King's Fund

National Evaluation of Total Purchasing Pilot Projects

Total Purchasing And Extended Fundholding Of Mental Health Services

FINAL REPORT

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This working paper forms part of the output of the National Evaluation of Total Purchasing Pilots which is led by the King's Fund.

Published by
King's Fund
11-13 Cavendish Square
London W1M 0AN

ISBN 1 85717 288 4

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

Further copies of this report can be obtained from the King's Fund Bookshop. Tel: 0171 307 2591.

This report has been produced to disseminate research findings and promote good practice in health and social care. It has not been professionally copy-edited or proof-read.

The Total Purchasing National Evaluation Team (TP-NET)

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

Acknowledgements

The authors would like to thank all those who took part in the interviews conducted for this study. The national evaluation of total purchasing pilots is funded by the Department of Health in England and the Scottish Office Department of Health.. The views expressed in this report are those of the researchers involved and not those of the two Health Departments.

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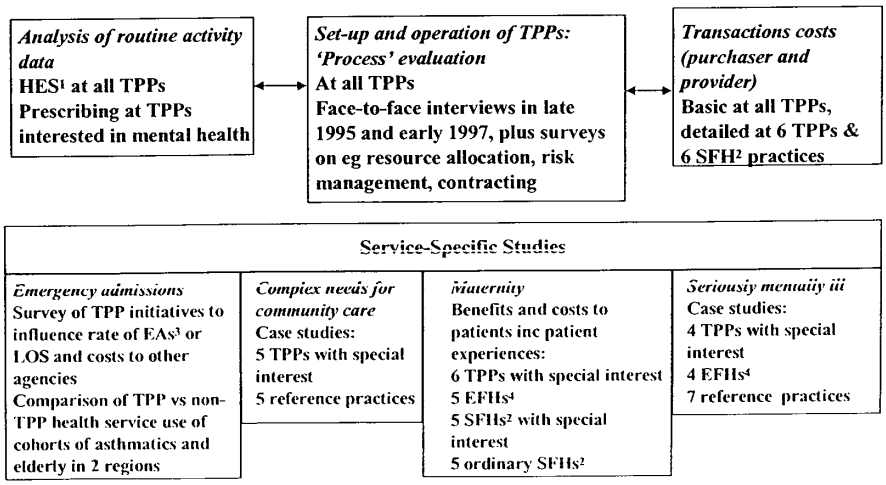
Boxes, Tables and Figures

Preface: The National Evaluation of Total Purchasing Pilot Projects

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

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

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



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

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

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

Nicholas Mays
Co-ordinator, Total Purchasing National Evaluation Team (TP-NET)
King's Fund, London
Date June 1999

Acknowledgments

We would like to thank all those who took part in or were associated with the pilot projects and who gave up their time to help with and be interviewed for this evaluation.

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

Title and Authors	*ISBN*
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Nicholas Mays, Nick Goodwin, Gwyn Bevan, Sally Wyke on behalf of the Total Purchasing National Evaluation Team (1997). *Total purchasing: a profile of the national pilot projects*	1 85717 138 1
Nicholas Mays, Nick Goodwin, Amanda Killoran, Gill Malbon on behalf of the Total Purchasing National Evaluation Team (1998). *Total purchasing: a step towards primary care groups*	1 85717 187 X
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Forthcoming reports from the final year of the national evaluation

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

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?*

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.*

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

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

Forthcoming book from the national evaluation of TPPs

Nicholas Mays, Sally Wyke, Nick Goodwin, Gill Malbon (eds) 1999 *Can General Practitioners purchase health care? The total purchasing experiment in Britain.*

Executive Summary

The project

Between April 1996 and December 1998 the National Primary Care Research and Development Centre carried out an evaluation for the Department of Health of 'Total Purchasing' (TP) and 'Extended Fundholding' (EFH) sites with an interest in mental health services.

The study involved an initial telephone survey of 40 sites (27 TP, 13 EFH). Six sites (3 TP, 3 EFH) were then studied in depth by means of face to face, qualitative interviews with key local stakeholders (including a sample of mental health service users) at two time points. A postal questionnaire was sent to the remaining pilots and responses were received from 25 sites (18 TP, 7 EFH). The overall response rate from the initial 40 sites was, therefore, 31 (78%).

Aims and objectives of the sites

Although the aims of the pilots were extremely diverse, a consistent objective was to improve the communication and information flows between primary and secondary care. A popular means of trying to achieve this was to increase the number of specialist mental health staff working with or in primary care. Systematic needs assessment and the involvement of mental health services users were low priorities for most of the pilot projects. *(see Interim Report for project and Gask et al 1998: King's Fund Working Paper).*

The priority in the sites was the development of services for people with common mental health problems in the community (anxiety and depression first and foremost) while the priority in secondary care, in line with government policy, is increasingly patients with long term and enduring mental health problems. There was a suggestion that these differing priorities might act as a potential barrier to change within mental health care.

Achievements

The most commonly cited outcomes of the pilots were improved relationships with key local stakeholders such as provider Trusts and health authorities. Tensions between the differing agendas of sites and Trusts noted at baseline appeared to have eased with improved communication.

Many of the pilots were successful in developing mental health service provision at a community and primary care level through the attachment of professionals such as CPNs to practices and the establishment of practice based mental health teams.

Joint working and collaboration with other local mental health stakeholders were the most common mechanisms used by pilots to achieve change but holding a budget and the *potential* to change contracts was seen as important for the pilots to be taken seriously by other local parties such as provider Trusts.

In line with the findings of the main TP-NET study, success was linked to the presence of : key individuals leading change,inter-agency cooperation and budget holding.

Problems and barriers to change

Many of the mental health pilots encountered significant problems with the level and quality of financial and activity information available from their local mental health providers.

Purchasing in-patient services for practice populations proved to be difficult, sites frequently suggested that purchasing in-patient services at a practice level was not practical.

Needs assessment continued to be relatively neglected area with nearly half of the sites studied having undertaken little or no needs assessment. This should perhaps be

seen in the context of a lack of needs assessment work being undertaken in general within mental health and limited availability of expertise.

Despite some notable exceptions, improved relationships with social services and mental health services users proved to be more difficult for many of the TP and EFH mental health pilots.

Implications for Primary Care Groups

Lack of adequate financial and activity information and poorly developed and/or incompatible systems will be a major challenge.

In some areas with relatively low deprivation or low in-patient referral there may not be a willingness or it may not be practical for a single PCG to take on responsibility for in-patient services and it may be more appropriately dealt with at a multiple-PCG level. There will, however, be an important balance to be struck between risk and flexibility.

There is probably a period of negotiation and a process of development of a mutual level of understanding of each other's problems and priorities which has to be worked through between PCGs and mental health providers. TP and EFH pilots which have become the focus of leadership for PCG mental health development will have an important role to play here. In areas where there has not been a history of such contact between primary care and mental health providers, however, PCGs may be faced with tensions around conflicting priorities.

The implications of a lack of formal needs assessment is difficult to assess. It does however seem possible, in the present climate within mental health care, that it will be difficult for PCGs to clearly negotiate for resources to address the needs of people with a broader range of mental health problems than those with a diagnosis of psychosis unless they can demonstrate the extent of morbidity, unmet need and current service utilisation more accurately than at present.

More work is needed on how to get the mental health service user viewpoint heard in primary care as PCGs take increasing responsibility for planning, commissioning and provision.

TP and EFH sites have considerable potential in the expertise they can contribute to PCG mental health policy and planning. There is no doubt that innovative developments have led to a potential raising of quality standards across an area. However, where the level of funding for services in the TP or EFH site has been proportionately greater than that available to the PCG practices as a whole, there is a possibility that such innovations may not easily survive or 'roll-out' if equity is to be achieved.

1. Introduction

'Total Purchasing' (TP) was the last development of the general practitioner fundholding scheme which was introduced into the NHS in 1991/92. Under it, a general practice, or group of practices, was delegated a budget by the local health authority (HA) to purchase a range of services which were outside the standard fundholding scheme. Unlike standard fundholding, the final responsibility for the use of resources delegated to practices remained with the HA, and TP was also introduced on a pilot basis. Four 'pioneer sites' established in 1994 were followed by a first wave of national pilot projects which began their first purchasing year in April 1996 (NHSE 1994). A 'second wave' of TP pilots began purchasing in April 1997. A further wave of 'extended fundholding sites' (EFH) with freedom to develop purchasing in selected specialties, also began purchasing in 1997. Although all these pilots ended officially at the end of March 1998, some sites negotiated with their local HA to continue beyond this date.

The 53 'first wave' TPPs (Total Purchasing Pilots) in England and Scotland have been the subject of a multi-centre collaborative evaluation funded by the Department of Health and led by the King's Fund, which has reported its findings (TP-NET, 1997; TP-NET, 1998a). The mean population per TPP was 33,000 (range 12,000-85,000) and the projects covered 1.75 million people, or 3.3% of the population of England and Scotland, ranging between 2% and 20% of their local HA or Health Board population. TPP were present in all regions but predominantly outside the main urban centres. TPPs were smaller than the new Primary Care Groups (PCGs) announced in the White Paper 'The New NHS' (Department of Health, 1997) which will cover populations of about 100,000. PCGs will, however, be able to take responsibility for devolved budgets in much the same way as TPPs. TPPs, therefore, are perhaps the closest model to PCGs which have been subject to extensive evaluation.

This report presents the final results from the sub-study to evaluate the impact of Total Purchasing on mental health care. Based at the National Primary Care Research and Development Centre at the University of Manchester and also funded by the

Department of Health, this study has responsibility for the evaluation of the impact of TP, as well as Extended Fundholding developments, on the provision of mental health care. The definition of a total purchasing site (TP) with a special interest in mental health was that it should have had an expressed interest in its business plan to reconfigure mental health services, or an informally expressed interest matched by an identifiable commissioning initiative. Of the 53 'first wave' TP sites, 27 met this criteria. For practices that were part of the mental health in-patient extension to standard fundholding (EFH), mental health was a priority by virtue of their entry into the scheme. Thirteen such sites joined the national pilot project. While the scope for change was less comprehensive than that within total purchasing sites, the aim was usually be to make significant changes to the nature of the care provided for people with mental health problems.

The aims and objectives of the sites at the start of the pilot projects were reported in our interim report and published as a Kings Fund Working Paper (Gask et al 1998).

2. Methods

The evaluation of Total Purchasing (TP) and Extended Fundholding (EFH) of mental health services has consisted of three main components. As summarised in Figure 1 below, part A of the study, *Strategies and services provided,* used telephone interviews and follow up postal questionnaires. Part B, *Effects on workers and stakeholders in the services* consisted of in-depth examination of six 'special study sites'. Part C, *Effects on mental health service users,* utilised interviews with individual mental health service users. Figure 1 below summarises the overall methodology adopted for the study. More detail about the methods employed in each part of the study is given below.

Part A: Strategies and services provided	**Part B: Effects on workers and stakeholders in the services**	**Part C: Effects on mental health service users**
Initial telephone interviews with representatives from all 27 TPP and 13 EFH sites with follow up postal questionnaires at the end of the pilot projects.	Face to face interviews with workers and key stakeholders and data collection at a sample of six special study sites (3 TPP and 3 EFH) at two time points.	Face to face interviews with a sample of 16 mental health service users registered with the practices at the six special study sites.

Part A: Strategies And Services Provided

Telephone interviews with all 40 pilot projects (27 TP and 13 EFH) with an interest in mental health services were carried out between September 1996 and August 1997 to establish their aims and objectives. The interviews were semi-structured and used a topic guide based on an examination of literature and guidance on mental health service commissioning. Initial contacts with people at the TP and EFH pilot projects (both telephone and face to face at a conference for the EFH pilots arranged by the NHS Management Executive in Leeds in 1996) were also used by the research team to inform the construction of the telephone interview guides. The main findings from these initial interviews have previously been reported elsewhere (Gask *et al.*, 1998; Lee and Gask, 1998).

In 1998 the pilots were followed up by postal questionnaire (see appendix 1) between January and December 1998 to establish their progress on the objectives outlined in the initial telephone interviews. Follow up questionnaires were sent to the sites approximately 12 months after the initial telephone interview. Respondents were asked about the following areas:

Budget setting
Progress on aims and objectives outlined telephone interviews
Contracting
Relationships with other key local stakeholders
Overall impressions of their pilot project's achievements

Of the 34 questionnaires sent out 25 were eventually returned, giving a response rate of 74%. Follow up phone calls by members of the research team accounted for a significant number of these returns but it has not been possible to obtain responses from the remaining sites. With the face to face interviews carried out at the six special study sites (which are discussed below), the overall follow up rate to the initial 40 sites was 78% (31/40).

Part B: Effects On Workers And Stakeholders In The Services

In the second part of the evaluation, six of these projects (3 TP and 3 EFH) were chosen to be, what we have called, 'special study sites' for more detailed study. Face to face, semi-structured, qualitative interviews were carried out in 1997 with representatives from the practices involved in the projects, the local provider trusts, health authorities, social services departments, as well as local voluntary sector and mental health user groups. Repeat interviews were then undertaken in 1998.

Preliminary information gained from the initial contact made with all 40 of the mental health pilots was used to chose the sample of six special study sites for more detailed investigation. These were chosen on the basis of willingness to participate and a combination of the five following criteria: innovation, 'representativeness', availability, local evaluation, and geography.

In terms of *innovation* whether a total purchaser or extended fundholder was attempting to introduce innovative or radical changes was a factor in special study site selection. By *'representativeness'* we mean their aims were broadly representative of many of the pilots being studied in the evaluation as a whole. For example, Site D, outlined below, included the attachment of CPNs to practices and this was an aim of a significant number of pilots. *Availability* relates to the decision to avoid approaching sites already working with other parts of the national total purchasing evaluation tracer studies (maternity and community care) so as not to overburden them. In the case of extended fundholders, it was also thought advisable to avoid sites where extensive plans already existed for *local evaluation* by other universities and organisations. Finally in terms of *geography*, factors such as whether the site is in the north or south, metropolitan or rural, were seen as relevant for examining total purchasing and extended fundholding in a variety of contexts and situations. We deliberately attempted to select a group of sites that would be geographically diverse.

The available resources enabled us to study no more than six sites in total. This part of the study is mainly descriptive. Since a deliberate decision has been made to study a small number of sites in greater depth this part of the study had insufficient power to detect quantitative differences in patterns of referral and service use.

An outline of each of the sites chosen is given below. Brief details only are given as it was part of our agreement with the sites that they would remain anonymous.

Site A

This TPP consisted of five fundholding practices. Two of the practices are located in relatively deprived areas. Two of the other practices have quite affluent practice populations but with a large proportion of elderly residents. The final practice has a more mixed population covering both deprived and affluent areas. It also has a number of refugees from Bosnia, Croatia and various parts of Africa on its practice list and a large number of ex-long stay psychiatric patients who have been discharged from a large mental hospital nearby. The main mental health focus of the TPP was

piloting various levels of community psychiatric nurse (CPN) attachment to each practice.

Site B

The four practices that formed this TPP serve populations with relatively low levels of deprivation but a with high number of elderly residents. The rural areas covered by the pilot also include a number of villages with the potential for social isolation. There are two main areas within mental health that the TPP aimed to address. The first was a detailed assessment of mental health need and service provision in the area with a particular emphasis on gaining user views and encouraging greater user involvement. Secondly, the pilot had been developing a primary mental health team to work with the practices. At the outset it was intended that this would consist of a team leader, four CPNs, counsellors/psychotherapists and a psychiatrist.

Site C

Site C consisted of three practices on the outskirts of a city. One of their main aims was to work with their community trust to develop local mental health services at a nearby resource centre. Services were to include outpatient and day services. It was also hoped that a 24-hour crisis service could be provided with 14 beds for short or overnight stays. It was intended that the facilities should not only be available for the three practices in the TPP but also the other practices in the locality.

Site D

There were two practices in this mental health EFH pilot. One is in a middle class, suburban area and the other in a more deprived urban location. The main aim of the project was to facilitate increased communication and closer joint working between the practices and the specialist mental health services. The principal means of achieving this was to be the attachment of two named CPNs (one to each practice) from the provider trust's continuing care team for people with severe and enduring mental health problems.

Site E

This was a single practice project based in a town but also with patients in more isolated rural areas. The project aimed to develop a practice mental health database. A practice based mental health team had also been established which initially consisted of a project manager, two CPNs, a care assistant, an administrator and a part-time software and statistics consultant.

Site F

This project included all but one of the practices in a commuter town. In total there were seven practices involved. One was an experienced first wave fundholder and the rest were sixth wave fundholders (April 1996) and part of a multi-fund. The pilot held a two-day workshop to explore the mental health needs of its population. This involved primary care professionals, personnel from the health authority, trust and social services as well as representatives from voluntary, user groups and housing agencies. The following six priority areas were identified: less severe mental illness; severe mental illness; elderly mentally ill; substance misuse; managing crises; and young children and adolescents.

Table 2.1 below outlines some basic characteristics of the special study sites.

Table 2.1: Basic characteristics of Special Study Sites

Site	No. of practices	Pilot population	Fundholding wave					
			1	*2*	*3*	*4*	*5*	*6*
A	5	58,000	2	1	2			
B	4	45,000	1		2			1
C	3	30,000	3					
D	2	30,000	2					
E	1	13,000	1					
F	7	49,000	1					6

The special study site evaluation was an example of case study research (Yin, 1989) which involves using single or multiple examples of an area, setting or organisation to examine a particular set of questions, issues or policies. Some documentary evidence was collected such as purchasing plans, project reports and business plans but the principal data source within these case studies was face to face, semi-structured, qualitative interviews with a wide range of individuals. No central 'blueprint' was established for TP (TP-NET, 1997) or EFH at the outset of the pilot projects. This resulted in considerable diversity within the projects. The qualitative approach to data collection adopted in this study gave the researchers flexibility in studying the variety of areas which the sites had chosen to focus on within mental health.

The respondents for this section of the study were representatives from:
Primary care
Community mental health teams
Provider trusts
Health authorities
Local authorities
Mental health voluntary groups
Mental health user and carer groups
Interviewees were identified by a 'key informant' (Gilchrist, 1992) at each of the special study sites. This key informant was usually the project manager but, for example, in the case of Site D which did not have a project manager, the health authority lead on the pilot project was able to identify potential participants. Respondents indicated by 'key informants' were also, in turn, able to aid the field researcher in identifying local mental health stakeholders or individuals with a key role in the pilot project. Forty-eight initial interviews for this section of the study were carried out between March and September 1997. Forty-five follow up interviews to ascertain the changes or progress associated with the special study sites were undertaken between March and October 1998. Greater detail about who was interviewed at the special study sites is given in appendix 2. Each interview lasted about an hour and the broad topics covered were:

The current state of local mental health services

Needs assessment
Aims and objectives and progress in developing mental health services
Local progress with implementing the Care Programme Approach
Relationships between key local mental health stakeholders; practices, providers, health authorities, local authorities, the voluntary sector, user and carer groups

Content analysis was used, on the tape-recorded interview data, to delineate both common themes and differences in the accounts provided by respondents.

Part C: Effects On Mental Health Service Users

The third part of the evaluation involved tape recorded, face to face, qualitative semi-structured interviews with a sample of mental health service users registered with the practices at the special study sites. Again these were interviewed at two time points first between September 1997 and February 1998, and then between September and December 1998.

A sample of 16 people was selected to examine what effects the initiatives introduced under TP and EFH may have had at the level of individual mental health service users. The user interviewees were recruited by a number of the individuals interviewed in Part B of the evaluation at the special study sites. These included GPs, community psychiatric nurses from both community and practice based mental health teams and people involved with voluntary and users groups. The main criteria for selection in this part of the evaluation were willingness to participate in the study and long term service use to allow the research to draw on users' experience of contact with a wide range of mental health services. The interview guide in this part of the study covered the following broad areas:

Contact with mental health services
Views about:
- Primary care
- Mental health services
- New services.
- Links between different professionals

Care Programme Approach

User involvement

3. Findings

Instead of presenting the results from each part of the study separately we will present data from all parts of the evaluation in relation to the following six key themes:

Needs assessment
'Mental illness' registers
Budget setting
Contracting
Changes in service provision
Relationships with key stakeholders

These were issues that were both established by the researchers as important at the outset of the research or emerged as common or significant themes in the interviews with participants.

3.1 Needs assessment

Guidance and advice on primary care led commissioning of mental health services has emphasised the importance of needs assessment (Thornicroft and Strathdee, 1996; Cohen, 1998). The evaluation, therefore, sought to establish the extent to which the projects studied had undertaken any formal needs assessment process to inform their purchasing initiatives. In our interim report (Gask *et al.*, 1998) we noted that just under half of the 40 sites studied had undertaken no 'formal' or specific needs assessment projects to inform the changes they attempting to introduce. The findings from the special study sites revealed a similar pattern. Three of the six special study sites had made needs assessment a high priority within their projects, where as with the other three it was not necessarily seen as of central importance.

Sites B and F adopted similar approaches in that they both undertook needs assessments based on quantitative data which was then used to inform multi-agency events which discussed needs in their areas more qualitatively.

Site B had appointed a health needs assessment (HNA) officer with money from its total purchasing management allowance. The officer examined the available quantitative information such as mortality ratios for suicide in the area or practice information such as prescribing data as an indicator of the level of depression in the local community. The HNA officer also spoke to individuals involved with local psychiatric services such the provider trust or mental health service users in order to get their views of local provision.

At an 'away day' representatives from primary care, secondary care, the health authority and social services met together to discuss mental health in their area, using the information collected by the HNA officer as a starting point. Amongst the themes to emerge was the lack of community mental health services in the area. A key focus for the project was therefore to improve community based provision. This eventually led to establishment of a mental health team attached to the practices, which will be discussed further in later sections of this paper. Reflecting on the importance of the away day in the subsequent development of the team:

> *'Bringing them together was useful . . . It showed we were serious, bringing people in from the beginning. It gave it some momentum that carried it through. So in some respects it did forge relationships'* (HNA Officer, Site B).

In the case of **Site F**, the project manager collected both quantitative information on existing service use and epidemiological indicators which were discussed a two day workshop facilitated by the King's Fund and based on the Community Orientated Primary Care (COPC) approach to needs assessment. The event again involved individuals from practices, the trust, the health authority, social services, housing agencies and representatives from local user and carer groups. The following six priority areas were identified: less severe mental illness; severe mental illness; elderly mentally ill; substance misuse; managing crises; and young children and adolescents. These became the focus for subsequent work within the pilot. Some of the specific initiatives that the project undertook are outlined in more detail later. As well as establishing the priorities for the project, many of the interviewees at Site F felt that

this event had also been useful for establishing and building relationships between key local stakeholders in mental health services.

The approach to needs assessment adopted at **Site E** (see Box 1) was focused at the level of individual patients. They established their own computer based needs assessment database in order to try and delineate the extent of mental health care need, not just for those with severe or enduring mental illness. The database has four main information areas; *registration, assessment, intervention,* and *care plan.* The reporting facility within the database means that it can then be used, amongst other things, to 'identify patients on the practice list with mental health problems with or without secondary care involvement' or as a means of 'monitoring the practice's use of mental health resources against agreed provider contracts' (Site E project report, June 1996). Utilising this system, the practice aimed to adopt an approach to needs assessment which was akin to that of care or case management.

The fact that the practice was developing its own information system did mean that there was an issue for the local trust about compatibility with their system. The individual assessments are carried out by the CPNs who are part of the primary mental health team set up by the pilot. The CPNs were employed by the local provider trust and the pilot contracted for them on a whole time equivalent (WTE) basis. As trust employees, the providers wanted the CPNs' contacts with patients recorded onto its own system. The trust felt it was unable to directly access that information from the practice database and so the compromise reached was that the CPNs would fill out diary sheets. This would record the patient contact information the trust wanted which could then be transferred onto their mainframe computer system. This meant, however, that the CPNs felt they were having to provide two sets of information - one for the practice database and another for the trust system. Of the two, they felt the information for the practice was more useful as the assessment data could be used a tool for monitoring individual users' well being or progress. The trust information on the other hand was more concerned with levels of activity for contracting purposes. This placed an extra administrative burden on them which they perceived as having little direct benefit for patient care.

Box 1: Information areas on Site E's computerised needs assessment database

Registration and screening - Patients are registered on the database and screened using Audit Commission criteria (A, B, C1 and C2) which determines an initial level of need based on diagnosis, previous use of hospital resources and mental health act status.

Assessment - The screening criteria indicates the level of assessment needed:

Categories A, B, C1 - Level 1 (high need) - 36 dimensions of mental health need rated on a five point scale of significance.

Category C2 - Level 2 (low need) - Short assessment (20 mins. approximately) providing advice and referral/linking facility to appropriate service.

Intervention - Clinician selects appropriate treatment option/visit frequency/duration from treatment/interventions list. Each option in the treatment/intervention list has the appropriate costing associated with it.

Care plan - Sets out the treatment activity and services expected. Actual activity and unexpected changes in treatment options/style, such as increased visit frequency, are recorded separately and reported routinely so that costings are as accurate as possible.

From Site E project report, June 1996.

The other three special study sites had not undertaken any formal needs assessment process or exercise. A comment by one of the GPs interviewed typifies the approach adopted by these sites:

> *'As far as I'm aware we just decided that there were certain aspects of care what we wanted to improve'* (GP, Site A).

3.2 'Mental illness' registers

Further analysis of the initial telephone interviews and the follow up questionnaires revealed the importance attached by many of the sites to 'mental illness' registers as a form of needs assessment. Through examination of both practice based records and secondary care information systems, pilots were able to set up a register of those patients from their practice lists with mental health problems. Of the 25 pilots who returned questionnaires, 15 had set up registers. From the initial telephone interviews we know that five of the non-respondents had set up registers and we are also aware that three of the special study sites had done so. So 23 of the 40 sites (57%) had established registers as part of their pilots. With many of the practices having computerised information systems they were able to establish the prevalence of particular diagnoses and levels of service use such as in-patient admissions or out-patient referral. However it has been argued that this kind of information would not necessarily give information about users 'needs' (Smith, 1998). A record of an in-patient admission, for example, would not necessarily indicate whether that person had needed to go into hospital or instead had needed respite from a difficult family situation or help with finding more suitable accommodation.

The registers did, however, also have a monitoring function which was seen as useful in several ways. Firstly, through comparison of practice information with Trust held records, the register was used to identify those who were in contact with primary care but may have lost or never had contact with secondary care. Where these people were actually in need of specialist input the registers were a useful means of highlighting this. Some of the pilots had also instigated annual reviews of those on the register which could act as an ongoing means of ensuring that people were getting the services and treatment they needed.

3.3 Budget setting

The issues of budget setting, and contracting, examined in the next section of the report, are closely linked. The agreement of a budget for the pilot between the practices, the Trust and the health authority was the first stage in the contracting process. Budget setting did not appear to have been particularly problematic for the

special study sites. A number of mental health sites overall, however, had experienced problems with setting budgets for their pilots. This became apparent both within the initial telephone interviews with all sites and the researchers' contact with some of the projects at a conference on mental health purchasing organised by NHS Executive in March 1997. The follow up questionnaires, therefore, specifically included a section on budget setting and Table 3.1 below summarises some of the findings on this issue.

Table 3.1: Budget setting amongst the follow up questionnaire respondents

		Total	TP	EFH
Was a budget set for mental health?*	Yes	20	16	4
	No	4	2	2
Where there any problems with budget setting? +	Yes	12	8	4
	No	11	10	1
Basis of the budget	Historic activity	9	7	2
	Capitation formula	3	3	0
	Mix of the above	7	6	1
Was holding a budget useful in mental health?	Yes	17	13	4
	No	4	3	1

* n=24 (18 TP, 6 EFH) - one of the respondents did not answer this question.
+ n=23 (18 TP, 5 EFH) - two of the respondents did not answer this question.

Four of the sites that responded to the questionnaire had not been able to set a budget for mental health within their pilot. Three of these gave further comments which gave some indication of the problems they had encountered:

> '*Major problems of identifying locality specific costs.*' (Project Manager, Site 2).
> '*Unable to disaggregate mental health contracts therefore not set (process of identifying expenditure had commenced before pilot).*' (GP, Site 10)

'Health authority not able to set a budget. Their figures for total spend (in-patients, day care, out-patients and community) was less than the fundholding spend on community - problem never resolved.' (Practice Manager, Site 16)

Just over half of the questionnaire respondents had reported problems with setting a budget. Eight of these were able to eventually establish a budget for their pilot but their comments suggest that, in common with those unable to set a budget, the problems centered around costs, prices and information on activity levels. On the issue of prices one respondent commented:

'Agreeing a budget was very difficult as the main provider and local health authority had difficulties coming up with prices. There seemed to be no precedent for this type of budget setting.' (Project Manger, Site 14)

Sites also identified problems with information on activity levels within mental health services:

'Information on activity very poor or not available, therefore had to set budget as percentage of Health Board . . . contract.' (GP, Site 7)

'Lack of Trust information. Nil in some areas!' (Project Manager, Site 4)

In a subsequent question, sites were asked whether holding a budget had been useful. Both Sites 4 and 7 felt that it had been, since the discussions around budget setting had led to improvements in the information available on activity levels. So although a lack of activity information had been a problem in setting a budget, they felt that improvements had subsequently been made once the problem had been identified.

Overall most sites felt that holding a budget for mental health services had been useful. Some sites gave fairly general reasons for this, such as *'more influence with the provider' (Project Manager, Site 1)* or *'more control' (GP, Site 11).* A perhaps more specific benefit of holding a budget cited by respondents, however, was

increased knowledge and information about resources in terms of what money was available and where it was being spent. For example three sites commented as follows:

'Identified where funds were being spent. Allowed V.F.M. analysis.' (GP, Site 8)

'Quantified finance available.' (GP, Site 13)

'Focused attention on accuracy of patient data and cost implications.' (Practice Manager, (Site 19)

Other sites felt they had used this increased knowledge and information to then go on to make changes and improvements in mental health services:

'Quantified size of resource and for a variety of reasons we have been able to reduce our in-patient mental health contract and reinvest the monies.' (Project Manager, Site 12)

'It enabled us to run a project to change the care of mental health in the community in a more original form.' (GP, Site 15)

'It enabled resources to be placed in the most effective manner. Reducing inpatient stays and better managed care.' (Project Manager, Site 17)

'We were able to make a saving and re-invest the savings into other mental health services.' (Practice Manager, Site 25)

For another site having a budget for mental health had allowed them to switch to another provider:

'It provided the much needed leverage to change to a provider who could supply a comprehensive and high quality service.' (Project Manager, Site 9)

Even one of the sites who had not been able to set a budget felt there had been at least some value in the process, commenting that:

> *'The process of trying to calculate a budget was useful in building bridges with those involved in mental health but did the lack of success indicate lack of health authority real interest in project?'* (Practice Manager, Site 16)

Of the minority of respondents who felt that holding a budget had not been useful, only one stated why they had not found it useful, commenting that:

> *'The budget was only indicative but it soon became clear that one in-patient in the high cost unit for an extended period could quickly take us over budget.'* (Practice Manager, Site 20)

3.4 Contracting

Implicit within total purchasing was the assumption that pilots would take advantage of the freedom the scheme offered them to contract independently for services that were previously outside the remit of standard fundholding (Robinson *et al.*, 1998). Within the mental health extended fundholding pilot the assumption was more explicit. The scheme was sometimes referred to as an 'in-patient pilot', with the specific remit of exploring the potential benefits or otherwise of practice based purchasing of in-patient mental health services (Department of Health, 1996).

In the case of the special study sites in this evaluation contracting does not always seem to have been of central importance to most of the projects themselves, whether they be total purchasing or extended fundholding pilots. In **Site D**, in particular, contracting did not seem to be that significant:

> *'We've not got into contracting in detail. The contracting side of things for GPs hasn't made much of a difference on a day to day basis'* (GP, Site D).
> *'In terms of how they contract for in-patient services, I haven't noticed any changes in terms of intentions'* (Trust Rep., Site D).

For **Site F** it also seemed that contracting was not that important:

> *'The money side has never been sorted out. The trust never agreed the pilot's slice and the health authority never let go. So in that term that's not been successful. But actually I found it largely irrelevant. We may not be contracting in it's technical sense really but we've been doing all the things contracting's meant to achieve. So we've been doing it without having to have the pound notes.* '(Project Manager, Site F).

Other sites wanted to change the form of some of the contracts they used:

> *'We haven't changed the contracts for acute (mental health) services. What we said at the start of the year is that we'd like to go on a cost per bed day or cost per case basis but we were told there wasn't really the activity data there to support that'* (Project Manager, Site C).

In general, **Site C** felt that the community trust, which provided the mental health services in their area, had not provided them with sufficient activity data. Without knowing how much resources were used by their patients the project could not determine if it was either under or overspending on its budget:

> *'We are funded on about 6% of the population budget and we pay back to the community trust precisely that . . . It could be we are getting 6% of the budget and using 20% of the service, in which case we have to pay more. But rather than saving any money on the project, altogether we've just had to put the money where it belongs and where it doesn't'* (Project Manager, Site C).

Site A had managed to alter the form of its contracts for mental health:

> *'The health authority contract on the basis of FCEs (Finished Consultant Episodes but the TP contract by OBDs (Occupied Bed Days) - only paying while somebody is in. We're trying to encourage the providers to discharge when*

appropriate and have the arrangements in the community for the discharge and we try to make sure they are only in hospital when they need to be. It wasn't a problem getting it changed because although the health authority contracted on the basis of FCEs, the trust monitored OBDs alongside that. So it wasn't a problem to convert it' (Project Manager, Site A).

In the initial round of interviews **Site B** had stated that it had hoped to develop more 'flexibility' within its contracts for mental health by moving beyond block contracts. The following quote from one of the follow up interviews shows, however, that they drew back from this. It was felt that an insistence on this could jeopardise good working relationships between the practices and the trust:

'We went back to block contracting in some areas. We've gone back to block contracts in psychology. It seemed to be creating a degree of angst . . . and in terms of developing relationships with the psychologists, the advice from our (mental health) team leader was to block and facilitate a better relationship' (GP, Site B).

Only **Site E** appeared to make any significant changes in contracting. It was felt that existing local day care provision both for elderly people and adults (16-65) with mental health problems was not suitable for most users and that the local day centre provided by secondary care did not have the flexibility to cater for every individual's needs. For elderly people with mental health problems the pilot moved the contract to an independent sector provider which ran 17 homes and contracted with them to provide a day facility in one of those homes. In terms of adult day care the pilot developed links with a local adult guidance service provided by the local authority. This service was able to offer individuals from the practice help with accessing college courses or voluntary work and had the added advantage of being free to the pilot since it was an existing service already funded by the local authority. This pilot also had a 'spot' purchasing budget of £15,000 a year which was used to provide practical support eg. To provide overalls and Wellington boots for someone to take up a training placement at a local zoo. Money has also been provided so that someone with long-term depression can visit her family.

Overall contracting, though, does not appear to have been used extensively by the special study sites as a lever for change. The sites, on the whole, seemed to be using collaboration and joint working, primarily with provider trusts, as the means of trying to develop mental health services in their areas.

In the follow up questionnaires, respondents were asked about their experience of contracting for mental health services within their pilots. The results from this section of the questionnaire are summarised in Table 3.2 below.

As shown in Table 3.2, most of the respondents to this question felt that contracting had been a useful part of their pilots. Respondents were also asked to comment on why they felt contracting had been either useful or not useful.

Table 3.2 Contracting for mental health services amongst the follow up questionnaire respondents

		Total	TP	EFH
Was contracting useful for achieving change in mental health?*	Yes	14	12	2
	No	9	5	4
Contract types used in mental health? + *(some sites had more than one type of contract)*	Block	18	15	3
	Cost and volume	4	3	1
	Cost per case	5	3	2
	Others	4	1	3
Quality indicators in mental health contracts +		13	9	4
Outcome indicators in mental health contracts +		2	2	0

* n=23 (17 TP, 6 EFH) - two of the respondents did not answer this question.

+ n= 22 (16 TP, 6 EFH) - three of the respondents did not answer these questions.

As with the issue of budgets, there were those who provided brief comments such as *'allowed GPs to address issues face to face with mental health professionals'* (Project Manager, Site 5), *'able to apply leverage'*(GP, Site 11), *'specified how and what we wanted'(GP, Site 13)* and *'allowed detailed input by GPs'* (Project Manager, Site 18).

Of the more detailed comments there were some that linked the contracting process directly to achieving changes. Below two respondents linked contracting to improvements in information provision and the establishment of a new mental health team respectively:

> *'Enabled exchange of ideas around provision of better information relating to patient care - and practices being informed of patient care. Historically information is very poor regarding inpatient/continuing care mental health - we now obtain monthly information.'* (GP, Site 7)

> *'The process facilitated a change where Primary Care became involved in planning. It has also been the catalyst whereby a new Team (additional support/out of hours) will be in place in the next month providing additional services to our patient population.'* (Project Manager, Site 14)

The comments of two other sites suggested that whilst the mechanism of contracts may have not been used to produce specific outcomes, the discussions around contracts had been useful for increasing the level of understanding between the parties involved:

> *'Despite apparent lack of progress, there has been a greater understanding achieved on both sides which should help the TPP GPs in deciding on future needs of the PCG.'* (GP, Site 10)

> *'Felt useful but in the end made little change - however became more sympathetic to Trust's difficulties.'* (GP, Site 3)

Of the nine pilots who felt that contracting had not been useful, only five provided further comments. One gave the reason that they were *'excluded from it'* (Practice Manager, Site 16) which referred to that fact that a budget had not been set for this pilot and so they were unable to establish any contracts of their own.

The other four commented as follows:

'Contract currencies are irrelevant. Contract type is unhelpful. And with the lack of clarity on costs we felt unable to move forward.'(Project Manager, Site 2)

'The lack of penalty and /or incentive clauses means the use of the contracting process to facilitate change is extremely difficult. The process is confirmation of an intention to seek change rather than a method of initiating change.'(GP, Site 8)

'The real change was achieved through service development and close working with the trusts. The block contract was incidental and amounted to a paper exercise.'(Project Manager, Site 9)

'We were a small fish in a big pond and it was not possible to use the project to influence change.' (Practice Manager, Site 25)

In terms of the actual nature of the contracts used by the questionnaire respondents, Table 3.2 above outlines the contract types used. This are not mutually exclusive since a pilot may have been using more than one contract type. Although within the initial telephone interviews sites had often stated they wanted to move beyond block contracts, Table 3.2 shows it remained the most frequently used contract type. The example of Site 8 below outlines some of the barriers it felt had prevented a move away from a block contract for community mental health services.

Site 8 Aim: To move away from a block contract for community mental health services.

Progress: 'None'

Aids: 'None'

Barriers: 'Inaccurate pricing structure. Unwillingness by provider to consider any alternative contract as it would have reduced their income. Risk of CPC (cost per case) contract too high for provider.'

Half of the questionnaire respondents had included quality indicators in their contracts. Sites had included stipulations in their contracts about things such as; accessibility to services, waiting time between referral and people being seen by a mental health professional, and communication such as the provision of care plan information or reports on long stay patients. Outcome indicators were only included in contracts by two sites. In one case this was readmission rates and the other site gave no details.

3.5 Changes in service provision and usage

3.5.1 Developing primary care based and attached mental health services

A common theme amongst the special study sites was that they wanted to address the issue of the provision of community mental health services in their area. Although a shift from hospital based services to more community orientated provision (i.e. community mental health teams based outside the hospital) may be a common objective within mental health services generally the significant difference with these pilot sites was that they also wanted community provision to be more closely aligned with primary care. This means either based at the practice or formally linked to it in some way.

As part of their pilots, **Sites A and D** attached CPNs to each of the practices in the pilot. In both cases it was felt, by both practice staff and those in the provider trusts that the CPNs were acting as a link or liaison between primary and secondary care. They were able to give GPs and the rest of the primary health care team information and feedback about patients from their practice who were being seen by secondary care services. The CPNs were also able to advise those in primary care about the care of people with mental health problems. Many of the GPs involved in the pilots felt that having the attached CPNs had given them more confidence in dealing with mental health issues within primary care. They felt that they could easily get advice or reassurance from the CPNs about any treatment decisions they had made or were going to make. The CPNs in **Site D** had also set up training sessions with the reception staff at each of the practices to discuss mental health issues. This had

helped to increase receptionists' confidence when dealing with people who were distressed when they came into the surgery.

The approach to CPN attachment differed slightly in **Sites A and D**. In the case of **Site D**, the focus was explicitly on people with severe mental health problems because the two CPNs (one attached to each practice) were from the trust's continuing care team. The attached CPNs had identified people on the practice lists with enduring mental health problems through reference to both trust and practice information systems. They then became the keyworker for all those patients, in some cases taking over this role from other members of the continuing care team.

The five practices involved in the pilot project at **Site A** each had an attached CPN from the trust's community mental health team. The level of each CPN attachment varied according to the needs of each practice. So in terms of whole time equivalents (WTEs) one practice shared their CPN with another practice and thus contracted for a 0.5 WTE of a CPN whilst the CPN working with another practice was dedicated to that practice and therefore a full WTE. As with Site D the attached CPNs had acted as a link between secondary and primary care. Their ability to advise GPs and the PHCT on mental health problems was also seen as invaluable by the practices. The pilot has commissioned an external evaluation of the practice attached CPNs which is still ongoing. This will compare the different models of CPN attachment at Site A in terms of issues such as their impact on referrals to other professionals or the impact on service users.

Both **Sites B and E** had gone beyond attached CPNs to set up primary mental health care teams (PMHTs). In the case of **Site B**, this consisted of a team leader, four full whole time equivalent CPNs and 1.5 WTE social workers. Counsellors (both those which were already employed by three of the practices under standard fundholding and 15 hours of extra counselling provided under the mental health pilot) were also seen as an integral part of the PMHT. Again the team was felt to have developed close liaison with those in primary care. The PMHT had also focused particularly on training around mental health issues for those in primary care via a newsletter and

training sessions on sexual abuse, anxiety, depression, mental health versus illness and prescribing in depression.

The PMHT in **Site E** initially consisted of a project manager, an administrator, two full time CPNs, a health care assistant and a part-time statistics and software consultant to work on the needs assessment database described earlier. Later on in the pilot, another CPN was added along with a mental health social care worker. Three sessional counsellors are also part of the team. The mental health social care worker will be discussed later in this paper. Some reservation was expressed by trust representatives that the practice could become too self sufficient and therefore detached from the other mental health services in the area. Overall, though, the team was seen as a 'Rolls Royce' service in which the team members were committed to trying to find innovative and creative solutions to the problems faced by people with mental health problems.

The mental health service users interviewed at the special study sites with primary mental health teams and attached CPNs were very supportive of these initiatives. Nine of the sixteen interviewed were in contact with members of PMHTs and a further two were being seen by CPNs attached to the pilot practices. In the case of the PMHTs, the users felt that the establishment of these teams had improved the provision of mental health services in their area in that there was now more support available to them in the community. The two in contact with practice attached CPNs also endorsed this development. In particular, they liked the convenience of being able to see the CPN at their practice. One of these also felt that when she had gone through a period of crisis the fact that the CPN attached to her practice had helped her to be admitted to hospital quicker than had been her experience in the past. With the small numbers involved clearly such experiences do not represent a definitive statement on users' views on these developments. They do, however, give some indication that the developments were viewed positively by mental health service users.

As part of their pilot, one of the questionnaire respondents had also set up a PMHT. This site was on the border of two health authority areas and two provider catchment areas. They hoped that setting up their own practice based team would allow them to manager the assessment and referral of patients at a primary care level rather than the situation, described in the initial telephone interview, where people *'just get winged off into the (secondary care) mental health team and goodness knows what happens to them'* (Project Manager, Site 9). Below is the response given by the project manager in the follow up questionnaire to a question about the progress had been able to achieve with the PMHT.

Site 9 aim: The development of a mental health team based in primary care.

Progress: 'This has been achieved and we have a mental health co-ordinator in post and consultant care within a primary care setting (e.g. outpatient clinics in the health centre).

Aids: 'Trust eventually supported development but progress initially slow. Very supportive clinical director who eventually pushed through the model.'

Barriers: 'One HA fairly against the model and blocked change of trusts.'

There were others amongst the questionnaire respondents who had sought to get CPNs attached to the practices in their pilots. Sites 2 and 8 were able to achieve this had through 'close working with the HA and Trust' (Project Manager, Site 2) and Site 6, had also wanted attached CPNs but, as is outlined below, had only managed to get a named link worker rather someone who was working directly with the practices.

Site 6 aim: Mental health staff attached to the practices.

Progress: 'CPN link person.'

Aids: 'Communications'

Barriers: 'Insufficient staff to attach to surgeries.'

In the initial telephone interviews, Site 1 reported that it had been able to psychologist attached to the four practices in its pilot. Site 12, stated that it aimed to increase the number of psychology sessions at a practice level and, as outlined below, it was able to achieve this.

Site 12 aim: To increase the number of psychology sessions at practice level.

Progress: 'We have made additional psychology sessions available - one whole time equivalent, with half of her time being allocated to deal with the elderly.'

Aids: 'Having money to invest in additional psychology.'

Barriers: 'Small numbers of patients do not make practice specific clinics a good use of resources.'

3.5.2 Reducing in-patient admissions

An important rationale for the pilots in instigating attached CPNs and PMHTs was that they may be able reduce the use of expensive in-patient services. It was envisaged that they would do this in two ways. Firstly, they would prevent admissions through CPNs and PMHT members increased monitoring and support of those people in the community who may be liable to experience crises and need to be admitted to hospital. Secondly, the length of each in-patient stay would be reduced by closer liaison between ward staff and the CPNs and PMHT members to ensure that patients were not staying in hospital any longer that was absolutely necessary.
We collected quantitative data on admission rates but augmented this with qualitative data because, even it we had used all sites, the power to show changes would have been limited.

Some of the special study sites formed their own impressions about the extent to which there has been any changes in in-patient usage as a result of their pilots.

Sites A and E felt there had been substantial changes in their in-patient usage. At **Site A** the number of occupied bed days (OBDs) for adult (under 65 years of age) in-patient mental health was 4,638 in the preparatory year of 1995/6. During the two 'live' purchasing years the figure had dropped to 3,350 and 2669 in 96/97 and 97/98 respectively. The financial savings from the reduced in-patient activity were not, though, returned to the pilot. Due to the trust generally being in financial difficulties the money was retain by the provider. At the time of writing precise figures were not available for in-patient activity at **Site E**. Representatives from the practice in the pilot estimated, however, that from about 1,400 OBDs in both 95/96 and 96/97, the figure for 97/98 would be about 450. Part of this reduction was accounted for by one patient who moved to another practice and who it was estimated would have used about 350 ODBs during the year. So that the provider was not faced with a sudden drop in revenue, it had been agreed that the contract between the pilot and the trust would have a 'floor' or guaranteed minimum level of 800 OBDs. In other words the trust would receive the money for 800 OBDs from the pilot in the live year of 97/98 whether the pilot had used them or not. At **Site D** the practices felt that there would not be any significant changes in their in-patient activity levels. They did feel, though, that there were less instances of 'inappropriate' hospital admissions because of the closer monitoring, increased support and earlier intervention by the attached CPNs.

The trust representatives from both Sites A and E, as well as those from other special study sites, had urged caution in the interpretation of any changes in in-patient activity. They had argued that in-patient activity often varied considerably from year to year. Any reductions, therefore, could not necessarily be attributed to the mental health pilots and may just represent natural fluctuations. Admissions and length of stays, it was contended, were both difficult to predict and account for. It was felt that a long hospital stay by one patient could have a dramatic effect on the in-patient activity figures in any one year.

In the initial telephone interviews other sites had stated that they hoped to be able to reduce in-patient admissions. Amongst the questionnaire respondents, as indicated below Site 17 felt that there had been a reduction in admissions.

Site 17 aim: Reduction of in-patient usage and ECRs (extra contractual referrals).

Progress: 'Considerable reduction in ECRs and in-patients was achieved.'

Aids: 'Managed care through additional CPNs made an overall saving and better care for the patients.'

Barriers: 'Mental health Trust lost income from in-patients - was seen as a cost not a saving. Health Authority could not see the savings as real money but merely reduced costs.'

Site 20 felt that it had been successful in making admissions more appropriate through *'critical event monitoring meetings with consultant, GP and mental health workers'* (Practice Manager, Site 20). It was also felt, however, that the local out of hours GP co-op could act as a barrier to improving the appropriateness of admissions because *'patients may not be well known to the deputising doctors'* (Practice Manager, Site 20).

As set out below, Site 5 felt that, although more information was now available, the level of admissions remained high.

When asked whether there had been a reduction in in-patient admissions, Site 16 commented as follows:

> *'Difficult to judge - many new services were put in place and beds were reduced because of reconfiguration not related to the pilot.'* (Practice, Manager, Site 16)

Site 5 aim: Reduction of in-patient admissions through more community support.

Progress: 'Accurate data is now available but activity remains high.'

Aids: 'Regular review - on a case by case basis if required.'

Barriers: 'Lack of community services to hold patients and speed up discharge. Case made forprovision of outreach facilities for patients who are mentally ill.'

At the time of writing this report, it has not been possible to obtain results from HSMC to confirm local assertions of reduction in admissions from HES data.

3.5.3 Influencing secondary care mental health provision

As highlighted in the outline of the special study sites, **Site C** had proposed to make changes in the local secondary care community mental health service provision. It had hoped to develop services at a local mental resource centre such as outpatient and day care services. It was also hoped that a 24-hour crisis service could be provided with 14 beds for short or overnight stays. When planning permission was sought, however, there were objections from local residents. The Site C project manager said that *'they played the nimby (not in my back yard) card'*. The community trust were sympathetic towards the development. The project manager felt, however, that their interest may have waned which may in part have been connected with a change in Chief Executive who did not seem to share his predecessor's support for the development.

Site 1 felt that as a total purchasing project it had had an important influence in the establishing of two secondary care mental health teams. The first of these was a home liaison team which undertook active support and outreach to people with severe and enduring mental health problems who would otherwise be frequently admitted to hospital. The second was an emergency and out of hours mental health team which had staff on call 24 hours a day and seven days a week. The Trust had wanted to set these up for some time and the TPP felt that it had been able to offer them the support

and funding to allow them to be established. In the follow up questionnaire the TPP reported that the teams were *'established and working extremely well'* (Project Manager, Site 1).

Site 14 undertook a needs assessment project which identified a lack of support services for people during times of crisis which fell outside of normal working hours. Through joint commissioning with social services, funding has now been obtained for an additional local mental health team that will also provide a service at weekends. It is hoped that this team will *'help avoid unnecessary admissions and facilitate early discharge'* (Project Manager, Site 14). As indicated below, Site 18 had also lobbied for more out of hours provision by their local community mental health team and were successful.

Site 18 aim: To ensure that there was adequate out of hours CMHT provision.

Progress: 'Service extended from 9.00am to 5.00pm to 8.00am to 8.00pm.'

Aids: 'Great co-operation with the Trust.'

Barriers: 'Financial resources.'

3.5.4 Changing provider

There were some pilots who stated in the initial interview that, because of their dissatisfaction with the provision of mental health services from their current provider, they were aiming to use their project to contract with a different Trust. Only one of the questionnaire respondents had been successful in changing providers and when asked about the mental health services provided by the new Trust, this site commented:

> *'Better services provided all round. First class and accessible inpatient unit. New locality mental health team set up in new premises with new operational policy . . . GPs impressed with new services.'* (Project Manager, Site 5)

As outlined below, Site 2 was not able to change its mental health provider.

Site 2 aim: To change mental health provider.

Progress: 'This has not happened and is unlikely to do so.'

Aids: 'None'

Barriers: 'Absorbed into a strategy for a wider area than TPP. This has prevented a TPP specific approach, although we have had input. Again lack of clarity on finances.'

Sites 9 and 13 did not change their provider either. Site 9 was on the border between the catchment areas of two providers and had wanted rationalise this so that its mental health services were provided by just one Trust. In the follow up questionnaire the Project Manager stated that they were prevented from doing this because they were unable to get budgets from both of the health authorities that they dealt with. In addition, the Trust that they favoured was reluctant to take on the whole service. This was because the Trust felt that they would need to recruit a new consultant to cope with the increased workload and the potential shift in resource was not enough to allow them to do this. In the case of Site 13, there was no change of provider because *'the providers have changed their modus operandi considerably and the service is much better'* (GP, Site 13)

3.6 Relationships with key stakeholders

Communication and relationships between the pilots and key local mental health stakeholders emerged as an important theme both from the telephone interviews and the interviews carried out at the special study sites. This section of the paper looks at that the issue in terms of communication and relationships between the pilots and five other key stakeholders. These are: secondary care providers; health authorities, social services, mental health service users, and other organisations such as voluntary or housing agencies.

3.6.1 Secondary care providers

As already highlighted, attached CPNs and PMHTs have been used by a number of the pilots to improve communication between secondary and primary care. This communication was largely at a clinical level. There is also the issue of relationships between the pilots and mental health providers at a managerial level.

At **Sites D and E,** in the initial stages at least, there seems to have been some tension between the pilots and the managerial level of the trusts. The trust managers seemed concerned that the outcome of the pilots may be a reduction in their funding. **In Site D,** in particular, the trust was concerned about any potential reduction in funding for in-patient beds. These fears became less apparent during the course of the project, however, when it was becoming clear that there would be no significant reductions in in-patient usage by patients from the practices in the pilot. Although during the follow-up interviews the trust representatives at **Site E** were still urging caution in interpreting the reductions in in-patient activity, they were keen to be positive about the pilot and praised the commitment shown by those involved in the project.

In the other sites such initial tensions did not seem to be evident. Representatives from the pilots at **Sites A and B** felt that relationships with trust managers were good and they were supportive of the changes the project had wanted to make in terms of CPN attachment and the PMHT respectively. Although in **Site C** there were problems, highlighted earlier, with a lack of information about activity there was felt to be a good relationship between the TPP and the community trust. This may have been a reflection of the fact that overall the pilot was satisfied with the actual services provided by the trust which was in contrast to the dissatisfaction it had with the services provided by the acute trust in their area.

In the follow up questionnaire respondents were asked to rate their relationship with their mental health providers on a ten-point scale (with 1 representing very poor and 10 representing very good) both before and after the pilot. Table 3.3 below shows to what extent respondents reported a change in their relationship with their secondary care providers.

Table 3.3: Relationship between the questionnaire respondents and their mental health providers

Nature of relationship with provider after the pilot*	Total	TP	EFH
Improved	20	16	4
No change	3	1	3
Worse	0	0	0

* n=23 (17 TP, 6 EFH) two of the respondents did not answer this question.

As Table 3.3 shows, most of the questionnaire respondents felt that after the pilot their relationship with their mental health provider had improved. The most common theme in the further comments provided was that increased contact had improved the relationship in terms of trust and understanding between the pilots and Trusts. The examples below are typical of many of the comments provided:

'Change occurred due to increased communications and contact with senior management and local CPN teams.' (Project Manager, Site 6)

'Identification of key personnel at provider has helped to sort out any problems and the new links between the TPP and the provider have definitely improved the working relationship.' (GP, Site 10)

'Regular meetings generated respect.' (GP, Site 15)

'The pilot has allowed for closer cooperation and liaison to take place. This has increased understanding and trust.' (Project Manager, Site 18)

The comments of three other sites suggest that, although overall there had been an improvement, there was still room for further improvement:

'Major change in consultant posts, only recently appointed new consultants. Relationship at an early stage.' (GP, Site 11)

'The relationship between psychiatrists and GPs are still not as they could be. This applies however to all practices - not just those in the TPP. Relations with Trust managers has improved. The Trust were particularly pleased with the additional investment in psychology.' (Project Manager, Site 12)

'MH Trust seen as distant by GPs, hard to engage with. Some meetings established which have helped to improve relationships slightly.' (GP, Site 21)

Another site felt that after initial problems, the relationship with the Trust was now good and provided a firm basis for future developments:

'The changes occurred through the formation of a Mental Health Strategy Group which included senior managers and clinicians from the local Trust, Health Authority, Social Services, Primary Care. This group started to work together after a stormy beginning. It eventually agreed that the new team should and would be commissioned and went about finding ways of getting funding. It has achieved this aim. The relationship built will be useful in the continuing changes such as PCGs.' (Project Manager, Site 14)

Of the three respondents who felt there had been no change in their relationship with their provider, only one provided any further comment:

'The Trust concerned is part of a recently merged Trust and despite assurances that the merger would assist the process and a number of promises regarding investment and improved communications, this has not really occurred. We also had a dispute with the Trust when we switched physiotherapy contracts, which damaged the level of trust in the trust (sorry about that!).' (Project Manager, Site 2)

3.6.2 Health Authorities

In the majority of sites the relationship between the pilot and the health authority was viewed extremely positively. Health authorities (HAs) were seen as supportive and willing to offer help and advice when needed but had allowed the sites to get on with

their projects without unnecessary interference. In Sites A, B and D the attempts by the pilots to strengthen community mental health service provision were broadly supported by the HAs. In Site D the HA had facilitated the attachment of CPNs that the practices wanted to pilot by providing new money to fund the CPNs time. Thus any reluctance that the trust may have had about funding the CPNs out of existing funds could be overcome.

The only significant tension between a pilot and a health authority seemed to be at Site B. Site B was disappointed that the health authority had not allowed them to continue as a total purchasing pilot after April 1998. The project had felt that it would be useful to carry on as a TPP in the run up to PCGs. This did not, though seem to have an affect on the relationship between those involved with the PMHT and those at the health authority responsible for mental health because the PMHT was always set to continue beyond the life of the total purchasing pilot.

As Table 3.4 below shows, the majority of the questionnaire respondents felt that their relationship with their health authority had improved after the pilot. Over a third, however, felt that there had been no change in the relationship or it had got worse.

Table 3.4: Relationship between the questionnaire respondents and their health authority

Nature of relationship with HA after the pilot*	Total	TP	EFH
Improved	15	12	3
No change	6	4	2
Worse	3	2	1

* n=24 (18 TP, 6 EFH) one of the respondents did not answer this question.

For most of the sites who felt that the relationship with the HA had improved, their comments suggested that as a result of the pilot their HA had greater recognition of the value of their perspective on mental health issues and therefore involved them more in local working groups and meetings. For example, four sites commented as follows:

> *'HA has slowly let go and allowed Primary Care to have a greater say in the development of locality services that better meet needs of patients.'* (Project Manager, Site 5)

> *'Recognition that we have problems in common and that a "bottom up" approach can be helpful.'* (GP, Site 8)

> *'GPs from the TPP are now included within HA working groups on mental health.'* (Project Manager, Site 12)

> *'Total fund manager's involvement in county wide initiatives/discussions has broadened local views.'* (GP, Site 21)

Three sites suggested that the link with particular individuals in the HA had been important in improving the relationship:

'Collaborative working with the deputy director responsible for mental health - TPP now more involved in HA working groups and contributes to policy documents.' (Project Manager, Site 9)

'Good HA lead person on mental health.' (GP, Site 11)

'Personal contact with the Mental Health Commissioner improved relationships.' (Practice Manager, Site 19)

One site felt that the fact that they had not sought to contract independently for mental health services may have helped to improve the relationship between the project and their health authority:

'Blocking back of contract has allowed HA to maintain some sort of control, which I feel they have appreciated. This has, however, not prevented them from seeking advice and discussing quality issues with the TPP.' (GP, Site 10)

Of those that felt there had been no change in the relationship with the HA, their comments revealed that this was because the relationship was good already. One of these sites did , however, qualify this slightly by stating that:

'The relationship was quite good already. The person in charge of the pilot changed during the 2 year period so this lack of continuity probably affected the chance of improving relationships.' (Practice Manager, Site 20)

The following comments were provided by three other respondents who felt there had been no change in the relationship:

'Determined disinterest in this area.' (Project Manager, Site 4)

'Discussions not really opened out with Health Authority'. (GP, Site 7)

'No change as they were not really part of our pilot and worried too much about budgeting problems of their own.' (GP, Site 15)

The three sites who felt that their relationship with their HA was worse after the pilot provided the following comments:

> *'Whilst the pilot was fully involved in the global strategy it is felt that this denied our ability/authority to make more rapid and locally specific development.'* (Project Manager, Site 2)

> *'Recent strategic review is almost wholly concentrated on secondary care.'* (GP, Site 13)

> *'Lack of true commitment to the pilot by the HA led to: a) No budget and so no clout b) Difficult to focus pilot on real change because of changes negotiated between HA and MHS (mental health services) without pilot's involvement.'* (Practice Manager, Site 16)

3.6.3 Social Services

The PMHTs at Sites B and E both have significant social care input. At Site B this is in the form of 1.5 WTE social workers. At Site E the mental health social care worker that is part of the PMHT is joint funded by the pilot and the local social services department. The social care worker receives referrals from both the CPNs in the PMHT and social workers within the social services department. Most of those on her caseload are women under 25 with children. She has arranged child-minding for women to attend courses, counselling or to prepare for a job and in addition she has set up a play group for the families of people with mental health problems.

Some links have been made in Sites A, D and F between the pilots and social services representatives. In the case of Sites A and D social service managers attended meetings which took place as part of the pilot. At Site A a social services representative attend some of the early meetings of the working group which was set up to look at mental health issues within the pilot. There was a proposal for a social services officer to be seconded to work with the pilot. It did not prove possible, however, to find funding for this and the relationship did not seem to have developed any further. Extensive restructuring of the mental health provision within social

services at Site A with the establishment of specialist mental health teams (provision had previously been based around generic teams) may also meant that social service managers were preoccupied with other issues. In the case of Site D and F although social service managers attended pilot meetings and the pilot board respectively but again finance was not available for specific initiatives and

At Site C there do not appear to have been any significant links between the project and social services. It was commented:

> *'I think the liaison between social services and the practices around mental health is loose to say the least but that's not just our practices that's all of them in the area. We've not really developed links with social services' (Project Manager, Site C).*

Amongst the questionnaire respondents, as Table 3.5 below demonstrates, less than half the sites reported an improved relationship with social services.

Table 3.5: Relationship between the questionnaire respondents and social services

Nature of relationship with HA after the pilot*	Total	TP	EFH
Improved	11	10	1
No change	13	8	5
Worse	0	0	0

* n=24 (18 TP, 6 EFH) one of the respondents did not answer this question.

Most of the sites who felt there had been no change in this relationship explained this by reporting that there had been little or no direct contact or involvement with social services in terms of mental health services.

Two sites stated that although there had not been direct contact between their project and social services, links did exist on a personal level:

'My links are personal and through the JCPT sub group for mental health where I represent the LMC but I often use my Total Purchasing hat.' (GP, Site 24)

'In terms of development within the team we have failed to include social services. However personal/team relationships with individuals in general are good across the TP project and they have been supportive to us in other areas.' (Project Manager, Site 9)

Some respondents, however, did feel there had been improvements in their relationship with social services. For example, three sites commented as follows:

'Close partnership/mutual enthusiasm and awareness of mutual benefits.' (Project Manager, Site 4)

'More dialogue has resulted in a common understanding of the problems and means to address them.' (GP, Site 5)

'Primary care and social services are both community based and have more in common than originally thought. Social services are recognising the benefit of a "preventative" strategy.' (GP, Site 8)

The comments of another four sites explained that the improvement in the relationship was due to the sites becoming part of joint commissioning and planning groups, which had social services involvement. For three other sites, though, the relationship had improved as a result of having social services staff attached to or based in the pilot practices. For example, as outlined below, Site 4 was particularly enthusiastic about the benefits of a practice-based post jointly funded with social service

Site 4 aim: Establishment of a social services community coordinator at primary care level.

Progress: 'Brilliant! Social services background. Developed voluntary agency support/welfare rights and citizen advice.'

Aids: 'Social services part funded and managed - 200% support.'

Barriers: 'None.'

3.6.4 Mental health service users' involvement

In our interim report we indicated that very few of the mental health pilots had sought to develop user involvement as part of their projects (Gask *et al.*, 1998). Of the special study sites only Site B had made user involvement a significant part of their pilot. The HNA officer had lead the developments in this area and had initially set up an event to bring together a number of the mental health user groups in the area. An ongoing user group had then been set up within the specific area covered by the TPP. The group was based at a social services day care centre in the area for people with severe and enduring mental health problems. The group has held 'Question Time' event where professionals such as consultant psychiatrists and members of the PMHT were invited along to be asked question by users on mental health issues. It is hoped in the future that the user group may develop into a reference group for the project board overseeing the PMHT offering their views by commenting on the board's minutes. One of the users interviewed in Part C of the study had been involved in the above group and felt it had been extremely useful. This interviewee commented in particular that the 'Question Time' event had been interesting and informative.

Of the other special study sites, Site F had involved representatives from local user groups in its two-day needs assessment workshop. It had hoped to include user representatives on its project board. The pilot was keen, however, to find user representatives who would not be overwhelmed by the often detailed and technical discussions within the project board meetings. There was a concern that unless people

were found who could participate actively in the meetings then it would merely represent token user representation on the board.

In the follow up questionnaires the respondents were specifically asked about the extent of change in their relationship with mental health user groups. Table 3.6 below summarises the results.

Table 3.6: Relationship between the questionnaire respondents and mental health user groups

Nature of relationship with user groups after the pilot*	Total	TP	EFH
Improved	10	9	1
No change	10	5	5
Worse	0	0	0

* n= 20 (14 TP, 6 EFH) five of the respondents did not answer this question.

Most of the comments of those who had noted an improvement in the relationship related this to greater contact with mental health user groups. This had resulted in greater understanding and revealed common aims. The comments from the following sites revealed the specific mechanisms which had helped to improved their relationships with user groups in their area:

'Developed by CPNs.' (Project Manager, Site 4)

'Improved relationships also because of (Joint Community Care Planning Group) - a forum that has user group input.' (GP, Site 7)

'We now have our own user group and also a lot of development work was undertaken in setting up the project with users. We interviewed all those who were willing from our list of severely ill patients to discuss service needs and from this flowed the group.' (Project Manager, Site 9)

'Local authority funding was obtained through the links made with social services for a drop in centre to be established which combined with open access to the CMHT has benefited the users.' (Project Manager, Site 18)

Most of the comments of those who perceived that there had been no change in their relationship with user groups suggested that this was because there had been little or no contact with them. One site, however, commented as follows:

'This was deliberately left until we had established a position where we had real influence. Lack of a budget meant that we never reached such a position.' (Practice Manager, Site 16)

Another site did not specify whether the relationship had improved or not but the comments it provided suggested that they had a problem of which group to engage with:

'We did not get involved directly with the user groups as it was felt they represented a larger population. We did however use them in the focus groups at the mental health needs assessment phase.' (Project Manager, Site 14)

The local user groups represented a population larger than that covered by the four practices in the pilot.

In the initial interview, Site 10 had outlined its intention to undertake a questionnaire survey of users as part of its pilot. As indicated below, it had eventually decided not to do this.

Site 10 aim: A project involving user questionnaires.

Progress: 'Questionnaires had been devised but review of value locally suggested that there may be less useful information obtained than first thought.'

Aids: -

Barriers: 'Some resistance to identification of users by GPs.'

Another site commented as follows on user involvement in a general section of the questionnaire:

> *'It is hard to get a clear view of service users opinions and I think it is probably impossible to have a summary. Some service users are not really well enough to be involved and those who are may have extreme views. I feel GPs or PHCTs are often good advocates for service users although that can seem patronising. It is heartening to see the development of services for an advocacy in (our city).'* (GP, Site 24)

3.6.5 Other organisations

There have been examples of the special study sites making links and building relationships with groups and agencies that are not necessarily part of the health service. The PMHT at Site B has established a bursary with RELATE for marriage guidance and sexual counselling. Similarly the PMHT at Site E has referred some people on to CRUISE for specialist bereavement counselling.

The mental health social care worker who is part of the PMHT at Site E has developed links with the housing agencies in the area. She is now involved with a cross-agency panel which meets to assess and advise the district council on housing people with special needs or who may be a 'welfare priority'. Also in terms of housing, one of the practices that formed part of the pilot at Site D has become involved with a housing project which aims to provide grants for people with mental health problems to make

improvements to their homes. The practice has been identifying people with mental health from its practice list that could benefit from money to improve their accommodation and living environment.

Site F put together a mental health resource directory, which was distributed to all the practices in the area. As well as containing information on specialist mental health services, it also details the local and national voluntary organisations and self-groups which primary care staff can direct their patients towards. The directory is in a loose-leaf format, which the pilot has undertaken to regularly update.

The questionnaire respondents were asked about the extent to which their relationship with mental health voluntary groups had changed after the pilot. Table 3.7 below summarises the results from this section of the questionnaire.

Table 3.7: Relationship between the questionnaire respondents and mental health voluntary groups

Nature of relationship with voluntary groups after the pilot*	Total	TP	EFH
Improved	10	9	1
No change	11	6	5
Worse	1	1	0

* n=22 (16 TP, 6 EFH) three of the respondents did not answer this question.

Of those respondents who felt there had been no change in the relationship five explained this by commenting that there had been little or no contact with mental health voluntary sector agencies. Two other 'no change' sites commented as follows:

> *'We tried to engage some of the voluntary organisations but they did not seem to want to be involved which we found strange as they claim they want to be involved but did not get involved.'* (Project Manager, Site 14)

'One tried to contact us for money so we steered clear of them.' (Practice Manager, Site 16)

Most of the sites that felt the relationship had improved, explained that this was as a result of greater contact with voluntary sector groups. This had increased their awareness and understanding of these agencies, as well as revealing common aims. The other comments revealed, more specifically, the various ways in which the pilots had had greater contact with mental health voluntary organisations:

'Voluntary sector organisations also have representation in this group (Joint Community Care Planning Group).' (GP, Site 7)

'Mainly through workshop events where such organisations have been represented. The mental health team now works with a range of individuals.' (Project Manager, Site 9)

'As part of the establishment of the CMHT a purpose built resource centre was provided which had facilities to incorporate representatives of the mental health voluntary sector.' (Project Manager, Site 18)

The one site that felt the relationship had got worse commented; *'Decreased due to death of local counsellor'* (GP, Site 3).

4. Discussion

The findings of the core evaluation suggested that TPPs found it initially harder to achieve their objectives in mental health than most other service areas. Out of a total of 28 main objectives in mental health identified by the first wave TPPs, in 1996/97 only 39% were achieved. This was the lowest percentage of any service area (TP-Net, 1998b, p.12) In the second 'live' year, there was an increase in the proportion of TPPs achieving their objectives in mental health (to 75%), however these achievements were primarily primary care orientated and with an 'easier' focus of developing the primary care team (TP-NET report unpublished data). In this final section of the report we summarise what our study can tell us about why mental health has been a problematic area within TP and also EFH, by first discussing what have been the main difficulties and barriers to change. Some of successes and the factors which have aided change will then be outlined. A final section discusses the overall nature and characteristics of the TP and EFH mental health pilots. At appropriate points in this discussion section, the implications for PCGs are highlighted.

4.1 Perceived problems and barriers to change

4.1.1 Information systems

One of the particular problems, identified by our study, which may have contributed to the difficulty in achieving objectives, has been the poor information systems within mental health. Sites often found that activity and costing/pricing data was inadequate. This in turn meant that a significant number of sites faced problems with setting a budget for their pilot for mental health services. The fact that the a site was developing its own information system also meant that there was an issue for the local trust about compatibility with their system. Others too have highlighted the poor information available around the country for effective commissioning of mental health services (Sainsbury Centre for Mental Health, 1998) and it seems likely that this will also be a major challenge for PCGs (Street and Place 1998).

4.2 Purchasing in-patient services

Another significant problem within mental health has been the difficulty of purchasing in-patient services for practice populations. Sites often commented that the unpredictability of in-patient mental health admissions meant that one long stay patient could change a practice's figures dramatically. Sites frequently suggested that purchasing in-patient services at a practice level was not practical. There is a debate about what, in future, will be the appropriate level to commission in-patient mental health services. The only specific reference to mental health in the White Paper (Department of Health, 1997) stressed that when PCGs eventually became Primary Care Trusts they will not be expected to take on responsibility for the *provision* of 'specialist' mental health services (although it is unclear what 'specialist' versus 'general' means and this is likely to be determined locally). Expectations about the extent of PCGs initial *commissioning* responsibilities remain unclear. Most of the mental health TP and EFH sites left the responsibility for purchasing high cost/low volume provision such as forensic mental health services to their health authority. For some sites, however, standard in-patient mental health services were also high cost/low volume. In some areas with relatively low deprivation or low in-patient referral there may not be a willingness or it may not be practical for the PCG to take on responsibility for in-patient services and it may be more appropriately dealt with at a multiple-PCG level. There will, however, be an important balance to be struck between risk and flexibility. The commissioning of in-patient services at a multi-PCG level reduces the risk of unpredictable fluctuations 'bankrupting' a budget. There is also a danger, however, that it reduces flexibility by hampering the ability of an individual PCG to change the balance of resources for mental health in their area. In a cash limited service, without access to or control over the in-patient budget, a PCG may not be able to facilitate a shift towards increased community mental health provision by freeing up resources which are locked into hospital based provision.

4.3 Differing agendas

In the initial round of interviews, and as noted in our interim report (Gask *et al.*, 1998), a problem was identified with differing priorities and agendas between primary and secondary care. It was clear to us that the priority in the sites was the development of services for people with common mental health problems in the community

(anxiety and depression first and foremost) while the priority in secondary care, in line with government policy, is increasingly patients with long term and enduring mental health problems. There was a suggestion that these differing priorities might act as a potential barrier to change within mental health. Within the mental health pilots this had meant a degree of reluctance by secondary care to become involved in developments and initiatives that might divert their attention away from the severely mentally ill.

Such tensions were not as apparent in the second round of data collection. Many sites reported improved relationships between primary and secondary care, with increased contact having lead to greater understanding between the two parties and movement on both sides. So the conflicting priorities may have acted as an initial barrier to co-operation and joint working rather than a lasting one. It seems that there is probably a period of negotiation and a process of development of a mutual level of understanding of each others problems and priorities which has to be worked through. TP and EFH pilots who have become the focus of leadership for PCG mental health development will have an important role to play here. In areas where there has not been a history of such contact between primary care and mental health providers, however, PCGs may be faced with similar initial tensions around conflicting priorities.

4.4 Needs assessment

As we reported in our initial report (Gask *et al.*, 1998) within the mental health pilots needs assessment was a relatively neglected area with nearly half of the sites studied having undertaken little or no needs assessment. This should perhaps be seen in the context of a lack of needs assessment work being undertaken in general within mental health. A recent survey of lead mental health commissioners at health authority level in England, by researchers at the Sainsbury Centre, found that little time was being spent on needs assessment and in some cases it was no more than half an hour a week, and there is both a perceived lack of expertise in this area at HA level and lack of data from providers with which to begin work (Sainsbury Centre for Mental Health, 1998). Mental health needs assessment in primary care may be in its infancy (Tait and Jones 1996) but population based methods are well developed in mental health (Johnson et al 1996) and it is not difficult to collect simple information on service contacts which

have been used to inform the planning process (Li et al 1994; Cohen and Paton 1999). Amongst the mental health pilots there were those, however, who did not particularly see the necessity for any systematic assessment of need. This view is reflected in the following quote from one of the initial telephone interviews:

> *'The view we have taken is a much more pragmatic view that the whole point about a primary care led NHS and Total Purchasing Pilots is that the needs assessment is what is carried around in the GPs head and their colleagues' heads and we tend to just rely on that so we are tending to concentrate on services where there is a feeling that either the provision is not as appropriate or directed as it should be or where the GPs feel strongly that there is an unmet need that should be met.'* (Project Manager, Site 12)

Should such a model of needs assessment persist within PCGs there is a danger that commissioning initiatives will be based on a small number of professionals' conceptions of service deficiencies. However, as yet it is not clear how much of a problem this will create. It does however seem possible, in the present climate within mental health care, that it will be difficult for PCGs to clearly negotiate for resources to address the needs of people with a broader range of mental health problems than those with a diagnosis of psychosis unless they can demonstrate the extent of morbidity, unmet need and current service utilisation more accurately than at present. Such people will include those with a range of disorders from depression to bulimia, personality problems and substance misuse who potentially take up a great deal of time, may not meet present criteria for referral to mental health services (although were often cared for at this level in the past) yet still require skilled intervention, often not available in primary care. Several of the sites viewed this as a priority in order to inform future service planning.

4.5 User involvement

Last, but not least, the lack of involvement of mental health service users and their representative groups in Total Purchasing and Extended Fundholding projects gives some cause for concern. Despite recognition that service users should be involved in purchasing decisions (Beeforth and Wood 1996) confusion remains about the purpose

and meaning of user involvement (Bowl 1996). In primary care it would appear from this study that patients retain *even* more of the traditional role as 'passive recipients' of care than they do within secondary mental health care (Glenister 1994). This was certainly borne out by the findings of the Audit Commission report on fundholding, which found that none of the fundholding practices studied had consulted on what services people with schizophrenia and their families actually wanted (Audit Commission 1996).

Given that the increasing powers of GPs *could* work to the advantage of severely mentally ill patients this is disappointing. Primary care is uniquely placed to provide accessible, non-stigmatised, community-based care (Sayce 1992) and little research has been carried out into primary care users' views of the mental health care that they receive from their GP and the primary care team. To be valid, a local needs assessment should use the experience of users and their families (Smith 1998). The underdevelopment of user consultation and involvement highlighted within this study, and identified more widely within primary care mental health provision (Sayce, 1992), when taken together with the lack of needs assessment, could mean that users own conceptions of their needs will continue to be marginalised.

4.6 Perceived successes and aids to change

Despite the problems and barriers within mental health, many pilots have been able to report successes, particularly, as we have indicated, in the area of developing the mental health resources available within primary care. It has certainly been the case, throughout the whole TP-NET evaluation, that developing primary care has been perceived as easier to achieve than achieving change in secondary care providers and this is not surprising given the time-span of the projects and the major problems in terms of recruitment of staff currently faced by many mental health trusts.

4.7 Talking to each other

However improved relationships and increased communication with key mental health stakeholders were perhaps the most commonly highlighted successes or positive outcomes of their pilots. The prime examples of these were improved relationships with provider Trusts and HAs. Despite some initial problems (including

those highlighted above around conflicting priorities) by the end of their pilots, largely through increased contact, most sites had reported improved relationships between primary and secondary care within mental health at both a clinical and managerial level. Relationships between HAs and practices had also improved at many sites and looked set to continue with GP involvement in district wide strategy groups on mental health in various areas. It also seemed clear that the HA had a vital role in determining the success of a pilot. With a supportive HA, change and development seemed more likely. Equally, if the HA were not committed to the pilot, this was often highlighted by sites as an important factor in the lack of change or success.

As well as being an outcome in itself good relationships, joint working and communication were important aids to change. It was a more commonly used mechanism than contracting, which does not seem to have been used directly by many of the pilots as a lever for achieving change in mental health.

4.8 Budget holding

Most sites felt that holding a budget and the potential for independent contracts had been important. They may have helped 'to bring Trusts to the table'. A telling comment from a representative from Site 1 in the initial telephone interviews was as follows:

> *'. . . you really can't do anything without money basically and when you've got the money people want to talk to you and it's as simple as that really.'* (Project Manager, Site 1)

So although pilots may not have been using their budgets and ability to contract independently directly to achieve changes, their *potential* to control budgets and change contracts meant that they were taken seriously by providers.

The discussions around budget setting and contracting had also made those in primary care more aware of what resources where available in mental health and where they

were being spent. In some cases, sites also felt that the process had helped to improve the level of financial and activity data available for commissioning.

4.9 Developing the primary care team

In terms of success in actual service changes the development of community services which are closely linked with primary care has been a significant theme within many of the mental health pilots (both total purchasing and extended fundholding). The main example of this is attached CPNs but some pilots have also established primary mental health teams consisting of a range of health and social care staff which have made significant strides towards developing comprehensive mental health support services in the community.

There is insufficient up-to-date national literature with which to compare the sites in the present study with respect to practice attachment of staff. Some sites already had various mental health staff attached at baseline (see Gask et al 1998), others did not, but there was an overall trend to develop this much further. This continues the movement first noted in fundholding practices by Corney (1996). Nationally there has been a gradual increase in referrals directly from GPs to CPNs (referrals form GPs constituted 36.7% of all referrals to CPNs in 1990 and 45.7% in 1996 (Brooker and White 1997) even though there has been a trend away from primary care service base (21% in 1990 compared with 14.4% in 1996: Brooker and White 1997). TP and EFH sites appeared to want to radically reverse this trend and these developments continued despite the absence of research evidence that any of the current models of practice-based provision are either clinically or cost-effective (Gask et al 1997).

However, to say this must not diminish the diversity and creativity demonstrated by many individuals for whom the primary aim has been to improve services in available to the community. Perhaps the major factor in explaining many of the successes in these cases has been the dedication, hard work and commitment of the staff involved directly in the initiatives themselves.

The importance of:

key individuals leading change
inter-agency cooperation
budget holding

as the key levers for change echo the findings of the main TP-NET study (Mays et al 1998).

4.10 The nature of the mental health TP and EFH pilots

The core total purchasing evaluation developed the following broad typology of TPPs (TP-Net, 1998b, p.17):

Under-performing - projects not achieving or not intending to achieve any changes in TP-related service areas;

Developmental - projects at a preparatory stage with the emphasis on developing the infrastructure and undertaking population needs assessment before active purchasing;

Co-purchasing - projects not holding a budget and/or undertaking no direct purchasing, but attempting to change HA purchasing activities;

Primary care developer - projects that were developing primary care services in TP-related areas, particularly through an emphasis on primary care substituting for secondary care. In this type, TPPs could either co-purchase with the HA or have independent contracts;

Commissioning - projects directly purchasing in TP-related service areas with their own budgets and independent contracts to achieve changes in secondary care;

Integrated - TPPs taking a strategic role, directly purchasing and influencing both secondary and primary care. In this type, TPPs manage an integrated budget spanning SFH, TP and General Medical Services expenditure.

In terms of their mental health activities, using the definitions above and on the basis of the information obtained during the follow up round of data collection, the sites in this study can be broadly characterised as shown below in Table 4.1. Table 4.1 shows that most of the 31 mental health pilots which were followed up (ie. the special study sites and the questionnaire responders) were part of the first four groups within the typology.

Table 4.1: Characterisation of the mental health pilots by 'TPP type'

TPP type	Total	TP	EFH
Under-performing	2	1	1
Developmental	3	2	1
Co-purchasing	9	7	2
Primary care developer	8	5	3
Commissioning	9	6	3
Integrated	0	0	0
Totals	31	21	10

Only two of the sites followed up as part of the study could be characterised as '***under-performing***'. The comments of the TP site suggest that their under-performance was due to a lack of interest by the Trust which had also provided insufficiently detailed activity data for the pilot to examine where resources were being spent and to thus establish what may have needed to be changed or improved. The EFH site felt that it's lack of progress could be attributed to a disinterested HA who also failed to establish a budget for the pilot which meant that the pilot was unable to initiate any changes in service provision.

The '***developmental***' sites had largely chosen not to change any of their mental health contracts but had instead decided to engage in *needs assessment exercises* and focus on building relationships with key local stakeholders. It seems likely that such sites will be able to contribute considerable experience to the PCGs that they are now part of, although they may problems of less well developed information technology in the

broader range of practices in a typical PCG (in comparison with the larger, previously fundholding practices in a TP or EFH pilot site).

A significant number of the mental health pilots chose to try and influence local provision through joint working and ***co-purchasing*** with their health authority. For one site, in particular, this was a conscious strategy designed to retain a good relationship with their HA by allowing the HA to retain a sense of control over the commissioning process. It was felt that the pilot's willingness to work with them would appear less threatening to the HA which, in the long run would, allow the pilot to be more influential.

Of the remaining sites eight could be characterised as ***'primary care developers'*** and nine as ***'commissioning'*** TPs or EFHs. The former group chose to focus predominantly on improving mental health provision at a primary care level. While the 'commissioning' pilots may have also had a significant interest in the development of primary care mental health provision they also showed a significant interest in areas normally defined as the responsibility of secondary care such as day care provision.

It remains to be seen how the knowledge-base of evidence in the field of mental health service provision can be successfully disseminated to PCGs in order to ensure the most cost-effective development of high-quality service provision and commissioning in mental health at both the primary and secondary level. It will also be interesting to see how the models developed by both of these groups of pilot sites develop in the light of the 'roll-out' of successful innovative models of working developed in the pilot, to a greater number of practices in a PCG. There is no doubt that in some cases the developments have led to a potential raising of quality standards across an area. However, where the level of funding for services in the TP or EFH site has been proportionately greater than that available to the PCG practices as a whole, there is a possibility that such innovations may not survive implementation of the new structures if equity is to be achieved.

As in the report by TP-NET (1998b) no sites have been characterised as 'integrated' because technically the budgets for General Medical Services (GMS), fundholding and total purchasing all remained separate and no virement was allowed between them. Conceptually, however, many of the 'commissioning' mental health pilots were beginning to consider the inter-relationship between spending in each area for mental health service provision.

4.12 Shortcomings of the study

Early considerations in the design of this evaluation suggested that there were major methodological problems in obtaining matched sites for the sites that are being studied. Appropriate reference sites might have been GP fundholders which use the same major provider of mental health services and which are similar in terms of rurality and social class mix. The value of using other Total Purchasing sites without a special interest in mental health needs was also explored. However, with limited resources, potentially limiting further the number of special study sites, it was decided to opt instead for collection of a range of reference data concerning service utilisation at both local and national levels (in association with HSMC at Birmingham). We also concluded that our available resources would not allow us to study more than six sites in depth.

However it soon became clear that, at a national level, the power of this study to detect quantitative differences in routine admission data was severely limited, because activity numbers were very low. Locally, It was also clear that the lack of adequate information about referral and utilisation of services that the sites themselves complained about made any attempt to collate this data routinely as part of the evaluation quite impossible. Where such data has been quoted, we have relied on the internal evaluations carried out by individual sites.

We have therefore opted for a primarily qualitative design, the focus of which would be to both describe and attempt to explain changes brought about in mental health care as a result of the novel approach to purchasing.

In the assessment carried out, the major shortcoming is that it has been impossible to assess the quality of service changes that have been brought about. The Audit Commission used the guidelines developed by the Clinical Standards Advisory Group on the care of schizophrenia (1995) as a 'gold standard' of care and found that only 7% of fundholders had changed their approach to care, however, given the focus of both fundholding and TP/EFH pilots on common mental health problems seen in the primary care setting this is perhaps not surprising. Certainly available resources prevented measurement of quality of care provided against a set of indicators even if a comprehensive set of valid indicators appropriate to primary care mental health provision had been available. We have simply been able to report what we have been told, but multiple interviewing, particularly at the special study sites, provides some validation for our findings.

5. Conclusion

As Abbot (1998) has pointed out, the agenda within the NHS has changed such that:

> 'The vision of "a primary care-led NHS" has moved from one led by entrepreneurial general practices or groups of practices (fundholding and TPPs) to one led by PCGs representing populations. This brings with it a shift from "entrepreneurial" values such as innovation and purchasing "bite" to "public bureaucracy values" such as equity and accountability.' (p.1)

Total purchasing emerged under the last Conservative government, which was strongly committed to fundholding and its focus on the practice. To a large extent, however, TP represented a conflation or hybrid of commissioning models (TP-NET, 1997). TP and EFH meant different things in different areas. Some retained their practice focus and their pilots acted as an extension of fundholding into other areas of service provision. For others, however, their pilots went beyond fundholding and represented an attempt to establish locality focused purchasing and commissioning of services. Although not without significant problems at times, TP and EFH have also represented a significant attempt by GPs and primary care to change and influence the nature of mental health services in their area - often with great dedication and innovation. TP may prove to be a significant step in the transition from the 'Internal Market' system to the 'New NHS' driven by PCGs (Mays et al 1998; Kiloran et al 1999). Regardless of whether this is the case or not, though, as we have tried to show in this study, it has provided some valuable lessons about the opportunities and pitfalls of trying to achieve change in mental health services.

Finally we would recommend that the opportunity for others sites to learn from the examples of good practice achieved in these pilot sites should not be lost.

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APPENDIX 1

Follow up postal questionnaire

FOLLOW UP QUESTIONNAIRE FOR THE EVALUATION OF TOTAL PURCHASING AND MENTAL HEALTH SERVICES

1. We believe that the number of practices in your pilot is . Is this correct?

Yes No, the correct number is:

2. What is the total list size for the pilot?

3. How would you describe the area covered by the practices in the pilot?

Urban Suburban Rural Mixed

4. What is your main mental health provider type?

Mental Health Trust Community Trust Acute Trust

Other, please specify:

5. Which type of the mental health team serves the pilot practices?

Geographical zoning Practice/pilot specific

6. How much do the practices spend in total on mental health annually?

7. What percentage is the annual mental health spend of their total expenditure?

8. Was a budget set for the pilot for mental health?

Yes No

9. Where there any particular problems with budget setting? If so what were they?

If no budget was set please go to Question 13

10. On what basis was this budget calculated?

Historic activity Capitation Mix of the two

11. What capitation formula was used to set the budget?

12. Was holding a budget useful and if so, why?

13. In the initial telephone interview you outlined the areas below that you were focusing on within your pilot project. In each case please could you indicate what progress you have made and what were the aids or barriers to progress.

a)

Progress

Aids

Barriers

b)

Progress

Aids

Barriers

c)

Progress

Aids

Barriers

d)
Progress

Aids

Barriers

14. Which, if any, mental health services have you directly purchased as part of your involvement in the pilot?

a. In 96/97:

b. In 97/98:

15. Which mental health services did you block back to the health authority?

a. In 96/97:

b. In 97/98:

16. Which contract types has the pilot used?

cost/casecost and volumeblocksessionalcost/attendance

other please specify:

17. Were there quality indicators in the contracts?

Yes No

If yes, please give details:

18. Were there evidence/outcome indicators in the contracts?

Yes No

If yes, please give details:

19. Did you find the contracting process useful as a means of achieving change in mental health?

Yes No

Please say why you felt is was either useful or not useful.

20. Have you set up a register of those patients with severe mental health problems on your practice lists as part of the pilot?

Yes No

21. If yes, how many patients are on this register?

22. How did your pilot define severe mental health problems?

23. Please tell us about your relationships with other mental health stake holders.

a. How would you rate your relationship with your mental health providers:

Before the pilot?

Very poor									Very good
1	2	3	4	5	6	7	8	9	10

After the pilot?

Very poor									Very good
1	2	3	4	5	6	7	8	9	10

Please say how and why there has been either change or no change in this relationship?

b. How would you rate your relationship with your Health Authority with regard to mental health:

Before the pilot?

Very poor									Very good
|	|	|	|	|	|	|	|	|	|
1	2	3	4	5	6	7	8	9	10

After the pilot?

Very poor									Very good
|	|	|	|	|	|	|	|	|	|
1	2	3	4	5	6	7	8	9	10

Please say how and why there has been either change or no change in this relationship?

c. How would you rate your relationship with Social Services with regard to mental health:

Before the pilot?

Very poor									Very good
|	|	|	|	|	|	|	|	|	|
1	2	3	4	5	6	7	8	9	10

After the pilot?

Very poor									Very good
|	|	|	|	|	|	|	|	|	|
1	2	3	4	5	6	7	8	9	10

Please say how and why there has been either change or no change in this relationship?

d. How would you rate your relationship with mental health voluntary sector organisations:

Before the pilot?

Very poor — Very good

1	2	3	4	5	6	7	8	9	10

After the pilot?

Very poor — Very good

1	2	3	4	5	6	7	8	9	10

Please say how and why there has been either change or no change in this relationship?

e. How would you rate your relationship with mental health user groups:

Before the pilot?

Very poor — Very good

1	2	3	4	5	6	7	8	9	10

After the pilot?

Very poor — Very good

1	2	3	4	5	6	7	8	9	10

Please say how and why there has been either change or no change in this relationship?

f. How would you rate your relationship with other local practices who have not been involved in the pilot:

Before the pilot?

Very poor									Very good
|	|	|	|	|	|	|	|	|	|
1	2	3	4	5	6	7	8	9	10

After the pilot?

Very poor									Very good
|	|	|	|	|	|	|	|	|	|
1	2	3	4	5	6	7	8	9	10

Please say how and why there has been either change or no change in this relationship?

24. Has there been any local evaluation of your pilot project?

Yes No

If yes, please give details, in particular, of what methods were used in this evaluation and who carried it out.

25. Overall how successful would you say your project has been with regard to mental health?

Very poor									Very good
|	|	|	|	|	|	|	|	|	|
1	2	3	4	5	6	7	8	9	10

26. In what areas of mental health would you say you have been most successful?

27. In what areas of mental health would you say you have been least successful?

28. What do you think are the outstanding issues or problems locally with regard to mental health?

29. Is there anything else you would like to mention which has not been highlighted in this questionnaire?

30. If required would you be willing to discuss any of the issues highlighted in this questionnaire further in a short telephone interview?

Yes No

31. Would you be interested in receiving a summary of the final findings of this research?

Yes No

32. Would you be interested in taking part in a workshop/seminar to discuss the experience and lessons of your involvement in the pilot?

Yes No

Thank you very much for taking the time to fill in this questionnaire.

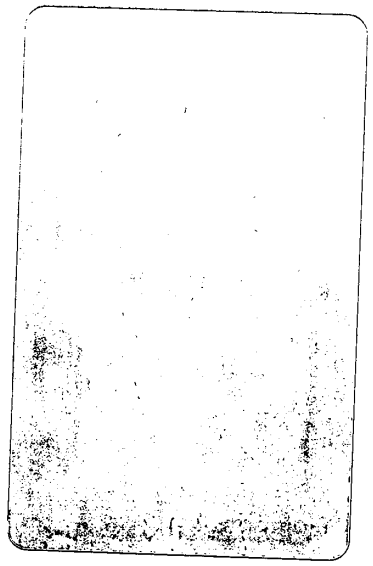
APPENDIX 2

Special study site interviewees

Special Study Site	First Round		Second Round	
	Number of interviews	*Interviewees*	*Number of interviews*	*Interviewees*
Site A	9	GP HA - Assistant Director of MH Project Manager 4 CPNs & CPN manager GP GP & Practice Manager SS - MH Adviser Practice 1 - Practice Manager MH User Group - approx. 15 Members	9	GP 4 CPNs & CPN Manager GP Practice Manager HA GP SS - MH Adviser Project Manager MH user group - approx. 15 Members
Site B	8	HNA Officer Project Manager & PMHT Leader 2 GPs SS - Senior Social Worker VS - CVS Co-ordinator SS - Community Care development officer HA - MH Development Manager Trust - MH Services Manager	5	HNA Officer PMHT Leader HA - MH Development Manager SS - Community Care development officer 2 GPs
Site C	5	Project Manager Trust - Business Development Manager CMHC Manager HA - Commissioning Manager Consultant Psychiatrist	3	Project Manager Trust - Business Development Manager CMHC Manager
Site D	10	HA - Counselling and MH Advisor CPN CPN 2 GPs & Business Manager Trust - Medical Director Trust - Business Manager HA - Assistant Director of Commissioning VS MH Group Co-ordinator GP GP	7	CPN GP Practice Manager & GP HA - Counselling and MH Advisor Vol. Sector - MIND Co-ordinator VS MH Group Co-ordinator 2 GPs & Business Manager

Site E	9	IT Consultant GP & Project Manager & IT Consultant & HA - MH Facilitator 2 CPNs & Administrator & Care Assistant Trust - CMHT Leader & Clinical MH Services Manager & Project Manager Trust - CPA Co-ordinator User Forum Co-ordinator & Carer Forum Co-ordinator 2 Youth Project Workers & Community Midwife Trust - FH Manager SS - MH Team Leader	15	Project Manager & IT Consultant & Administrator Trust - CPA Co-ordinator & Project Manager MH User Forum Co-ordinator Trust - FH Manager & Contracts Manager SS - Care Manager SS - MH Team Leader Healthcare Assistant & MH Social Care Worker & Primary Care Worker for Eating Disorders 2 CPNs Carers Organisation Co-ordinator EMI Home Manager Adult guidance service rep GP HA - Locality Co-ordinator 2 District Council Housing Officers & MH Social Care Worker Local Authority Housing Adviser
Site F	7	Project Manager User Self Help Project Co-ordinator GP Trust - Crisis Intervention Team Leader 2 GPs 2 CPNs & CPN Team Leader Advocacy Co-ordinator	6	GP SS - Principal Officer (Adults) CMHT Leader User Self Help Project Co-ordinator GP Project Manager

Key& = Joint Interview
GP = General Practitioner
CPN = Community Psychiatric Nurse
MH = Mental Health
HA = Health Authority
SS = Social Services
HNA = Health Needs Assessment
PMHT = Primary Mental Health Team
VS = Voluntary Sector
CVS = Council for Voluntary Services
CMHC = Community Mental Health Centre
FH = Fundholding
EMI = Elderly Mentally Ill
CMHT = Community Mental Health Team



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The evaluation is led by Nicholas Mays, King's Fund, London
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LSE HEALTH, LONDON SCHOOL OF ECONOMICS AND POLITICAL SCIENCE Houghton Street, London, WC2A 2AE T: 0171 955 7540 F: 0171 955 6803 ***Lead:*** Gwyn Bevan, Ray Robinson	***Main Responsibilities:*** Resource allocation methods (Bevan); Contracting methods (Robinson).

ISBN 1-85717-288-4

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