King's Fund

National Evaluation of Total Purchasing
Pilot Projects
Working Paper

TOTAL PURCHASING AND EXTENDED FUNDHOLDING OF MENTAL HEALTH SERVICES

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

The Total Purchasing National Evaluation Team (TP-NET)

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

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We would like to thank all those taking part in the pilot projects who have given up their time to help with the evaluation and we are very grateful to Max Bachman for his extremely useful comments on an earlier draft of this report.

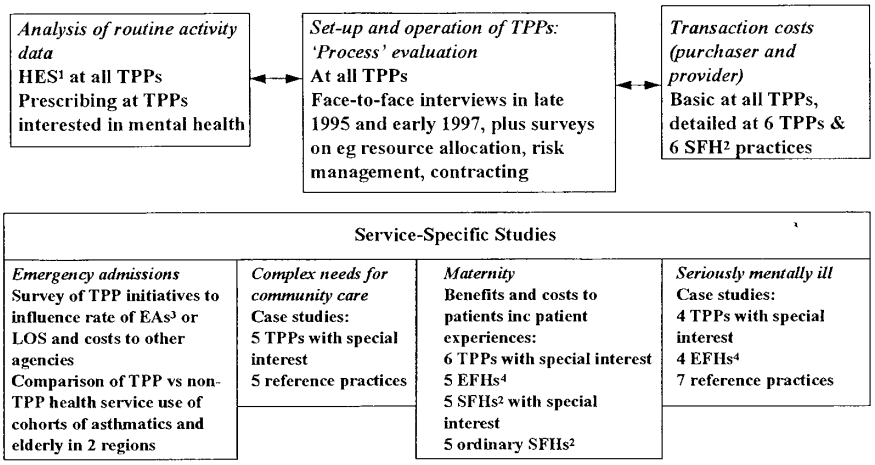
CONTENTS

Preface: The National Evaluation of Total Purchasing Pilot Projects

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

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

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



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

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

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

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King's Fund, London
January 1998

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

Title and Authors *ISBN*

Main Reports

Nicholas Mays, Nick Goodwin, Gwyn Bevan, Sally Wyke on behalf of the Total Purchasing National Evaluation Team (1997). *Total purchasing: a profile of the national pilot projects* 1 85717 138 1

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

Working Papers

The interim report of the evaluation, *Total purchasing: a step towards primary care groups*, is supported by a series of more detailed Working Papers available during the first half of 1998, as follows:

Nicholas Mays, Nick Goodwin, Gill Malbon, Brenda Leese, Ann Mahon, Sally Wyke 1 85717 188 8
What were the achievements of total purchasing pilots in their first year and how can they be explained?

Gwyn Bevan 1 85717 176 4
Resource Allocation within health authorities: lessons from total purchasing pilots

Ann Mahon, Brenda Leese, Kate Baxter, Nick Goodwin, Judith Scott 1 85717 191 8
Developing success criteria for total purchasing pilot projects

Ray Robinson, Judy Robison, James Raftery 1 85717 189 6
Contracting by total purchasing pilot projects, 1996-97

Kate Baxter, Max Bachmann, Gwyn Bevan 1 85717 190 X
Survey of budgetary and risk management of total purchasing pilot projects, 1996-97

Ann Mahon, Helen Stoddart, Brenda Leese, Kate Baxter 1 85717 197 7
How do total purchasing projects inform themselves for purchasing?

John Posnett, Nick Goodwin, Jenny Griffiths, Amanda Killoran, Gill Malbon, Nicholas Mays, Michael Place, Andrew Street 1 85717 193 4
The transaction costs of total purchasing

Jennifer Dixon, Nicholas Mays, Nick Goodwin 1 85717 194 2
Accountability of total purchasing pilot projects

James Raftery, Hugh McLeod
Hospital activity changes and total purchasing
1 85717 196 9

Sally Wyke, Jenny Hewison, James Piercy, John Posnett, Linda Macleod, Lesley Page, Gavin Young
National evaluation of general practice-based purchasing of maternity care: preliminary findings.
1 85717 198 5

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

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

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

Abstract

This report describes the aims, methods and interim findings of a study to evaluate the impact of Total Purchasing and Extended Fundholding on the provision of mental health services. All baseline telephone interviewing has now been completed and we can report on findings from the analysis of semi-structured telephone interviews with representatives from 27 Total Purchasing Pilot (TPP) and 13 Extended Fundholding (EFH) sites.

Given that there has been no central template for what topics or areas the pilot sites should address, there has been a great deal of scope for local interpretation and initiative. Consequently the range of areas and issues within mental health that pilot sites are attempting to tackle is quite diverse. In preference to merely listing the objectives and areas of focus of each site the evaluation has instead sought to outline some common themes or dimensions of total purchasing or extended fundholding and mental health. We have charted progress of sites along each of these dimensions which are:

- needs assessment
- communication between secondary and primary care
- locus of service provision
- primary care role in severe mental health problems
- user involvement
- overall approach to total purchasing

Perhaps the most striking things about the sites are the differences rather than the similarities. Each is developing along the dimensions we have identified at a different pace, depending on local circumstances, resources, personalities and their interests. Variations in the level and quality of mental health provision across the country also mean that sites have embarked on Total Purchasing from very different starting points.

In the first year of this study we have delineated what the sites hope to achieve. Now we will set about exploring if they succeeded. We consider that there is considerable potential for the study of these pilot sites to inform the development of GP commissioning. It is possible that

several of these sites will become the focus for local commissioning for mental health services when this is underway, as they will be seen by their peers to have developed essential expertise in this field.

1 Introduction

Total purchasing sites have considerable freedom to organise hospital and community services for their patients. One of the opportunities and challenges is to improve the organisation of care for mentally ill people in line with the wishes of the primary health care team, the Department of Health, the mentally ill people they serve and their carers and representatives. Many of the total purchasing sites have this as a priority. However mental health services are amongst the more difficult to configure and are also often expensive, so changes might be slow or might not always meet the aspirations and expectations of all the interested parties.

The definition of a total purchasing site with a special interest in mental health is that it should have an expressed interest in its business plan to reconfigure mental health services, or an informally expressed interest matched by an identifiable commissioning initiative. For practices joining the mental health in-patient extension to standard fundholding (extended fundholding sites) mental health is a priority by virtue of their entry into the scheme. While the scope for change is less comprehensive than that within total purchasing sites, the aim has usually be to make significant changes in the nature of the care provided for mentally ill people.

Guidelines and expectations from the Department of Health and from the NHS Executive are more extensive and explicit for mental health services than for other areas of work within the NHS. These form an important component of the description and evaluation that we are carrying out.

2 Methods

General aims and methods

A national consortium is currently evaluating total purchasing and has reported its preliminary findings (Mays, Goodwin, Bevan and Wyke on behalf of TP-NET 1997); this section of work is studying the effects of total purchasing, and of extending standard fundholding into in-patient mental health services, on mental health care in three general areas:

a) the effects of purchasing decisions on strategies and services provided;
b) the effects of purchasing decisions on workers and stakeholders in the services;
c) the effects of purchasing decisions on people using mental health services.

Consequently there are three main components to the study as follow (Table 1):

Table 1: Main components of the study

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 a follow up postal questionnaire and selected telephone interviews 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 20 mental health service users who are registered with the practices at the six special study sites.

Part A: Strategies and services provided

This part of the study involves the collection of information from all total purchasing sites with a special interest in mental health and all extended fundholding sites. It addresses a wide variety of questions, comparing the information at the beginning of the pilot projects with the situation at the end of the pilot projects. Development of this section was informed by the Department of health publication ***Commissioning Mental Health Services*** (Thornicroft and Strathdee 1996) and a series of other relevant Health Service Guidelines (eg. *The Spectrum of*

Care- local services for people with mental health problems; 24 hour nursed care for people with severe and enduring mental illness; ***An Audit Pack for the Care Programme approach)***. We were also informed by our preliminary discussions with staff from practices interested in being involved in pilot sites of total purchasing or extended fundholding.

The main research method used in this part of the evaluation was qualitative, semi-structured telephone interviews carried out with representatives from all of the TPP and EFH sites. These were either the lead GP or the project manager at each of the pilots and were carried out between September 1996 and August 1997. The interview guide used covered the following areas:

- Current state of local mental health (MH) services
- Aims for TP/EFH and MH
- Needs assessment
- Care Programme Approach
- Relationships with:
  - MH provider
  - Health authority
  - Local authority
  - MH voluntary sector
  - MH user groups
  - Other local practices.

The semi-structured nature of the both these telephone interviews and the face to face interviews outlined in the next section, however, allowed flexibility in the nature of topics covered. It also permitted emerging themes from preliminary analysis of the initial data to be incorporated and explored with later interviewees. Content analysis was used on the tape recorded interview data to delineate both common themes and differences in the accounts provided by respondents. Follow up postal questionnaires will be sent to all site representatives interviewed in this part of the evaluation around the end of the pilot projects in

April 1998. Additional, selected telephone interviews may also be undertaken to allow the further exploration of issues highlighted in the responses to these questionnaires.

As part of this section of the evaluation, routine dataset information is also being collected for all the sites in collaboration with the Health Services Management Centre at the University of Birmingham. Purchasing plans are also being collated, again in collaboration with HSMC.

Part B: Effects on workers and stakeholders in the services

This part of the study involves the collection of information by personal interviews from a selected sample of Total Purchasing sites with special interest in mental health and a selected sample of GP in-patient sites which we will call the Special Study Sites. It addresses questions relating to mentally ill people (especially severely mentally ill people) looking at changes over time and differences between total Purchasing and extended fundholding sites and the overall pattern of service development in the districts in which they are sited.

The interviews were again semi-structured and the interview guide used in the telephone interviews was also utilised in the face to face interviews. The extended nature of the face to face interviews, however, allowed the issues to be covered in more depth. Interviews were also undertaken with a wider range of individuals. Respondents for this section of the study were representatives from:

- GP practices
- Community mental health teams
- MH providers
- Health authorities
- Local Authorities
- MH voluntary groups
- MH user and carer groups

Interviewees were identified by a 'key informant' (Gilchrist, 1992)), at each of the special study sites, who was usually the project manager or lead GP. 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. The interviews for this section were carried out between March and September 1997. Follow up, repeat interviews to ascertain the changes or progress associated with the special study sites will be carried out between March and May 1998.

Criteria for selection of special study sites

A sample of study sites (both total purchasing and extended fundholding) was chosen based on initial expressions of interest and a combination of following criteria:

Innovation

Whether a total purchaser or extended fundholder was attempting to introduce innovative or radical changes was a factor in special study site selection.

'Representativeness'

Special study sites were also chosen on the basis that 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

It was considered necessary to avoid sites already being used by other parts of the national total purchasing evaluation tracer studies (maternity and community care) as special study sites so as not to overburden those working within them.

Local evaluation

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.

Geography

Geographical factors such as whether the site is in the north or south, metropolitan or rural, were seen as relevant for examining Total Purchaser and Extended Fundholder in a variety of contexts and situations.

We concluded that studying less than two or three total purchasing sites and two extended fundholding sites would not provide information perceived as useful by the staff in the sites. The available resources would enable us to study no more than six sites in total at the same depth. This part of the study will be mainly descriptive. Since a deliberate decision has been made to study a small number of sites in greater depth the power of this study to detect quantitative differences in patterns of referral and service use will be limited.

Outline of the six special study sites

Total Purchasers

Site A

This TPP in the south of England consists of five fundholding practices (one first wave and four second wave). 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 (which is also the first wave fundholder) 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. With regard to mental health the main focus of the TPP is piloting various levels of community psychiatric nurse (CPN) attachment to each practice. Other concerns of specific practices in the pilot are the sectorisation of the secondary mental health teams and a focus on the appropriateness of some of their psychiatric extra contractual referrals (ECRs).

Site B

The four practices in this TPP in the north of England serve populations with relatively low levels of deprivation but a 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 aims to address. The first is 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 is developing a primary mental health team to work with the practices. This will consist of a team leader, four CPNs, counsellors/psychotherapists and a psychiatrist.

Site C

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

Extended Fundholders

Site D

There are two practices in this mental health EFH pilot in the Midlands. One is in a fairly middle class, suburban area and the other in a more deprived urban location. The main aim of the project is to facilitate increased communication and closer joint working between the practices and the specialist mental health services. The principal means of achieving this is the attachment of two named CPNs from the community mental health team - one to each of the practices.

Site E

This is a single practice project in a town in the south west of England. The project is developing a practice mental health database. A practice based mental health team has also been established which consists of a project manager, two CPNs, a care assistant, an administrator and a part-time software and statistics consultant.

Site F

This project includes all but one of the practices in a commuter town in southern England. In total there are seven practices involved. One is an experienced first wave fundholder and the rest are part of a multifund and sixth wave fundholders (April 1996). 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.

Part C: Effects on mental health service users

We aim to record the proposed changes in practice in those sites relating to people with mental health problems. We have selected a sample of patients who would or could be affected by those changes, and will interview them at several stages of the development of the projects to map out the changes in their experience. In total 20-25 users registered with the practices in the six special study sites will be interviewed. They have been recruited by a number of individuals interviewed in Part B of the evaluation outlined above. These include GPs, community psychiatric nurses from both community and practice based mental health teams and people involved with the voluntary and users groups. The main criteria for interviewee 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.

Repeating the semi-structured interview exercise will give the opportunity to examine longitudinal changes. The interview guide used covers 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 Initial findings from Part A: Strategies and services provided

An initial analysis has been carried out of the telephone interviews completed with representatives from all sites between September 1996 and August 1997. Some of this analysis was used to provide feedback to interested pilot projects at a conference on mental health purchasing organised by the NHS Executive at the beginning of March 1997.

Given that there has been no central template for what topics or areas the pilot sites should address, there has been a great deal of scope for local interpretation and initiative. Consequently the range of areas and issues within mental health that pilot sites are attempting to tackle is quite diverse. In preference to merely listing the objectives and areas of focus of each site the evaluation has instead sought to outline some common themes or dimensions of total purchasing or extended fundholding and mental health.

The following six main dimensions have been discerned from a preliminary analysis of the initial data:

- needs assessment
- communication between secondary and primary care
- locus of service provision
- primary care role in severe mental health problems
- user involvement
- overall approach to total purchasing

Needs assessment, user involvement and the role of primary care in severe mental health problems were issues specified by our interview guide but the remainder emerged as important themes from analysis of the interview data. In the following sections, the figures in brackets refer to the number of sites out of the 40 sites (27 TPP and 13 EFH) whose activity or aims fits the description outlined.

Needs assessment

Thirty of the pilot sites (18 TPPs, 12 EFHs) had sought to identify those people registered with their practice or practices with mental health problems by developing a case register. These were compiled from a combination of sources including information from patient notes and records, drug registers, diagnostic categories, CPN caseloads, and care programme approach (CPA) records at both practice and provider level. Reconciliation between practice and provider information was then attempted, with many sites reporting that the respective data did not match up.

Beyond identifying those individual patients with mental health problems registered with the practices, in terms of deciding which particular areas of mental health service provision should be the focus of their pilot, the degree to which any more formal needs assessment process has been undertaken varied considerably between the sites. In total, 19 of the 40 sites (14 TPP, 5 EFH) had undertaken no formalised needs assessment and instead the areas of focus for their pilot were based on, what one respondent called "gut feeling", or another "anecdotal". This is where knowledge of service use, unmet need and any gaps in provision drew largely on GPs personal experience and the information gleaned from talking to patients during consultations. One site did not undertake a formal exercise because the health authority had recently undertaken extensive needs assessment as part of formulating a new mental health strategy for the district.

There were pilot sites, however, that were attempting a more systematic and detailed approach to needs assessment. Table 2 below outlines the areas of needs assessment these sites were engaged in. These are not mutually exclusive in that sites may have been undertaking more than one of these activities.

Table 2: Approaches to needs assessment

Approach	No. of TPPs	No. of EFHs	Total No.
Survey of stakeholder views	5	3	8
Health needs assessment workshop	1	1	2
Analysis of service use	1	1	2
Practice based computer needs assessment software	0	1	1

Surveys of stakeholder views (8) aimed to find out what key individuals or groups felt were the gaps in local mental health provision and how psychiatric provision could be improved. This involved interviews with: members of the primary health care team (2); members of the primary health care team and mental health professionals in health and social services (1). Users were also surveyed utilising: interviews (1); and questionnaires (2). The example below shows how one site incorporated number of the above approaches into its assessment of need:

Example

One site described its method of needs assessment as a triangular approach which consisted of:

- Desk top work on service use and referrals
- A survey of health and non-health professionals such as practice and district nurses, CPNs, teachers and people in voluntary organisations
- A random survey of 92 residents in the area about their health needs

Having identified the priorities they intend to follow this up with interviews with groups of patients with special needs.

Other respondents in the study said that they were intending to carry out further needs assessment work. One was going to send a questionnaire to mental health service users and two others were going to carry out user interviews. A further two sites were going to set up focus groups with users as a way of exploring service deficiencies and areas for improvement.

Health needs assessment workshops had been undertaken by two sites. They had organised one or two day events involving representatives from a range of primary care, health, social service, voluntary, housing, user and carer organisations. These individuals came together to discuss the mental health needs within the local areas and to identify areas for further work within their respective pilots. For example, one of the sites generated six priority areas of: managing crises; severe and enduring mental illness; substance misuse; elderly mental health; less severe mental illness; children and adolescents.

Two pilot sites ran specific projects aimed at analysing service use. In the first of these, the site had undertaken what it called an 'outcomes pilot'. This involved the CPN attached to the two practices examining the GP referrals to secondary care over a six month period. Specifically the project aimed to look at reasons for referral, expected intervention and outcome from the GP's perspective. When the site representative was interviewed they were waiting for the results from this exercise from the CPN. In the other site, over a three week period, a wide range of professionals involved in providing care for people with mental health problems were asked to outline their role and the clients they were working with in terms of twenty diagnostic categories. Thirty practitioners, including health visitors, GPs, practice nurses, nurse practitioners, community mental health team members, psychotherapists, staff from alcohol and day services, took part in the exercise. As a result the project felt that it had been able to delineate who was working with whom in terms of patient diagnostic groups, which could then lead onto discussion about whether the appropriate professionals were dealing with specific mental health problems.

One pilot site was seeking to develop its own computer based needs assessment package. Based on stand-alone database software, the package would allow the practice to store and access information related to individual patients with mental health problems in four areas: registration; assessment; intervention; and care plan.

Communication between primary and secondary care

Communication between primary care and the specialist mental health services is an area which many of the sites have sought to address. It was felt that the traditional methods of communication between the two sectors where contact is mainly through referral letters, discharge letters or telephone conversations did not always provide practices with enough information about the care and service being provided to the patients from their practices. For example, one GP said, "You can think that someone is in hospital and meet them on the high street and they are on extended leave." Many sites were, therefore, seeking to improve communication between secondary and primary care. Table 3 summarises the methods being used. Again these categories are not mutually exclusive as many sites will have been using a number of these methods.

Table 3: Methods employed to improve communication between primary and secondary care

Method	No. of TPPs	No of EFHs	Total No..
Increased face to face contact	15	12	27
Practice attachment of mental health staff	7	4	11
Practice based mental health staff	3	2	5

Under the general heading of increased face to face contact, a number of initiatives were being undertaken as part of the pilot projects. The most common means (21) was the establishment of regular meetings or forums, with managers and clinicians from the practices and the provider trust, to discuss organisational and clinical mental health issues. Three pilots (3) had identified joint training and learning sessions around areas such as the care programme approach as important means of increasing the mutual understanding of the respective roles and skills of practitioners in the primary and secondary care sectors. The establishment of a new community based mental health unit in the locality providing out-patient and CPN services, which one pilot (1) had encouraged and lobbied the health authority for, was also

seen as a means of increasing communication. Since the GP unit is next door it was felt that there would be more contact and interaction between primary and secondary care staff. The two sites (2) who had undertaken health needs assessment workshops, outlined above, also identified that these had been important vehicles for improving communication.

Beyond increased face to face contact a significant number of sites saw shifts in working practices of mental health professionals as a means of improving communication and information flow. Eleven sites (11) felt that the attachment of staff such as psychiatrists, CPNs or psychologists to a practice or practices would offer opportunities for discussion, education and training with the primary health care team around mental health issues. Some pilots (7) had gone even further. They felt that practice based mental health professionals would not only improve patient access to psychiatric skills at a primary care level but since these professionals would continue to be employed by trusts it would also offer opportunities for better communication with secondary care. Predominantly, CPNs were being based in practices and acting as the main link worker between primary and secondary care as well as undertaking and supporting mental health work in the practice. These sites envisaged that communication would be improved by having a professional who could act as link worker between the two sectors. In one of these pilot sites a counsellor working at the practice was seconded from the local provider specifically to try and provide continuity and co-ordination between the two sectors. It was felt that this may provide some consistency in terms of referrals to secondary care since the counsellor would be familiar with the type of problems those in the trust were best placed to deal with.

Location of service provision

Before going into their respective pilot projects, those in the study had a number of mental health staff working at a primary care level. These are summarised in Table 4 below. Again the figures are not mutually exclusive as each site may have had more than one type of mental health professional working with them.

Table 4: Mental health staff working at a primary care level before the pilot projects

Practitioner	Type	No. of TPPs	No. of EFHs	Total No.
Counsellor	Employed by practice under fundholding	18	9	27
	Trust employed and purchased through fundholding	7	1	8
	Funded by health authority	2	1	3
CPN	Practice attached	12	7	19
	Practice based	1	0	1
Social worker	Practice attached	5	1	6
	Practice based	2	1	3
Psychologist	Sessions at practice	7	5	12
Psychiatrist	Sessions at practice	13	3	16

Within the pilot projects some sites wanted to shift the balance of mental health provision further within their area. Table 5 summarises the changes they intended to make in terms of location of mental health staff.

Table 5: Intend shifts in service provision

Intended shift	No. of TPPs	No. of EFHs	Total No.
Local community base	3	0	3
Practice attached	4	7	11
Practice based	5	2	7

In terms of shifting provision towards a local community base this is concerned with the physical location of services. Three sites wanted some services to be based in their own or

nearest town. For example, one site wanted to ensure that a planned new mental health unit providing CPN and out-patient services was located within their town so that it was accessible to the patients from their practices and those of other practices in the town. It was felt that being a total purchasing pilot would give them some influence over the health authority and trust. Another site was intending to lobby for the new community mental health team to be based in their local community hospital, again to ensure accessibility for the patients registered with the pilot practices.

The latter two areas of intended shifts in provision are concerned with the ways in which secondary care employed mental health staff interact with primary care. Eleven pilots (11) wanted to either get or increase the number of professionals attached to practices. As highlighted earlier it was hoped that this would act as a link between primary and secondary care thus facilitating improved communication and information flows. With attached professionals also providing clinics and sessions at practices it was also felt that accessibility to mental health services would be increased for patients.

Some sites (7) also wanted staff such as CPNs to be practice based and therefore to be even more accessible to their patients. There was also a general feeling that, for example, CPN screening of all GP referrals could allow patients to be directed towards the most appropriate services and practice based staff would allow improved monitoring of patients to prevent in-patient admissions before people reached crisis point.

Example

One pilot has set up a practice based mental health team consisting of a project manager, two CPNs, a care assistant and an administrator. All GP mental health referrals are assessed by the CPNs to establish the level of need and the appropriate intervention - either within the practice based mental health team or from external health, local authority or voluntary sector organisations.

Demand for both practice attached and practice based services has caused some tension between primary and secondary care. One site in particular felt that the trust perceived the

pilot site as a potential threat to their existing strategy of developing community mental health teams and resource centres for the district as a whole. The fear was that the pilot may draw too many resources and services in to their practice. In other areas, trusts had questioned the sustainability of practice based services for the whole district because of limited financial resources. Thus, they could not envisage the developments initiated by pilot sites being rolled out to the entire area.

Primary care role in severe mental health problems

People with severe mental health problems are a priority within central government policy on psychiatric services. For this reason the evaluation has sought to explore the potential role of pilot sites in the care of severe mental illness. Table 6 summarises the positions of the TPPs and EFHs in this area.

Table 6: Primary care role in the care of the severely mentally ill

Degree of Involvement	No. of TPPs	No. of EFHs	Total No.
Extensive	7	5	12
Joint working	5	6	11
Limited	15	2	17

A number of pilot sites (12) saw the potential for increasing the role for primary care with regard to people with long term and enduring mental health problems. It was felt that those in primary care were ideally placed to help in the monitoring and support of the severely mentally ill. They felt that members of the primary health care team could follow up missed appointments, identify problems early through their contact with carers and also have an important role in the general health care of those with long term mental health problems in areas such as dentistry, chiropody and cervical smears. A greater role for primary care in monitoring and supporting those with severe problems would be also be a means of preventing expensive admissions and thus freeing up more resources to help address the

problems of the large numbers of those with less severe problems which form the bulk of mental health work in primary care.

Example

Having set up practice based registers of those with long term mental health problems using assessment sheets filled out by GPs one pilot has now initiated annual face to face reviews for all those people on the mental health register.

Other sites (17), though, saw a more distinct separation with primary care focused on the care of more moderate problems and specialist services concentrating on the severely mentally ill. Between the two positions, however, a few sites (11) did want to attempt to develop protocols with secondary care about how to deal with different severities of conditions like depression. It was felt that this would help to clarify when people should be referred on to the specialist services or dealt with in primary care.

User involvement

It is noticeable that very few of the mental health pilot sites have set up any specific initiatives around user consultation or involvement. Table 7 summarises the degree to which each site had involved mental health service users in their pilot projects

Table 7: Extent of user involvement in the mental health pilots

Degree of Involvement	No. of TPPs	No. of EFHs	Total No.
Limited or GP as proxy	20	10	30
Survey of user views	5	1	6
Involvement in needs assessment workshop	1	1	2
Ongoing user involvement	1	1	2

In most cases (30) user involvement was limited or GPs were acting as proxies for user views drawing on their experience of consultations with their patients to represent patients opinions

about services. Some sites were also using local voluntary groups as representatives of user opinions.

A few sites (6) had been attempting to directly elicit patients views of mental health services by means of questionnaires (3) interviews (1) and focus groups (2). Others (2) have had some user involvement in needs assessment workshops or events, together with a range of people from health, local authority and voluntary organisations.

Only two sites (2) seemed to have, as yet, set up any ongoing user involvement in their project. In one of these sites, for example, a workshop had been organised to bring together user groups in the area and discuss what was needed. From this they are hoping to set up a standing group which can then be consulted and involved on a continuing basis.

Example

One pilot project had initially set up a strategic group to oversee the pilot project consisting of GPs, the practice manager and managers from the trust, health authority and social services. User involvement on this group proved problematic. So another group was set up involving CPNs, social workers, representatives from a mental health voluntary organisation and a carers support group, along with three users and carers. The latter group had then gradually taken on greater responsibility for influencing the focus of the project.

Some sites were intending to set up some user involvement in the latter stages of their pilot projects. Ten sites were hoping to elicit user views about mental health services through focus groups (6), questionnaires (3) and interviews (1). One site was intending to have a user led evaluation of their pilot project facilitated by a user group from outside their district. Another site was at the early stages of exploring the possibilities of involving users and had asked a representative from a national user group to come and speak to the project board about the options.

Overall approach to the pilots

Although, in the case of total purchasing, it is not exclusively relevant to the mental health study, a final important aspect to have emerged from the telephone interviews is the general

approach that sites are adopting their pilot projects. Table 8 outlines the approaches adopted by the pilot sites.

Table 8: Overall approach to the pilot projects

Approach	No. of TPPs	No. of EFHs	Total No.
Practice focus	3	6	9
Practices or area focus	18	7	25
Joint GP and HA	6	0	6

A few (3) of the total purchasing sites seemed to be approaching their pilot as an extension to fundholding, providing additional funds to directly purchase a wider range of services for their practice and its population than under standard fundholding. One GP felt that, being caught between two providers, their practice had historically been neglected in terms of mental health provision. Total purchasing was seen as a chance for his practice to get a greater share of mental health resources. When asked if he thought that other practices might be disadvantaged by any of the changes the pilot brought about, he said, "I hope so - it's about time we got something for ourselves."

Most TP sites (18), though, saw total purchasing as an opportunity to experiment with purchasing for a group of practices or an area. Where the pilot projects include more than one practice, they are often purchasing together but they are cases where the pilot site sees itself as purchasing and affecting change for a whole town even if the other practices in that are not part of the project or even fundholders.

Example

One area as a town has always nominally pooled their resources under fundholding, but now they have developed a commissioning group with the total purchasing practices, standard fundholders and non-fundholders in the area, and are keen to develop a joint approach.

Another pilot site questioned the approach they saw as dominant under fundholding, namely using contracting as a lever to affect change. In contrast they wanted to enter into discussions between clinicians, and wanted changes to be rolled out to other practices. The site also felt that general practice could be isolating but that total purchasing was enabling them to develop a wider view of the health needs of their local area as a whole.

Six of the sites (6) saw total purchasing as a collaboration between themselves and the health authority. One site was aiming to purchase and develop services jointly and in line with the health authority's wider district strategy for mental health, moving it away from what it saw as the narrower focus and concerns of fundholding. The other sites in this group (5) saw themselves as piloting ideas and services for the health authority which if deemed successful could be rolled out to the other practices in the area.

Some of those interviewed also had an early assessment of total purchasing. One felt it was being used as valuable means of piloting new ideas and services that might otherwise not have gone ahead. It was felt, however, that the crucial distinction between the site and the health authority commissioning schemes that involved GPs was the financial incentives. The respondent said, "When you've got the money people want to talk to you and it's as simple as that really." In comparing total purchasing with health authority purchasing another site felt that total purchasers were more able to make changes because they were not as politically accountable as the health authority and would not be criticised by the local newspapers. Another interviewee felt that total purchasers could make changes quicker than health authorities, and used the analogy of the difference between turning a speedboat around and turning a cruise liner around.

The extended fundholding pilots had a slightly different remit to that of total purchasers. By looking at the purchase of in-patient mental health services most sites felt that their main aim was to reduce and explore alternatives to in-patient admissions. Despite this more specific focus than total purchasing pilots, this had not prevented the extended fundholders from trying to examine a wide range of areas of mental health service provision. In terms of their

approach to extended fundholding, as single practice projects, four of the sites were focused on services and purchasing for their own practice. In a further two sites, each containing two practices, the practices had decided to work largely independently within the pilot. Although there were some areas of joint working around specific areas where the combined size of their practices list either gave them more influence or made contracting for services more viable, their primary focus was on their own practices and populations. Within the other seven EFH pilots, practices were attempting to develop services and purchasing jointly. Five of these pilots contain two practices, another consisted of three practices and the final site contained seven practices.

Conclusions from the telephone interviews

Analysis of the telephone interviews has highlighted some of the important and common areas across sites involved with total purchasing and extended fundholding of mental health services. Ultimately the evaluation will aim to discover how successful or otherwise the mental health pilots have been in affecting change in these areas. In addition, it will seek to identify the specific factors which have aided or impeded progress in direct relation to GP and primary care centred purchasing and mental health.

4 Discussion

The principles behind total purchasing and extended Fundholding were been greeted with some considerable enthusiasm by both sides of the internal market 'divide' (Tomlin 1995; Hadley 1996; Colin-Thome 1996). Fundholding was seen as encouraging 'cherry-picking' and to divert attention and funds away from the seriously mentally ill (Hadley and Goldman 1995; Hadley 1996; Shepherd et al 1996). The Audit Commission report briefly addressed mental health by assessing the impact of fundholding on the care of people with Schizophrenia, using the guidelines developed by the Clinical Standards Advisory Group (1995) as a 'gold standard' of care. They found that only 7% of fundholders had changed their approach to care, only half reviewed the patients seen within the practice annually and none had consulted on what services people with schizophrenia and their families actually wanted (Audit Commission 1996). In a study of the impact of fundholding on distribution of mental health workers, Corney (1996) has shown that this has led to more 'in-house' services being developed and greater practice attachment of staff. Trusts may be caught in a difficult conflict between the national priority to care for the seriously mentally ill and the local priorities of fundholders to care for the less severely mentally ill who are most numerous in primary care.

Total purchasing, when there is a real attempt to assess local need, develop and negotiate clear strategies, might have helped to reduce this conflict. However change is not always easy to achieve within the NHS. Perhaps the most striking things about the sites are the differences rather than the similarities. Each is developing along the dimensions we have identified at a different pace, depending on local circumstances, resources, personalities and their interests. Variations in the level and quality of mental health provision across the country also mean that sites have embarked on total purchasing and extended fundholding from very different starting points. Needs assessment in mental health care in the primary care setting is still in its infancy (Tait and Jones 1996) and this has been confirmed in the initial findings in our study in that nearly half of the sites continue to rely solely on the 'gut-feeling' of the leàd clinicians. This may be appropriate in cases where the site is focusing on limited change in specific areas. The attempts by some sites at more formal and extensive assessment, however, provide a stronger foundation for more wide ranging shifts in provision.

The level of involvement of mental health service users in Total Purchasing is also limited. Despite acknowledgment that the increasing powers of GPs could work to the advantage of severely mentally ill patients, as GPs are uniquely placed to provide accessible, non-stigmatised, community-based care, there has been only limited work carried out on how to get the mental health service user viewpoint heard in primary care (Sayce 1992) and there has been little research carried out into primary care users' views of the mental health care that they receive from their GP and the primary care team.

In February of last year we were invited to present our preliminary findings to a workshop attended by a large sample of the pilots we have been studying. We found this particularly stimulating and the experience has helped us to shape some of our tools for the second year of our study. Topics discussed over the two day workshop formed three overlapping clusters: 'political' issues facing the health service many of which are outside the control of GP purchasers, the inertia of the 'system', the need to find creative solutions.

There was general recognition that a number of problems such as shortage of professional skills, lack of resources, budgetary inflexibility, professional 'conservatism' and boundary problems are shared by all working within the health service. Within the 'system' there are particular problems which add to the sense of 'inertia' and contribute to the frustrations of those trying to bring about change. These include problems in dealing with health service managers (purchasers and providers), communication failures and information deficits (budgetary, process and outcome of care). Rigid working practices, especially the 'pretence of multidisciplinarity' in community mental health teams came in for considerable criticism, and there was a suggestion that much depended on the personality of the lead manager or clinician who might either have the vision to drive change through or block it completely.

Nevertheless a number of 'creative solutions' were shared by participants. These included both the use of contractual levers to bring about change and the development of closer working relationships (both 'carrot' and 'stick' approaches) and there was general enthusiasm and mutual support for challenging established practices. A number of buzz phrases sum up

the discussion: 'added value',' breaking down barriers', 'mutual learning' and 'change of ethos'. The conference concluded that in managing change it is essential to pay attention to the process of how this is being attempted. Goals must be informed by evidence and not simply driven by opinion, bias or prejudice.

In the first year of this study we have delineated what our sites hope to achieve. Now we will set about exploring if they succeeded. If they have, we will discover what 'creative solutions' they found and if they have not we will seek to describe the 'barriers' and 'blocks'. We consider that there is considerable potential for the study of these pilot sites to inform the development and priority saetting of GP commissioning and Primary Care Groups (Department of Health 1997). It is possible that several of our sites will become the focus for local commissioning for mental health services when this is underway, as they will be seen by their peers to have developed essential expertise in this field. The central role of primary care within mental health care provision must be acknowledged within mental health policy development (Butler et al 1997). It seems likely that the conflict is far from over.

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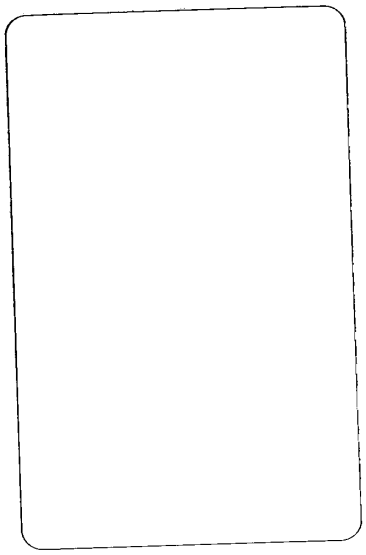

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