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Developing Primary Care in the New NHS

Lessons from total purchasing

Total Purchasing National Evaluation Team

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The 1997 and 1998 Health Service White Papers set out a ten-year strategic agenda of evolution and change for publicly funded health care in the National Health Service (NHS). Primary care organisations in England, Wales and Scotland (primary care groups, local health groups and primary care trusts respectively) now have a central role in the strategic development of the NHS, and a duty to work with other agencies to improve health and health services.

Total Purchasing Pilots (TPPs) were a time-limited three-year (1995–98) experimental extension of standard general practice fundholding, set up as sub-committees of their local health authorities. They comprised one or a group of standard fundholding general practices, which volunteered to take a delegated budget from their local health authority to commission potentially all the hospital and community health services (HCHS) for their registered populations.

Total purchasing was the first major 'internal market' policy initiative to be extensively evaluated by the Department of Health and Scottish Office. This report draws together the main evidence from the evaluation in order to inform the development of the new primary care organisations in the NHS. The report outlines how it is important to take time to build effective organisations, with a clear vision and agenda for action. It outlines how TPPs achieved service change, their progress in relation to the context in which they were working and the mechanisms they adopted to achieve change. The report draws out the implications of the total purchasing experiment for the development of primary care organisations throughout the UK.

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The Total Purchasing National Evaluation Team (TP-NET)

The national evaluation of total purchasing pilots in England and Scotland is a collective effort by a large consortium of health services researchers. The study is led by the King's Fund, but also involves the National Primary Care Research and Development Centre at Manchester, Salford and York Universities, together with researchers from the Universities of Edinburgh, Bristol, Southampton, York and Birmingham, the London School of Hygiene and Tropical Medicine and the London School of Economics and Political Science.

Full details of the individuals involved, their affiliations and main responsibilities in the study are listed at the end of the report.

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Glossary

A&E	Accident and Emergency
CHC	Community health council
CHS	Community health services
CMHT	Community mental health team
CPN	Community psychiatric nurse
DH	Department of Health
DHA	District health authority
DRG	Diagnosis-related group
EBM	Evidence-based medicine
EFH	Extended fundholding
EL	Executive letter
FCE	Finished consultant episode
FHSA	Family health services authority
GMS	General medical services
HA	Health authority
HB	Health board
HCHS	Hospital and community health services
HES	Hospital episode statistics
HImP	Health Improvement Programme
HRG	Hospital resource group
IT	Information technology
LBD	Lost bed day
LHCC	Local health care co-operatives
LHG	Local health group
NHS	National Health Service
NHSE	National Health Service Executive
OBD	Occupied bed day
PACT	Proactive care team
PCG	Primary care group
PCT	Primary care trust
PEI	Purchaser efficiency index
SFH	Standard fundholding
TP	Total purchasing
TPP	Total Purchasing Pilot
TP-NET	Total Purchasing National Evaluation Team

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The authors are very grateful to all respondents at TPPs throughout the country who generously devoted time and energy to the national evaluation.

More information about the evaluation as a whole is available from: Gill Malbon, King's Fund, 11–13 Cavendish Square, London W1M 0AN.

National evaluation of total purchasing pilot projects: main reports and working papers

Title and authors *ISBN*

Main reports

Mays N, Goodwin N, Bevan G, Wyke S, on behalf of the Total Purchasing National Evaluation Team (1997). *Total Purchasing: A profile of the national pilot projects.* 1 85717 138 1

Mays N, Goodwin N, Killoran A, Malbon G, on behalf of the Total Purchasing National Evaluation Team (1998). *Total Purchasing: A step towards primary care groups.* 1 85717 187 X

Killoran A, Mays N, Wyke S, Malbon G (1999). *Total Purchasing: A step towards new primary care organisations.* 1 85717 242 6

Wyke S, Mays N, Abbott S, Bevan G, Goodwin N, Killoran A, Malbon G, McLeod H, Posnett J, Raftery J, Robinson R (1999). *Developing Primary Care in the New NHS: Lessons from Total Purchasing.* 1 85717 296 5

Working papers

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Malbon G, Mays N, Killoran A, Goodwin N. *A profile of second wave total purchasing pilots: Lessons learned from the first wave.* 1 85717 195 0

Killoran A, Griffiths J, Posnett J, Mays N. *What can we learn from the total purchasing pilots about the management costs of Primary Care Groups? A briefing paper for health authorities.* 1 85717 201 9

Street A, Place M. *The Management Challenge for Primary Care Groups.* 1 85717 227 2

Place M, Posnett J, Street A. *An analysis of the transactions costs of total purchasing pilots: Final report.* 1 85717 244 2

Robison J, Robinson R, Raftery J, McLeod H. *Contracting by total purchasing pilot projects 1997–98.* 1 85717 249 3

Lee J, Gask L, Roland M, Donnan S (1999). *Total Purchasing and Extended Fundholding of Mental Health Services: Final report.* 1 85717 288 4

Killoran A, Abbott S, Malbon G, Mays N, Wyke S, Goodwin N (1999). *The transition from TPPs to PCGs: lessons for PCG development.* 1 85717 289 2

Forthcoming reports from the final year of the national evaluation

Malbon G, Mays N, Killoran A, Wyke S, Goodwin N (1999). *What were the achievements of TPPs in their second year and how can they be explained?* 1 85717 293 0

Goodwin N, Abbott S, Baxter K, Evans D, Killoran A, Malbon G, Mays N, Scott J, Wyke S (1999). *Analysis and implications of eleven case studies.* 1 85717 294 9

Wyke S *et al.* (1999). *National evaluation of general practice based purchasing of maternity care: Final report.* 1 85717 295 7

Forthcoming book from the national evaluation of TPPs

Mays N, Wyke S, Goodwin N, Malbon G (editors). *Can General Practitioners purchase health care? The total purchasing experiment in Britain.*

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Summary and conclusions

The 1997 and 1998 Health Service White Papers set out a ten-year strategic agenda of evolution and change for publicly funded health care in the National Health Service (NHS). Primary care organisations in England, Wales and Scotland (primary care groups, local health groups and primary care trusts respectively) now have a central role in the strategic development of the NHS, and a duty to work with other agencies to improve health and health services. Whilst these changes have been introduced without piloting, there have been a number of initiatives from which developing primary care organisations can learn. These include general practice commissioning, general practice fundholding and total purchasing (TP).

Total Purchasing Pilots (TPPs) comprised one or a group of standard fundholding general practices, which volunteered to take a delegated budget from their local health authority* to commission potentially all the hospital and community health services (HCHS) for their registered populations. TPPs were a time-limited three-year (1995–98) experimental extension of standard general practice fundholding, set up as sub-committees of their local health authorities. Total purchasing did not directly influence individual practices' activities associated with standard fundholding or general medical services, and budgets for the three activities were not integrated.

Total purchasing was the first major 'internal market' policy initiative to be extensively evaluated by the Department of Health and Scottish Office. This report draws together the main evidence from the evaluation in order to inform the development of the new primary care organisations in the NHS, which came into being in April 1999. A large number of more detailed analyses of total purchasing from the study are listed in the bibliography preceding this report.

Effective organisations (section 4)

TPPs took time to build effective organisations. They learned some hard organisational and management lessons along the way. Most TPPs never did get to grip with such issues as using population level needs assessment to inform service development and priority setting, or engaging patients and the public in service development. The evaluation suggests that the new primary care organisations will need:

- a strong executive management team with an identified leader and a mandate to take strategic decisions on behalf of the wider group
- a clear vision and agenda for action
- to develop a sense of collective responsibility and corporacy (i.e. to involve all general practitioners in planning and managing use of resources)
- sophisticated project management capacity
- investment in clinical and management information systems
- partnerships with external organisations to develop their public health role and to develop the role of patients and the public in their organisational development
- adequate funding of organisational and management arrangements
- time to develop without further policy upheaval.

Service change and how it was achieved (section 5)

TPPs selectively targeted service areas in which they had an interest and in which they felt they had some chance of achieving success as purchasers. No matter what their stated aims, the majority of achievements were made using relatively simple extensions of the primary care team and the development of intermediate care services. Fewer TPPs attempted to change the provision of secondary care.

Many TPPs developed schemes that successfully integrated various services, both horizontally and vertically, and some of them were successful in managing emergency hospital activity (in comparison with local populations) through these schemes. This shows the potential of primary care based purchasers to contribute to the successful management of demand for emergency hospital services once they have been given a choice, leverage and an incentive to do so. However, few were able to fund their primary

* Where 'health authority' is referred to in the rest of this report, it should be taken to include both English health authorities and Scottish health boards.

and intermediate care schemes through the transfer of resources from the secondary sector. Some lacked health authority support for doing so, and many faced trust intransigence. Those that were able to withdraw sufficient resources from their acute contracts to fund their services did so by agreeing the shift of funding with the acute trusts at the *beginning* of the service development process.

Holding the budget was necessary, but not sufficient, for TPPs to achieve change in pattern of service delivery; organisational development was also important. Although some services were developed without independent contracts, the most successful TPPs did contract separately from their local health authority, and contracts were needed to sustain lasting change.

This suggests that primary care organisations should:

- begin by developing services in which there is local interest before moving on to more challenging areas as they gain experience
- recognise that worthwhile strategic change can be delivered by relatively simple primary care and intermediate care based developments, and that these developments will give them the potential to contribute to the management of demand for emergency hospital services
- recognise that integration between services is feasible and offers exciting opportunities to overcome traditional service boundaries, including those between health and social care
- take a collaborative approach to developing integrated services, with clear aims, and prior agreement on funding of the developments from disinvestment in secondary care services
- be aware that health authority support, use of the Health Improvement Programme and service agreements will be necessary to achieve lasting change
- realise that the service as a whole will require robust regulatory arrangements to ensure balance and efficiency of service provision, and to minimise the conflicts of interest inherent in a situation which makes them both purchaser and provider.

The importance of national and local support (section 6)

There was a complex interplay between what TPPs were trying to achieve, the context in which they were developing and the effectiveness of the mechanisms through which they were attempting to achieve change. This interaction was summarised diagrammatically as follows (see also Figure 4):

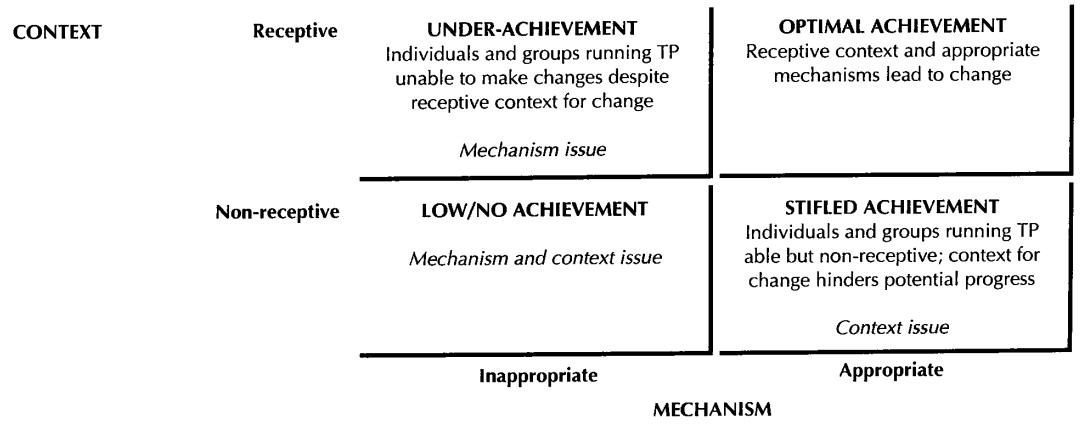

Figure A: Achieving objectives in total purchasing – the interplay between context and mechanism

The presence of national policy and political change was particularly important, and many TPPs fell by the wayside due to political uncertainty about the future of GP budget holding in 1997 and 1998. National debate and policy initiatives around particular services (mental health, maternity and cancer services) had an impact on the ways in which TPPs developed. TPPs found the framework provided by *Changing Childbirth* particularly valuable as a starting point in their service developments. A supportive health authority was also important. The evaluation suggests:

- given the centrality of primary care to the Government's agenda for the NHS, the new primary care organisations are likely to experience a more facilitative political and cultural context than TPPs. Nevertheless, they should be given time to establish themselves and to develop before any other radical change is considered
- primary care organisations are likely to be sensitive and responsive to national shifts in policy; National Service Frameworks may therefore have an important impact on the way in which local services and commissioning are developed; as may the implementation of the White Paper *Modernising Social Services*
- uncertainty and mistrust between agencies (e.g. between primary care organisations and hospital trusts or between primary care organisations and social services departments) should be dealt with openly. Cultural barriers will need to be broken down for service change to occur
- the National Health Service Executive and health authorities will have to face up to the possibility that primary care organisations will want substantially to alter the size, shape and scope of acute trusts' workloads. If this is not tolerated and supported by national and local policy there will be little point in having primary care led commissioning in England and Wales, and little point in expecting the operation of the Joint Investment Fund to achieve shifts in location of care in Scotland.

1. Why is the experience of total purchasing still relevant to the development of primary care organisations?

The 1997 and 1998 Health Service White Papers for England, Scotland and Wales set out a future for local health systems. Whilst there are some key differences in the approaches to development outlined in the English, Scottish and Welsh plans (see Box 1), primary care organisations in all three UK countries now have four key roles[1, 2, 3]:

- contributing to the improvement of the health and health care of their patients and populations, including reducing inequalities in health, within the context of the local Health Improvement Programmes (HImPs)
- developing primary care and community health services to improve the quality of services and to integrate more fully primary, community and social care services
- advising on, or commissioning directly (in England and Wales), a range of hospital services
- involving users and the wider community in the development of health services.

Whilst the changes to NHS organisation of primary care are being introduced without piloting, there are a number of initiatives from which developing primary care organisations can learn. These include general practitioner (GP) commissioning, GP fundholding and total purchasing. This report draws together key findings from the evaluation of the national Total Purchasing Pilot Projects (TPPs) in England and Scotland. The evaluation was funded by the Department of Health (1995–98) and the Scottish Office (1995–97). It seeks both to report on important findings and to make them accessible to primary care organisations. Many of the findings have resonance for primary care organisations throughout Britain, but where appropriate, specific reference is made to primary care groups (PCGs) in England.

Box 1: Key differences in approach to development of primary care organisations in England, Wales and Scotland

England	*Wales*	*Scotland*
• primary care groups (PCGs)	• local health groups (LHGs)	• primary care trusts (PCTs) and local health care co-operatives (LHCCs)
• geographically continuous populations of approximately 100,000	• based on unitary authorities. Geographical boundaries *must* be coterminous	• PCTs usually cover populations of whole health board areas (size varies because of population dispersal) • LHCCs cover populations of 70,000–100,000
• moving towards integrated budgets at PCG level, including hospital and community health services (HCHS), prescribing and GMS	• moving towards integrated budgets at LHG level, including hospital and community health services (HCHS), prescribing and GMS	• moving towards integrated budgets for community health services, prescribing and GMS services at LHCC level. Health board retains control of budget for hospital services
• gradual movement towards delegation of budgets for HCHS, prescribing and GMS	• gradual movement towards delegation of budgets for HCHS, prescribing and GMS	• delegation of budget for primary and community services to PCT, and for prescribing to LHCC
• responsible for advising on or directly commissioning secondary and tertiary services	• responsible for advising on or directly commissioning secondary and tertiary services • responsible for building effective links between providers of primary, community, secondary and social care	• responsible only for advising on commissioning of secondary and tertiary care services through HImP • some responsibility for achieving strategic shift in delivery of care from hospital to community through Joint Investment Fund (JIF) controlled by PCTs. Possible role of 'managed clinical networks'

TPPs comprised one or a group of standard fundholding (SFH) general practices, which volunteered on a three-year pilot basis to take a delegated budget from their local health authority to commission potentially all the hospital and community health services (HCHS) for their registered populations. These included accident and emergency, maternity, mental health and continuing and community care services (called here 'total-purchasing-related services') which had previously been excluded from standard fundholding.

The White Papers, and subsequent guidance, offer a ten-year strategic agenda of evolution and change for publicly funded health care in the NHS. Instant transformation is neither expected nor realistic. In contrast, TPPs have been comparatively small-scale projects with experimental, time-limited status. The key differences between English PCGs and TPPs have been summarised previously,[4] but are reproduced here in Box 2.

Box 2: Differences and similarities between TPPs and PCGs

TPPs

- small (average 30,000 population)
- responsible for commissioning potentially all hospital and community services
- GP-led
- volunteer practices, and time-limited (three years)
- rural and suburban
- many simple/informal projects
- ring-fenced TP budget and SFH budgets (GMS not included)
- some pilots still with indicative budgets and some with fully delegated budgets after two years
- intended to be a purchasing organisation (although in practice some mainly developed provider roles)
- no structure for clinical governance within TPPs
- not required to address public health or inequalities issues

PCGs

- large (approximately 100,000 population)
- responsible for commissioning potentially all hospital and community services
- GP- and nurse-led
- compulsory: all practices and not time-limited
- all parts of England
- more complex formal organisations
- moving towards integrated budgets, including SFH, TP and GMS
- moving towards delegated and independent budgets (i.e. legally the responsibility of PCGs)
- responsible for commissioning services plus health improvement and primary care development
- arrangements for clinical governance aimed at improving quality and consistency of primary care delivery
- required to address public health and inequalities issues

Despite these differences, previous analysis of data from the national evaluation[5] has shown that there are a number of important similarities between the two types of organisation. The policy underlying the set up of both TPPs and PCGs is premised on four implicit assumptions:

- groups of general practices are best placed to shape the delivery of local health services
- groups of general practices are able to function collectively and collaboratively to secure improvements in services
- these groups need a formalised relationship with the health authority (HA) to ensure accountability for the use of resources, as well as strategic steer and support
- commissioning/purchasing based on a delegated budget provides a key incentive and mechanism for securing service change.

TPPs and PCGs also shared some key tasks, including:

- developing new ways of working together with other primary care practitioners as groups of general practices to develop services
- investing in organisational development
- investing in gathering and defining the necessary information to inform change
- finding ways of working collaboratively with local providers
- developing primary and community-based services and improving the interface between health and social care
- finding ways of influencing the use of secondary care services.

These similarities mean that the experience of building TPP organisations, and their effectiveness in securing improvements in services, provides important lessons for the development of primary care organisations in the UK.

Our previous report to the Department of Health[5] described the development of the concept of total purchasing in relation to standard fundholding (SFH) and in the changing policy context brought about by the election of the Labour Government in May 1997. This report also described, in detail, the methods of the evaluation to the end of the first 'live' year of total purchasing, and the findings to date of the evaluation in relation to the development of PCGs.

The aim of this final report is to draw together, succinctly, the main evidence from the final year of the national evaluation in relation to the development of new primary care organisations in the NHS from April 1999. It draws on data and conclusions from all components of the evaluation programme, but particularly on three recent working papers that describe, respectively, the achievements of TPPs in their second 'live' year (1997/98),[6] the nature of their developments and achievements and how these were brought about from a series of detailed case studies[7] and lessons that can be learned from the transition from TPPs to PCGs.[8] All working papers are listed at the beginning of this report and provide further detailed information on methods and findings.

2. Methods

The aims and objectives of the evaluation, rationale for the research design, and description of the methods used in the first two years of the evaluation have been described extensively elsewhere.[5] Here we present a summary of the aims and objectives, design and methods of the evaluation. We focus on the methods used in the third and final year of the study.

2.1 Aims and objectives

The research brief prepared by the Department of Health's Research and Development Division was clear that TP was 'the extension of general practitioner fundholding',[9] indicating that, in general terms, the Department and the National Health Service Executive (NHSE) were expecting similar consequences to SFH.

The aim of the evaluation was therefore 'to assess the costs and benefits attributable to total purchasing'. The objectives identified in 1995 were to collect evidence on:

- 'the factors associated with successful set-up and operation of total purchasing;
- the costs and effectiveness of total purchasing; and
- the benefits to patients through total purchasing'

in order to indicate the 'best models for further development of fundholder-based purchasing in a primary care led NHS'.[9]

Under the *costs* of TP, the research brief included a focus on the operating costs of the scheme, transaction costs (i.e. the total costs of negotiating, specifying and monitoring contracts and managing spending between purchasers and providers) and policies to minimise these costs. The research brief also included research on budgetary management policies on overspends and underspends and the use made of any 'savings' from TPPs' budgets. This was on the grounds that there might be straightforward budgetary incentives in TP similar to those in SFH, linked to the ability of projects to make and spend their own 'savings'.

The brief divided the *effects* of TP into two parts: 'benefits to patients' and 'effectiveness'. Under 'effectiveness', a range of aspects of health services where TPPs might have been expected to bring about measurable changes, such as in referral and investigation patterns, quality standards in contracts, prescribing patterns, the balance between primary and secondary based care and provider configuration were listed. There was also an interest in detecting any divergence between TPP, HA and national purchasing priorities and strategies. 'Benefits to patients' suggested that the DH believed it possible that the TPPs might be able to bring about measurable improvements such as a greater responsiveness to patients' wishes in the services that they purchased, or better access to primary and secondary care, or higher levels of patient satisfaction, or, even, improved health outcomes. Researchers were encouraged to give some thought as to how these effects might be assessed.

Finally, the research brief highlighted a number of specific services to be given special attention as part of the evaluation. The list included services that had not previously been included in the SFH scheme, such as accident and emergency (A&E) services, emergency medical inpatient care, services for the seriously mentally ill and community care. There was a concern to assess the extent to which the TPPs opted to use different providers, altered the content of services, differed from the local HA in their strategies and met the requirements of national policy, where relevant (e.g. the *Changing Childbirth* initiative in England[10]) in these new service areas.

2.2 Research design

The evaluation of the 'first-wave' projects consisted of a large number of interrelated elements, some of which were carried out on all pilots and some of which were only carried out on sub-samples of TPPs. This 'thick and thin' design was chosen to make the best use of the research resources available. Figure 1 summarises the evaluation programme.

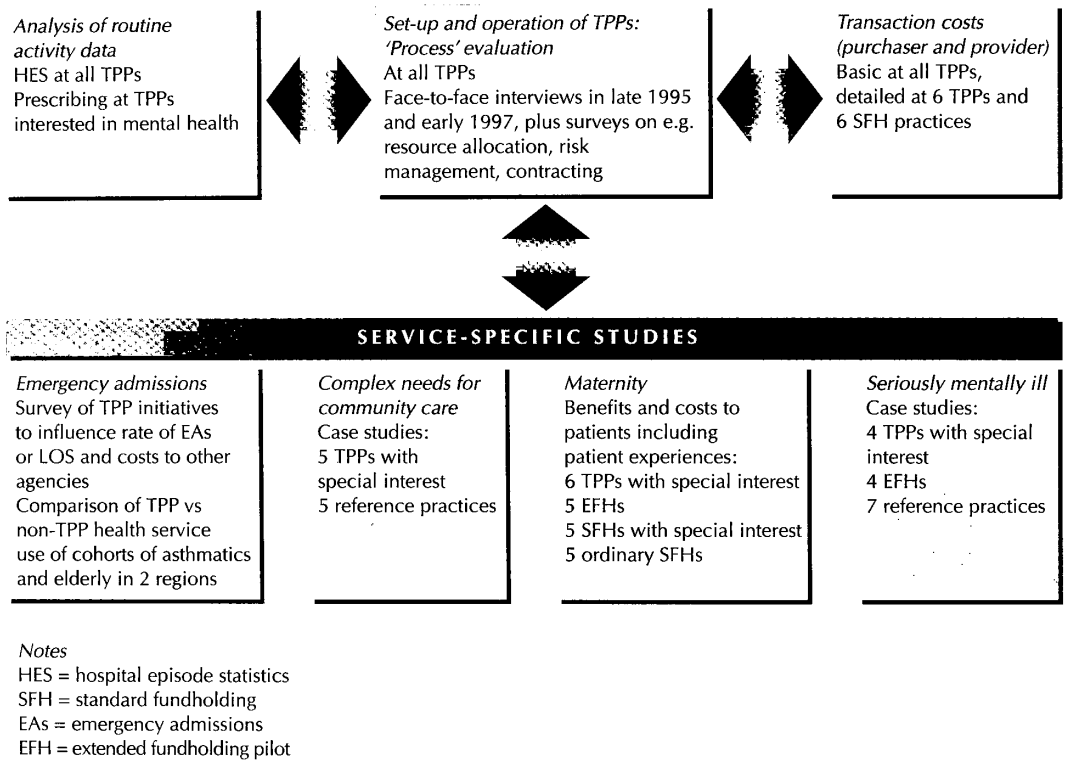

Figure 1: Main components of national evaluation of 'first-wave' TPP projects

2.3 *Set-up and operation of the TPPs*

The aim of the third year of the evaluation was to identify different types of TPPs and their impact, taking account of their local contexts, in order to be able to identify the ingredients of successful devolved purchasing based in primary care and successful primary care development. By then it was apparent that 'success' was likely to be related to the context of the pilot, the content of its purchasing objectives, its managerial resources and the processes through which it attempted to implement its objectives.[5] Further data on progress against achievements, management costs and the involvement of the TPPs in the development of the PCGs in England were collected by a mixture of telephone interviews and postal questionnaires from participants at all 'first-wave' TPPs at the end of the second 'live' year. The questionnaire covered progress on TPPs' main objectives as stated in 1996/97, the direct management costs of TP in 1997/98 and TPPs' experiences of developing into PCGs (see Malbon *et al.*[6] for more details of the methods of data collection and analysis).

In addition to monitoring progress in 1997/98 on all the 'first-wave' TPPs, a sub-sample of 12 TPPs was selected purposively for more detailed, case study investigation. Single-practice TPPs were excluded since it had become apparent after the change of government in May 1997 that budget holding at individual practice level was likely to be abolished. The case study multi-practice TPPs differed in location and size. They were selected in order to enable investigation of the emerging types of TPPs, their organisational features and the financial and managerial tools and levers which they used to bring about service changes. The case studies were also used to look at the extent to which the TPPs contributed to, and complemented, existing and future local commissioning arrangements (e.g. the new PCGs, which began to be planned alongside the TPPs in the second half of 1997/98), the management investment required to support TP, the ability of the TPPs to bring about change, and the implications for maintaining such investment in the longer term. By identifying examples of 'best practice', the findings provide an empirical basis for

practical guidance. More details of the rationale for the design of the third year of the evaluation and purposive sampling of the case study sites can be found in Goodwin *et al.*[7]

The final year of the evaluation was undertaken during a period of great uncertainty and change within the Health Service. Whilst the flexibility of the methods allowed us to capture this period of change, there are certain limitations to the data. In particular, it was necessary to rely in the main on self-reported data on the achievements at the TPPs. These were corroborated by multi-stakeholder interviews at each case study TPP and through analysis of hospital activity data where feasible.[11, 12]

Progress with the development of independent contracting arrangements at remaining first wave TPPs was followed using postal questionnaires and follow-up telephone surveys in 1998.[13] In addition, details of budgets set for TPPs in the financial year 1997–98 were gathered from postal surveys of health authorities in 1997 and followed up in 1998. Budgets and when they were set were analysed in relation to TPPs' achievements.[14]

2.4 Transaction costs

The direct managerial costs of the TPPs were estimated at all 'first-' and 'second-wave' TPPs using data from face-to-face interviews and telephone and postal monitoring surveys. The wider transaction costs associated with TPP purchasing (costs over and above the costs of services themselves) compared to previous health authority purchasing in the presence of SFH practices were analysed in detail from face-to-face interviews on a sub-sample of seven TPPs between 1996 and 1998.[15]

2.5 Analysis of changes in hospital activity

Changes in hospital activity (i.e. in patient episodes, length of stay) before and after the advent of TP were compared between TPP and non-TPP populations using routine NHS hospital episode statistics (HES) in England and SMR1 data in Scotland (in 1996/97 only). The pattern of TPP patients' use of hospital services was compared both with the pattern in a sub-group of local non-TPP practices which used the same hospitals and with the whole of the remainder of the HA population. Analysis focused on those TPPs which had independent contracts and which were actively attempting either to reduce emergency admissions or to reduce length of stay.[11, 12]

2.6 The development of specific services purchased by general practitioners for the first time through TP

Sub-studies were undertaken to examine patterns of care purchased, service costs and patients' responses to four services purchased by TPPs in comparison with the same services purchased by the HA. The four service areas were emergency admissions (study separately commissioned and on-going), community and continuing care for people with complex needs (mainly older people),[16, 17] services for people with serious mental health problems,[18] and maternity care.[19] In the case of the latter two services, the evaluation of the TPPs was linked to an evaluation of a series of pilot extensions to SFH in which volunteer fundholding practices took purchasing responsibility for one additional service beyond the scope of SFH (these practices were called extended fundholders). In each of the four service areas, the focus was on a small sub-sample of TPPs that had made the particular service area a priority in their purchasing strategies.

3. Profile of 'first-wave' TPPs in 1996/97 and 1997/98

Of the 55 'first-wave' TPPs sent questionnaires by post or telephone in 1998, 41 responded (75 per cent). Of the 14 that did not respond, four had ceased to operate as TPPs from April 1998. Characteristics of the other ten non-respondents were as varied as those of respondents. Given that TPP was to end officially in March 1999 (and in March 1998 for some, including the Scottish TPPs), and given that the Government had announced its plans for the replacement of SFH and the internal market as early as December 1997, lack of participation may have reflected a belief that TP was now an irrelevance and, therefore, there was no benefit in co-operating with the evaluation. Table 1 gives the basic features of the 'first-wave' of national TPPs in England and Scotland, which were studied between 1995 and 1998.

Table 1: Basic characteristics of 'first-wave' TPPs, 1996/97 and 1997/98

Characteristics	*1996/97*	*1997/98*
Basic features		
Number of TPPs	53	41*
Number (%) of single-practice TPPs	36%	44%
Number (%) of multi-practice TPPs	64%	56%
Size		
Mean number of practices per TPP	3	3
Median number of practices per TPP	3	3
Mean number of general practitioners per TPP	17	17
Median number of general practitioners per TPP	16	14
TPP patient population		
Range in patient population	8100–84,700	6653–81,000
Mean TPP patient population	31,300	29,384
Median TPP patient population	28,200	24,500
HA patient population		
Mean percentage of HA population served by TPPs	6%	6% (*n*=39)
Median percentage of HA population served by TPPs	6%	5%
Mid-range (25%–75%) of HA population served by TPPs	3%–8%	3%–7%
*Organisational features***		
Proportion of TPPs with a dedicated TP manager	66%	–
Proportion of TPPs with a 'complex' organisational structure	38%	–
Proportion of TPPs with a 'simple' organisational structure	30%	–
Management costs at 1997/98 prices		
Mean per capita cost	£2.96	£3.10
Median per capita cost	£2.82	£3.08
Range of per capita cost	£0.02–£7.08	£0.05–£7.07

Notes

* Four TPPs had dropped out of the evaluation by June 1998. Two four-practice projects had divided into eight single-practice TPPs (53+6=59 and 59–4=55) and 14 TPPs did not respond (55–14=41)

** These data were not collected for TPPs in 1997/98

Table 1 shows that the TPPs continued to vary widely in size and management costs in their final year. There was no sense of convergence in their organisational set up, reflected in the management costs, which showed no sign of decreasing, despite the fact that set-up costs incurred in years 1 and 2 ought to have come to an end. TPPs were on average slightly smaller in the second 'live' year than the first. However, this can be directly attributed to the fact that two multi-practice projects broke into eight separate projects.

The continued diversity allowed a comparison of achievements against characteristics of the TPPs in order to begin to tease out some of the feature's successful projects (see section 5).

It is clear from Table 1 that all TPPs were smaller than the primary care organisations currently being developed, which will cover populations of between 46,000 and 255,000. The new primary care organisations are also developing in very different contexts to those of the TPPs, being seen as mainstream, central players in the new system.

4. Developing primary care organisations

Until recently, primary care in the UK was based on a small business model, with GPs working as independent contractors to the NHS, usually within a partnership. Although partnership size has increased, and group practices have increasingly employed practice managers, nurses and others, and increasingly work with other practice-attached community staff as part of a primary health care team, the basic organisational form of '*the practice*' has not significantly altered. The structure survived even the advent of the multi-fund of fundholding practices. In this arrangement, although fundholding practices agreed to pool their management allowances to provide administrative services such as finance and personnel in common, any savings achieved against practice budgets were specific to practices themselves and were not shared with others in the multi-fund.[20] Thus practices maintained their integrity and financial independence as organisations.

As we have suggested, an implicit assumption of both the total purchasing model, and the model underlying the primary care NHS reforms of 1998/99, is that groups of general practices are the fundamental building block to planning and delivery of local health services, and that *they are able to function collectively and collaboratively to secure improvements in services*. This implies collective responsibility for budgetary management as well as for service development. The experience of larger TPPs in the national evaluation was that before any goals could be achieved, attention had to be paid to their own development as health care organisations. The lessons from TPPs for the organisational development (OD) of other primary care organisations are therefore considered in this section.

Whilst most smaller TPPs were able to achieve objectives with relatively little investment in OD, the largest TPPs required substantial time and investment before progress could be made. After three years, including one preparatory year, some TPPs were still at an early stage in becoming effective commissioning organisations.[4, 5] By the second 'live' year, however, many larger projects had 'caught up' in terms of their ability to achieve objectives,[6] and this section examines the lessons which can be learned from TPPs for the development of PCGs as effective multi-practice organisations.

4.1 The organisation of decision-making

Whereas PCGs have been provided with guidance on how to structure their organisation,[21] TPPs were free to decide how to develop. Organisational analyses of the TPPs, particularly those researched in-depth through case studies in 1997/98,[7] highlight the importance within multi-practice projects of an executive or decision-making group. This body most often comprised lead GPs from the practices within the TPP (usually one from each) with a project manager in attendance or as a full member. The executive group's function was to determine the focus of the TPP, and to make and oversee the implementation of commissioning and service development plans.

Such an executive group was usually distinct from the TPP board, which typically included HA senior officers and met less frequently, to oversee the development of the project from a strategic point of view. Formally, the boards were sub-committees of the HA, as the legislative arrangements required for the delegation of NHS money beyond SFH to independent organisations were not in place during the life of the TPPs.

The willingness of those within TPPs to invest such an executive group with authority varied, but generally where such willingness was most in evidence progress was faster. Willingness was often associated with a consensus commitment to a specific local health care issue (e.g. protecting a local hospital, improving mental health care), but also confidence in the leadership of the TPP (see below).

PCG boards carry out the functions of TPP executive groups and also some of those of the TPP board. Their governing arrangements have been set out by the DH.[15] Unlike TPPs, PCGs are distinct bodies formally accountable to HAs (not HA sub-committees), and their boards will include representatives of nursing, social services departments (SSDs), HAs and the public, as well as general

practitioners. Thus the arrangements for PCG organisation are much more formal and determined by the NHSE than those for TPPs. Questions of accountability and representation are complex: unlike general practitioners (the majority of whom will continue as at present to be self-employed contractors), many non-GP members are employed by other organisations (community trusts, SSDs). PCG boards will need time to develop custom and practice in dealing with these issues, and to manage the possible conflicts of interest inherent in such arrangements.[22] (Some TPPs did include such representatives in their organisational structure, but usually these were not invited to share executive responsibility for decisions.)

A key feature of most TPPs has been their reliance on a few highly motivated individuals, whose vision and leadership drove the TPP forward. Many lead GPs have only been able to give time to TP by 'stealing' time from their clinical workloads, or by fitting TPP activities into spare time such as lunchtimes and evening meetings. This has also been the case in at least one of the GP commissioning groups.[23] At the same time, in many projects, a majority of GPs have remained relatively marginal to, and even ambivalent about, TPP activity. Although the sustainability of such TPPs has been questioned, given that previous work has shown how the loss or removal of a key player can be devastating to the future progress of the project,[5] it is likely that young and complex organisations needed the energy, determination and vision of such leaders in order to become established and to pursue their objectives successfully in a relatively short time. PCGs and other primary care organisations are unlikely to succeed without them.

Despite the importance of leadership, analysis of data from case studies[7] suggests that successful TPPs have created a sense of collective ownership across the organisation as a whole. The greater participation of non-lead GPs has led to a reduction in lead GP workloads. The sense of collective ownership came partly from inter-practice communication, which was achieved in a number of ways. In many cases, TPPs created a number of sub-groups in order to permit and encourage the participation of the non-lead GPs, and sometimes of other stakeholders. The sub-groups could be around clinical areas (such as breast cancer) or managerial (such as ECR management). One case study site was unusual in having as many as 25 sub-groups across 12 practices (with 30 general practitioners), although this partly reflects the fact that all but two of the practices had not been fundholding prior to TPP, and were, therefore, commissioning a range of elective and community services for the first time. This may be a helpful model for PCGs with low proportions of SFH general practices. The cumulative effect of a sub-group structure was to ensure the participation of the majority of general practitioners in some aspect of TPP work *outside the boundaries of their own practice*. Thus, some level of inter-practice working became the norm for most GPs in the TPP case studies.

Generally, the sub-group structure seems to have been successful in increasing organisational cohesion, although not all TPPs used it, and not all sub-groups adopted a truly corporate perspective. It is reasonable to predict that many primary care organisations will use sub-groups as a means of managing workload and encouraging participation and the development of specialist expertise in particular areas, particularly as not all practices will be represented on their boards. Where general practitioners in TPPs did see themselves as part of a single clinical group (which was more likely in smaller TPPs), the TPPs tended to succeed best in budgetary management.[24]

A small number of TPPs attempted to develop democratic structures that avoided executive groups, believing these to be too hierarchical given the independent practices and practitioners in the TPP. The Department of Health's (DH's) guidance on PCG boards[21] rules out this possibility for PCGs. It is, nonetheless, useful to observe that in two case study sites where such a 'flattening' of structure was attempted, quite strong informal leadership arrangements developed. In another two sites, care had been taken to appoint a project manager who could not be identified with any one constituent practice, so as to avoid suspicions that any one practice was dominant or accusations of divided loyalties. However, neither TPP was notably successful in establishing itself as a solid and effective organisation. PCGs may be well advised to confront potential problems of hierarchy, conflict and mistrust between practices rather than to seek to avoid them.

Certainly, multi-agency PCG boards require the corporate ability to manage creatively debate and dissent (as well as budgets!).

4.2 Management skills

A common aspect of the largest and most successful projects has been the employment of a competent project manager working full-time on TP, with sufficient skills to be able to cover a wide range of sophisticated tasks, including financial risk management, the facilitation of group decision-making, and the linking of clinical and budget management, as well as the more obvious tasks such as contracting, information gathering, the development of IT systems and human resources management.

In some cases, project managers had a small team of support staff and developed leadership roles. Some became an executive manager of the TPP (in two of the 11 case studies these people were titled Chief Executive of the TPP). When this happened, non-lead general practitioners were more willing to delegate responsibility for their practice's interests to the project manager (an 'external' representative) as an active member of the executive board. This could be regarded as a major organisational development in primary care.

The lack of project management capacity has inhibited TPPs. Some were forced to withdraw because they lacked a project manager, which led to excessive calls on GP time and poor communication within the TPP. In one case study site, a TPP project manager was employed with no experience of contracting, which meant that unreasonable contracting demands alienated both local trusts and the HA. The good and bad experiences of TPPs with project managers suggest the potential importance of non-clinical management support in developing primary care organisations.

4.3 Information management and technology

TPPs had to invest considerable time and effort in the negotiation and development of information to inform contracting,[13, 25] and poor information systems for mental health contributed to difficulty in achieving objectives for those TPPs focusing on mental health as an area for development.[18] Most successful TPPs needed to invest in new and more appropriate information technology, particularly where collaborating practices used different systems for SFH, and, in some cases, no IT at all for non-SFH work. Additionally, a few TPPs had already made and/or implemented plans to centralise administrative systems across all practices by 1998. PCGs will certainly want to consider how to do this, although the multiplicity of existing systems means that to do so will require both money and time. Case study site personnel expressed many concerns about IT deficits and incompatibilities apparent in those practices that would be their future PCG partners. Such deficiencies will need to be rectified by PCGs within the framework of the national information and IT strategy.[26]

4.4 Alliances and collaborations

Many TPPs recognised the need to make effective alliances with other agencies such as NHS trusts and SSDs, sometimes co-opting representatives of such organisations onto sub-groups. Typically, this was in order to enhance particular services, such as maternity, mental health and continuing care,[16–19] and where such collaborations were successful, it was usually the case that the other agencies were equally keen to achieve change.

Developing relationships with SSDs was an important focus of many TPPs with respect to emergency admissions, care of the elderly and mental health. Some TPPs achieved real collaboration and joint working despite initial scepticism from SSD staff.[16, 17] One 'second-wave' TPP in a case study representing a whole town (rather similar to a PCG) had created a very inclusive multi-agency public health sub-group to address the breadth of health issues faced by a deprived urban population. Recent policy in both England and Scotland[27, 28] and the development of Health Action Zones in England[1] has re-emphasised the importance of flexible partnership working in health and social care, and has proposed radical mechanisms through which these may be achieved, including integrated provision of care, lead commissioning of care and pooled budgets. A National Service Framework on care of older people is also promised soon,[27] and with such

guidance there are real opportunities for PCGs and PCTs (in Scotland) to learn from TP best practice and develop integrated services.

TPPs believed that a good relationship with the HA was important, and was associated with the successful achievement of objectives.[5] Because no detailed government guidance was issued to define organisational arrangements for the TPP/HA relationship, local organisations made local arrangements. Though it will clearly be important for PCGs to achieve effective working relationships with their HAs, the increased emphasis on formal accountability, on the one hand, and the devolution of commissioning responsibilities from HAs to PCGs, on the other, means that future relationships are likely to be rather different from those experienced by TPPs.

4.5 Resources for management

A final message for primary care organisations in relation to OD is that effective organisational management arrangements require adequate financial resources. As is described later in this report (see section 5), and in more detail in Malbon *et al.*,[6] there was a significant relationship between higher achieving projects and higher direct management costs per capita, particularly in the case of larger projects in their second year. This suggests that greater investment in the management infrastructure of the TPP, including information systems, was associated with achieving service objectives. However, as we have seen in Table 1, the level of management spending varied widely between the pilots, largely because there was no 'blueprint' as to how to go about TP. In addition, costs appeared to bear no relation to the characteristics of the population served.

Eighty-five per cent of costs were associated with activities such as communication, co-ordination and decision-making within organisations, rather than commissioning and contracting with other bodies. In multi-practice TPPs, the costs of co-ordination were significant, and increased as the size of the project increased.[15] The bulk of the total transactions costs related to the TP manager and team, but 24 per cent was incurred by the GPs involved in the scheme by way of locum payments and additional payments for their time. Thus an important determinant of management spending was the extent to which individual GPs were actively involved in the management of the project and were reimbursed for their time. Not all the GPs' time was reimbursed since some of the GPs were plainly enthusiasts.

The costs of making primary-care-led purchasing more universal might well be higher than in TP, since other parts of the national evaluation showed the importance of involving most of the GPs actively in budgetary management. Only about 30 per cent of TPPs routinely involved all the GPs in decisions about managing budgets. In most, only the lead GP(s) was involved. This was more common in multi-practice than single-practice pilots. This probably explains why multi-practice TPPs were more likely to report variations between actual and planned spending and were more likely to be dissatisfied with their financial management systems. Smaller and single-practice TPPs did not appear to be more likely to report problems due to overspending on rare, costly referrals, probably because of their selective approach to purchasing.[29] This suggests that the larger TPPs particularly had a considerable way to go before it could be said that they had integrated the roles of clinical and resource management at individual GP level. Such integration was easier to accomplish in a single-practice environment than when it entailed the development of new relations between previously independent practices.

Thus, PCGs will need to be aware that such costs are likely to be increased, at any rate in the first few years, while organisational cohesion is achieved both by developing communications and decision-making systems to inform and engage all PCG staff, and by developing and achieving a harmonised, PCG-wide IT capability.

4.6 Summary lessons on organisational development

Box 3 summarises the key elements from the organisational arrangements of successful TPPs, which will need to be considered when developing primary care organisations. Organisations are likely to be more effective where all criteria are met, although clearly balances will need to be found, for

example between streamlined executive efficiency on the one hand and inclusivity and partnership on the other. As well as following the example of successful TPPs in these respects, primary care organisations will also need to tackle the challenge of effectively involving the public in policy-making decisions, which TPPs had not yet succeeded in doing.

Box 3: Summary lessons on organisational development

Primary care organisations need:

- a strong executive management team with an identified leader and with the mandate to take strategic decisions on behalf of the wider group
- a clear vision and agenda for action
- to develop a sense of collective responsibility and corporacy (i.e. to involve all general practitioners in planning and managing use of resources)
- sophisticated project management capacity
- investment in clinical and management information systems
- partnerships with external organisations to develop their public health role and to develop the role of patients and the public in their organisational development
- adequate funding of organisational and management arrangements
- time to develop without further policy upheaval.

5. What did TPPs try to do and what did they achieve?

Because the TPPs operated as selective purchasers and chose which areas to focus on, it was not possible to monitor quantitatively the full range of consequences of their endeavours. Thus assessment of achievements depended on their own reports of their main and other objectives and their reports of their subsequent achievements 12 months later, at the end of the 1997/98 purchasing cycle.

5.1 *Self-reported achievements*

Achievements against TPPs' own objectives (which varied greatly in scope and ambition) were distinguished from achievements in TP-related areas (i.e. service areas new to GP-led purchasing: maternity; services for the seriously mentally ill; care of the frail elderly in the community; A&E services; emergency admissions; inpatient length of stay; and alternatives to acute hospital inpatient services). TPPs making changes in TP-related service areas were thought to be more likely than others to be influencing local health services in a major way and were also more likely to have been following the broad goals of the initiative (i.e. extending purchasing beyond SFH). As in previous analyses,[5] three researchers at the King's Fund independently placed each TPP into one of five performance groups. Broadly, TPPs in Group 5 attained (and could provide supporting evidence of) all their planned objectives, together with other developments. Those in Group 1 attained none. Further detailed description of the rationale and methods for summarising data on TPPs' reported achievements in this way is provided in Malbon *et al.*[6]

Figure 2 shows the distribution of TPPs according to their achievement of their own objectives (that is, regardless of scale of ambition, where the TPP started from, or whether the objective could have been met through standard fundholding or some other route). The wide range of achievements reported by the 50 TPPs responding in 1996/97 was continued by the 40 responding in 1997/98. TP status in itself did not automatically lead to an ability to achieve objectives. For some TPPs, the context in which they developed was more conducive to success than in other areas (see section 6), others had some difficulty organising themselves (see section 4).

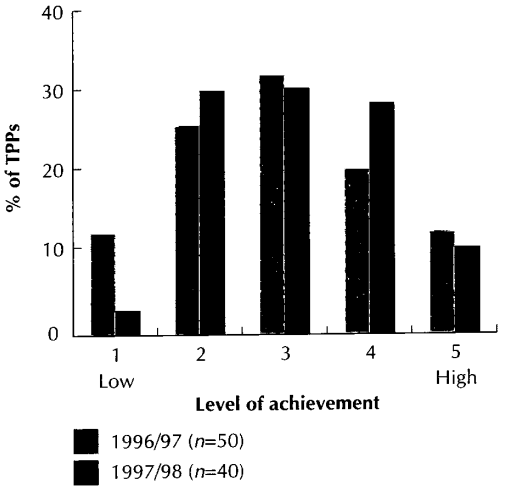

Figure 2: TPPs in five groups according to their level of achievement in their 'own terms', 1996/97 and 1997/98

Figure 3 shows that a similar range of 'success' was seen in TP-related areas, although there was an overall improvement in the level of achievement of TPPs in these areas between 1996/97 and 1997/98.

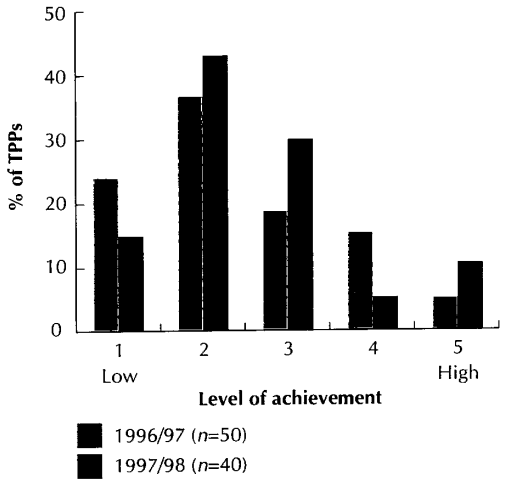

Figure 3: TPPs in five groups according to their level of achievement in TP service areas, 1996/97 and 1997/98

Table 2: Achievements and non-achievements of 'first-wave' TPPs by service area, 1996/97 and 1997/98

Service area of main objectives	*No. of objectives*	*% reported achieved*	*No. of objectives*	*% reported achieved*
	1996/97		*1997/98*	
Early discharge	22	64	18	72
Community and continuing care	19	53	36	67
Maternity	27	52	10	70
Managing emergency services	32	44	16	75
Mental health services	28	39	20	75
Primary care team development	15	87	10	70
Information and needs assessment	12	83	22	64
Other	35	59	40	72
Total	190	54	172	70

5.2 *Service areas targeted by TPPs*

Table 2 shows the main service areas targeted by the TPPs in the two purchasing cycles studied and the proportion of objectives reported as achieved in each year.

Looking first at the areas in which TPPs chose to focus in 1996/97 and in 1997/98, the table suggests that TPPs may have become more astute in choosing their objectives as they gained experience. There were fewer objectives in the area of management of emergency services in their second 'live' year (which involved negotiation with secondary care providers and is a notoriously difficult area to manage). There were fewer objectives in the area of mental health services, which had been a difficult area in the previous year (although focusing on these areas did bring success in 1997/98). There were also fewer objectives in maternity services, reflecting either early success in achieving these objectives so that they had had time to move on or the loss of national impetus in the area as the *Changing Childbirth* initiative slid down the national policy agenda.[19]

However, there were more objectives in community and continuing care in 1997/98, possibly because TPPs had experience of setting up services at a primary and community level and found it an easier area on which to focus. The larger number of objectives related to information collection and needs assessment may reflect a national policy shift and a recognition of the deficit in relevant information for purchasing. As a result of these shifts in focus between the two 'live' years of purchasing, there was far less variation in achievements between service areas in the second versus the first 'live' year of purchasing. Table 2 thus presents a picture of TPPs learning what kinds of objectives they could manage over time, and focusing their efforts on more achievable goals.

5.3 *Similar approaches to achieving different goals*

More detailed analysis of the specific mechanisms or service developments through which TPPs attempted to reach their objectives shows that there were strong similarities between service areas. Tables 3, 4 and 5 present more detailed information for 1997/98 in three service areas – emergency services, mental health, and community and continuing care.

The tables show that whilst some TPPs attempted to influence secondary care providers through contracting, others achieved change through primary care based service developments, and that *these primary care based developments were similar whatever the service goal.* For example, TPPs which stated that they wished to improve their management of emergency services put in place services such as intermediate care facilities, while those that wished to develop better community care for the frail elderly bought access to more nursing home places. Nursing home beds are one form of intermediate care facility, and vice versa.

Table 3: Achievements and non-achievements in managing emergency services, 1997/98

Main objectives	*No. of achievements*	*No. of non-achievements*
Change in contract currency	3	1
Intermediate care facility	3	0
Increased primary care to reduce admissions	3	0
Rapid response out-of-hours team to reduce admissions	1	2
Pre-operative assessment team	1	1
Research to assess ways of reducing emergency admissions	1	0
Total	**12**	**4**

Table 4: Achievements and non-achievements in mental health, 1997/98

Main objectives	*No. of achievements*	*No. of non-achievements*
Enhanced community mental health team (inc. CPNs, counsellors, etc.)	7	2
District-wide strategy	3	1
Practice-based CPNs only	2	0
Change of provider	1	0
Common service specification between providers	1	0
Contracting for emergencies	1	1
Change of contract currency	0	1
Total	**15**	**5**

Table 5: Achievements and non-achievements in community and continuing care, 1997/98

Main objectives	*No. of achievements*	*No. of non-achievements*
Improving the community team, e.g. by integrating community and practice nursing	7	1
Purchasing nursing home beds	6	3
Developing care packages and shared protocols with social services	2	0
Employing a practice-attached social worker	2	0
Redirecting resources from acute to community services	2	0
Changing contract currency	1	1
Changing provider	1	0
Developing the local community hospital	1	2
Undertaking health and social care needs assessment	1	0
Setting up a hospital-at-home scheme/GP out-of-hours service	1	4
Utilising GP beds	0	1
Total	**24**	**12**

A different categorisation of the approaches to achieving objectives in the areas of emergency services, mental health and community and continuing care is summarised below and makes this point even more clearly:

- straightforward *expansion or co-ordination of the primary health care team* which developed integrated care (e.g. integrating practice and community nursing services or practice-attached psychiatric nurse) (35/45 'successful'; 78 per cent)
- *traditional contracting mechanisms* such as altering the contract currency or changing providers (to influence secondary care providers to improve services or reduce costs) (10/14 'successful' in 1997/98; 71 per cent)
- more *complex primary care developments*, mainly in the field of emergency services and including out-of-hours work (e.g. hospital-at-home or rapid-response team to prevent unplanned admissions, better co-ordination of out-of-hours service) (2/8 'successful'; 25 per cent)
- *strategic developments/policies* (e.g. district-wide protocols or joint plans with the local authority social services department) (4/5 'successful'; 80 per cent).

From this, it can be seen that the majority of the objectives were pursued through relatively simple primary care extensions and changes in management arrangements, and that these approaches to achieving objectives were likely to be successful. Few if any of the mechanisms used were entirely novel, but it was apparent that having the potential to hold a budget and contracts for a wider range of services had encouraged the practices to look at the balance and location of the care offered to their patients.[6]

Far fewer tackled contracting approaches to changing specialist, secondary care, though those that did, by the second year, were mainly successful. Less successful were approaches that attempted to develop more complex primary care based services, usually including out-of-hours care.

5.4 *Developing integrated care – the potential of TPPs*

Whatever their original objectives (whether they were relatively simple plans to extend or improve primary care services or more difficult tasks such as attempting to reduce emergency admissions amongst older people), many of the TPPs developed services which resulted in greater integration between primary and community care services; between primary, community and social services; or between primary and secondary care services. These developments included:

Integration between primary and community care services, such as:

- new and extended counselling services
- practice-attached midwives
- practice-based community psychiatric nurses
- practice-attached self-managed community nursing team
- new practice-based physiotherapy services
- practice-attached community pharmacists for prescribing advice
- specialist nurses in the care of chronic conditions.

Integration between primary, community and social care services, such as:

- TPP-attached community care co-ordinators
- multi-disciplinary proactive care teams for care of older people or mentally ill people in the community

Integration between primary, community and secondary care services, such as:

- community places as an alternative to acute hospital beds (GP beds in community hospitals, nursing home beds, or places in hospital-at-home schemes)
- hospital discharge co-ordinators to speed discharge
- multi-disciplinary elderly care team with access to day care and respite facilities
- testing facilities formerly available only in hospital by consultant referral.

Some of the examples of primary and community care integration certainly did not require TP status to be achieved, but TP may have made things easier for the practices. For one thing, where the pilot involved more than one practice, the beginnings of inter-practice organisation were in place to facilitate the sharing of information on a range of issues. A good example of this is given in Box 4.

This development was not particularly novel and had been developed elsewhere in non-TPP practices, but was perceived as a real success by TPP and HA respondents, with the potential for other practices to learn from their experience.

Box 4: Integrated care – primary and community care services; community pharmacist project

Context	*Service development*	*How change was brought about*	*Reported consequences*
Locality-based TPP: 16 practices, 35 GPs. Deprived, urban population of 67,000. No budget.	Part-time community pharmacist funded jointly by TPP and HA to advise on more cost-effective prescribing by GPs and acute sector. Additional aims to enhance the primary care role of community pharmacists.	Monthly reports by pharmacist adviser to sub-group of GPs with recommendations for change. Production of joint acute/primary care formulary agreed by GPs and consultants. Review of repeat prescribing. Initiated GP/community pharmacist discussions.	Some containment of prescribing costs. Greater prescribing of statins and more cost-effective prescribing of wound-healing drugs. Greater engagement of GPs in TPP strategies. Greater shared understanding of prescribing issues. More consistent prescribing. Pharmacists unwilling to extend role without additional incentives.

A number of TPPs were concerned to improve the relations between the staff whom they employed directly and those who worked for the local community health services trusts. In some cases, this was simply a matter of persuading the community NHS trust to allocate designated community nurses to primary health care teams (PHCTs). In others, community nurses in a PHCT moved to a self-managed nursing team model. Other TPPs negotiated new arrangements for team midwifery, mainly to ensure continued contact between GPs and midwives and between GPs and women (Box 5).[19]

Box 5: Integrated care – primary and hospital-based services; practice-based midwifery

Context	*Service development*	*How change was brought about*	*Reported consequences*
Single-practice TPP, 7 partners. Provider introduced geographically based team midwifery just before TPP had started. Practice lost attached community midwives.	By 1998 the TPP had agreed with the provider that: • antenatal care should be delivered in the practice and not in women's homes • GPs are available for the antenatal clinic and that women may see them or midwives may call on them.	The TPP had been actively negotiating with the provider to change contract currency. They noticed high FCEs per delivery caused by high antenatal admission rates and rates of caesarean section. The TPP attributed this to their loss of involvement in antenatal care. Discussion between GPs, the obstetrician and team of midwives.	TPP pleased that team midwifery approach now based in practice so they could see women and talk to midwives. Discussion prompted by contracting process had resulted in service change. Change in contract currency led to some money being saved, which was reinvested in other areas. GPs now felt involved in planning maternity care.

Very often, where TPPs managed to integrate primary, community and social care services, they had an impact on secondary care services too. The TPP illustrated in Box 6 provides such an example.

Box 6: Integrated care – primary, community, secondary and social care services for older people

Context	*Service development*	*How change was brought about*	*Reported consequences*
Single-practice TPP with 2 surgeries. Population of 16,000, relatively deprived urban area.	Community care co-ordinator – an experienced social worker acting as bridge between practice, social services and voluntary sector. Admission and discharge co-ordinator. Multi-disciplinary elderly care team – co-ordinated by manager of self-managed nursing team. Health and social care professionals attend. Also community geriatrician.	Variety of mechanisms to achieve change: • changed community nursing contract to get practice-based self-managed team • joint funding of community care co-ordinator with SSD • direct employment of discharge co-ordinator • contract with community trust for community geriatrician.	Ability to address less severe problems has potential to prevent health crises. Initial assessments shared between health and social care. Much speedier referral and assessment. Much speedier access to a range of services, including day hospital. Proactive care for older people with health problems.

Another example of how a larger TPP commissioned a full range of integrated services that resulted in patients achieving appropriate care in the least costly setting is provided in Box 7.

Box 7: Integrated care – intermediate care

Context	*Service development*	*How change was brought about*	*Reported consequences*
Non-geographical locality based TPP, 8 practices (42 GPs). 81,000 urban population. Budget holding. Direct purchasing.	Range of interrelated services: • GP referrals to intermediate care team • discharge planning team • intermediate care beds: hospital-at-home, spot purchase of nursing home beds • discharge alert register.	Design informed by knowledge of other schemes, needs assessment, literature review. Involvement of all key stakeholders. Heavy marketing to A&E consultants, nurses, hospital-at-home nurses, all TPP GPs. Peer pressure on GPs – league table of referral to scheme. On-going systematic review and evaluation, with reporting.	Emergency admissions prevented, discharges speeded up. Sharing of experience with emerging PCGs across the district.

Many of the techniques and approaches being used by TPPs to develop services (including integrated care) are also familiar in managed care settings in other health systems.[30] Myles *et al.*[31] identified a range of managed care techniques at health policy, systems management and disease management level in TPPs concerned with developing community and continuing care services. They concluded that ' ... *the models of care being developed by the TPPs taking part in this study could represent the progenitor of primary managed care approaches to providing services for older people with complex needs in the UK.*' It remains to be seen whether these approaches are similarly adopted by primary care organisations in the 'new NHS'.

5.5 *Influencing use of secondary care*

One of the toughest tests for TPPs was whether they were able to alter the pattern of use of unplanned inpatient services. Routine activity data were used to examine trends in hospital use for the 'first-wave' of TPPs with objectives either to reduce acute emergency admissions or to reduce length of stay. These were compared with trends for the local practice populations, which used the same hospitals and with trends for the rest of the HA population. Because TPPs with such aims were expected to use contracting mechanisms to achieve their objectives, analysis of this data focused on those TPPs with independent contracts with their acute care providers. TPPs were said to be 'successful' if they experienced a smaller increase, or larger decrease, in the number of emergency admissions in the targeted specialities compared to local practices using the same hospitals.

In 1996/97, 80 per cent (16/20) of TPPs with objectives in this area were shown to have performed better than their peers in this regard.[11] In 1997/98 79 per cent (11/14) of the TPPs were similarly successful.[12] Table 6 shows data on the proportion of main and secondary objectives held by TPPs with independent contracts, to reduce emergency admissions or length of stay, which were shown to have been 'successful' from analysis of routine data.

Table 6: 'Success' in achieving objectives relating to emergency admissions or length of stay

Objective to reduce:	*% 'successful' (number)*			
	'Main' objective only		*'Secondary' objective only*	
	1996/97	*1997/98*	*1996/97*	*1997/98*
Emergency admissions	70% (7/10)	50% (4/8)	33% (2/6)	60% (3/5)
Length of stay	50% (6/12)	62% (5/8)	50% (3/6)	100% (5/5)

The strategies developed by TPPs to reduce acute hospital use varied but most were community-based extensions of the primary care team, or intermediate care facilities based on integration of social, primary, community and secondary care services, such as those described in section 5.4. In 1997/98 the TPPs generally continued to develop projects which they had started in 1996/97 rather than launch new initiatives, although they tended to focus more explicitly on older patients.

However, even when TPPs were able to reduce their reliance on acute hospitals, the funding of the alternative services was problematic. In 1996/97 only half of the TPPs with independent contracts reported that they were able to achieve the savings they had predicted from their main acute contracts. Hospitals were resistant to having resources shifted out of their contracts and were particularly reluctant to move away from contracts based on finished consultant episodes (FCEs) as the basis of volume calculations and towards the length of stay-sensitive pricing desired by some TPPs. Some HAs were also concerned about potential destabilisation of NHS acute trusts if resources followed patients into the community. Indeed, HAs rarely seemed to support their TPPs in the task of securing more activity-sensitive contracts. Disinvestment from existing providers was also found to be a barrier to progress in shifting services from secondary to primary care in other studies.[32] In 1997/98 almost all of the 'successful' TPPs made use of other sources in order to fund their initiatives to reduce hospital use, including growth money (from increases in list size or movement towards capitation target) or winter pressure monies.[7] There were very few exceptions in which a TPP was able to withdraw sufficient resources from their acute contracts to be able to fund their alternative services. In these cases a shift of funding was agreed with the acute trust at the beginning of the service development process, for example by capping the acute trust's contract and diverting funds directly to intermediate care developments.[7]

These findings are important in considering the potential of PCGs to manage emergency hospital activity through the development of more integrated or intermediate care facilities. PCGs may have more influence over their acute trusts than TPPs, because of their size and because they are more likely to be seen as central players in local health service development. On the other hand, PCGs' potential to destabilise trusts through major service shifts may be even stronger than for the TPPs and may be even more strongly resisted. Support for service reconfiguration will have to be managed co-operatively through Health Improvement Programmes with support from both the HA and the NHSE, and with prior agreement from acute trusts to fund intermediate and primary care through transfer of resources.

5.6 *Association between achievements and some basic characteristics of TPPs: the 'determinants of success'*

There were many subtly interacting factors at work which determined TPPs' successful achievement of their objectives, particularly the interactions between whether the context in which TPPs were developing was receptive, the content of their objectives (what they were trying to achieve) and the mechanisms they developed to achieve their goals. These are described in more detail in section 6. In this section, we examine a range of simple descriptive features of TPPs in relation to their self-reported achievements in 1997/98.

Despite the importance of holding a budget, examination of achievements in relation to budget setting[14] showed that there was no obvious relationship between achievements and how early the budget was set in the purchasing year or per capita spend. This suggests that having their own budgets did not automatically enable TPPs to make progress. They were most often necessary, but not sufficient to enable the TPP to be taken seriously as a purchaser by provider organisations. This was certainly felt to

have been the case amongst GPs developing mental health[18] and maternity services care services.[19]

The allocation of a budget is likely to have conferred status on the practices and it gave notice to providers that the practices had some control over the resources used by their patients. Agreeing and being granted a budget by the HA early in the year (and some TPPs never received one) may well have been seen as a marker of HA support and HA confidence in the practices. Over two-thirds of the lower-achieving TPPs (Groups 1 and 2 in Figure 2) reported difficulties in agreeing a budget with their local HA. By contrast, higher-achieving TPPs were more likely to be able to report accurately on the state of their spending against budget and to have either stayed within budget or under-spent; i.e. they got a budget and they knew how to spend it.

Table 7 presents a simple analysis of some of the more easily measurable factors associated with self-reported achievement in 1997/98.[6] It should not be taken as an exhaustive description of the potential range of factors associated with TPP achievements.

Table 7: Characteristics of low and high achievers, 1997/98

Characteristics	*Low achiever in own terms (n=13)*	*High achiever in own terms (n=15)*	*Significant/ not significant (N.S.) (95%)*
Size			
Mean number of GPs per TPP	14	19	N.S.
Median number of GPs per TPP	12	17	–
Mean number of practices per TPP	3	4	N.S.
Median number of practices per TPP	1	3	–
Mean population size	23,800	34,400	N.S.
Median population size	20,000	29,400	–
Proportion of single-practice TPPs	62%	27%	Significant
Proportion of small multi-practice TPPs (2–5 practices)	23%	47%	Significant
Proportion of large multi-practice TPPs (>5 practices)	15%	27%	Significant
Experience and level of support			
Proportion of TPPs with first, second or third wave fundholders in their pilot	89%	100%	N.S.
Proportion of TPPs which said the HA was providing 'fair–good' support	69%	100%	N.S.
Independent contracting and management costs			
Proportion of TPPs which had independent contracts	50%	77%	N.S.
Mean number of independent contracts, 1997/98	7	4	N.S.
Median number of independent contracts, 1997/98	6	5	–
Mean management costs per capita, 1997/98	£1.63	£3.96	Significant
Median management costs per capita, 1996/97	£1.46	£4.28	–

TPPs with more experienced fundholders, a more supportive HA and higher management costs were more likely to have brought about their objectives in 1997/98, though only the last factor was statistically significant.

Higher-achieving TPPs were also more likely to have independent contracts, suggesting their importance as a mechanism for change. TPP-based respondents in the survey of contracting mechanisms also felt that actively commissioning services through the use of independent contracts was important,[13] and that without them they would not have been as successful in achieving service change. The importance of independent contracts is brought out in the sub-study of maternity care.[19] Developments in maternity services often relied in the early stages on informal discussions between midwives, their managers and the TPPs or extended fundholding practices; the impetus for change had often come from midwives rather than from GPs. However, where informal agreements were followed up and formalised in independent contracts, changes were more likely to have been sustained; where contracts had not been developed, service development lost impetus and changes were not sustained.[19] This suggests that service agreements between PCGs and acute trusts are likely to have an important role in ensuring that once shared goals have been agreed, neither party will be able to withdraw in the face of less favourable circumstances.

Table 7 shows that the findings reported in our interim report,[5] that in the first 'live' year, the *smaller* TPPs were more likely to have been high achievers, were reversed in the second year, and that larger TPPs were more likely to have been high achievers in 1997/98. There are two likely explanations for this: it took the larger projects longer to develop the organisational maturity and decision-making systems for effective purchasing; and in 1997/98, the smaller, especially single-practice, TPPs were

undermined by a shift in the new Labour Government's planned policy away from individual practices holding budgets and towards more collective forms of fundholding. HAs may have anticipated this and reduced their support for the single-practice TPPs, especially after the publication of the December 1997 White Papers. This was certainly the perception of all the extended fundholding practices in the study of maternity care.[19] Providers presumably took their cue from the HAs and gave less deference to the wishes of the small TPPs. This suggests that in a system such as the NHS, the extent to which devolved purchasers are able to bring about service and resource shifts will depend, in part, on the extent to which they are perceived to have the support of government and the central agencies of the NHS.

5.7 *Summary lessons for developing primary care organisations from analysis of the achievements and activities of the TPPs*

In the absence of a 'blueprint' for development, TPPs exhibited a wide range of objectives, both in terms of services targeted and their levels of ambition. PCGs are likely to be in a similar position, and will need guidance and support, especially in the early stages of their development. The experience of TPPs as a whole suggests that GPs were far more comfortable in developing primary care and related community health services with which they had direct familiarity, either for their own sake, or as a substitute for specialist hospital care, than they were in attempting to influence the behaviour of secondary care specialists through contracting. This can be seen as a rational response from primary care organisations, which chose to change what they knew they had a better chance of influencing. We can expect similar developments from primary care organisations as they begin their activities in 1999.

Undoubtedly, primary care organisations will be concerned, as were TPPs, to increase vertical and horizontal integration, and the experience of TP is that enhanced and integrated community services can provide models of care which reduce hospital usage (although it is true that there is a lack of robust evidence that such initiatives necessarily achieve higher quality, more cost-effective care[33]). It may be easier for PCGs, for example, to achieve such integration than it was for TPPs, both because of economies of scale, and because the 'new NHS' provides increased incentives for community trusts to co-operate with primary care, thereby perhaps generating more 'clout' for PCGs to bring about change in negotiating service agreements with acute trusts. Whilst the replacement of contracting with longer-term service agreements may well result in a slower pace of change, PCGs may be able to expect greater change in return for longer-term agreements.

Although such integration may improve service co-ordination and the quality of patients' experiences, it poses new regulatory problems. The incentives facing PCGs are for them increasingly to purchase services from their own GPs and practice staff, rather than from elsewhere in the NHS. In a small way, such issues arose in relation to the TPPs. For example, a few TPPs wished to provide their own specialist outpatient services rather than refer their patients to hospital specialists on the grounds that they could provide services of equally quality, closer to patients' homes and at lower cost. The practices would receive additional income from providing outpatient clinics. Local health authorities had to set up ad hoc arrangements to ensure that the GPs had the skills and facilities to undertake the new work, that they did not provide services beyond the agreed scope of the clinics and that the results of treatment were satisfactory. Far more difficult to monitor was the risk that the GPs might skew the balance of services offered to their patients inappropriately in favour of services which they themselves were remunerated for providing.

In future, all HAs will need to ensure that their PCGs are securing an appropriate balance of primary, community and secondary care services for their populations, and that their decisions as to which services to provide in-house and which to commission from outside are justifiable and can be monitored. This will be particularly important where PCGs set up new services previously provided elsewhere in the NHS or not at all.

Other findings summarised in this section reinforce recommendations made in section 4. It will take time for primary care organisations to develop as effective primary care providers, developers and purchasers. Those containing a large number of

practices without previous commissioning or purchasing experience may need particular support. The support and confidence of HAs as well as the potential 'bite' of service agreements will be important, as will adequate support for management development and information systems. Box 8 summarises the lessons for primary care organisations from this section of the report.

Box 8: TPP achievement and service development lessons for primary care organisations

Primary care organisations should:

- begin by developing services in which there is local interest before moving on to more challenging areas as they gain experience
- recognise that worthwhile strategic change can be delivered by relatively simple primary care and intermediate care based developments, and that these developments will give them the potential to contribute to the management of demand for emergency hospital services
- recognise that integration between services is feasible and offers exciting opportunities to overcome traditional service boundaries, including those between health and social care
- take a collaborative approach to developing integrated services, with clear aims, and prior agreement on funding of the developments from disinvestment in secondary care services
- be aware that health authority support, and the use of the Health Improvement Programme and service agreements will be necessary to achieve lasting change
- realise that the service as a whole will require robust regulatory arrangements to ensure balance and efficiency of service provision, and to minimise the conflicts of interest inherent in a situation which makes them both purchaser and provider.

6. Explaining progress – the importance of context and mechanisms of change

As we have described, whether a particular TPP was successful in achieving its objectives or in effecting wider change in the local configuration of services was dependent on interactions between the context in which TPPs were developing, the content of their objectives (what they were trying to achieve) and the mechanisms they developed to achieve them (how they tried to achieve them). In this section, we summarise our findings in relation to the contexts in which TPPs developed and the mechanisms they used to achieve change, in order to draw out lessons for developing primary care organisations. These complex interactions and the theoretical approach taken to understanding them are described in more detail in the report of the case studies of TPP development reported by Goodwin *et al.*[7]

6.1 Contexts in which TPPs developed

Whether an innovation 'works' is very much dependent on the context, or circumstance, in which it is implemented.[34] This was certainly the case with total purchasing in that some developments worked well in some places, some of the time. A good example of this comes from the contrasting experience of two case study TPPs attempting to influence use of secondary care services by reducing length of stay and preventing emergency admissions. In one case study, a care manager was appointed to facilitate effective relationships between ward-based hospital staff, community nurses and social services to ensure that the necessary packages of support and care were assembled for individual patients. However, the HA refused to give the TPP control of a delegated budget for fear that its plans to shift resources might 'destabilise' the local acute trust. The small size of the TPP, its lack of a delegated budget, and an effective HA veto on resource-shifting meant that the TPP had very little leverage to fulfil its objectives. Another TPP (described in section 5.6) with similar objectives, but with a delegated budget, independent contracts and the support of the HA managed to reduce length of stay and shift resources from acute to intermediate care to achieve this.

In the interim report[5] we identified some key contextual factors which influenced the success of TPPs to date. The receptiveness of the cultural, political, historical, geographical and financial contexts in which TPPs were developing was found to influence their relative success in achieving objectives. Analysis of case study TPPs suggests the continued importance of these issues and extends some of the key contextual influences.

6.1.1 The cultural context

The 'cultural' context of developments in relation to the NHS refers to deep-rooted assumptions and values that permeate organisations and which are associated with individual's expectations of objectives, styles of working and how quickly they expect change to occur. General practice based organisations, such as TPPs, had very different cultures from bureaucracies like HAs and SSDs, and bridging the cultural divide between individuals working in these organisations often took time and created tensions.[5] However, recognition of these differences in organisational culture, combined with a shared vision for the future, often helped to shift an apparently unreceptive cultural context into a receptive one. For example, Box 6 details extensive joint working between social services, a TPP and a community trust to develop innovative, 'seamless' services for vulnerable older people, which broke down traditional care boundaries. These innovative developments were achieved despite considerable scepticism from SSD staff, and determination from the HA not to allow 'destabilisation' of acute or community trusts.[27]

Another cultural value generally held by TPP GPs was a strong desire to remain primarily clinicians, not managers of services. However, this put a strong limit on their ability to work in a public health role, or at an inter-agency level within their TPPs. Some GPs in case study TPPs recognised their commitment to what is seen as the 'core' work of general practice; this enabled them to find ways to reconcile competing demands and to continue their joint role as provider and manager/purchaser of services.

6.1.2 The political context

The national policy changes surrounding the election of the Labour Government in May 1997 were the biggest single contextual influence on the ability of TPPs to achieve objectives and make progress in 1997/98. In Scotland, the move away from primary care based commissioning led to the end of all TPPs in March 1998. In England, the larger, locality based TPPs most resembled PCGs and were at a considerable contextual advantage in their development. On the whole, they had supportive HAs keen to learn from their experience, were clearly going to continue in some form after the official end of the pilot, and maintained considerable commitment and enthusiasm from all staff for continued development of services. They did not lose impetus and achievements continued apace. Smaller, non-locality based TPPs, on the other hand, suffered from continued uncertainty over their fate; many lost momentum and enthusiasm and some projects just 'petered out'.

Other national policies had an impact on TPPs' developments. For example, one TPP was keen to identify objectives that reflected national priorities and chose cancer services as a priority following the Calman-Hine report,[35] which recommended the partial reorganisation of cancer services. Consequently, the TPP helped the health authority to reorganise units run by two separate trusts into a single team working on two sites. It is unlikely that cancer care services would have been addressed by the TPP in this way had it not been for the Calman-Hine report. Similarly, the ability of the TPP to convince trusts to co-operate with the approach was greatly aided by the presence of the report. In the same way, case study TPPs developing *Changing Childbirth*[10] initiatives in the field of maternity care did so because it was an objective of national concern. As *Changing Childbirth* slid down the list of national priorities in England, so did the local impetus to achieve change in service delivery.[19]

Other analyses have pointed out that one of the paradoxes of the 'internal market' reforms of the NHS was that while seemingly freeing the periphery (health authorities and GP fundholders) to develop policy and services, they also marked a period of greater control from the centre and greater responsiveness of the periphery to the centre.[36, 37] The evaluation showed that TPPs were reliant on central support for both the concept of GP budget holding and for policy around specific services (such as cancer and maternity care). When central support for these waned, HAs provided less support to TPPs, and TPPs experienced a less supportive political context.

6.1.3 The geographical context

The geography of TPPs, in terms of whether they were locality or non-locality based, seemed to be an important determinant of whether they worked with non-NHS agencies. Most borough councils and SSDs are locality based and coterminosity of boundaries between TPPs and other agencies facilitated joint working. Some attempts at integrating care, for example through the addition of a care co-ordinator or a social worker to the TPPs' PHCT, foundered because of the differences in service areas covered.

As indicated in section 6.1.2, the move to PCGs based on 'local communities' favoured the locality projects – at least those with larger populations. These TPPs continued to progress since they were at an advantage compared to non-locality projects and, therefore, could develop as a unit. Such TPPs also reported greater responsiveness and better relationships with other agencies because of their ability to develop their PCG around an existing structure. Thus, TPPs based on geographical localities have been at a contextual advantage following the policy changes in *The New NHS*.

6.1.4 The financial context and the ability to fund innovations

The financial context was a significant factor in determining the ability of the case study TPPs to bring about change. Whilst the size of the budget was not straightforwardly associated with level of achievement[14] (and see section 5.6), having a delegated budget, perhaps reflecting greater HA commitment to the project, seemed to allow the larger TPPs to exert sufficient leverage to conduct meaningful negotiations with providers and gain acceptance for changes, and/or to use a competitive tendering processes. For example, one TPP in the case study, with a 60,000 population, was able to pool SFH and TPP budgets for child and adolescent health, and change provider through a competitive

tendering process to establish a service which TPP GPs felt was more orientated to the needs of the community. Another TPP with a delegated budget was able to invest growth monies in establishing a rehabilitation team based at the local community hospital. However, the TPP was unable to release any savings from the acute trust as the trust would not change its contract currencies to reflect the shorter length of stay of rehabilitation patients discharged early. Provider reluctance to release funds to TPPs has been widespread (see section 5.5).

As we have said in section 5.5, an ability to find alternative sources of funds to help finance proposed changes was also associated with success in a number of case studies. Joint or external funding, such as use of growth monies or winter pressure monies, was often used to achieve service developments. This suggests that achieving shifts in patterns of care was highly dependent on the availability of alternative sources of money locally.

TPPs operating in districts with a significant financial deficit faced much greater challenges. Various strategies were employed to overcome this barrier to change. For example, one case study TPP was constrained by its necessary pro rata contributions to the district's financial recovery plan. It, therefore, received a reduced budget and could not identify growth money elsewhere in the local system. With very able TPP and SFH managers and effective management of the combined TP and SFH budgets, the practices within the TPP agreed to pool their resources and agree collective contracts with providers to increase flexibility between SFH and TPP budgets. The TPP was thereby able to cap acute trust growth monies to fund an intermediate care scheme in advance of achieving its planned reductions in admissions (see Box 7).

6.1.5 Summary – the contexts in which TPPs developed

The contexts in which TPPs developed influenced both the pace of change (how quickly a TPP was able to make progress) and the context of change (what the TPP was able to do). Box 9 summarises the receptive and unreceptive contexts in which TPPs developed over the life of the pilots.

Box 9: Key 'receptive' and 'non-receptive' contextual variables influencing the ability of TPPs to achieve their objectives

Aspect of context	*Receptive*	*Non-receptive*
Cultural	Supportive organisational culture	Opposing organisational culture
	Innovation – ability to challenge established practice	Inertia – reliance on established values and working practices
	Openness and trust	Secrecy and mistrust
	Commonality – shared values between agencies (TPP, HA, SSD)	Incoherence – incompatible values between agencies (TPP, HA, SSD)
	Positive self-image and sense of achievement	Lack of clear purpose and no sense of achievement
Political	Concordance with Labour's policies for primary care (large, locality-based TPP)	Lack of concordance with Labour's policies for primary care (small, non-locality-based TPP)
	National policy backing for service changes (e.g. Calman-Hine)	National/local opposition to service changes proposed
	Favourable local political agenda	Obstructive local political agenda
Historical	History of working together	No history of working together
	Advanced and integrated IT system with history of information exchange on activity and costs	Under-development and incompatible IT systems with little previous exchange of information on activity and costs
	TPP established through practice/GP-led initiative	HA developed TPP without grass roots support
	Local historical issues supporting TP innovations	Lack of purpose behind TP innovations – no local historical issues to act as a basis
Geographical	TPP patient population entirely within one health authority	TPP population spread across more than one health authority
	Provider/social service catchment area congruent with TPP population	TPP population divided between catchment areas
	Potential for provider competition	Monopoly provider only
Financial	Local financial environment favourable – can identify sources of extra funding	National and local financial environment unfavourable – no sources of local funding
	Availability of adequate direct management resources	Management resources inadequate to establish effective TP organisation
	Flexibility/integration of budgets	Inflexible/ring-fenced budgets

6.2 Mechanisms for change

Whilst *context* can be seen to be highly relevant in determining the pace of change within TPPs, the mechanisms through which TP was implemented ultimately determined the ability of projects to succeed. This is because people, not contexts, brought about change and because, even in the worst of contexts, some scope to make changes still existed.

Throughout the evaluation, three central and recurring themes have been identified as important mechanisms through which TPPs achieved their objectives:

- key individuals leading change and willing followers
- inter-agency co-operation
- budget holding and contracting.

6.2.1 Key leaders and willing followers

As we have shown in section 4, key individuals had a very important role in providing legitimacy for change for TPPs, and in supporting organisational development. Indeed, projects with the following characteristics were more likely to make progress:

- where lead general practitioners were willing to put additional time into the project and were able to demonstrate the advantages (potential and actual) of TP to the other general practitioners
- where the project manager had a high degree of technical and managerial skill to act, internally, as co-ordinator and facilitator to the project and, externally, as its main representative to external agencies
- where HA 'leads' were willing to support TPPs
- where provider groups, particularly clinicians, were willing to take an active interest in the objectives of TPPs, and to contribute to service developments.

However, analysis of case studies in the second 'live' year also suggests that more successful TPPs had developed an inclusive process of project leadership and management. These TPPs had a greater sharing of roles and responsibilities between the practices and between individuals within the TPP. This process of inclusiveness helped projects to survive better when key players left the organisation. A few case study TPPs lost their project manager during 1997/98 following uncertainty as to their potential future employment once the TPP pilot had run its course. In one case, the loss of the project manager had a significant negative impact on the ability of the project to sustain developments, since there was no other individual in the TPP with enough dedicated time to take over project responsibilities. However, in another TPP, project management was taken over by the full-time data manager for the project, whose elevation to the chief co-ordinating role was significantly helped by the previous development of a cohesive inter-practice GP team and a high level of collaboration and information exchange between the practices of the TPP.

Thus whilst visionary, energetic leaders were clearly still important as TPPs matured, TPPs became more stable as more participants became involved and took responsibility for some aspects of the TPPs' developments. The most productive TPPs had a combination of strong leadership and the inclusion of a range of other key players and stakeholders willing to play an active role in the organisation whilst being happy to be led. The most effective TPPs in 1997/98 were characterised by having:

- formal management of colleagues by lead GPs
- willingness by non-lead GPs to defer responsibility to key leaders (including to non-clinical managers)
- willingness of non-lead GPs to take on collective project responsibilities (e.g. to join a sub-group in a clinical area, to use activity data to review their own practice).

6.2.2 Inter-agency co-operation

Inter-agency co-operation was stressed by most respondents in TPPs as a key enabling factor to achieving objectives. Thus, TPPs have been more likely to achieve their objectives where relationships between different agencies have been co-operative or collaborative. This is particularly true of the TPP–HA relationship, but is also true of TPP relations with providers, local social services, voluntary agencies and between the practices of the TPP pilot itself.

The most successful integrated approaches to care delivery described in section 5.4, and in maternity care,[19] continuing and community care,[16, 17] and mental health,[18] were only developed with inter-agency co-operation and recognition of shared goals. A common theme amongst the more successful case study TPPs was the progression from a base of constructive dialogue and good relations with HAs, trusts and social service departments to the fruition of forms of joint working and integration of care, enshrined in contracts.

6.2.3 Budget holding and contracting

Findings from the final year of the evaluation support the interim conclusion[5] that holding a budget was

an important prerequisite to achieving strategic change. TPP case studies that remained without a delegated budget were limited to small-scale, local patterns of service change, whereas some TPPs with a delegated budget, budgetary management and independent contracts had considerable impact on local patterns of service delivery.[7]

In section 5.6 we showed that those TPPs with independent contracts were more likely to be higher-achieving TPPs than those without. It was suggested in the interim report[5] that the *potential* to hold independent contracts was an important catalyst to working effectively with trusts; it encouraged service providers to plan with TPPs the kinds of services they all wanted. However, as discussed in section 5.6, the sustainability of changes to maternity services was greater in those general practice based purchasers that had enshrined informal agreements in contracts. Where there was no formal agreement (contract), changes were not as likely to be sustained after the life of the pilot. In summary, the analysis of TPPs' experiences in the field of maternity services concluded: '*GP involvement in planning care can achieve change if it is accompanied by a collaborative approach with trusts and supported by health authorities and written agreements (contracts)*'.[19] Thus collaboration supported by written agreements is likely to be important in achieving sustainable change in the delivery of care.

6.3 *The interaction between context and mechanisms*

The fact that different TPPs progressed to varying degrees can be most fully explained by the *interplay* between context and mechanisms of change. In other words, the ability of a project to achieve its objectives should be regarded as the product of a specific mix of variables, which act as either barriers or catalysts to change. The likelihood of a particular TPP being able to progress, therefore, depended on the overall energy for change at the project's inception and the abilities of those involved in the process to overcome contextual barriers or capitalise on potential advantages as the project developed. This means that it is possible for change to be made in an adverse context (such as a local financial crisis) if the abilities of individuals and their inter-relationships can overcome these barriers. Similarly, a helpful context did not necessarily ensure change if the abilities of, and relationships between, individuals and groups in the process were poor.

In addition, time was an important factor. TPPs did not begin from the same starting points. The quality of relationships with providers and the extent to which practices and general practitioners in the TPPs had worked together previously varied. In particular, the larger TPPs required considerably more time to set up appropriate organisations before they could progress compared to the smaller projects. Thus, whilst smaller rather than larger TPPs appeared to have achieved more by the end of the first 'live' year, over time the larger projects 'caught up', assisted by the particularly favourable political circumstances of the time.

Figure 4 attempts to show diagrammatically the interplay between context and mechanisms over time. The vertical axis represents the context in which TPPs operated and the horizontal axis the mechanisms, or the way in which TPPs went about their business. Where context is termed 'receptive', this equates to an advantageous situation where the ability to achieve objectives is high (or the barriers are low), whilst the opposite is true for 'non-receptive' contexts. Where mechanisms are characterised as 'appropriate' this has the effect of making achievements more likely, the opposite again being true for mechanisms being characterised by 'low ability'.

CONTEXT		Inappropriate	Appropriate
	Receptive	**UNDER-ACHIEVEMENT** Individuals and groups running TP unable to make changes despite receptive context for change *Mechanism issue*	**OPTIMAL ACHIEVEMENT** Receptive context and appropriate mechanisms lead to change
	Non-receptive	**LOW/NO ACHIEVEMENT** *Mechanism and context issue*	**STIFLED ACHIEVEMENT** Individuals and groups running TP able but non-receptive; context for change hinders potential progress *Context issue*
		MECHANISM	

Figure 4: Achieving objectives in total purchasing – the interplay between context and mechanism

The cells in Figure 4 represent the potential outcomes for a TPP. Thus, where the context was 'receptive' and mechanisms appropriate, the more likely it was for achievements to be made. TPPs that moved closest to this optimal position were those that had achieved the most (see Box 10).

Box 10: An example of a receptive context and appropriate mechanisms

Context	*Aims*	*Mechanisms*	*Outcome*
Large non-locality in an urban area. Good cultural context: • good HA support • positive self-image. Good political context: large TPP did not fold when policy changes announced. Good historical context: history of working together. Mixed geographical context: • pockets of deprivation • TPP spread over wide area. Poor financial context: HA had massive financial deficit which TPP contributed to pro rata. OD/mechanisms: • very able and experienced TP project manager • clear vision from the lead GP • sophisticated organisational structure with involvement of non-lead GPs • had budget based on weighted capitation.	To provide a more integrated community and practice nurse service. To set up an intermediate care scheme to: • prevent delay in discharge • reduce the number of emergency admissions.	Tendered for new contract with community trusts. Prepared a business plan based on literature reviews and conducted an audit of A&E. Sophisticated use of contracting: capped the acute contract and diverted 4% to fund the scheme. Employed a hospital discharge co-ordinator. Developed a database of vulnerable patients' social and health details Increased the choice of place where care can be delivered.	Switched provider. Intermediate care scheme operational since 1997. Gradual increase in use of scheme by GPs (86%). Achieved integrated working across the secondary and community boundary, based on multi-disciplinary working. Managed to divert 10% of acute admissions to their spot purchased beds and reduced the rate of admission. TPP increased the number of admissions to intermediate care by almost 100%.

The top-left cell in Figure 4 describes a situation in which the context for change was reasonably 'receptive', but where mechanisms were not effective or were inappropriate. For example, Box 11 describes a TPP with a receptive context, but which did not achieve its potential.

Box 11: An example of a reasonably receptive context, but TPP did not achieve its potential

Context	*Aims*	*Mechanisms*	*Outcome*
Small locality TPP in rural area. Mixed cultural context: • HA had supported the TPP (although support was waning) *but* • trust unwilling to alter contract currency. Mixed political context: • small TPP *but* geographically contiguous • discussions around PCG took over from TPP development in 1997/98. Good historical context: good historical relationships between practices (although no history of working together). Good geographical context: • low levels of deprivation • TPP locality based. Financial context: • received a budget • capitation winner • GPs are generously remunerated for TPP work. OD/mechanisms: • full-time TP project manager • sophisticated organisational structure with involvement of non-lead GPs.	To set up a multi-disciplinary rehabilitation team based in a local community hospital. This would promote independent living amongst older people.	TPP established a sub-group, which included GPs, TP manager and a community trust rep. Acute trust and social services were also consulted *but* acute trust was resistant, and especially unwilling to alter contract currency. Substantial proportion of TPP's growth money invested into the project. Set up a primary care based 'fallers clinic'.	The rehab team was set up and was felt to have been successful by TPP respondents. No systematic audit had been undertaken and data were not available on the relative lengths of stay of patients who remained in the acute sector. Progress made in 1997/98 was not substantially different to 1996/97. A number of its smaller-scale objectives had fallen off the agenda due to PCG discussions.

The bottom-right cell in Figure 4 describes the situation in which the mechanisms were appropriate but where contextual barriers were difficult to overcome. An example of a small TPPs' attempts to overcome significant contextual barriers is given in Box 12.

Box 12: An example of stifled achievement

Context	*Aims*	*Mechanisms*	*Outcome*
Small, two-practice TPP in rural area. Cultural context poor: • HA unwilling to delegate budget – still notional Dec. 97 • HA concern over destabilisation of acute monopoly provider • atmosphere of secrecy and mistrust between some people at TPP, HA and trust. Good historical context: • history of working with voluntary sector • history of service developments in community care. Good geographical context: although small, geographically contiguous area. Poor financial context: notional budget only as could not reach agreement on basis of funding. OD/mechanisms: • able and experienced TP manager • clear vision from lead GP • sophisticated system of sub-groups in clinical and management areas.	To work with other agencies to provide integrated, primary managed care. To provide accessible, local services in primary care setting and in local community hospital.	Inter-agency co-operation at operational but not at strategic level. Sophisticated approach to contracting (preferred provider and referral matrix; financial incentives, good monitoring) but HA and trust resistance. Gleaning information from trust was a real difficulty and could not resource developments through transfer from acute trusts.	Initial changes radical: • TPP ran community hospital • innovative joint working with voluntary sector • integrative approach to mental illness services across primary, community, social and secondary care boundaries • intermediate care for chronic illness • innovative approach to care for older vulnerable people. Progress slowed in second year as negotiations on budget halted and became bitter. Project halted prematurely by HA in Feb. 1998. Independent enquiry blamed poor clarity of aims from HA.

The final cell in Figure 4 describes the worst scenario – a 'non-receptive' context and mechanisms that did not work. These were largely problems for the smaller TPPs. It has been difficult for any achievements to be made by TPPs in this group (see Box 13).

Box 13: An example of a non-receptive context and inappropriate mechanisms

Context	*Aims*	*Mechanisms*	*Outcome*
Small non-locality in a rural area. Mixed cultural context: • poor relations with the HA • TP project manager employed by HA • good relations with the CHC. Mixed historical and geographical contexts: • low levels of deprivation and unemployment • very different population profile between HA and TPP. Mixed financial context: • received a mix of historic and capitation budget • limited freedom to use budget (unless TPP contracted with its 3 main providers HA insisted on block contracts). OD/mechanisms: • undeveloped organisational set-up • strong lead GP.	To implement *Changing Childbirth.* To further release funds from the acute trust contract through early discharge. To improve IT systems.	Held discussions with the main acute provider. Main acute provider were developing their own plans for implementing *Changing Childbirth* and were unwilling to involve the TPP. Initial gains were achieved, but due to the setting of a late budget in 1997/98, the TPP was unable to continue. Carried out an ad hoc review of systems in the TPP. Began looking for money to fund project but became aware of the 'planning blight' while waiting for national policy and developments such as NHS Net for general practices. Software houses also not keen to develop for small-scale pilot.	TPP project was abandoned. Unable to achieve further savings. IT systems were reviewed but not improved.

6.4 *Summary lessons – the importance of the interaction between context and mechanism*

This section has shown that there was a complex interplay between what TPPs were trying to achieve, the context in which they were developing and the effectiveness of the mechanisms through which they were attempting to achieve change. The presence of national policy and political change was particularly important, and many TPPs fell by the wayside because of political uncertainty about the future of TP as an extension of fundholding. National debate around particular services (mental health, maternity and cancer services) also had an impact on the ways in which TPPs developed. *Changing Childbirth*[10] was particularly influential in providing TPPs with guidelines for service development. The support of health authorities was also important. Other analyses[36, 37] have suggested that there is now local sensitivity and responsiveness to national shifts in policy; health authorities and primary care organisations are responding quickly to policy changes; primary care organisations should therefore be given time to establish themselves and to develop before any other radical change is considered. Analyses also suggest that National Service Frameworks could have an important impact on the way in which local services and commissioning are developed, as could the implementation of the White Paper *Modernising Social Services*.

As we have seen earlier, some TPPs faced an unsupportive health authority and trust intransigence when trying to make developments. There was a good deal of uncertainty and mistrust between agencies (e.g. between primary care organisations and hospital trusts or between TPPs and SSDs). Some TPPs realised this tension had to be faced and offered a more co-operative approach to developments, which often worked. However, the centre has to face up to the possibility that primary care organisations will want substantially to alter the size, shape and scope of acute trusts' workloads. If this is not tolerated and supported by national and local policy there will be little point in having primary care led commissioning in England and Wales, and little expectation that the Joint Investment Fund (JIF) in Scotland can be effective as an incentive to shifts in services.

Box 14 summarises these lessons for developing primary care groups.

Box 14: Summary primary care organisations on the importance of context

- given the centrality of primary care to the Government's agenda for the NHS, the new primary care organisations are likely to experience a more facilitative political and cultural context than TPPs. Nevertheless, they should be given time to establish themselves and develop before any other radical change is considered
- primary care organisations are likely to be sensitive and responsive to national shifts in policy; National Service Frameworks may therefore have an important impact on the way in which local services and commissioning are developed, as may the implementation of the White Paper *Modernising Social Services*
- uncertainty and mistrust between agencies (e.g. between primary care organisations and hospital trusts or between primary care organisations and social services departments) should be dealt with openly. Cultural barriers will need to be broken down for service change to occur
- the National Health Service Executive, health authorities and boards will have to face up to the possibility that primary care organisations will want substantially to alter the size, shape and scope of acute trusts' workloads. If this is not tolerated and supported by national and local policy there will be little point in having primary care led commissioning in England and Wales, and little point in expecting the operation of the Joint Investment Fund to achieve shifts in location of care in Scotland.

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