King's Fund

National Evaluation of Total Purchasing Pilot Projects

The transition from TPPs to PCGs: lessons for PCG development

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

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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.

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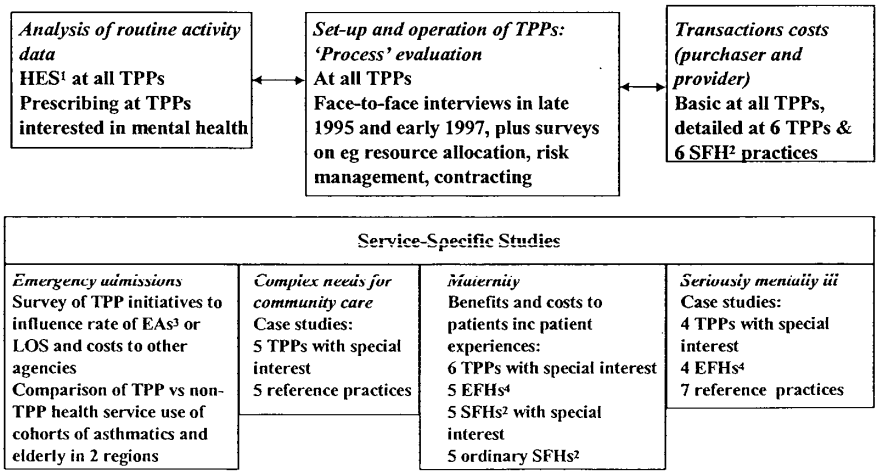
Preface: The National Evaluation of Total Purchasing Pilot Projects

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

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

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



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

Further details about the evaluation design and methods are available in the interim report of the evaluation which was published by the King's Fund early in 1998 and entitled *Total purchasing: a step towards Primary Care Groups*.

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

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Nicholas Mays, Nick Goodwin, Amanda Killoran, Gill Malbon on behalf of the Total Purchasing National Evaluation Team (1998). *Total purchasing: a step towards primary care groups*	1 85717 187 X
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1-85717-288-4

Forthcoming reports from the final year of the national evaluation

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.* King's Fund Publishing
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Killoran A, Abbott S, Malbon G, Mays N, Wyke S, Goodwin N (1999) *The transition from TPPs to PCGs: lessons for PCG development.*
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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

Nicholas Mays, Sally Wyke, Gill Malbon, Nick Goodwin, (eds) 2000 *Can General Practitioners purchase health care? The total purchasing experiment in Britain.*

1. Introduction

'The New NHS' (DH, 1997) provides a new policy context for the development of local health systems. Primary Care Groups now have a key role in improving the health and health care for the 100,000 or so people they serve, within the framework of local Health Improvement Programmes. The White Paper states that the PCG model grows out of previous models of primary-care based commissioning: standard fundholding (SFH), community fundholding, multi-funds, locality commissioning groups and total purchasing (TP). Total Purchasing comes closest to the commissioning model envisaged by the White Paper. Consequently the experience of TPPs, their development and effectiveness is highly relevant to the future development of Primary Care Groups.

An earlier report (Killoran et al, 1999) highlighted the key messages for PCGs and HAs from the national evaluation of TP. The present report aims to describe in more detail the ways in which the structure, role and impact of TPPs may be instructive to PCGs. Practical illustrations are used to demonstrate how particular changes in services were achieved in the context of local conditions, and these may be useful exemplars for PCGs. It should be noted that English PCGs are the main focus of this report, although some of the material and conclusions will be of relevance to the rather different arrangements in Wales, Scotland and Northern Ireland.

The objectives are:

- To consider the future roles of PCGs in the light of the development and performance of TPPs.

- To consider the changes in local health systems in the light of the experience of a 'whole-district' TPP.

This report is complementary to two other working papers that report findings of the final phase of the process evaluation of TPPs. These papers report the overall achievements of TPPs nationally (Wyke et al, 1999), and examine the nature of

achievements through in-depth case studies (Goodwin et al, 1999). This report draws on these findings with respect to the lessons for PCGs.

1.1 The New Policy Context.

'The New NHS', together with other policy initiatives and directives, provide a very different policy context to the one in which TPPs were introduced. PCGs are now a central feature of future local health systems. Table 1 summarises the differences and similarities between TPPs and PCGs. PCGs are part of the mainstream NHS planning and management structure and processes. TPPs were comparatively small scale, time limited pilot projects. PCGs, in marked contrast, are larger, and structure relationships between GPs, HAs, nursing, social services and the public in organisations responsible for developing and implementing strategies to improve the health and the health care of the communities they serve. Despite differences, TPPs perhaps come closest in practical experience to some of the key aspects of PCGs, being based on some common, although perhaps implicit, assumptions:

- Groups of GP practices are the fundamental building block to planning and delivery of health services locally, and are able to function collectively and collaboratively to secure improvements in services.

- A formalised relationship with the HA is required to ensure accountability and strategic steer and support.

- Commissioning/purchasing based on a delegated budget provides a key incentive and mechanism for securing change.

Box 1. Differences and similarities between TPPs and PCGs.

TPPs	PCGs
• Small (approximately 30,000 population)	• Large (approximately 100,000 population)
• Responsible for commissioning potentially all hospital and community services	• Responsible for commissioning potentially all hospital and community services
• GP-led	• GP-and nurse-led
• Volunteer practices, and time-limited (three years)	• Compulsory: all practices and not time-limited
• Rural and suburban	• All parts of England and Wales

Box 1 cont. Differences and similarities between TPPs and PCGs.

• Many simple/informal organisations	• More complex formal organisations
• Ring-fenced TP budget and SFH budgets (GMS not included)	• Moving towards integrated budgets, including SFH, TP and GMS
• Some pilots still with indicative budgets and some with fully delegated budgets after 2 years	• Moving towards delegated and independent budgets (i.e. legally the responsibility of PCGs)
• Intended to be a purchasing organisation (although in practice some mainly developed provider roles)	• Responsible for commissioning services plus health improvement and primary care development
• No structure for clinical governance within TPPs	• Arrangements for clinical governance aimed at improving quality and consistency of primary care delivery
• No requirement to address public health or inequalities issues	• Required to address public health and inequalities issues

PCGs have three primary functions:

- *developing a wider public health role and addressing health inequalities;*

PCGs are expected to play an important role in the development of local Health Improvement Programmes (HImPs), particularly assessing the health needs of their communities, involving the public and working with other agencies. Health promotion and disease prevention services should feature in investment plans, as should strategies to reduce the level of variations in quality of and access to services.

- *developing primary care and community health services;*

PCGs are expected to develop and support the provision of primary care and community health services within their boundaries; to improve the quality of services; and to integrate more fully primary and community health care services.

- *advising on, or commissioning directly a range of hospital services.*

PCGs are expected to participate in the commissioning of secondary and tertiary hospital services, either directly, or in collaboration with HAs (taking at the minimum an advisory role).

2. Methods

This report is based on the final year of the process evaluation of the TPPs that comprised two studies:

- A monitoring postal questionnaire survey of the lead GPs in all first and second wave TPPs conducted in June 1998. The overall aim was to determine the progress TPPs had made in achieving their objectives in their second live year of purchasing (1997/98), and the factors influencing their performance. (See Malbon et al, 1999 for full details of methods.)

- In depth case study analysis of twelve multi-practice TPPs. The aim was to determine what mechanisms TPPs used to secure improved service outcomes, within their particular local contexts. The sampling frame provided for the selection of larger multi-practice sites both non-locality and locality based, as the study of such projects was judged to be most relevant for informing future policy. In addition Wakefield whole-district second wave TPP was selected, as this appeared to come close to the future district-wide arrangements envisaged by the new Labour government. The field work involved interviews with lead GPs, TPP project managers, HA staff, social services representatives and others, and was undertaken in two phases: spring and autumn of 1998. (See Goodwin et al, 1999 for full details of methods.)

This final year of the evaluation was undertaken during a period of great uncertainty and change. There are certain limitations of the data, particularly with respect to reliance on self-reported achievements, although multi-stakeholder interviews provided some degree of corroborative evidence. In one case study it was possible to provide corroboration of self-reported achievement though the TPP study of analysis of hospital activity data (see Raftery and McLeod, 1999).

As stated above this report attempts to draw on the findings of these two studies to assess the implications with respect to the future defined role of PCGs.

3. PCG Development: Fit for Purpose - learning from TPPs.

GPs have not traditionally been used to working collectively, and TPPs therefore offer a rare insight into how this can be done. The experience of the larger TPPs was that in order to carry out the functions required, it is necessary for groups of practices first to pay attention to their own development as health care organisations. Lessons from TPPs for organisational development (OD) are therefore considered here first.

3.1 Developing effective primary care organisations

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 (Mays, Goodwin, Killoran, Malbon, 1998). By the second 'live year', however, many larger projects had 'caught up' in terms of their ability to achieve objectives (Malbon et al, 1998), and this section examines the lessons which can be learned from TPPs for the development of PCGs as effective multi-practice organisations.

Organisational analyses of the TPPs, particularly those researched in-depth via case studies (Goodwin et al, 1999) highlights 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 member. The executive groups' 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 a TPP "board", which typically included HA officers and met less frequently, to oversee the development of the project from a strategic point of view. Formally, these were sub-committees of the HA, as legislative arrangements required for the actual delegation of money to independent organisations were not in place.

The willingness of those within TPPs to invest an executive group with authority varied, but generally it appears that 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).

PCG boards carry out the functions of executive groups and also some of those of the TPP board, and the framework for their governing arrangements have been set out by the DH (DH, 1998b). Unlike TPPs, PCGs are distinct bodies formally accountable to HAs, and their boards will include representatives of nursing, SSDs, HAs, and the public, as well as GPs. Questions of accountability and representation are complex: unlike GPs (the majority of whom continue 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 interests inherent in such arrangements (Shapiro, 1998). (Some TPPs did include such representatives in their organisational structure, but usually these were not invited to share executive responsibility for decisions).

A key structural feature in 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 TPP by "stealing" time from their clinical workloads which, as a result, has increased those of their partners. At the same time, it has been the case in many projects that 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 (Mays et al, 1998), it is nevertheless likely that these 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.

TPP case study analysis (Goodwin et al, 1999) 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 reduction in lead GP work-loads. In many cases, TPPs created a number of sub-groups in order to permit and encourage participation in non-lead GPs, and sometimes of other stake-holders. One case study site was unusual in having as many as 25 sub-groups across 12 practices (30 GPs), 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 GPs.

Generally, the sub-group structure seems to have been successful in increasing organisational cohesion, although not all TPPs used them, and not all sub-groups adopted a truly corporate perspective. It is reasonable to predict that many PCGs will use sub-groups as a means of managing work-load and encouraging participation, particularly as not all practices will be represented on PCG boards. Where GPs did see themselves as part of a single clinical group, TPP tended to succeed best in budgetary management (Bevan et al, 1998).

A small number of TPPs attempted to develop democratic structures which avoided executive groups, believing these to be too hierarchical. The DH's guidance on PCG boards (DH, 1998b) 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 nevertheless developed to fill the vacuum created by the absence of formal structures. 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 of privilege or 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 and conflict rather than to seek to avoid them. Certainly, the multi-agency composition of PCG boards require the corporate ability to manage creatively debate and dissent.

A common aspect of the largest and most successful projects has been the employment of a competent and dedicated project manager with sufficient skills to be

able to cover a wide range of sophisticated tasks, including financial risk management, the facilitation of group decision-making, 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.

The lack of such 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.

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 which 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 (DH, 1998e).

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 on to sub-groups. Typically, this was in order to enhance particular services, such as maternity, mental health and continuing care (Wyke et al, 1998; Gask et al, 1998; Myles et al, 1998), and where such collaborations were successful, it was typically the case that 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. One case study site representing a whole town had created a very inclusive multi-agency public

health sub-group to address the breadth of health issues faced by a deprived urban population (see box 3). Moreover, some (four of the case study sites, for example) had attempted to set up patient participation groups, although as yet no effective mechanisms for public consultations had been established.

TPPs believed that a good relationship with the HA was important, and was associated with the successful achievement of objectives (Mays et al, 1998). Because no detailed government guidance was issued to define organisational arrangements for the TPP/HA relationship, local organisations made local arrangements. Though it is clearly 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 relationships are likely to be rather different from those experienced by TPPs. (See below, 4.2, for an account of some related anxieties expressed by TPP informants.)

A final message for PCGs is that effective organisational management arrangements require adequate financial resources. The evaluation of TPPs found 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 (Malbon et al, 1998). In particular, 85% of costs were associated with activities such as communication, co-ordination and decision-making within organisations, rather than with contracting and commissioning (Posnett et al, 1998). Such costs are likely to be increased in PCGs, 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.

Summary lessons for PCGs

Box 2 summarises the key elements of organisational arrangements of successful TPPs which will need to be considered when developing PCGs. 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, PCGs also need to tackle the challenge of effectively involving the public in policy-making decisions, which TPPs did not succeed in doing.

Box 2. TPP organisational and management lessons for PCGs

Key elements of successful TPPs:

- A strong executive management team with the mandate to take strategic decisions on behalf of the wider group.
- The development of a clear vision and agenda for action.
- An inclusive approach leading to the development of collective responsibility and corporacy.
- Sophisticated project management capacity.
- Investment in clinical and management information systems.
- Ability to engage effectively and create partnerships with external organisations.
- Adequate resourcing of organisational and management arrangements.

3.2 Developing a wider public health role and addressing health inequalities

In specifying that PCGs have a central and legitimate role in developing HImPs, the White Paper gives these new organisations a public health role and responsibilities which hitherto have not been given so explicitly to primary care organisations. Neither GMS nor SFH provided incentives to GPs to initiate public health activity, or to be involved in public health strategy, beyond the narrow contractual requirements relating to health promotion and disease prevention.

This new role is likely to provide substantial challenges for PCGs, to judge from the experience of TPPs which, on the whole, did not develop, or attempt to develop, a public health role. It may help that PCGs are based on localities: research into primary care commissioning excluding TPP has shown that, for example, health needs assessment capacity appears to have been more likely to improve in locality- or district-wide collaborations (often with the HA playing a key role) than in multi-funds and SFH consortia (Smith et al, 1998). However, the benefits of a locality-based

approach will not be apparent immediately: PCGs are initially working within a framework to which they were themselves able to contribute only a limited amount, because HImPs were drawn up at a time when PCGs were themselves still forming. A more comprehensive PCG contribution to HImPs will be expected in future years.

Needs assessment and strategy development.

TPPs reported little understanding of what needs assessment meant, or of how to use needs assessment techniques, although more TPPs were undertaking needs assessment in the second year than the first (Mahon et al, 1998). Population based approaches to needs assessment drawing on public health epidemiological information were very under-developed, as was the use of methods for involving users in service development (Wyke et al, 1998). TPPs' selection of priorities for service development was largely based on the experience and views of GPs (Mays et al, 1998), with the result that initiatives more often attempted local fixes than they contributed to broader strategy.

Despite this generally low base, there were many examples of small scale projects, e.g. questionnaire survey of the experiences of older people on discharge from hospital, undertaken in conjunction with the local Age Concern. A more sophisticated example, the development of a mental health strategy, involved some epidemiological analysis of the level of mental health problems of the TPP population, review of good practice based on research evidence, work on establishing a shared register with providers, a survey of mental health users, review of current providers and cost benchmarking of two providers. A few of the case-study sites had arranged public health input and activity using resources outside the TPPs, while one appointed its own health needs assessment officer (see box 4).

TPPs were involved in district-wide strategy development to varying degrees. TPPs contributed to locality commissioning forums where they existed, and/or in district-wide forums for specific services, particularly in relation to their areas of established priorities and interests. There is evidence that some TPPs undertook service reviews in a range of areas on behalf of the HA for the whole district, or that their own service

reviews of particular areas initiated district-wide reviews. This appears to have been the case particularly where TPPs were co-purchasing with the HA. However, in many instances, particularly in relation to acute and mental health services, achievement of TPPs' own objectives were hampered by a lack of strategic forums or frameworks at district level. Where HAs did give a strategic lead, this often enabled the TPPs to participate and to develop their own strategy productively. The degree to which TPP priorities were aligned with national and district priorities was an important contextual factor that influenced progress (e.g. Wyke et al, 1998; Goodwin et al, 1999).

Equity

Equity issues may be divided into those relating to equity of resource allocation enabling and supporting services, and those relating to equity of actual services provided.

The resource allocation process for PCGs may be easier for HAs with the existence of national guidance (DH, 1998c). There was no equivalent in the case of TPPs, and as a result, TPPs and HAs spent much more time and energy on the challenge of agreeing a budget (Bevan, 1999). The evidence from TPPs indicates that the majority of HAs were at different stages of developing their resource allocation processes. While the majority was seeking to apply capitation-based budgets, there was some way to go before TPPs would actually achieve their "fair-share" allocation. For example, one case study TPP in a deprived area agreed a budget which was shown to be substantially below a notional capitation-based budget which took particular account of its level of deprivation. It should be noted that there was no association between the level of funding, in terms of per capita spend, and the level of achievement: the crucial enabling factor was the ability to purchase as such (Bevan, 1999).

While there was little direct evidence that changes brought about by TPP were increasing inequalities in service provision, certain consequences do raise concerns. In particular, case study TPPs provide a number of example where TPPs have achieved some marginal changes in hospital provision, reducing their costs, for example, through contract currencies linked to length of stay. Trusts consequently increased

costs to other purchasers for their services. As with SFH, benefits secured for TPP populations were not available right across the district. Locality-based PCGs should reduce such variations within localities, and it may also be desirable for PCGs to work together rather than as competitive purchasers in the future, to ensure district-wide equity.

Conversely, there were example where the changes brought about by TPPs were pushing up standards across the district. Some HAs revised their own contracts to "roll out" TPP improvements to the rest of the population. For example, new service specifications for maternity services based on the implementation of Changing Childbirth by a TPP were applied district-wide. Also, TPP models for the prevention of unnecessary emergency medical admissions were more widely applied through the Winter Pressures initiative.

Promoting Health

A minority of TPPs reported achieving a range of objective is in the area of health promotion and disease prevention. These were generally small scale developments driven by local perceptions of need rather than being explicit responses to Health of the Nation. Developments were often undertaken with the support of health promotion services of the public health department, and involved collaboration with the local authorities (social services, schools, etc.) and local voluntary and community groups. As already mentioned, one case study TPP took steps to advance its wider public health role, based on the creation of a "Health Improvement Team", to address the needs of its deprived urban population (box 3).

Box 3. Health Improvement Team

Context	Service development	Achieving change	Outcome
Locality-based TPP: 16 practices, 35 GPs. Deprived, urban population 67,000. No budget.	A range of public health initiatives: lottery bid for a Healthy Living Centre; health and lifestyles survey of population; teenage health days and school liaison; easy access anonymous teenage emergency contraception service for teenagers.	Sub-group of one GP, two HA reps. including a public health doctor, health promotion rep., borough council rep. Strong unifying focus from a wide range of organisation and activities in the town; task-centredness released and focused energies. May have benefited from more attention as a result of TPP not having a budget to manage.	More and more effective links with many other agencies. No measured outcomes at this stage.

The prevention of coronary health disease was the principle focus of many health promotion efforts. initiatives were diverse including:

- a Heartstart Campaign, funded by the British Heart Foundation, involving training of TPP staff in resuscitation and how to train members of the public invited to the practice;
- appointment of a Cardiac Nurse Adviser to provide clinics for at-risk patients, training to GPs and Practice Nurses and a community education programme;
- a co-ordinated approach to cardiovascular disease (identification, assessment and management), supported by the appointment of a pharmaceutical adviser, and which included protocols for the care of patients with heart failure and hypertension.

There were also a number of examples of initiatives in areas of sexual health, prevention of drug misuse, asthma and breast cancer (see box 4).

Box 4. Breast cancer standard

Context	Service development	Achieving change	Outcome
Locality-based TPP, 4 practices, 16 GPs. Relatively affluent rural population, 31,000. Budget-holding. Direct purchasing of majority of contracts.	Standards for management of breast cancer in primary care.	Local prevalence created GP and nurse interest. Health Needs Assessment Officer appointed by TPP led the work (reviewing literature, facilitating workshops, arranging training).	Documentation summarising evidence of epidemiology, pathology, diagnosis, treatment, management and referral criteria. Used by PHCT members. Audit data not yet available.

Lessons for PCGs.

'The New NHS', 'Our Healthier Nation' (DH, 1998a), Health Action Zones, and National Service Frameworks present a very different context from that experienced by TPPs. In principle, there are important new opportunities for developing the public health role of PCGs, although a significant shift of culture will be involved in moving from a GP-led clinical perspective to an approach based on partnership and population models. New initiatives such as Health Living Centres, Health Action Zones and New Deal for Communities offer potential for collaborative working with communities to tackle inequalities.

Public health specialists will have a crucial role in supporting PCGs in needs assessment, reviewing evidence of clinical effectiveness, etc. Health promotion specialists could also make an important contribution to supporting partnerships with PCGs and other agencies in supporting community development initiatives.

The constitution of the PCG boards, with their nurse, SSD and lay representation, provides for a much broader interpretation and assessment of the health needs of communities. The public health role of nurses could be nurtured, including their potential to undertake needs assessment, develop population health programmes, and provide nurse-led responses to the needs of particular vulnerable groups. Lay members of PCG boards will need to be supported and linked to wider mechanisms for involving the public if they are to have more than a tokenistic role.

If PCGs are to fully recognise their strategic responsibilities in these areas in a way that TPPs did not, then these will need to be defined and reinforced within accountability and performance management frameworks.

3.3 Developing primary care and community health services across the TPP and PCG

A minority of first wave TPPs in 1996/7 (8/52) could be identified *almost exclusively* as 'Primary Care Developers', meaning that they were not concerned with commissioning services from others. Rather, they were concerned with developing the range and depth of primary care services which practices themselves could provide (Mays, Goodwin, Killoran and Malbon, 1998). Motivations for such primary care development were varied. In some cases, the intention was to reduce the strain on GPs by changing the skill mix of and allocation of responsibilities between the PHCT (e.g. box 5); in others, it was the frankly acknowledged intention to enhance GP remuneration. For example, GPs in one case study site supported nursing home beds as an alternative to hospital, paying themselves for the extra out of the savings made by reduced use of hospital.

Analysis of the achievements of TPPs in the first 'live' year (1996/7) showed that pilots were far more likely to implement change successfully when this involved developments in primary care than when this involved changing the way in which specialist secondary care providers behaved (Mays et al, 1998). To concentrate on primary care development was therefore a rational strategy.

Distinct from such primary care development, at any rate in motivation, some TPPs sought to substitute less costly for more costly forms of provision. This might include substituting services provided by PHCTs for services previously provided by NHS trusts, or by substituting, for example, community hospital for acute hospital services.

However, the boundary between primary care development and service substitution is not a clear one, and the effects of both might be similar. For example, the provision of more physiotherapy or ophthalmology in the practice might reduce referrals to hospitals, whatever the original intention or motivation.

A wide variety of schemes, whether chiefly intended to enhance primary care or to substitute services, were put in place by TPPs, such as:

- new and extended counselling services;
- practice-attached midwives;
- practice-based community psychiatric nurses (e.g. box 5);
- new physiotherapy services (e.g. box 6);
- practice-attached pharmacists to advise on GP prescribing (e.g. box 7);
- specialist nurses in the care of chronic conditions like diabetes;
- testing facilities formerly available only in hospital by consultant referral.

As far as can be ascertained, none of these developments necessarily required TPP status to be achieved, but TP may have made things easier for the practices, for example, by having developed the elements of an inter-practice organisation without the potential for the sharing of information.

Box 5. Development of Community Mental Health Services.

Context	Service development	Achieving change	Outcome
Suburban non-locality TPP, 5 practices. 58,000 population. Budget-holding. Direct purchasing of majority of contracts.	Appointment of more CPNs. CPNs take direct referrals from PHCT and monitor and work proactively with seriously mentally ill.	Practice profiles and activity review to assess needs. Subgroup of non-lead GPs, CPNs, HA, TPP manager; development of service specification. Collaborative relationship between the GPs & CPNs. Direct negotiation with mental health provider. Supportive relationship with the trust managers/clinicians. Contract pricing based on estimated reduction in acute admissions; and change in contract currency from Finished Consultant Episodes to Occupied bed days (ongoing savings not realised as trust repriced services).	Enhanced availability of mental health professionals for TPP patients Improved hospital discharge liaison in mental health Reduced occupied bed days, lengths of stay in hospital & prevention of admissions, particularly for acute admissions under 65 yrs. HA incurred increased prices. Overall impact on provider neutral.

Box 6. Acute Back Pain.

Context	Service development	Achieving change	Outcome
Locality based TPP, 5 practices (21 GPs). 30,700 deprived inner city population. Budget-holding. Direct purchasing of the majority of contracts.	Physio-led service: 4 clinics each week in one practice. Central booking system. Group session for chronic back pain once a fortnight.	Orthopaedics identified as a problem: waiting list, perceived poor outcomes. Sub group to review service: reference to guidelines, service specification. Contract out to tender. Development monies available. Good relationships between TPP and Community Trust and community physiotherapists.	Increased and easier access for patients with acute back pain to effective treatment.

Box 7. Community pharmacist project

Context	Service development	Achieving change	Outcome
Locality-based TPP: 16 practices, 35 GPs. Deprived, urban population 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.	Monthly reports by pharmacist adviser to sub-group of GPs with recommendations for change.	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.
		Production of joint acute/primary care formulary agreed by GPs and consultants. Review of repeat prescribing.	Greater shared understanding of prescribing issues. More consistent prescribing.
	Additional aims to enhance the primary care role of community pharmacists.	Initiated GP/community pharmacists discussions.	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 trust to allocate designated community nurses to PHCTs. In others, community nurses in a

PHCT moved to a self-managed nursing team model. Other TPPs negotiated new arrangements for team midwifery. For example, in one case, the acute trust had arranged team midwifery on a geographical basis with midwives visiting women at home. GPs had valued their previous contact with both women and midwives, and used evidence of an increase in ante-natal admission rates to negotiate practice-based ante-natal care, thereby restoring the contact which they had missed.

Two-thirds of first wave TPPs reported a purchasing objective in 1996/7 which related to vertically integrated services, i.e. the creation or co-ordination of a range of services linking acute, community and primary care so that patients could receive appropriate care in the least costly setting.

A wide range of schemes were introduced to ensure that such alternatives were available and utilised:

- community beds as alternatives to acute hospital beds (GP beds in community hospitals, nursing home beds, places on hospital-at-home schemes);
- hospital discharge co-ordinators to speed discharge;
- arrangements within primary care to prevent unnecessary admissions (liaison personnel in PHCTs, admission protocols, care pathways);
- enhanced domiciliary care capacity (usually including close working with SSDs to provide integrated social and health care at home).

Boxes 8 and 9 show how some TPPs commissioned examples of such services, while box 10 shows how one large TPP commissioned a full range.

Box 8. Rehabilitation Services

Context	Service development	Achieving change	Outcome
Locality based TPP, 4 practices. 35,400 population, small town. Budget-holding. Direct purchasing of majority of contracts.	Rehabilitation team: providing hospital–based services, at home, and in nursing homes and rest homes. 'Fallers' clinic.	TPP commitment to protect and develop local hospital. Enthusiastic GPs. Investment of growth monies; joint funding with community trust in first year.	Early discharge from acute hospital to local community hospital. Reported prevention of admission / readmissions Increased independence of patient (measured by Rapid Disability Rating Scale). Reported improvements in patient choice, satisfaction and quality of care.

Box 9. Early discharge and prevention of emergency medical admissions

Context	Service development	Achieving change	Outcome
Non locality TPP, 3 practices. 20,000 urban population with pockets of deprivation Copurchasing with HA.	More active use by GPs of existing fast response service to avoid inappropriate medical admissions. Appointment of a case manager to: • ensure appropriate discharge arrangements • work with GPs, PHCTs & SSDs to provide appropriate community based services & avoid readmission. Development of management guidelines to avoid readmissions.	Needs assessment: analysis of admissions data, tracking patient pathways. Credible competent case manager. Collaborative relationships with trust and SSD.	Reduction in occupied bed days and finished consultant episodes.

Box 10. Intermediate Care

Context	Service development	Achieving change	Outcome
Non-geographical locality based TPP, 8 practices (42 GPs) 81,000 urban population Budget-holding. Direct purchasing.	Range of inter-related 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 Ongoing systematic review & evaluation, with reporting	Emergency admissions prevented, discharges speeded. Sharing of experience with emerging PCGs across the district

Evidence suggests that many of these initiatives were successful in reducing hospital use (Raftery and McLeod, 1999), although not necessarily in persuading trusts to release money as a result. More success was reported in achieving early discharges than in managing emergency admissions (Mays et al, 1998). However, the development and active management of new processes and resources seem to be an important feature in many cases; contracting with the acute provider alone appears to have been less successful (Walsh et al, 1998).

Some TPPs were also interested in better integrating health and social care by improved collaboration with SSDs (horizontal integration) (see box 11). Some projects secured improved relationships by means of arrangements such as joint assessment procedures, attached social workers, or shared data. One introduced an inter-agency assessment process for all new SSD clients over 65, including the use of a summary record as a patient-held record, used by all care and nursing agencies visiting patients.

Box 11. Integrated provision for older people			
Context	**Service development**	**Achieving change**	**Outcome**
Single practice TPP with 2 surgeries. Population 16 000, relatively deprived urban area	**Community Care Co-ordinator** - an experienced social worker who acts as bridge between practice, social services and voluntary sector. **Admission and discharge co-ordinator** - **Multidisciplinary 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	Proactive care for older people with health problems. Much speedier referral and assessment. Initial assessments shared between health and social care. Ability to address less severe problems has potential to prevent health crises.

Developing consistency in primary care

By bringing together practices into new groupings under the auspices of the TPP, it became possible to think about shared standards of care across previously independent practices. The managerial and clinical resources of the TPP could be used to develop evidence-based standards which individual practices might not have had the time or expertise to put in place. For example, one TPP reviewed the provision of school health and family planning services across a whole district and produced new standards and protocols. In another case, the TPP developed and implemented standards for the management of breast cancer in primary care (see box 4), which involved agreement between GPs and nurses in all the practices to change clinical behaviour. This was relatively unusual; in general, TPPs were reluctant to review the GPs' own behaviour (cf. Harrison, 1997). In part, this was simply a pragmatic means of avoiding conflict in the TPP as it was developing. On the other hand, as later investigation of the TPPs in 1997/8 showed, it demonstrated a more profound

reluctance of lead GPs to be seen to be interfering in the work of colleagues in other practices.

Some TPPs beginning to collate information on referrals, overall hospital use and prescribing at GP level across practices. More specifically, a few chose to increase consistency of extra-contractual referrals (ECRs) by managing these at TPP rather than individual GP level. The managerial and clinical resources of the TPP could be used to develop evidence-based standards which individual practices might not have had the time or expertise to put in place. For example, one TPP reviewed the provision of school health and family planning services across a whole district and produced new standards and protocols.

This has implications for the concept of 'clinical governance' enunciated in recent government policy statements (DH 1998d). More than two-thirds of the lead GPs in TPPs had a negative view of clinical governance (Malbon et al, 1998), fearing interference with clinical freedom. Such reservations have found echoes more widely. The General Medical Services Committee (GMSC) of the British Medical Association successfully sought concessions from the Secretary of State that no patient in a PCG should be denied the drugs for treatments which his/her GP regarded as necessary. The GMSC argued that the national terms of service of NHS GPs (Section 43) made it impossible for them to deny needed drugs or treatments irrespective of the financial position of the PCG. As a result of the Secretary of State's decision, health authorities will have to set aside reserves in case PCGs overspend, for example, by prescribing 'reasonably', but in excess of the PCG's drug budget. In essence, this means that PCGs face a 'soft' budget constraint. The only GPs who could be required to work within a 'hard' budget constraint would be those employed by PCGs under the NHS (Primary Care) Act of 1997 in Personal Medical Services Pilots.

The actions of the GMSC suggest that there is limited support among GPs for trying to improve the quality of primary care within a fixed budget, although initiatives like that described in box 3 may offer a model for those who do wish to attempt such improvements.

Lessons for PCGs

Undoubtedly, PCGs 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 achieve higher quality cost-effective care (Coulter, 1996)). It may be easier 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 achieving more 'clout' to bring about change in negotiating service agreements with acute trusts. However, the replacement of contracting with longer-term service agreements may well result in a slower pace of change.

Although such integration may improve service co-ordination and the quality of patients' experiences, it poses new regulatory problems. PCG practices are being encouraged increasingly to in effect 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 equal 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 arrangement 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 in favour of services which they themselves were remunerated for providing.

All HAs now 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.

PCGs are expected to develop high quality primary care services by means of coherent strategic investment plans for practice based and PCG-wide services. Improving the quality and consistency of primary care within a PCG will need to include the following elements, most of which were not attempted by TPPs:

- the collection and sharing of previously sensitive information between practices, clinicians and professional groups on aspects of care, outcome and resource use;
- extension of the use of existing audit tools and processes across the PCG as a whole;
- development of new guidelines and protocols;
- disaggregation of PCG budgets to practice level for management purposes;
- development of locally relevant incentives, sanctions and peer forums to encourage all primary care professionals to work in conformity with agreed guidelines, standards and protocols.

These activities will require effective clinical leadership from the PCG GPs and other clinicians. The leaders of the PCG will have to be able to manage controversy and to engage the support of GPs who may be initially hostile to the basic concept of improving the quality of primary care through collective action and comparisons between practices and clinicians.

3.4 Advising on, or commissioning directly a range of hospital services

The White Paper explicitly rejects the "market model" for the commissioning of hospital services. Whereas the NHS reforms of the 1990s sought to use competition to contain the ever-expanding costs of the acute sector, the White Paper appears to signal instead a "counter-weight" model, whereby the balance between hospital and community services, which has shown a chronic tendency to allow hospital services to attract unduly both resources and power, is adjusted by increasing the strength, scope and coherence of a more integrated primary/community health care sector.

It may be, therefore, that the sort of developments outlined in section 3.3 which represent alternatives to hospital care may attract more PCG energy and dedication than will direct commissioning with secondary and tertiary care.

There are in any case limits to what TP can teach PCGs about the direct commissioning of hospital services from TPPs. First, TPPs were invariably *selective* purchasers, "blocking back" to HAs some services (such as forensic psychiatry, services for people with learning disabilities, A&E, complex community care packages), and co-purchasing other services with the HA. Second, in most cases, TPPs had previously effected changes to elective services via SFH rather than TPP.

Commissioning effective and high quality health services

Some changes were designed to make services more accessible, e.g. increases in the amount of, and changes in the location of outpatient services such as day hospitals, screening and testing services, or the moving of whole services to a more local setting (e.g. boxes 8 and 9). More generally, many sites saw the development and enhancement of their local community hospital as an important objective.

Some changes were designed to improve the quality of hospital care, and to manage better the acute/primary care interface: for example, by agreeing protocols (e.g. boxes 4,7,13). Other sites replaced services which appeared to have poor patient outcomes (e.g. boxes 6,9). One case study site sought to move beyond a simple block contract for mental health services with its community trust provider by paying much closer attention to the nature of individual care packages and the degree to which they were fully multi-disciplinary. It was doing similar work in relation to general medicine in the acute trusts, trying to ensure that unnecessary tests and out-patient appointments were avoided and that discharge arrangements were better co-ordinated.

Some TPPs (five of the twelve case study sites, for example) sought to influence acute providers by changing the contract currency, believing that this would enable them to control hospital activity better. However, few successes were reported, presumably because of the problem of scale: the typical TPP was simply not large enough to

persuade the trust to make such a major contracting and accounting change (Robinson, Robison and Raftery, 1998).

Some changes sought to rationalise and/or simplify the pattern of service provision, by reducing the number of providers of particular services (boxes 12,13). For example, one TPP was served by two different trusts for physiotherapy. The two trusts had a long history of poor communication with one another, especially at the boundary between acute and community health services, despite encouragement from the TPP to improve liaison. The TPP opted to move its entire physiotherapy contract to one of the two trusts.

In another, concerns about the costs and efficiency of community health services' providers led the TPP to go to competitive tender between two Trusts for all items of community health services. As a result, the TPP practices were able to negotiate what they wanted, which included practice-attached community nursing.

Box 12 describes how one TPP made its child and adolescent psychiatry service much more accessible to its rural population, at the same time improving links between the service and the PHCTs.

Box 12. Child and Adolescent Mental Health Services

Context	Service development	Achieving change	Outcome
Locality TPP, 12 practices, (30 GPs). 45,000 rural population Budget-holding.	More local service; outreach clinics planned. Meetings to assess and review practice referral patterns.	Shared belief in project across TPP PHCTs and provider. Service specification. Out to tender: multi-agency selection panel. Practices pooled their budgets (TPP & SFH).	Patients being seen sooner and closer to home. Improved liaison between PHCTs & consultant psychiatrist in relation to individual patients.

However, it is worth noting that the relationship between "the market" and such reductions was not necessarily straightforward. For example, a site which did not have a budget nevertheless "played the market" , with the HA's support, in order to reduce

the number of its urology providers from fourteen to two (box 14), whereas another, which did have a budget, nevertheless needed the intervention of the HA's Chief Executive in order to bring about the changes which it wanted to make its mental health services (box 13). This suggests that the loss of market 'bite' may not be an impediment to effecting service change where PCGs are able to enlist the support of relevant allies, especially when planned changes support local HImP objectives.

Box 13. Changing mental health services

Context	*Service development*	*Achieving change*	*Outcome*
Locality-based TPP: 6 practices. 36,000 population, county town. Total budget £6 million. Direct purchasing of majority of contracts.	Objective; to establish a community-based mental health service, and to avoid high numbers of ECRs. 2 existing providers declined to provide joint service. Contract moved to local community trust, with disengagement arrangements for 'loser' trust. Phased in during 1998/9. No community mental health team as yet.	Good relationships with trust and HA. Backing by HA chief executive essential to persuade trust of financial viability of new contract.	Anticipated benefits: fewer ECRs; improved continuity of care and development of community mental health team.

Box 14. Changing contracting for urology

Context	*Service development*	*Achieving change*	*Outcome*
Locality-based TPP: 10 practices. Urban, deprived population, 67,000. No budget.	Streamlining provision of urology services (previously 14 providers). Putting the service out to tender, and accepting two (two rather than one in the expectation that competition would drive up quality).	Good relationship with the HA, and the latter's willingness to adjust urology contracts.	Clinical specifications, local outreach clinic.

Monitoring the performance of providers of services against service agreements

Many TPPs attempted both to improve the quality of information received about provider activity (e.g. A&E admissions, lengths of stay), and/or to scrutinise the data more carefully. There was some reluctance or lack of capacity on the part of NHS trusts to co-operate, and some data were only available after considerable delay. It seems that such initiatives in themselves did not lead to many service changes, but that they could be important in helping to bring about service changes which had already been envisaged and aimed for.

One case study site was experimenting with ways of monitoring performance by patient outcome over time, although this was in its early stages at the time of data-gathering. The intention was that patients receiving specified surgical interventions would be followed up over time to track the intervention's impact on their health, with the ultimate intention that the number of successful treatments rather than the number of treatments should be at the heart of service agreements.

Contributing to the national drive to reduce waiting lists and times

This was not commonly a TPP priority, although some did review waiting lists with providers, and some service developments resulted in shorter waiting times. In one case, GPs had managed elective admissions in order to make budget savings, which were then contributed to the district-wide financial recovery plan (thus working counter to the national drive to *reduce* lists and times). No evidence was presented that sites had reviewed their own referral thresholds as a way of addressing waiting list problems, and there was evidence of TPPs putting patients on waiting lists as a response to financial pressures.

Lessons for PCGs

In principle, PCGs will be able to commission virtually all health care. However, the experience of TPPs suggests that most will only undertake selective commissioning at first. It is also likely that PCGs may want to join together in order to commission many hospital services such as emergency, cardiac and cancer services, partly in order

to share the work-load and partly because such shared commissioning may in any case be more appropriate (Killoran et al, 1998).

The effectiveness of long-term service agreements is as yet uncertain. On the one hand, they are likely to provide less 'bite' than contracting, with less scope for the early switching of providers. This is particularly the case as Glennerster et al (1996) suggest that larger commissioning groups are less good than fund-holding at "exercising the exit sanction and forcing micro efficiency gains from hospitals and community trusts" (page 54). However, they also suggest that collective groupings may be preferred "where a local monopoly provider exerts a powerful sway", a context which may become more common because of trust mergers, which are likely to decrease the extent to which genuine 'contestability' exists.

On the other hand, such agreements also create fewer risks of destabilisation of providers and may enable a slower but more effective strategic development of services, particularly where PCGs work together.

To achieve this, PCGs and HAs alike need to ensure that desired developments in acute services are given weight in PCG commissioning plans and in local HImPs. It will also be important that national service frameworks and the recommendations of the National Institute for Clinical Effectiveness (NICE) are reflected in service agreements, and that these are tied in to accountability and clinical governance arrangements. In the case of TPPs, accountability arrangements around national and local priorities and targets were relatively weak (Dixon et al, 1998). It is also clear from TPPs that a key mechanism in the development of commissioning expertise was the bringing together of primary care and hospital clinicians (Dixon, 1998). Such dialogue had the advantage of engaging GPs and creating ownership of commissioning decisions in a way which national service frameworks and NICE recommendations will not necessarily replicate. On the other hand, there should be a reduction in the time devoted to contracting discussions, and there will be less need for the local multiplication of reviews of evidence etc. to assist in PCGs' commissioning for quality.

4. A "Whole Health System": The Wakefield Experience

Wakefield's *Partners in Health* was unique in that it was a district-wide TPP, and therefore offers a glimpse of how a local 'whole health system' might develop. It provides some indication of whether, and how, numbers of independent practices can learn to work closely together to develop and implement strategies for both commissioning and delivering health care. It therefore foreshadows the transformation of the local health system which, it can be anticipated, will be undertaken in many districts, and provides some important insights and lessons.

Origins.

TP was not conceptualised as a project but as a 'way of working....the way we do business': both a vision of working in partnership, and the practical processes for doing so. It was an attempt by the HA to strategically manage the changing roles of HA and general practice, and develop new relationships and organisational capabilities, based on the concept of partnership, to respond to the strategic issues facing the district.

Wakefield HA served a population of 317,000 with a total budget of approximately £157m. *Partners in Health* encompassed all the 45 general practices (approximately 190 GPs). The district was served primarily by one local major acute trust (based on two sites) and one community trust.

Partners in Health was introduced in April 1996 (i.e. in the second wave of TPPs). By that time the district had achieved 85% fundholding which had led to significant financial difficulties, particularly the lack of flexibility to deal with growing emergency workload for which GPs were not financially accountable through fundholding. The district faced a significant financial deficit and had agreed a plan with the NHS Executive Regional Office to achieve financial balance by the end of the 1998/99 financial year. The critical financial situation and the belief in the need to link clinical decisions with resources to affect real change, were why the HA sought to become a district-wide TPP. The HA wanted to involve GPs in policy development

and increase GPs' awareness and responsibility for effective use of the totality of resources. In fact, it appeared to be the only possible way forward.

Partners in Health.

The processes for developing partnership working between the HA and general practice were the key features of *Partners in Health* and are summarised below.

Processes and mechanisms for implementing *Partners in Health.*

- *Partnership management arrangements/structure-* comprising:
  -Five geographical localities (aggregates of GP practices) ranging in size from 55,000 to 77,000 population.
  -A Strategy Board (lead GPs of each of localities, HA CE and directors and HA chairman) operating as a sub-committee of the HA;
  -Five locality boards of GP representatives, and locality managers.
  -'Tripartite' meetings for involving both acute and community trusts in decision making processes, and developing relationships between GPs and clinicians.

- *Organisational development-* a strategic approach to reviewing and managing the change in the respective roles and responsibilities of the HA and localities, and the redistribution of management costs. This was based on a major organisational development project.

- *Leadership* that fostered a culture of partnership working

- *Resource allocation and budgetary management framework*, linked to the development of information systems. Weighted hospital and community services capitation budgets were allocated to localities (to practice level then aggregated to locality level). Management and monitoring of budgets at a locality level, based sharing of individual practice activity and expenditure information. Flexibility for localities to pool total purchasing and fundholding budgets.

- *Incremental devolution of commissioning responsibilities-* approximately 65% of the total HA budget (total purchasing and fundholding budgets combined) covered services that were copurchased by localities with the HA. Localities negotiated collectively and collaboratively to set contracts with trusts, in association with the HA.

- *Performance management framework*, based on a system of Locality Corporate Contracts and Business Plans, with a series of review meetings held on a quarterly basis, and mid year and end year reviews.

- *Collaboration between localities in developing services*, including piloting different service models on behalf of each other to be subsequently applied district-wide if appropriate and effective.

- *Participatory approach to district-wide strategy development for acute service reconfiguration.* Joint clinician/GP discussions of specific patterns for future service development in the preparation of a major public consultation document setting out options for the future pattern of service provision.

The early achievements of *Partners in Health* were about putting new processes and systems in place which have led to changes in understanding, attitudes, behaviours and relationships between the HA and GPs.

Localities were given the opportunity to develop their own identities and ways of working including, processes governing GP representation, decision making procedures and communications. For example one locality board developed a complex voting system based on the list size of practices. Two locality boards had a system of lead GP, chairman and deputy chairman, with the locality manager operating as an executive forum to the board. The lead GP was replaced by the chairman when his/her one year term of office ended. One locality board established a strategy subgroup, comprising three GPs, there practice managers, a practice nurse and the locality manager to discuss wider locality strategy. The HA had to learn to adapt its style of working, for example in presenting information in a more accessible way, avoiding the use of jargon, to enable genuine debate. It was recognised that early attention needed to be given to organisational development: that 'to make Partners in Health work meant standing the HA on its head-and saying we need to review the role of the HA'. The Partnership Organisation Development (POD) project built on work undertaken as part of the national work on *Defining the Essentials: the Functions, Roles and Costs of HA and GP Purchasers* (Griffiths 1996).

It produced a model of a new health authority based on three overlapping functions and distribution of management resources, as shown below:

- Commissioning and implementation-locality based - 50%
- Shared strategic functions - 30%
- Core functions - 20%.

The two year phase of development shows that the time and effort, and management resource, involved in establishing a decentralised system is substantial and should not be underestimated. Partnership working has to be built on a sound infrastructure.

However, *Partners in Health,* did address both strategic and locality-led service planning and development issues, which proved important in yielding some early wins, as well as acting as focuses for developing relationships and capabilities. A summary some of these service developments are shown in box 15. This pattern of development also illustrates that it is possible to develop a system which can allow and encourage diversity as part as an emergent strategic picture.

Localities made an important contribution to the planning of the acute service reconfiguration and influencing the future pattern of services in a number of areas. The bilateral HA/locality relationship was regarded as an enabling factor in gaining the Trusts' acceptance of the need to rationalise services. GPs contributed through the management of elective admissions and return of fundholding savings towards the financial recovery plan. The allocation of notional budgets to practice level and the sharing of information within the localities was viewed as essential for engendering a shared ownership and responsibility for management the district's financial deficit. It was the basis for encouraging GPs to review and start to question their own activity, expenditure and practice, which proved more problematic and difficult in some localities than others.

Early locality-driven priorities were in primary, community services and secondary care areas. Each locality took the lead in planning and development work in a specific area with subsequent take up of plans by other localities. For example new models in methadone prescribing and services were piloted in three localities which was then rolled out to others in 1997/98. One locality worked with the Public Health department and the Acute Trust to revise the service specification for ophthalmology.

Each locality progressed a specific joint project with their corresponding locality based social services teams to test out relationships and new models. These included mental health, substance misuse, sexual health and minority communities.

Localities copurchased with the HA services from providers based on joint negotiation with trusts. Therefore localities, in practical terms, did not have a great degree of budgetary autonomy. The dominant approach was through collaborative and collective working across localities.

Box 15. Achievements in 1997/98

Strategic developments:
- GPs significantly involved in planning the acute service reconfiguration.
- Localities' contribution to managing activity, and achieving the financial recovery plan.

Locality-led service developments:
- Development of integrated nursing teams.
- Development and launch of a District Drug Formulary.
- Bed audit undertaken through collaboration between two localities.
- Development of protocols for cardiology.
- Piloting a new service model for methadone prescribing and services for drug users.
- Service specifications for family planning and for school health services, out for consultation.
- Development of service specification for development of ophthalmology services at Pindersfield Hospital, and employment of an optometrist in primary care.

The System in Transition.

The New NHS White Paper was viewed as a stimulus for the 'natural next stage of evolution of *Partners in Health*', an extension of the concept of partnership working to trusts and more particularly local government. PCGs were seen as 'one group within a network of health-related organisations'. The future configuration of PCGs was agreed to be based on the five existing geographical localities. Although the groupings were smaller than the requirement of 100,000 population, it was felt that any merging of localities at that stage would damage the relationships and corporate working that had been built across practices. Also the PCGs would be coterminous with social services localities. The five emerging PCGs were expected to operate at level 2 from April 1999. It was anticipated that two PCGs would quickly seek Trust status, with passage of enabling legislation. While new challenges were emerging some HA respondents felt that in Wakefield at least the 'pain barrier' had been breached!

5. Conclusion.

This report summarises the lessons for PCGs, based on the final year of the national TPP evaluation. Although the policy context is now very different, the experience of TPPs has relevance to the early development of PCGs. Particular lessons have been highlighted and illustrated in each section of the report. The key overall messages are:

- The piloting of Total Purchasing has stimulated the development of multi-practice organisations that have the capacity to improve health services in a number of areas. The performance of TPPs has been influenced by their maturity as corporate managed entities. The size of the projects has influenced the pace of their development and the scale of their impact.

- The case study analyses in particular served to demonstrate the importance of many different local contextual factors which enabled TPPs to make progress or which prevented them from doing so.

- The application of Total Purchasing on a district-wide basis developed the capacity of both the HA and general practice for increased devolution of commissioning as well as a platform for the development of primary care services.

- The impact of projects has primarily been at the interface between primary, community and secondary care. Many TPPs have developed and extended services in the primary and community health care setting, but were less successful in influencing the pattern of secondary care.

- Overall, there is little evidence that this GP-led model created the capacity for primary care to operate at a strategic level or to take on a wider public health role.

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