could be helpful when the project sites arising from the Primary Care Act go live (Department of Health, 1996).

However, it remains the case that the most pressing problem with regard to information systems related to the lack of guidance from the centre on computer systems designed specifically for TPP, and a concomitant lack of standardised software. As a result, practices each had to start from scratch, with some using modified fundholding software, frequently found to be inappropriate, or, in a few cases, devising their own systems. This represents a missed opportunity. There is, however, perhaps some excuse for this complete lack of co-ordination in that TPPs were introduced as three year pilots so that major investment in IT specifically for TP would have been expensive and possibly not cost effective to use. Such excuses must be set, however, against the cost of not developing such systems, which has shown itself in delays in purchasing, and hence in not showing the TPPs in their best light. Nevertheless, it remains the case that the availability of information is fundamental to the purchasing process, and unless IT systems can meet these needs, progress in purchasing, and particularly in changing contracts on the basis of local needs will, at worst be unable to proceed, or at best, proceed unnecessarily slowly.

With regard to HNA, many TPs were given guidance and support from their HA public health departments and relations were on the whole good, with input perceived as being useful. However, although the central role of health needs assessments was recognised by the

projects, the depth of understanding and practice varies, with TPPs needing guidance on the meaning of the term 'HNA' and how to undertake them.

Over three quarters of the projects reported that they had undertaken needs assessments or would do so in the future. It is clear however, that the term HNA is not being interpreted consistently by the projects - many had no previous experience and there is a great disparity in what is undertaken and the range of staff involved. One project commented that they were '... unsure of what HNA was ...' whereas another had a sophisticated description of it as 'bridging the gap between the strategic/locality purchasing and the way GPs provide care on an individual basis'. Needs assessment is said by some to be a 'buzz-word'. Approaches varied from GP opinion to more structured approaches involving a variety of people and resources. It is unclear how the issues for HNAs had been prioritised by the projects. The projects did not agree about whether patients should be involved in HNA and there should be debate on this issue. HNA is currently practised at varying degrees of sophistication by the projects and there could be mutual learning and collaboration.

The use of HNAs to systematically assess the health needs of their local population was not well understood by the majority of the projects. Many HNAs initially undertaken by the TPPs were on national or HA/B problems. Many TPPs now recognise the need for project level HNAs so the focus is on local purchasing. This focus on local HNAs is in agreement with Fulop (Fulop & Hensher, 1997) who found that needs assessments instigated by local routine data or anecdotal evidence were more likely to lead to service change than those instigated by national policy or pressure from an individual within the health authority. It may also be the case that many of the early priorities for TPPs are to change the delivery of services where there are known long term local problems with which the GPs are familiar. In the future, as the focus of priorities changes from short to long term planning and more strategic issues, the use of HNA may become more widespread.

Of those HNAs being undertaken, many were in community services where data are poor, for example, contract minimum data sets for community nurses and health visitors, or the health needs of terminally ill patients. It is perhaps in part due to the lack of appropriate IT systems for collecting information and limited evidence on effectiveness of some community services that the level of involvement and understanding of projects in such HNAs was so varied.

For undertaking HNAs the TPPs need support (especially from public health medicine) whilst at the same time maintaining ownership themselves. Many TPPs received support from the public health medicine department (just over half received very useful or useful public health support) but there were some difficulties. Those TPPs where little support was given did usually want more support but often did not know exactly what they needed or what PH skills were available. Lack of communication and commitment by both GPs and public health departments were highlighted as areas for improvement. From the perspective of the health authority this need to support the project sometimes presents difficulties as they need to be available and equitable to all the practices/localities of their area and not just to those involved with the TPP.

The two different cultures of general practice and public health have in some cases been overcome but in others acted as an obstacle to joint working. GPs were not often sure what questions they should be asking public health and, likewise, public health were very HA orientated and not at ease with GP information systems. Those projects where there was real integration in terms of a GP working in public health or a public health doctor seconded to the project appeared to progress the most. Such joint working and training in use of current IT systems may also facilitate a greater understanding of how HNA relates to and can be used to inform purchasing priorities and contracting by primary care.

Most TPPs recognise the importance of using evidence for informing purchasing decisions, however, much of the evidence used for the main changes discussed in this paper was 'soft' rather than 'hard', that is, predominantly based on local knowledge rather than published research. There was no consensus on what constitutes 'good evidence' and TPs appear to be in need of guidance on how to access usable evidence.

Although the four main changes of the TPPs should be interpreted cautiously, they do provide some insight into the use of evidence. Although the importance of evidence based medicine was recognised by the pilots, evidence in the form of an RCT, literature review or other research evidence was probably not used. On only a few occasions it is likely that evidence based medicine had been was used, for example, evidence is available and may have been used for the development of protocols for the treatment of leg ulcers and stroke care. The interviewees reported that changes were often chosen because they reflected a particular local issue such as a known poor quality service, potential closure of a community hospital, a particular interest or a national initiative. Such statements cannot easily be linked to the use of

evidence. For the shift from secondary to primary care it is unlikely that evidence had been used to inform this change. The evidence for such organisational changes is not available and whether it will produce benefits for patients, or for the specialty of primary care, is as yet unknown. Some of the more general changes stated, such as greater use of protocols and further development of needs assessments, are probably evidence based.

From the provider interviews in the preparatory year, it appears that the projects gave more EBM information to acute Trusts than to community Trusts. However, this evidence included 'historic data' and 'views of local people' which are not always sources of high quality evidence. These results are in agreement with the study by Farmer and Williams (1997), who examined the use of evidence in making purchasing decisions by health boards and GP purchasers. Each was asked to rank factors which may influence purchasing decisions. Although health boards were clearly influenced by public health doctors, GPs were not. Instead GPs were heavily influenced by experience and hunch. One of the reasons put forward for this was that GPs are very 'operational' in their approach to management, lacking both the time and skills to access effectiveness information in the form of published research. Farmers study also reported a high use by GPs of their own practice based data and information from their secondary care providers. From this TP study, problems were highlighted with the quality, usability and access to provider information. If this is the case, but TPPs continue to rely quite heavily on local information, the focus should be on more quality data and integrated IT systems.

The importance of EBM does appear to be recognised by most pilots. Despite the incomplete information available, we can conclude that the pilots need guidance in the sources and application of useful evidence as it appears that many of their main changes are made without an evidence base. The NHS Confederation publication *Acting on the evidence* (Walshe and Ham, 1997) found that although most HAs and trusts had discussed clinical effectiveness at some point in the previous year, this was not undertaken frequently and almost half of HAs and over two thirds of trusts had no written strategy on improving clinical effectiveness. It is therefore not surprising that use of EBM in the strictest sense was not a priority for TPPs. Barbara Stocking (Stocking, 1995) has emphasised that one reason why HAs do not use research findings is that at the time they need answers to a particular question the research is not there. Walshe and Ham (1997) have recommended for health authorities and trusts that greater attention should be given to making sure that policy on clinical effectiveness is carried

through and implemented. Unsurprisingly, this evaluation indicates that these factors also hold true for the TPPs.

Although these results are preliminary and the use of EBM will be explored further in the ongoing evaluation of total purchasing in Wales, it is clear even at this stage that the use of EBM to inform TP purchasing decisions is very limited. An opportunity exists to give more guidance and support to these projects in order to enhance purchasing decisions.

It is clear from the results of this study that IT, health needs assessment and the use of evidence to inform purchasing will need to be developed further by the majority of the TPPs. Only then will they have the ability to influence health services for the benefits of their patients.

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