King's Fund

National Evaluation of Total Purchasing Pilot Projects Working Paper

Accountability of Total Purchasing Pilot Projects

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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 pilot projects 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 Policy Institute, but also involves the National Primary Care Research and Development Centre at Manchester, Salford and York Universities, together with researchers from the Universities of Bristol and Edinburgh, the Institute of Health Policy Studies at the University of Southampton, the Health Services Management Centre at the University of Birmingham and the London School of Hygiene and Tropical Medicine.

Acknowledgements

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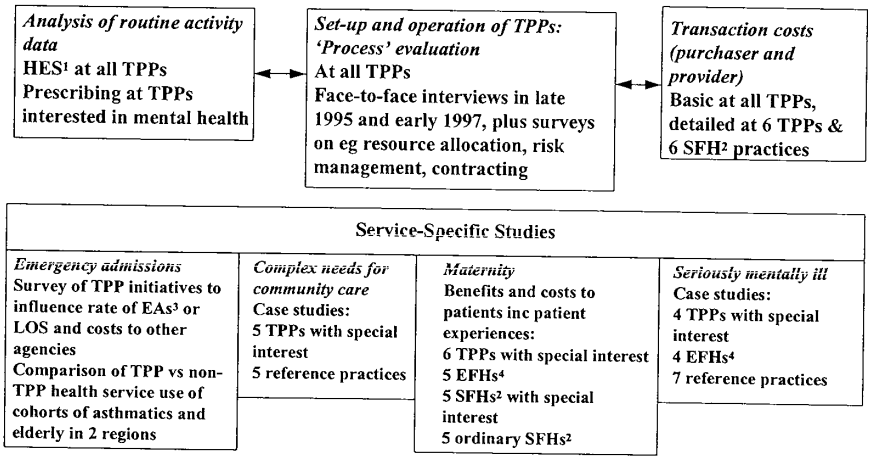
Contents

Preface: The National Evaluation of Total Purchasing Pilot Projects

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

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

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



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

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

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

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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 *What were the achievements of total purchasing pilots in their first year and how can they be explained?*	1 85717 188 8
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Total purchasing and community and continuing care: lessons for future policy developments in the NHS

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

1 Introduction

What is accountability?

Accountability has been defined as:

'The construction of an agreed language or currency of discourse about conduct and performance, and the criteria that should be used in assessing them' (Day and Klein, 1988).

In political science, *public* accountability has been broadly defined as, 'giving an account of performance by those who administer on the public behalf'. Two main dimensions of public accountability are usually identified: *political* accountability - which concerns the relationship between the elected representatives and the people; and *administrative* accountability which concerns the relationship between the administrative agencies which implement law and policy (New, 1993).

Administrative accountability

All NHS bodies are administratively accountable by statute to the Secretary of State for Health via the NHS Executive (NHSE) and, ultimately, to Parliament for the management of the resources allocated to the NHS and the performance of the Service. In addition, NHS bodies are accountable to the House of Commons Public Accounts Committee for their spending and to the Parliamentary Commissioner for Health in cases where maladministration is suspected in the NHS.

Political accountability

It has been said that political accountability for the Health Service is 'formally upwards, informally downwards' (Day and Klein, 1988). The Secretary of State for Health is accountable to Parliament (and thus, ultimately, to voters) for the performance of health authorities. There are, nevertheless, several formal mechanisms for 'downward' accountability to the local public; for example, NHS Trusts must hold an annual public meeting and publish an annual report; and health authority meetings must be open to the public.

More systematically, there is a statutory responsibility for every health authority to have a functioning Community Health Council (CHC) to represent the public interest and to consult on plans for major changes in local services. In addition, the *Local Voices* initiative (Department of Health, 1991a) encouraged health authorities and GP fundholders to consult

the public or users directly on strategy and on specific purchasing decisions. However, efforts to consult the public or users directly have generally been informal, unsystematic and patchy. In a health care context, *'clinical* accountability' can be added to political and administrative accountability in that health professionals are also accountable for their clinical behaviour to professional bodies; for example, doctors are accountable to the General Medical Council.

Accountability of health authorities

While GP fundholders are separate from local health authorities, total purchasing pilots (TPPs) are sub-committees of the local health authority. Thus TPP accountability should be considered in the context of health authority accountability as a whole.

Health authority performance and financial management is planned and reviewed through the annual performance management cycle. Health authorities must take account of and apply central policies (set out in the planning and priorities guidance published annually by the NHSE (NHS Executive, 1996a), in Executive Letters and Health Service Guidance) in the development of local policies and the purchasing of services. A corporate contract is agreed each year by the health authority and the local Regional Office of the NHSE setting out the health authority's goals for the year against which managerial performance is reviewed. There is no national template for the corporate contract and management objectives are likely to vary by region and by health authority. In a recent review, the issues found to be most typically covered in the annual performance reviews were:

- Patient's Charter standards;
- waiting times targets;
- Efficiency Index targets;
- management costs and reductions;
- The *Health of the Nation* targets;
- the proportion of GP fundholders in the health authority;
- supervision registers for the mentally ill;
- the Care Programme Approach;
- the proportion of elective surgery carried out as day cases;
- progress of resettlement plans for long stay patients;
- arrangements for continuing care;
- acute services reorganisation;
- clinical outcomes (Woolley and Ham, 1996).

In some of the areas listed above, such as management costs, waiting times targets and Patient's Charter standards, there are quantifiable targets for health authorities to meet or

work towards and sanctions if targets are not reached. Financial management by health authorities is also reviewed each quarter as well as in the annual performance management review. However, in most areas, targets and the review process are softer because outputs are more difficult to measure. Health authorities are simply expected to demonstrate progress, but the process of review is based on discussion rather than reliance on quantitative indicators.

As part of the annual review of performance, Regional Offices may expect to see progress against local strategic objectives, including any major changes in service configuration. The extent and quality of consultation by health authorities with the public directly, or indirectly via CHC representatives, may feature as part of this process.

Fundholding and total purchasing

The fundholding scheme, and its later variant total purchasing, gave GPs and their practices the responsibility for managing NHS resources directly to purchase care for patients. Standard fundholders are responsible for managing funds to pay for elective inpatient and day case services, outpatient care, prescription drugs, diagnostic tests, and practice staffing. Their budgets are separate from the local health authority budget, and are managed independently by the fundholding practice - since the fundholding budget is legally the practice's responsibility. There is clear guidance from the NHSE on the services which can be bought using the fundholding budget, although there are more flexible, informal, and local arrangements over the extent to which fundholders can make savings, and what they can be spent upon.

There are looser arrangements for total purchasing, and the practices which have signed up to the scheme are known as 'pilots' - denoting its experimental nature. Crucially, and unlike fundholding, the budget for total purchasing is not assigned to the TPP to manage independently, but is managed jointly by the health authority and the TPP, with the TPP established as a sub-committee of the health authority. While funds have, theoretically, been delegated to TPPs in line with the NHSE concerns that TPPs should have independence and autonomy in their purchasing, the health authority is, ultimately, responsible for the TPP's funds and is in a strong position to influence how the funds are used.

There is no prescribed list of goods and services which TPPs can purchase, as there is in standard fundholding. In theory, a TPP can, in addition to holding a separate fundholding budget, hold a budget for *all* the rest of its patients' hospital and community health services.

In reality, most TPPs have chosen to take the responsibility for purchasing only a limited selection from the services not covered by the fundholding scheme. Typically, these include emergency admissions, general medicine, care of the elderly and paediatrics (Robinson, Robison and Raftery, 1998). The responsibility for purchasing services such as accident and emergency (A&E), services for people with a learning disability and many tertiary hospital services typically remains with the health authority, although the TPP may be able to exert some influence over the purchasing process (Robinson, Robison and Raftery, 1998).

This still means that the TPPs typically have responsibility for significantly more NHS resources than was the case in standard fundholding. This extra purchasing capacity, plus the nature of services which the TPPs can now purchase, means that there is much greater scope to influence and change local services, for example, by shifting care from secondary to primary and community settings.

Despite the fact that resources for total purchasing still 'belong' to the health authority, this does not appear to have deterred practices from volunteering to join the scheme: in April 1995 four total purchasing pilots (TPPs) went 'live'; 49 in April 1996; and 33 in April 1997.

An accountability framework for fundholding and total purchasing

In 1995, guidelines were issued by the NHSE - *An Accountability Framework for the NHS* (NHS Executive, 1994) - outlining the areas for which health authorities should hold fundholding practices accountable. In 1996, the NHSE indicated that this framework should also apply to TPPs (NHS Executive, 1996b).

The Accountability Framework indicated that health authorities were required to hold fundholders and total purchasers to account in four main areas: management accountability and financial accountability (i.e. administrative accountability); accountability to patients and the wider public; (i.e. political accountability); and professional accountability.

The specific criteria which health authorities could use in these areas are outlined below.

Management accountability

Fundholding practices (and, by extension, TPPs) are required to publish an annual practice plan and submit it to the health authority. The plan should set out how the practice (TPP) intends to use its fund and management budget over the year and demonstrate the practice's (TPP's) contribution to national targets and priorities as well as any locally agreed objectives.

As part of their annual planning, fundholders (TPPs) are required to announce major shifts in their purchasing intentions in the same way as district health authorities.

Health authorities are required to confirm that fundholders' (and TPPs') plans are consistent with national priorities, and '*in aggregate, meet national targets and objectives set out in the annual planning and priorities guidance*'.

Fundholders (TPPs) are required to submit a brief annual report to the health authority setting out performance against plan and highlighting significant developments. Fundholders (TPPs) and health authorities must hold regular review meetings to identify areas for development and future planning.

Accountability to patients and wider public

Fundholders (TPPs) are required to publish key documents which relate to the management of their fund, for example major shifts in purchasing, annual practice plans and performance reports. These documents should be sent to the health authority and CHC and a copy or summary should be made available at the practice for consultation by patients. While the accountability framework document encourages practices to involve patients in service planning and review, no specific requirements are made explicit. Fundholders (TPPs) are required to have appropriate systems for handling complaints.

Financial accountability

Fundholders (TPPs) are required to prepare and make available annual accounts for independent audit by the Audit Commission, and expenditure and activity by fundholders must be monitored by the health authority on a monthly basis. The use of savings must also be approved by the health authority/region. Furthermore, fundholders must state in their annual practice plan how they intend to deliver their contribution to the local efficiency targets set by the NHS Executive.

Clinical and professional accountability

Fundholders (TPPs) are expected to take part in clinical audit of their general medical services (GMS) activities. Fundholders (TPPs) are expected to make sure that clinical audit is conducted in the services they purchase on behalf of patients in acute and non-acute settings.

The guidance was described by the NHSE as a 'framework' for accountability. How mandatory some of the more specific requirements were, whether or not specific 'hard' targets

should be achieved, and the mechanism which the health authority could use to influence the fundholding practice or TPP, were not made clear. Unlike the system of performance review between health authorities and Regional Offices, there was no mention of the need for a corporate contract between the health authority and its sub-authority purchasers. In a technical sense, it was not clear whether or not the health authority could have a corporate contract with itself (the TPP sub-committee).

2 Methods

Semi-structured interviews were conducted with all 49 first wave TPPs in England and Scotland at two points - in the preparatory year (autumn 1995), and again at the end of the first year of total purchasing (late spring 1997). The lead GP, lead manager within the TPP (called here the TPP manager), and lead manager for total purchasing within the health authority (called here the health authority lead) were interviewed. The semi-structured interview included questions on the extent to which formal structures existed locally to demonstrate the accountability of the TPP in three of the areas outlined in the government document '*An accountability framework for the NHS*': managerial, financial, and political accountability (to patients and public) (NHSE, 1994). Questions were not asked about professional accountability for GMS since the main focus of the study was on the GPs as *purchasers* of services.

Semi-structured interviews were also conducted with a manager responsible for total purchasing at each of the eight Regional Offices in England, and a representative from the Scottish NHS Management Executive, in the summer of 1996. All questions asked in the interviews were open-ended. The analysis was conducted in four main stages: the interviews were summarised by main themes decided on *a priori* grounds; a content analysis of the interview summaries was carried out; themes and issues were refined and summarised; finally examples of the responses were selected to illuminate the themes identified.

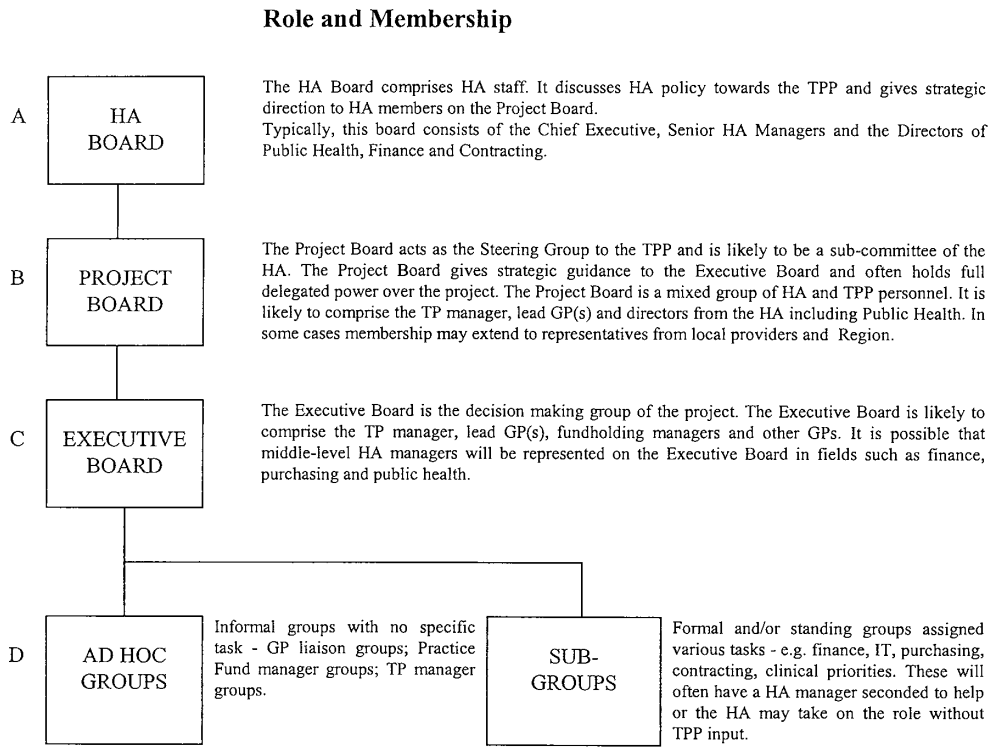
3 Results

Managerial accountability

Accountability structure

By the autumn of 1995, almost all the TPPs had formed a 'project board' to oversee the development and activities of the TPP on which health authority staff were represented. The typical structure of a TPP is shown in Figure 1.

Figure 1 Typical Organisational Structure of a TPP



These groups feed information and proposals to the Executive Board for discussion and decision.

In some sites, particularly smaller ones, the Project Board and Executive Board is combined into a single decision making body.

Just under half had been made formal subcommittees of the health authority by autumn 1995 (mid-way through the 12-month preparatory period). The Project Board typically included the lead GPs in each practice involved in the TPP, the TPP manager and various health authority

representatives (for example, it was sometimes chaired by a non-executive director of the health authority). In many, voting rights had been made explicit. The Project Boards tended to meet regularly (typically monthly) to oversee development of the TPP and report back to the health authority. The majority of TPPs had also formed Executive Boards comprising TPP practice staff (typically GPs and TPP managers) which met more frequently (usually weekly) to discuss day to day operational matters.

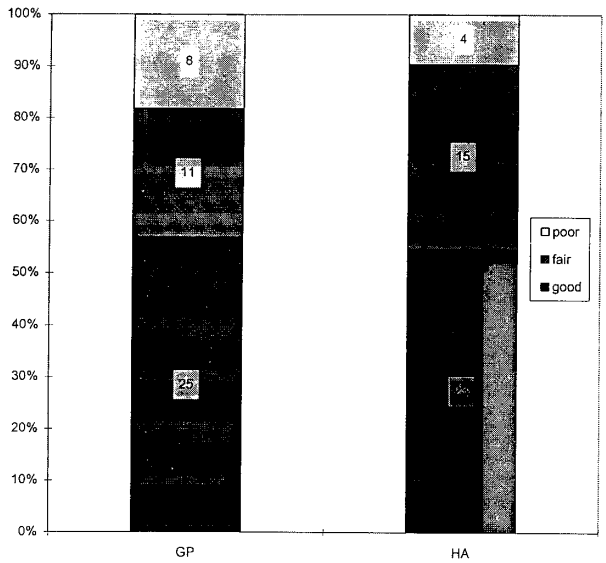
In spring 1997, two-thirds of these TPP structures had remained the same. In the remaining third, minimal changes had been made; for example, the Project Board had become a formal subcommittee of the health authority, or 'clinical subgroups' had formed below Executive Board level, usually involving GPs (who were not the lead GPs) to review and develop plans for a particular clinical service.

Roles and relationships with the health authority

In 1995, almost all GPs and project managers in the TPPs agreed on the role they thought the health authority should play in the project. Typically, lead GPs and TPP managers thought that the health authority should provide support, advice, information and expertise. In the words of some respondents, the health authority should: have *'eyes on, hands off'* ; *'be there when you need them'* ; be *'like a 'big daddy' - ultimately to support the TPP to independence';* be *'like a benign grandparent, provided they are not too fussy';* and *'should let go'.* To a far lesser extent, other roles were mentioned, including the need to be responsible for developing strategy for health services, monitoring progress, ensuring accountability, and determining the budget.

How far the health authorities lived up to these roles in the preparatory year is reflected in the responses from the TPP and health authorities to a question about the quality of their relationship. The results are summarised in Figure 2.

Figure 2 Relationship between TPP and Health Authority as reported by the lead GP and the Health Authority lead (1995)



Fifty seven per cent of the lead GPs described the relationship with the health authority as good and 25 per cent as fair (response rate 90 per cent). Typical responses were:

'Relations are good because the health authority gives the TPP freedom, partly because it [the TPP] is not threatening to do anything radical.'

'Relations are closer than when the practices were just fundholders and total purchasing has shown the GPs some of the complexity of the health authority role.'

However, a fairly common complaint was that the health authority did not act quickly enough for the TPPs, or had been obstructive:

'Despite the health authority being nice, helpful and working hard, it is too conceptual and does not have enough of the "barrow boy mentality" to really do deals and achieve much.'

'Their role should be to encourage and facilitate what the site is doing. What they are actually doing is damping down enthusiasm.'

Eighteen per cent described their relationship as poor, typically because of a lack of trust, or begrudging nature, or lack of enthusiasm on the part of a few of the managers with whom the

TPP had contact, or a relationship based upon perceived excessive control by the health authority:

'The relationship is one of mutual suspicion and mistrust.'

'Support is slow in coming and when it does come it is with control... it feels like a top-down process with the health authority slowing things down.'

By contrast, *some* respondents from TPPs thought that there was not enough direction from the health authority:

'What is the strategic aim? ... I think we still feel very vague about this.'

'It is like having a timetable for a journey without having a map.'

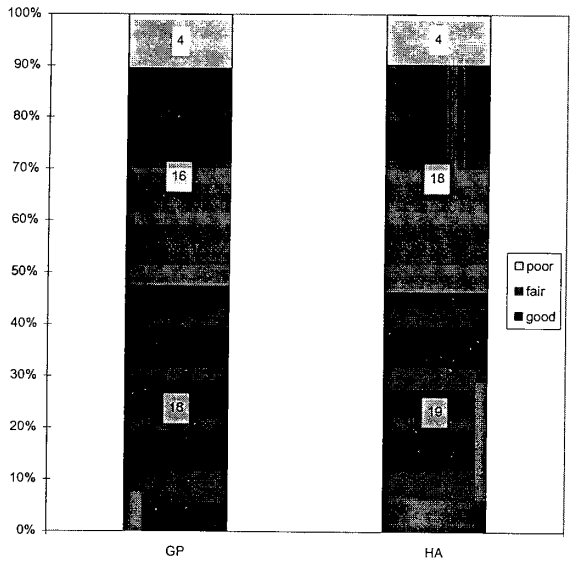
Several reported good relations with senior level managers in the health authority (such as the chief executive), but poor relations with lower level managers who were thought to be more begrudging, mistrustful and more likely to feel threatened by the TPP.

Overall, relations with the health authority were thought to be much closer compared to relations under standard fundholding.

In general, the pattern of responses by health authority leads was similar - over half reporting the relationship as good, approximately one third as fair, and less than 10 per cent as poor (response rate 86 per cent). Relationships were often described by the health authority lead as good because of regular communication and open discussion with TPP staff, and when the TPP was thought to be motivated by improving local services and not trying *'to change the world or destabilise things.'* Relationships were described as poor typically when the GPs were thought to be *'suspicious of a hidden agenda by the health authority'*, particularly in relation to the resource allocation process, or because the TPP was perceived to be *'wanting to go-it-alone too early'* without enough consideration of the implications of its plans.

By the spring of 1997, after nearly a year of total purchasing, the lead GPs and health authority managers in each TPP were asked similar questions about their relationship. An increased fraction of GPs (just over 40 per cent as against 25 per cent in 1995) were inclined to describe their relationship with the health authority as fair, and a smaller proportion as good (47 per cent as against 57 per cent in 1995), although the vast majority thought relations were good, or fair (87% in 1997 and 82% in 1995), as shown in Figure 3.

Figure 3 Relationship between TPP and Health Authority as reported by the lead GP and the Health Authority lead (1997)



Typically relationships were deemed good where there was: mutual trust; GP contact with the health authority *('personally I had never seen a public health physician before becoming a total purchaser');* greater sharing of information; and more TPP independence.

Typical reasons why relations were poor or fair were generally the reverse of those mentioned above. In addition, the budget-setting process had proved awkward. Again, TPPs frequently described relations with middle managers in the health authority as less good than those with senior managers.

'It [the relationship] started out as competitive and has now become begrudging . The health authority are not going to see this, are they? They would kill us.'

'The health authority was a bit choked that the TPP could be so independent... the TPP realised it had to work with the health authority.' However *'...the health authority does not love us dearly , but on the other hand they do co-operate,'* although *'... there is still some mumbling about the TPP behind our backs.'*

Some thought that the health authority staff were *'not very bothered'* about total purchasing - the few pilots which mentioned this tended to be small or single practice TPPs.

There was a marked tendency for all respondents to characterise the relationship as co-operative or collaborative. Furthermore, most TPPs saw themselves as in partnership rather than in competition with the health authority, although a few thought the idea of a partnership was too cosy - *'We are collaborative, but different.'*

Health authority leads responded in the same way as the lead GPs (as shown in Figure 3), although the health authority managers were not always in agreement with the view of the lead GP at individual projects. Relations were described as good usually when the TPP was thought to act *'sensibly'* and took notice of health authority advice.

The level of turnover of health authority staff was often mentioned by health authority leads as having impeded the health authority's relationship with the TPP. As with the responses given by the GPs, relations were reported to have weakened during budget-setting because of disagreements over the allocation process or the final budget. Many health authority leads admitted that they had been slow to respond to requests by the TPP (for example, in providing data) and this had soured relations.

The TPP managers were asked in 1997 whether or not the relationship had changed over the first year of 'live' total purchasing. Sixty three per cent reported that it had grown stronger, 23 per cent that it was the same and 14 per cent weaker (response rate 71 per cent). Reasons for a stronger relationship included greater communication and understanding between the TPP and health authority, although this appeared to be highly influenced by specific individuals at the health authority with whom the TPP had had contact over the year:

'There was a very mixed level of commitment on behalf of the health authority's directors at the start of the project - they were not supporting or helping. Lately, and this is surprising, some of the directors who were the biggest obstacles to the TPP have become some of the project's best allies.'

The main reasons cited for worsening relations included a lack of trust and suspicion on the part of individual health authority managers, and excessive health authority control over the TPP during the year.

Roles and relationships with regional offices

The NHSE encouraged a 'hands-off' approach to the TPPs in line with their 'pilot' status as experienced fundholders. As a result, there was little central guidance or regulation of total purchasing from the NHS Executive.

The TPP managers were asked about the extent to which the pilots had had contact with the Regional Offices in their preparatory year (1995/6). Over 85 per cent of TPP managers reported minimal or no direct contact (response rate 88 per cent), with most suggesting that it was appropriate that contact with the Regional Offices had been minimal. The lack of 'interference' was appreciated.

However, those who were in contact, reported that it had generally not been useful:

'The region organised a seminar on total purchasing but it was badly very organised, based on a very poor programme that just reiterated problems, giving no clues on the way forward. The region's role so far has not been useful as contact and interest has been minimal and support negligible.'

'The Regional Office's input has been wishy-washy and unhelpful. They have no vision or strategy or plan regarding total purchasing.'

Fourteen per cent reported having had more than minimal contact and reported that the regions had organised workshops on specific subjects between TPPs in the region to facilitate group learning, and, in a few cases, had worked with the TPPs to develop criteria to assess their performance. This was viewed as being useful and supportive.

A few expressed other expectations of the region's role:

'They do have an essential role as an ultimate arbiter. The site is responsible to them in the end.'

'Region's role is very much to manage the 'centre' on our behalf, We've got a dichotomy of views coming in. We seem to be saying, right, if it's about localities and people locally having the influence, we should be able to get on with it within a broad framework, but tend to feel from the Executive that they are saying that with one voice and with another voice saying, 'well you need to do this and that'.'

The manager responsible for total purchasing and fundholding in each of the eight Regional Offices in England (called here 'regional leads'), and a manager responsible for total purchasing in the Scottish Office were asked about their role in relation to the TPPs in the summer of 1996 (a few months after the TPPs had gone 'live').

The regional leads saw the TPPs as collaborating (rather than competing) over purchasing with their host health authority. While the regional leads were quick to outline what the aims

and objectives of total purchasing were, most had done little to assess and evaluate how far these were being, or could be, met. Three regions were exceptions in that they had developed their own criteria for assessing the performance of TPPs. However, most reported they had no direct role in monitoring the performance of the TPPs, or in assessing their accountability, and thought that the assessment should be included through the annual performance review of the health authority using the corporate contract. The regional leads tended to think that the TPPs were performing adequately, but had no data to support that view. Finally, little effort had been made to flesh out the limited official guidance on total purchasing even though regional leads generally thought it desirable to have more clarity about the operations of TPPs (Strawderman, Mays and Goodwin, 1996).

Control over purchasing priorities and TPP autonomy

In 1995, almost all TPP respondents reported that key decisions relating to the development of the TPP were taken at the level of the TPP, and ratified by the Project Board. This remained unchanged in 1997. Key players in this process were the lead GPs. There was varying involvement by other GPs in the TPP. While there was significant involvement of health authority staff at most projects, these staff did not appear to play a key role in decisions affecting the development of the TPP in most cases. In a small minority of TPPs, health authority staff were represented on clinical subgroups reviewing specific services.

The TPPs tended not to purchase all NHS services, but typically had contracts for acute services and maternity care (Robinson, Robison and Raftery, 1998). In 1995, priorities for purchasing tended to be based on GPs' views on local service issues, influenced by their interpretation of their own experience of treating their patients. While the health authority purchasing plans were available to the TPPs to review when designing their own, obtaining information on historical service delivery patterns (in order to put together a business or purchasing plan) had not been straightforward since health authorities and providers had difficulty disaggregating information for TPP patients. Such difficulties also led to widespread problems for budget setting. Information problems caused great frustration, and, as a result, as one TPP GP put it, business plans were often informed by the '*gut feelings of the GPs*'. In a minority of instances, the TPP simply followed the same plans as the health authority for the services which they were purchasing. Formal consultation with patients over these plans appeared to be rare, although approximately half of TPPs had involved health authority public health staff in an attempt to assess needs to inform purchasing. The majority of TPPs had shared and discussed their purchasing intentions with health authority representatives on the Project Board, and in several pilots, the TPPs' purchasing intentions were published in the same document as the health authority's.

The high degree of freedom as to what to purchase perceived by the TPP staff was reflected in responses by health authority leads in 1995 when asked about the degree of autonomy afforded to the TPPs in decision-making. Thirty six per cent reported that the TPPs had been given 'total' autonomy in decision-making (response rate 92 per cent). Fifty five per cent aimed to give the TPPs as much freedom as possible, but with qualifications. These were typically that the TPP should work within the framework of health authority strategy, or should not do anything which would worsen local health services. A typical response was:

'The TPP is given total autonomy to spend the health commission's [health authority's] resources. However, the TPP will be asked to justify purchasing decisions if it diverts from those laid out in the Health Investment Plan.'

However, while the health authority documents often included aspirations towards achieving certain policy objectives which the TPP was also meant to work towards in its purchasing plans, some health authority leads pointed out how little the GPs knew about these policies:

'They didn't know what Changing Childbirth *was!'*

Only 9 per cent of respondents reported that the TPP had little or no autonomy in decision-making.

The high degree of autonomy which the health authorities claimed to give to TPPs in 1995 appeared to be confirmed by the responses in 1997 from the TPP manager and lead GP. The vast majority (95 per cent) of responses revealed that key decisions over the development of the TPP occurred at practice/TPP level, but were generally ratified by the health authority subcommittee and/or Project Board.

A typical method developed by a TPP for getting its objectives agreed was as follows:

'The TPP[s] decide on strategies and then decide[s] who are the key players for each strategy and then go and lobby the key player to get them on board. It is then taken to the Director of Primary Care as a fait accompli.'

However, a minority of TPPs reported that they had little room for manoeuvre:

'The health authority comes with instruction as to what can and cannot be done. We should have been given total freedom.'

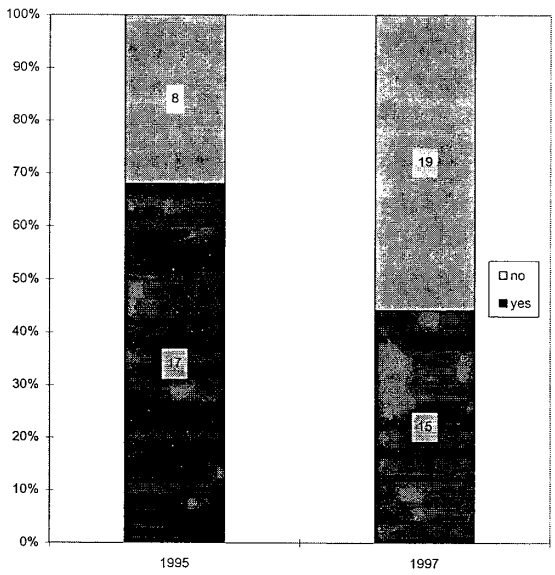
'It [total purchasing] has been under civil servant control who don't know what is going on and who will put a brake on any idea so that nothing drastic happens.'

Reviewing and reporting performance

(i) *Importance of accountability under total purchasing compared with fundholding*

In 1995 and 1997 the lead GPs were asked whether or not they thought accountability was a greater issue to them as total purchasers than as standard fundholders. The results are illustrated in Figure 4.

Figure 4 Is accountability more of an issue than in standard fundholding? (Responses by lead GPs)



In 1997, interestingly, a lower proportion (44 per cent) than in 1995 (68 per cent) thought that accountability was a greater issue. This could be because in 1995 many lead GPs and TPP managers expected that TPPs would purchase more services independently, whereas by 1997 many had chosen to contract jointly with the health authority or simply 'blocked back' money to the health authority to purchase on their behalf (Robinson, Robison, Raftery, 1998). In 1995 and 1997, of the GPs who thought that accountability would be more of an issue, financial accountability was highlighted, since the TPPs would be responsible for more NHS funds and because their actions as total purchasers could potentially affect their GMS responsibilities. One GP summed up this situation:

'There is a greater requirement for accountability and for ensuring financial probity because in the TPP the GPs can act as both purchasers and providers. It is, therefore, more important than before to avoid accusations of conflicts of interest...'

In both years, the GPs who responded that accountability would be no more of an issue than under fundholding typically referred to professional and clinical accountability (to patients mainly), or thought that since the TPP budget belonged to the health authority, financial accountability was an issue for the health authority rather than for them. For example:

'Because there is no real budget there is nothing to be accountable for.'

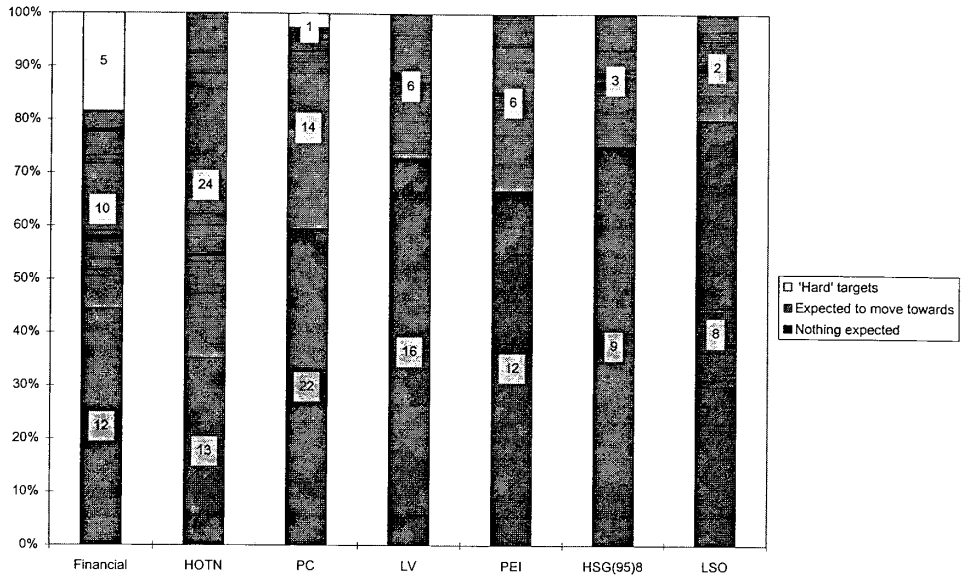
(ii) Process of reviewing performance

In 1995, almost all TPP GPs thought that the main process by which they would be held to account would be through regular review at the TPP Project Board or health authority subcommittee. Many also thought that they would be held to account through their purchasing plan/intentions. But most acknowledged that not all the 'rules of engagement' had been fully worked out with the health authority at that time. At the same time, approximately two-thirds of health authorities reported that they had no plans to develop a corporate contract with the TPP akin to the corporate contract between the health authority and the Regional Office. Of these, the typical comment was that such a contract would be *'too much red tape'*. Yet, one third of health authority respondents reported health authority plans to develop a separate corporate contract with their TPP, and one health authority had developed a 'constitution' specifying criteria by which the TPP would be held to account.

(iii) Reporting performance

In 1995, the lead GPs were asked what they believed they would be expected to achieve by the health authority with respect to several national policy objectives: the *Health of the Nation* strategy (Department of Health, 1992); the *Local Voices* initiative (Department of Health, 1991a); the Patient's Charter (Department of Health, 1991b); NHS Efficiency Index targets (Appleby, 1996); and the HSG(95)8 guidelines for continuing care responsibilities between the NHS and local authority social services (NHS Executive, 1995). They were also asked whether or not they thought they would have to work towards the local strategic objectives of the health authority. The results, shown in Figure 5, categorise the responses according to whether the lead GPs understood they were required to achieve any 'hard' or specified targets; whether they believed that they were expected to work generally towards policy objectives; or whether no expectations had been raised by the health authority.

Figure 5 **Lead GPs' understanding of what the TPP would have to achieve with regard to financial management and key policy areas (1995)**



Key: **Financial** = financial management; **HOTN** = *Health of the Nation* targets; **PC** = Patient's Charter targets; **LV** = *Local Voices*; **PEI** = Purchaser Efficiency Index targets; **HSG(95)8** = meeting guidelines for NHS and social services continuing care responsibilities; **LSO** = local strategic objectives.

The responses show that six months before the TPPs went 'live', the TPP GPs reported that they had not been asked to deliver on 'hard' targets in any area, with the exception of financial targets (they were expected to balance the total purchasing budget) (see below), and Patient's Charter standards. Significant numbers of lead GPs thought that they would be expected to deliver on the same targets as the health authority, although what exactly these were had not been made explicit to them. In the majority of cases, GPs had not been made aware of any expectations which the health authority might have in these policy areas.

In most cases, the lead GPs expressed willingness to work towards health authority requirements in these areas. Some TPPs had been working towards the same policy objectives in any case, for example, working to achieve *Health of the Nation* targets locally, and (a few) were attempting to involve the public or patients via the CHC or through patient focus groups. Many also responded that targets set out in the Patient's Charter and the NHS Efficiency Index were being addressed through their standard fundholding activities and that, no further requirements were placed upon them by the health authority as a result. A notable proportion had difficulty with two specific policies: the NHS Efficiency Index (*'it is rubbish,' 'it fundamentally goes against total purchasing,' 'we are going to have difficulty getting*

agreement [with the health authority] over this one'); and *Local Voices* - many thought that it was difficult to involve patients meaningfully. In general, the responses indicated that the lead GPs expected that they would have to work towards targets, but that measured achievement against them would not be a formal and explicit requirement:

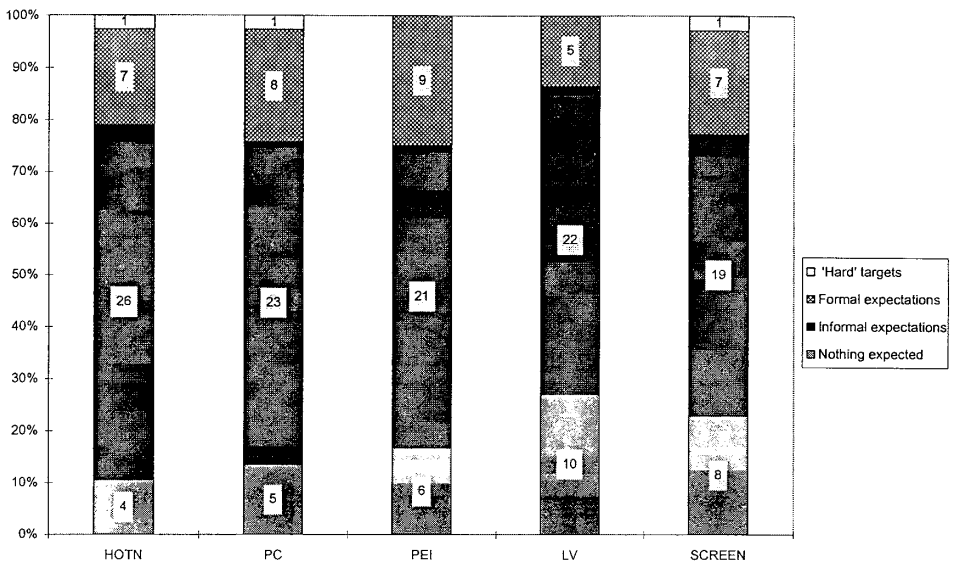
'Whether or not we achieve them will be in the lap of the Gods.'

'We have a mature and mutual understanding with the health authority over the targets.'

'We will be expected to comply, but we will not lose sleep over [attainment of] the targets.'

In 1997, health authority leads were asked about how they intended to hold TPPs to account for the funds they spent during 1996/97, and what the TPPs were expected to achieve in key policy areas: *Health of the Nation*; the Patient's Charter; the Purchaser Efficiency Index; *Local Voices*; breast and cervical cancer screening; and other local strategic objectives. As the GPs had responded a year earlier, most of the health authority leads reported that the mechanism for reviewing TPP performance was through regular meetings of the Project Board. Figure 6 groups the responses of the health authority leads for each individual policy area. Each policy area is then assessed according to whether the TPPs were required to achieve 'hard' targets; whether they were required generally to demonstrate progress towards targets; whether they were expected to work to achieve targets, but monitoring was informal; or whether no expectation was given.

Figure 6 Health authority leads' expectations of what TPPs should deliver in key policy areas (1997)



Key: **HOTN** = *Health of the Nation* targets; **PC** = Patient's Charter targets; **PEI** = Purchaser Efficiency Index targets; **LV** = *Local Voices*; **Screen** = National breast and cervical screening targets.

The responses of health authority leads show that more often than not there was an *expectation* that the TPPs would work towards national and local policy objectives, but that there was little or no explicit monitoring of the TPP. Typically, it was assumed by many health authority leads that *Health of the Nation* targets were being worked towards by practices anyway (and monitoring at practice level was difficult), and that cervical cancer screening was conducted as part of the routine delivery of General Medical Services by practices. Breast cancer screening was typically left by the TPP to the health authority to purchase. Patient's Charter standards and the NHS Efficiency Index targets were thought to be more pertinent to fundholding than total purchasing, and, typically, health authority leads reported that they monitored attainment of these in aggregate across the entire health authority population with any identified problems investigated at practice level. There was a common implicit assumption that TPPs comprised 'good practices' which were performing better against targets than other practices in the health authority, and thus could be left alone as far as possible. Several health authorities pointed out the difficulty of monitoring targets at TPP level because of the poor quality of available data. Indeed, since health authority leads expressed difficulties in achieving the same policy objectives themselves, some had taken a

lenient approach to such achievement in TPPs. For example, regarding *Health of the Nation*, one manager said:

'We struggle with that as a health authority, never mind the TPPs [having] to demonstrate that.'

The responses by the TPP managers in 1997 revealed a very similar picture. Again, the TPP managers said that they were prepared to go along with most targets, with the exception of the NHS Efficiency Index and the expectations set out in *Local Voices*. The TPP managers also confirmed that the health authority was generally ambivalent as to whether the TPP needed to demonstrate that it was progressing towards the targets. Only a minority of TPPs had collected information to check their progress towards some of the targets, but this information had not been verified by the health authority.

The health authority leads were also asked in 1997 about the extent to which they thought the TPP could destabilise local services, and whether or not the impact of purchasing by TPPs on non-TPP patients locally had been monitored. In the majority of responses, the health authority leads thought that there was *potential* for destabilisation. The minority (typically those in which the TPPs were small) thought not. Most thought that this danger was more theoretical than real, on the grounds that the TPP was deemed to be responsible and aware of its responsibilities towards patients from non-TPP practices. While formal monitoring of the effect of TPP purchasing on other patients was almost non-existent, health authority leads reported that informal monitoring through the Project Board and contacts with other local practices and with providers was taking place.

Financial accountability

Content analysis of the summaries of interviews with health authority leads showed that, in the overwhelming majority of TPPs, the requirements and approach to financial monitoring were similar across the country. As indicated in the responses above, TPPs and health authority leads reported that monitoring of financial performance occurred regularly (monthly or quarterly) through meetings of the Project Board. Typical activities included monitoring expenditure and activity against budget, attempting to explain variances, and encouraging the TPP to take action to avoid overspends. However, in some cases, even straightforward monitoring of activity and expenditure could not be accomplished because of severe deficiencies in the health authority and/or TPP information systems. A few TPPs had to monitor expenditure using ad hoc paper records rather than routine computerised financial systems.

At TPP level, monitoring tended to occur more frequently, often weekly at the meetings of the Executive Board of the TPP (see Figure 1). Typical activities at this level included validating the provider activity data which generated invoices to ensure that the TPP was not being overbilled.

Every health authority indicated that, although details had not been finalised, the TPP accounts would be audited in the same way as the health authority's accounts - by external auditors.

There was next to no activity by health authorities to query or investigate the rationale for expenditure on specific NHS services by TPPs - only six health authority leads mentioned monitoring the quality of services purchased, but none gave any details of how they were doing so. None mentioned investigating the appropriateness of the services purchased. The strong tendency was to adopt either the approach taken for standard fundholders, or to treat the TPP as an integral part of the health authority (which it is in law). The result was that monitoring and audit were dominated by accounting concerns and almost never with appropriateness or value-for-money. This is also reflected in the modest extent to which health authorities required TPPs to demonstrate achievements against national policy targets, as discussed earlier.

Only one health authority lead mentioned the possibility that standards could be developed against which the performance of GP-led purchasers could be assessed, but the health authority lead admitted having no knowledge of any which could be used.

On the management costs of TPPs, the health authority leads reported auditing the management cost accounts of the TPP in the same way, or in very similar ways, to the management cost accounts of standard fundholders. Again, the prime focus of such audits was on whether the money spent had been devoted to the intended purpose and/or had been spent legally. There was no mention of, say, comparing the management costs of the TPP with other similar pilots. Given the large range of variation in direct management costs per capita for first wave TPPs (from £0.26 to £8.05, mean £3.00 (Mays, Goodwin, Bevan and Wyke, 1997)), it might have been expected that health authorities would have been concerned to ensure that the management costs of its local TPP were appropriate.

Accountability to patients and the wider public

The total purchasing initiative was part of a wider effort to move towards a more primary care-led NHS. In addition, total purchasing developed in a national context in which 'working towards a well informed public' was one of the five strategic objectives for the NHS as set

out in the Conservative White Paper *A Service with Ambitions* (Department of Health, 1996). In practical terms, democratic accountability of TPPs, like fundholders, was based on the requirement to make key documents publicly available (see above), whilst the active involvement of patients in service planning and review was encouraged (NHS Executive, 1994). However, no specific requirements for patient involvement were made explicit.

This section is based on the responses given by every lead GP in first wave TPPs interviewed between January and March 1997, towards the end of the first 'live' year. During the interviews, each lead GP was asked the following question:

> *What efforts have been made by the TPP to consult the practice population over the range of services purchased by the TPP, or any major changes in contracts? [prompt: has the TPP involved the CHC and, if so, how?]*

In interpreting the responses of the lead GPs to this question, the analysis focuses on the extent to which different levels of patient accountability had been reached as outlined in the NHS Executive consultation document *Involving Patients: Examples of Good Practice* (NHS Executive, 1997). Specifically, the responses of the lead GPs were classified as follows:

- neither informing nor consulting patients;
- informing patients;
- consulting patients.

Neither informing nor consulting patients

Forty-six per cent of lead GPs questioned (24/49) reported that the TPP had done nothing either to inform or consult patients on the development of the project or any changes which they wished to make to local services. Most of the respondents held the view that there was little or no need for any formal consultation with patients since a high level of awareness of patient needs and wants was already available through day-to-day contact with patients at surgeries.

In addition, GPs expressed scepticism about patients' views as follows:

'[Patient consultation] would be a waste of effort since patients are not in the best position to give an informed and constructive opinion'

These GPs appeared not to have followed the requirements set out in the fundholding/total purchasing accountability framework (NHS Executive, 1994) which mentions making key

documents, such as annual practice plans and purchasing intentions, available at TP practices for consultation by patients. Most GPs in this group either assumed that patients were unlikely to be interested in any of the developments or that the dissemination of information to patients directly was inappropriate.

Informing patients

Fourteen per cent of lead GPs questioned (7/49) reported that patients had been informed, rather than consulted, of developments concerning the TPP. The main mechanisms used were practice newsletters or leaflets, posters attached to surgery notice-boards, or more detailed waiting room displays. In these cases, the TPP was performing the minimum in terms of patient accountability. Although most GPs in this group felt that informing patients was necessary and would be likely to stimulate patient interest, the responses of GPs also reveal a common disappointment that the information provided to patients was not necessarily taken up with any enthusiasm. The following observation was a typical response:

'[The TPP informed patients] through a practice leaflet, poster and a press release ... but there have been no enquiries from any patient'

Consulting patients

The remaining GPs in the interviews (21/49) had attempted actively to consult patients through patient participation groups, patient fora, satisfaction surveys and occasionally through patient interest groups (where a proposed change to a service was discussed at length between a wide range of interested parties including the TPP, health authority, providers and patients). However, those that had attempted to consult patients typically took the view that there was really little or no need for any formal consultation. One GP, for example, felt that the TPP had been coerced into a consultation process:

'We only organised a public meeting [on total purchasing] because it was felt "politically correct" to do so'

Whilst thirty members of the public attended this meeting, a far lower level of public participation was more usual. Indeed, the ability to engender public and patient involvement in consultation groups was difficult in most cases and several patient participation groups had been disbanded because of this. The following examples were typical:

'At our last forum group only three people turned up ... one of whom left when he realised he was in the wrong meeting'

'At the open meeting that we held initially it was decided that a patient participation group be set up since this was asked for at the meeting - but this has not survived due to patient apathy'

'We had to cancel our forum meetings because numbers decreased to the point where participants were usually just practice employees and Health Service workers rather than patients'

Whilst the general level of patient interest and involvement in consultation groups has been low, there have been some instances of more successful approaches to patient involvement. For example, one TPP set up a 'Friends' group - a patient interest group set up by a single practice TPP to discuss purchasing priorities for the patients of the town. This process culminated in a decision that the TPP would not purchase IVF treatments. In another TPP, 1500 patients were moved to attend four public meetings before the project went 'live' from which a newsletter and patient participation group were established at the public's request. Such successful integration of public and TPP, however, has not been the norm and the experience of most TPPs appears to highlight the difficulty faced, similarly, by health authorities in generating any significant public interest or patient participation routinely.

Informing and consulting Community Health Councils

The accountability guidelines make explicit reference to the expectation that copies, or summaries, of relevant documents be sent to CHCs whilst closer relations with CHCs to share or develop ways of involving patients and carers be encouraged (NHS Executive, 1997). The interviews with lead GPs in TPPs, however, suggest that formal links with CHCs were rare. For example, only 2/53 projects in 1995 had a CHC representative on the Project Board, rising to only 5/52 projects by 1997. In only one of these cases was it clear that the CHC and TPP were co-operating closely. Several other TPPs reported informal contact with CHCs which was typically no more than the occasional telephone call. Most TPPs reported no contact with the local CHC.

3 Discussion

Accountability of TPPs

The evidence from this study suggests that a generally loose, relatively informal, framework of accountability existed between health authorities and TPPs during the first 'live' year of the scheme, 1996/97. By and large, health authority respondents believed that practices involved in total purchasing were 'good' practices which could generally be trusted to behave responsibly. Health authorities kept track of TPP activities and plans through the meetings of the Project Board, but, with the exception of financial matters, did not generally require TPPs to show demonstrable achievement against 'hard' performance targets. The main requirements seemed to be that the TPPs should stay within budget.

There were, however, general expectations of performance - for example, that the TPPs would work towards achieving national policy goals - although progress towards them appeared to be monitored superficially, if at all. Indeed, there was a widespread reluctance by health authorities to hold the TPPs more formally to account through, for example, a corporate contract. This may reflect the difficulty, noted by several health authorities, of monitoring progress meaningfully at TPP or practice level given the data available. Health authority staff also tended to believe that a corporate contract was only appropriate between legally separate bodies, not between a sub-committee and the health authority. Thus, a common approach taken by health authorities was to monitor activities across the whole health authority, and, only if there were problems, to investigate further at TPP or practice level. This may have reflected a realistic appraisal of how difficult it would be for the health authority to influence TPP behaviour, given the scepticism expressed by some GPs towards initiatives such as the NHS Efficiency Index, and measures to improve accountability to the public, such as *Local Voices*.

Relatively informal accountability measures may also have reflected pragmatism since it would have been time-consuming to develop and implement more formal procedures. The impression given by health authority leads was that they were stretched enough, coping with implementing a variety of policy initiatives as well as fulfilling their own purchasing role, while at the same time experiencing a high turnover of staff. In many ways, the fact that the TPP was a subcommittee of the health authority (rather than, for example, a go-it-alone fundholding practice) made it convenient for the health authority to monitor the TPP less explicitly, given other pressures on managers' time. Furthermore, the Regional Offices and the NHSE appeared to have been very keen to encourage total purchasing, and not to burden or antagonise the pilot projects. As with fundholding, total purchasing was designed to develop at the 'grassroots'. The prevailing view at the centre and the Regions appeared to be

to let the TPPs get on with minimal interference (Strawderman, Mays and Goodwin, 1996). In any case, under the pilot arrangements, GPs could simply withdraw from total purchasing with impunity if excessive demands were made upon them.

A legitimate question raised by the study is whether it was appropriate or necessary, given the TPPs' legal status as a part of their local health authorities, to 'performance manage' TPPs any differently from other parts of the authority's activities. Similar questions could be raised over the extent to which it would have been appropriate for locality commissioning groups (with or without delegated budgets from the health authority) to demonstrate accountability separately from the health authority.

The answer to these questions depends upon the extent to which health authorities, Regional Offices, and the NHSE envisaged specific national policy initiatives being implemented at TPP level. The results of this study raise potentially interesting questions about the extent to which centrally designed policies, such as the NHS Efficiency Index, and *Local Voices* are applicable, desirable, or indeed workable at local level. The potentially conflicting nature of policies is likely to be thrown in to sharper focus at practice/TPP level than at the level of the larger population of a health authority. Lead GPs were very quick to point this out and, as a result, refused to go along with some policies. For example, it was commonplace for GPs to criticise the Purchaser Efficiency Index for the fact that it only recognised activity within acute hospitals whereas the TPPs were, in many cases, attempting to shift patient care from hospital to primary and community settings with the encouragement of the NHSE. Thus holding TPPs to account for implementing policies may demonstrate these weaknesses more clearly.

Turning to 'downward' accountability, it is clear that informing, consulting or involving patients in developing or implementing plans and in reviewing the progress of projects has not been a high priority for TPPs. Most lead GPs have not placed a high value on formal patient input whilst highlighting a number of difficulties when attempting to involve patients directly. Consequently, accountability to patients and the wider public remains unfulfilled in most TPPs.

These conclusions are similar to those presented in previous work examining the level of accountability to patients and the wider public developed through fundholding (Goodwin, 1996). Generally, the internal market reforms of the first half of the 1990s did little to alter the traditional position of patients and the public in terms of their involvement in decision-making ('voice') and in terms of their ability to choose between primary and secondary care purchasers ('exit'). Whilst the introduction of TPPs continued a trend in the rhetorical

promotion of greater public accountability, the evidence from this part of the study of TPP accountability suggests little has changed in practice.

Implications for Primary Care Groups

The evidence on 'upward' and 'downward' accountability of TPPs has obvious relevance when considering the proposed introduction of primary care groups (PCGs), set out in the Government's White Paper *The New NHS* (Secretary of State for Health, 1997). Ultimately, PCGs, covering populations of approximately 100,000, will be responsible for purchasing almost all primary and secondary care on behalf of their populations. Health authorities will largely lose their purchasing role (with the exception of mental health services), but retain and enhance their role in developing strategy, and in monitoring and holding PCGs to account.

Compared to TPPs, the proposed PCG structure is likely to improve 'upward' accountability significantly, since all PCGs will be entities recognised in primary legislation. They will be formally accountable to their host health authority through locally negotiated 'accountability agreements'. These agreements will set out the criteria against which performance shall be measured in order that national standards can be attained. Moreover, each PCG will be required to contribute to, and to work within, the health authority's *Health Improvement Programme* (i.e. the local health strategy). Each health authority will also have the power to withdraw all or some of the devolved responsibility from PCGs if they do not meet their targets. As a result, 'upward' accountability of PCGs to health authorities is likely to be far more rigorous than under TPPs where accountability was characterised by relative informality, perhaps not surprisingly in view of their pilot status.

Whilst 'upward' accountability is likely to be improved as a result of PCG development, the exact nature of the accountability mechanisms to be employed by health authorities in relation to individual PCGs is likely to differ depending on the level at which PCGs operate. A PCG can choose one of four levels to start. Level 1, the least ambitious, will advise the health authority on its commissioning, whilst Level 2 PCGs will take on responsibility for commissioning a range of hospital and community health services using a devolved budget in much the same manner as current TPPs. Level 3 PCGs, however, will be more radical departures from existing TPPs since they are intended to be free-standing commissioning organisations with their 'own' budget, accountable to the health authority for commissioning almost all hospital and community health services for a registered population. Level 4 PCGs will do the same, but have the added responsibility for the delivery of all Community Health Services and all GMS activity and other payments previously determined by the national GP contract.

NHS Executive proposals make it clear that both Level 1 and 2 PCGs will be formal committees or sub-committees of their health authorities, whilst Level 3 and 4 PCGs will have far greater management autonomy (NHS Executive, 1998). As a result, it is likely that accountability mechanisms will become progressively more formal from Level 1 to Level 4 since responsibility for the management of funds and commissioning of services will increase and require far greater scrutiny. However, as Mays and Goodwin (1998) point out, the autonomy of Level 3 and 4 PCGs may be highly constrained in practice through requirements to work within central and local strategic guidance including a range of new national *Service Frameworks*. In addition, it remains unclear whether PCGs will be allowed to manoeuvre resources significantly between trusts with the same degree of freedom that was enjoyed under fundholding and, to a lesser extent, in total purchasing. Indeed, it is possible that the greater managerial autonomy being offered through advanced forms of PCGs may be offset by strict central strategic guidelines, policed through stronger upward accountability. The combination of greater financial delegation to PCGs and stricter central control from the NHSE over the content of services and the attainment of targets suggests a potential for tension where local needs and national policy initiatives conflict.

Whilst more formal 'upward' accountability appears to be a significant part of *The New NHS*, the lack of 'downward' accountability to patients observed in TPPs, is likely to be little changed by the proposals. Whilst all PCGs will be required to involve the public in their decision-making, the mechanisms for this involvement are not spelled out. Since most previous attempts at greater patient involvement appear to be both difficult and unsuccessful without major effort (Mays and Goodwin, 1998), it is likely that PCGs like their predecessors, will continue to find greater public involvement hard to implement.

Finally, the advent of PCGs raises the issue of clinical accountability *within* PCGs which the TPPs, by and large, ignored. Fundamental to the PCG concept is the idea that GPs and practices act collectively, rather than individually, to manage a common budget. However, the potential rationing implications of this make it unlikely that all practitioners will accept collective responsibility for managing a budget. It is likely that some GPs will refuse to be bound by the decisions of the collectivity since their personal and traditional decision-making autonomy will be reduced as a result. As Goodwin and Mays (1998) point out, whilst information feed-back and well structured peer review may be able to reduce inappropriate variations in the performance of professionals, in some cases, there may be need for sanctions where embedded and unjustifiable differences in opinion and performance exist. It is feasible that such sanctions could be imposed by a Level 4 PCG if it set the terms and conditions of practitioner employment, but the mechanisms which could be employed by PCGs at other levels to solve such problems appear to be lacking. The issue of *clinical governance* and the

move to greater collective responsibility is probably the most significant challenge inherent in the creation of PCGs, yet its implications for accountability have yet to be resolved.

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