Primary Care Groups: A new opportunity for collaboration and participation?

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Abstract

Current initiatives in the UK are placing a greater emphasis on collaboration between primary care and other organisations such as social services, as well as on community participation. This paper reviews the development of primary care groups, examines their organisation and explores their potential to deliver improved collaboration and participation. Drawing on recent research evidence the paper questions whether these new primary care organisations do provide a basis for increased opportunities. The discussion is set within a broader policy context to provide an analysis of how far current government goals in relation to primary care are being met.

Introduction

The development of primary care as the focus for health care is central to the government's proposals for NHS reform in England set out in the White Paper The New NHS: Modern, Dependable (DoH, 1997). Similar proposals have emerged for Northern Ireland, Scotland and Wales although there are distinct differences in England which will be examined later in this paper. In April 1999 England had 481 Primary Care Groups (PCGs) - local integrated commissioner/provider bodies, 17 of which became Primary Care Trusts (PCTs) in April 2000. PCGs and PCTs are the latest development in primary care commissioning and have evolved from earlier purchasing organisations such as multi-funds, GP Commissioning Groups and Total Purchasing Pilots (Mays et al., 1998). It is also clear that their development draws on the wider experience of locality based commissioning which increasingly involved collaboration between Health Authorities (HAs) and General Practitioners (GPs) (Exworthy, 1993; Hudson et al., 1998). However, PCGs/PCTs also involve social services and community NHS trusts, through board and nurse representatives respectively. This builds on another main theme in the White Paper, that of partnership. In reforming the NHS partnership is seen as replacing market mechanisms and PCGs are to provide a local focus for such collaboration. They are also to be seen as local organisations representing natural communities (DoH, 1997) with a lay representative on the board. They must additionally demonstrate their public accountability to patients and their local community in line with the White Paper's emphasis. Finally PCGs are to become more involved in public health through their contributions to Health Improvement Programmes (HImPs), their commissioning activity and by promoting health. This involves developing new collaborations - not only with public health physicians and health authority staff, but also supporting and promoting public health activity within PCGs and the community (Taylor et al., 1998).

The new policy and organisational context raises a number of key questions:

- To what extent do PCGs, and in the future PCTs, represent a new dawn for improved collaboration and participation?
- Will these organisations deliver a more integrated approach to health and care services - a goal which has eluded previous policy initiatives (Exworthy and Peckham, 1998a)?
- Can they deliver greater patient/public accountability and involvement when current health authority practice and the experience of general practice
approaches has been so patchy and often underdeveloped (Lupton et al., 1998)?

PCTs only became operational in April 2000, so this paper reviews the potential of PCGs to provide a focus for collaboration and participation in health and social care. It examines the organisational context of PCGs and considers the experience of fundholding and Total Purchasing as the forerunners of primary care commissioning along with research on public involvement in primary care. It also draws on research on localisation and collaboration in health authorities and social services conducted in two NHS Regions in 1998/99. In this sense the paper primarily reviews the English context of collaboration and partnership but will draw lessons from developments in the other UK countries. Whilst immensely important, the role of PCGs and public health is not reviewed here. However, as discussed later, there are important links between these issues and public health policy where a key government goal is to reduce health inequalities (DoH, 1998a).

PCGs - a new framework for partnerships

The Labour Government came into power promising to abolish the internal market in health care. The new approach is based on partnership and collaboration and the details of the policy were set out in a 1997 White Paper The New NHS: Modern, Dependable. In addition to partnership and collaboration key themes included:

- developing clinical governance;
- extending management and financial control across the NHS;
- involving clinicians in service planning;
- removing the worst aspects of the internal market; improving public accountability;
- developing PCGs - integrated provider/purchaser primary care agencies.

A number of these themes were central to NHS Planning and Priorities Guidance (NHSE, Autumn, 1997). This latter also set out the core principles of the NHS, placing a renewed emphasis on equity, effectiveness, partnership and accountability - issues which were further elaborated in Partnership in Action (DoH, 1998b) a year later. In this the government outlined a number of proposals: to remove legal boundaries on the pooling of budgets; for transferring funds between agencies to allow lead commissioning; and widening the powers of health and social care agencies to provide integrated services. This emphasis on partnership was further echoed in the more recent Social Services White Paper Modernising Social Services (DoH, 1998c). In welcoming these proposals, the House of Commons Health Select Committee have supported the need for integrated health and social care. They see the involvement of social services and community NHS trusts in PCGs and Primary Care Trusts (PCTs) as 'providing an excellent opportunity for improved collaboration between health and social services, but falls well short of unifying the two agencies' (House of Commons, 1999: para. 68). How far then do PCGS represent a change from the previous context of health and social care collaboration?

PCGs - a new integrated organisation

The development of PCGs represents a marked departure from previous approaches to primary care led purchasing and commissioning in the UK. One key difference is the change from voluntary to mandatory approaches to primary care purchasing. PCGs also act at a supra-practice level, combining groups of general practitioners within populations of approximately 100,000 people (ranging from 50,000 to over 200,000) with clearly defined geographical boundaries. The PCG's
role is to improve the health of their population, to develop primary and community based services and commission health care provision on behalf of its population (DoH, 1997). Despite initial praise for PCGs by some sections of the UK medical establishment, the medical profession has recently raised concerns about whether, and how, they will work. These focus on issues such as time frames (PCGs had to be established by April 1999), organisation, complexity of task, management, funding and accountability. There have also been anxieties about PCGs having to take on a rationing role and clinical governance - policing the professional practice of their members. These have raised questions about the roles and relationships between general practitioners within PCGs and the mechanisms to be used to both define poor performance and to change the clinical practice of members deemed to be under-performing.

The idea of the integrated provider/purchaser primary care organisation is closely associated with the development of Health Maintenance Organisations (HMO) in the USA. This model has been explored by many other countries including Canada, the UK (where clear resemblance’s can be seen in GP Fundholding) and New Zealand. The relevance of the US experience in these countries is debatable and Saltman (1998) has suggested that many aspects of managed care, as developed within the model (for example, patient lists, capitation and gatekeeping to secondary care), already exist in a number of European countries (Robinson and Steiner, 1998; Saltman, 1998). Within the UK these approaches are being developed within a health care system which has both a stronger population focus and an emphasis on health gain for populations as well as individual needs (Ham, 1996).

The pressure to develop managed care organisations in the US arose from concerns about the high cost of the health care system and the underdeveloped nature of primary care. While there are some similarities between UK PCGs and HMOs there are also key differences. Here we have a single payer or funder and, while financial control is an issue, the UK has not experienced the USA type spiralling increases in health care costs. General practices in this country have also been working with practice lists and part capitated funding for many years. There is little competition between practices for patients and, particularly since 1991, GPs have begun to work more closely with health authority commissioners. The development of PCGs also owes much to the experience of GP fundholding, GP commissioning, their derivatives such as multi-funds and total purchasing (Mays et al., 1998) and the Labour Government’s need to find acceptable alternatives while retaining many of the basic elements of GP led purchasing (Hudson, 1999a).

How far PCGs will develop as integrated commissioner/ provider organisations is unclear. Their developmental nature, set out in the White Paper, allows a gradual move from advisory committee to independent organisation with trust status (DoH, 1997). There will likely be spasmodic development and movement between levels may be limited to a few leading examples if the pattern of previous experiences in GP fundholding and TPP are followed (Glennerster et al., 1994; Le Grand et al., 1998). However, the government is keen to see a small number of PCTs established in April 2000 with more in 2001 (NHSE, 1999). The TPP experience suggests that PCGs may be slow to take on the mantle of commissioner/provider and rather focusing on specific areas of activity seen to be important by the group, letting the health authority take responsibility for other areas of commissioning. To see why this may be the case we need to examine the organisation of PCGs a little more and explore some of the research on primary care commissioning both in the UK and abroad.

PCGs as organisations

As suggested above PCGs are new types of organisation and there are few comparable models against which they can be assessed. Whilst there has been some GP led commissioning in the UK, its assessment to date has been a complex task. One
review of the evidence on different models of purchasing and commissioning (Le Grand et al., 1998), developed five criteria for assessing performance:

- efficiency
- equity
- quality
- choice
- responsiveness and accountability

The authors concluded that whilst much of the evidence was inconclusive, devolved commissioning with some degree of GP involvement was important in promoting quality, choice and responsiveness. These and a range of other evaluative criteria have been applied both to TPPs in trying to understand their contribution to health care purchasing and to the development of PCGs (Mays et al., 1998). Key lessons from the evaluation are that:

- TPPs with smaller populations, fewer GPs and small groups of practices achieved more than others;
- TPPs with higher per capita management costs achieved more in the first year than others;
- higher achieving TPPs were more likely to report receiving fair or good support from their HA;
- TPPs with some independent contracts were more likely to be higher performers.

Other factors associated with achieving objectives included the existence of key individuals leading change; good collaborative and co-operative relationships with other agencies and holding a budget. Interestingly the potential to contract was found to be just as important as the actual act of contracting.

The development of PCGs within current health policy appears to be building on the lessons learnt from the Total Purchasing Pilots, although the evaluation findings suggest there may be dangers in developing large multiple practice organisations. Interestingly, in this context, a recent review of the US managed health care literature suggests that

'....from an organisational perspective, closed or tight organisational structures such as staff - or group-model HMO - make the largest impact upon performance.' (Robinson and Steiner, 1998).

Looser organisational structures such as Independent Practice Organisations (IPOs), which are associations of practitioners similar to PCGs, had less influence on physician behaviour. These studies provide important lessons for the development of integrated primary care purchaser/providers in the UK, both in terms of clinical governance and the ability of organisations to control their members' expenditure through changes in referral patterns and choice of treatments (Peckham, 1999).

PCGs, however, represent a significant development from TPPs and other forms of GP led commissioning in having boards with representation from community nursing, social services and the wider community. This provides a formalised collaboration between the medical and community nursing professions, social services and the population at large but there is little previous experience on which to develop such approach. There have also been fierce debates about the nature of PCG boards and the relative power of representatives, raising very pertinent questions about the way members will work together and how they will relate to their own constituencies (Hudson et al., 1999).
An additional problem with PCG organisations is that there are a number of different levels outlined in the White Paper. At level one they will operate more as an association of practices, advising health authorities on commissioning issues. Level two is more formal and the Group will effectively be a sub-committee of the health authority. Levels three and four provide for more independent status, with full health care commissioning responsibility and potentially primary care service provision (DoH, 1997). There is also the possibility, actively promoted by central government (NHSE, 1999), of developing a Primary Care Trust at levels three and four which involves broadening the community health services provision role. Thus, conceptually, as PCGs develop and move up through the levels they will gain greater responsibility and independence from the health authority, at the same time increasing their role in developing and supporting inter-agency collaboration and public participation. While this is presented as a developmental approach it is not clear how PCGs will move through these levels and whether it is a stepped progression (Hudson, 1999a; Meads, 1999).

There are clearly dangers here, for example, where a PCG at level one may involve practices with little interest in wider commissioning and organisational activities, but a committed few drive forward proposals for independent status at levels three or four or even for Trust status. The resultant organisation may end up looking more like an US IPO or old style multi-fund with a very narrow perspective on commissioning and income generation from service provision as a way of maintaining support from the wider practice constituency (Meads, 1999; Meads et al., 1999). Surely this is not how PCGs were intended to operate by the government? However, given the emphasis in government guidance on structural over functional elements, it is not surprising that PCGs are defining their own areas of activity.

Another key problem with PCGs is that, while collaboration and participation are defined as key characteristics, the relative power differences between members must be a concern. What is clear from the guidance is that GPs are to be the dominant players. This was evident from their ability to select a chair before the rest of the board was appointed and because boards need to have a majority of GPs present to be quorate. Much debate about PCGs has focused on the election and appointment of GPs with less attention paid to the selection of primary care nurses, social services and lay representatives. Moreover, there has been little discussion on the management and organisation of PCGs and their managerial and administrative capacity to fulfil the task they have been set. Collaboration and public participation require resource support and commitment, features which may be lacking in many PCGs (Lupton et al., 1998, Hudson, 1999a). There is little real evidence to date on whether PCGs will provide an effective focus for developing collaboration and participation. Nor is there any substantial, relevant previous experience, whilst early indications suggest that these may indeed be difficult areas for PCGs to tackle.

**PCGs - collaboration in practice**

So how well will PCGs perform in terms of developing and achieving collaborative approaches with social care agencies? Both the NHS and Social Services White papers place a significant emphasis on developing partnerships between PCGs and social services (DoH, 1997; DoH, 1998c). The House of Commons Health Select Committee (1999) has stressed the value of involving social services and community NHS trusts in PCGs. However, a recent survey of health authorities, social services and housing departments in the Northern and Yorkshire, and South and West Regions (Exworthy and Peckham, 1998b) suggests that although all social services departments are represented on PCG boards the level of representation varies. In this survey two respondents reported councillor representation (one in each region), 10 reported Director or Assistant Director representation (eight in Northern and Yorkshire and two in South and West) and 13 reported locality or area manager representation (six and seven respectively). It would appear that where PCGs are coterminous with unitary
authorities social services representation is more likely to be at director or assistant director level. Conversely, the larger the local authority area and the greater the number of primary care groups covered, the more likely the representation is to be at area manager level. These findings were similar to a survey undertaken for the Association of Directors of Social Services (ADSS) in the summer of 1999 (Hudson, 1999b). This found that around 10% of PCGs had Director level representatives, 33% Assistant Director and the remainder were third tier managers. Interestingly around 15% of the boards had additional social services representation and nearly 20% had an elected member presence (although not always a social services committee member). This difference in levels of representation may have important implications for the sort of partnership that is developed between PCGs and social services. Higher level representation may result in a more strategic approach, potentially ideal for commissioning roles, whilst area manager level may lead to the more operational approach suited to local developmental and service provision roles. Hudson's survey for the ADSS found that around 10% of SSD representatives needed more time and support to undertake their PCG activities and that feedback mechanisms were very patchy.

In the two region survey few (five) housing departments indicated that they would be represented on PCG boards. In the South and West Region one indicated it would be represented at councillor level. While actual representation is low in that region nearly half the housing department respondents expressed a wish to be represented through co-option. The desire for representation may be related to the predominantly two-tier nature of local government in this region compared to Northern and Yorkshire. Clearly there are compelling reasons for housing involvement in PCGs both on broad housing and public health grounds as well as in relation to community care issues. The ADSS survey in the summer of 1999 found that only about 10% of PCGs had local authority representation from departments other than social services.

These findings suggest that there is a strong desire for collaboration and partnership and this has been noted elsewhere. However, the survey by Exworthy and Peckham (1998b) also found that there are differences in how agencies viewed existing partnerships. Health authorities are more likely to report stronger partnerships than social services. Again, not surprisingly, housing departments reported poorer levels of collaboration than social services. When asked about service integration all respondents thought services and organisations would become more integrated in the future. The survey asked respondents to indicate key factors which encourage or hinder collaboration at a locality level. The majority emphasised the need for good quality personal relationships based on commitment and trust which was seen to be best achieved through joint working. In particular, respondents cited joint priority setting, developing joint structures and having joint responsibilities. One interesting point to arise from the survey was that both social services and housing departments emphasised the importance of the national agenda for encouraging collaboration. Lack of trust and debates about budgets were identified as the principle hindrances. However, accountability issues were also highlighted, for example, differing organisational and geographical boundaries, the lack of clear priorities and lack of time made available for collaborative working. When asked to identify measures of effectiveness of collaboration, respondents provided a wide range of indicators although there was little consensus between organisations. A number, however, were more frequently cited, such as user satisfaction as a measure of the effectiveness of joint working and joint services as a measure of service configuration. These may have important lessons for primary care groups and other agencies in developing responsive locally based services.

Not surprisingly the current focus on collaboration remains at an organisational level. This engagement has, in some places, provided opportunities for more directed joint working on health improvement around Single Regeneration Bid funding and on service delivery (NHSE et al., 1999). Similar messages about organisational links were identified in an Social Services Inspectorate (SSI) report on services for older people (SSI, 1999). The SSI found a broad range of small-scale partnerships between social
services, primary health practitioners and professionals but few strategic partnerships. This may reflect the traditional general practice focus and link (Rummery and Glendinning, 1998) with a lack of engagement by GPs, in particular, in joint working. The SSI identify potential through joint investment plans for PCGs (and PCTs) to develop more integrated services with SSDs and are thus optimistic about future collaborations. PCT status also brings the re-organisation of community health services with, in England, the potential for transferring in community nursing services from Community Health NHS Trusts. This may provide a greater impetus for developing PCT/SSD, and even wider LA, partnerships as traditionally, much of the service level collaboration at a primary care level has occurred between community nursing and social services (Ottewill and Wall, 1990).

This optimism was also found by Hudson et al., (1999) who followed up their two region survey with a number of in depth case studies. They interviewed PCG board members and other key stakeholders (NHS Trusts, housing, CHCs etc.) and found an enormous amount of goodwill towards the concept of the PCG and their potential to develop good partnerships. It was also clear that while there was little experience of utilising the autonomy outlined in Partnership in Action, there was support for the principle of the freedoms promised therein. Such goodwill will be extremely important but it is not clear how far this can overcome other problems identified, such as the enormity of the task, low resourcing of PCGs, tensions between practices and GP board members and unease about the current boundary arrangements and size of some PCGs. At present it seems there is a will for PCGs to develop new ways of working. Certainly there is also some hope for developing primary care and community services based on experience from the TPP pilots and the intentions of PCGs. However, it was clear from this research that there are still considerable difficulties around working with local communities.

**PCGs - participation in practice**

While the concept of public involvement in health care has been central to government policy for many years there is little experience of it in general practice and primary care (Peckham, 1994; Lupton et al., 1998; Taylor et al., 1998). The history of patient and public participation has been mixed, with weaknesses in general practice but some strengths in community nursing and wider primary health care services. The focus has been on individual patient contacts whilst the broader concept of community or public participation is very underdeveloped. Yet the idea of community involvement in primary health is not new - in the 1930s it provided the basis for the Peckham community health project in London. More recently the World Health Organisation focused attention by including public involvement within its definition of primary health care developed at the Alma Alta conference (WHO/UNICEF, 1978), further elaborated in more recent policy statements (WHO, 1991).

The WHO definition recognises both individual and group dimensions to involvement. Yet general practice in the UK is primarily geared to individual demand and a major challenge for practitioners as we move towards developing primary care groups is a shift of focus from the patient and the practice list to the wider population - the community and geographical populations. The idea of the Peckham Health Centre lives on and the development of new healthy living centres is part of the current government’s strategy for public health (DoH, 1998a). Initiatives like Bromley by Bow in London and those being developed in Bristol and Sandwell are the forerunners of new community orientated health centres or health parks.

How far these centres and PCGs will be able to manage the individual patient partnership within a broader population perspective remains to be seen. Accountability to your patient and accountability to a population - or to the government for effectively using resources - will create tensions requiring careful management. Yet patient and public involvement are essential to the delivery of good
health care and while the relationships may be complex, the rewards for professionals and health care service users are clear. There is growing evidence to suggest that patient involvement leads to improved clinical outcomes (Coulter, 1997) and clearly an informed service user may gain more than simply improved health. There are also important issues in terms of addressing the health care needs of the community which require partnerships between local people and professionals (Lupton et al., 1998). This presents enormous challenges for primary care practitioners and for GPs, in particular, will require refocusing their relationship with the public and their patients (Peckham et al., 1998). The need to make such changes is widely acknowledged within policy documents such as Patient Partnership (NHSE, 1996) and the recent White Papers Primary Care: delivering the future (DoH, 1996) and The New NHS: Modern, Dependable (DoH, 1997) as well as by the profession itself (Toop, 1998; Gallium and Pencheon, 1998).

The association between the public and primary care is complex, dominated by the much researched and debated context of the GP/patient relationship. The wider situation of primary care and the public has, for most GPs, come more recently although other practitioners, such as health visitors, have recognised its importance for many years.

The patient remains central to primary care practice. However, there is a growing recognition that their role is changing from one of passive recipient to one of informed partner. This reflects wider changes in the relationship between public services and users which have been developed in areas such as social care (Lupton et al., 1998). This concept of partnership between practitioner and user involves a whole person focus, a high level of patient knowledge, caring, empathy, trust, appropriately adapted care, patient participation and shared decision making (Leopold et al., 1996).

The population focus has traditionally been the practice list - the aggregate of individual patients. Participation has therefore revolved around how patients can be involved in the practice beyond their relationship with their doctor. Developing patient participation groups is often seen as the most effective method of involvement in general practice but, as Pritchard comments, progress has been slow, with relatively few practices establishing such groups (Pritchard, 1994). Doubts have additionally been expressed about who participates in such groups (Agass et al., 1991) as well as the ability of patients to shape the agenda of general practice given their dependence on the GP and, in many cases, his/her involvement (Richardson & Bray, 1987). Patient participation can, however, be very effective both in terms of benefits to the practice through the development of care and support schemes and for patient groups where they can articulate their concerns and, in some cases, input into practice decisions (Peckham et al., 1996).

GP fundholding helped to develop the concept of the participating patient population. This introduced the exploration of the health needs of practice populations (Harris, 1997) and, an acknowledgement at least, of an input into service planning and priority setting. However, this was also an area which was very slow to develop (Audit Commission, 1996). The NHSE Accountability Framework (1995) required the development of public accountability although there is little evidence of this being achieved by primary care purchasers (Lupton et al., 1998). Whilst the focus on the practice population has been an important step, there is already a further shift, moving beyond individual practices to looking at whole populations - in particular communities or areas.

Primary care and the public

The shift towards primary care commissioning has provided a significant impetus to explore public involvement. However, most work in this area of health care commissioning has been undertaken by health authorities (Lupton et al., 1998) where there is little evidence of public involvement. In the West Midlands Smith et al. found
a 'conspicuous absence of significant user involvement' (1997:40) and the TPP evaluation (Myles et al., 1998) found no evidence of any appropriate and specific initiatives being developed. One explanation for this is the perception that GPs are themselves best placed to understand patients' needs because of their close relationship and wider consultation process is therefore unnecessary (Tranter and Sullivan, 1996; Myles et al., 1998). Le Grand et al. (1998) suggest that the idea of the GP as the natural and obvious advocate of the patient was accepted uncritically in policy. Thus, until recently there has been less focus on issues of patient/ public involvement in primary care and there is some reluctance among practitioners to accept any challenges to their ability to fully represent the health needs of their patients. There is also evidence to suggest that GPs are not effective collaborators with community groups or supporters of participative activities (Taylor, 1997; Taylor et al., 1998).

The development of multi-practice arrangements such as GP commissioning and Total Purchasing, and now Primary Care Groups, has, however, shifted attention beyond the practice list to geographically defined populations. Within the UK the preoccupation with populations has traditionally been the role of the DHA, thus creating a distinction between the patient centred approach of general practice and primary care and the population focus of the health authority (Ham, 1996). This is new ground for many GPs and there is clearly a tension between these approaches which will need to be managed. It is not new, however, to all primary care professionals. Health visitors have had a public health remit, with a focus on communities and populations, for many years - a role which has become more widely recognised and seen to be increasingly important (DoH, 1995; Cowley, 1997).

Moving to a population focus will require Primary Care Groups and the professionals within them to become more outward looking, forming alliances with local community and voluntary groups, working with other statutory agencies and developing new skills such as needs assessment. Experience of these approaches is very limited in general practice and it is not clear that all GPs will want to go down this road (Peckham et al., 1998). One major issue is that, despite policy intentions, PCGs are not on the whole constituted around natural communities.

The formal connection with their communities is through the board lay representative. The government envisaged that this representative would act as a conduit to the community (Milburn, 1998) but this in itself raises complex questions around how such a conduit will work, what mechanisms exist to support such individuals in their role, how they are selected and so on. Early evidence suggests that lay representatives may be quite isolated but they do at least provide a public voice on PCG boards. An important link which merits further exploration is that between PCGs and local authorities, especially district and unitary authorities. Developing these links, potentially around discussions on public health and HImPs, may provide significant opportunities to engage in wider discussions about public involvement and accountability which owe more to the legacy of Health for All and Healthy City approaches than the NHS.

It is these issues of participation and public health that now distinguish England, Scotland and Wales. In the latter two countries the establishment of national assemblies and, in Wales, the coterminosity of local health groups and local authorities may have important consequences. The Scottish Parliament is likely to have a significant influence on health issues and may be in a stronger position to address public health across departmental boundaries. The two national assemblies are also closer than the House of Commons to services and the people - it is rather like each region in England having a local Parliament. Given the emphasis on the public health role and accountability in The New NHS it will be interesting to observe developments to see what lessons there might be for England. In Northern Ireland the debate about how PCGs are to function has been more complex given the pre-existing
joint health and social services boards. Decentralisation to PCGs seemingly threatens existing joint arrangements rather than creating new ones.

**Conclusion**

In the UK, PCGs and their counterparts represent a new organisational context for health and social care services. The inclusion of social services and lay representatives is a significant change to previous attempts at collaboration and participation. Although still in the early days of what the government has identified as a ten year programme of NHS modernisation, it is useful to assess the direction of travel. The discussion of the three questions addressed by this paper provides such an initial assessment.

Clearly the primary care organisations being developed in the UK are substantively different to previous NHS structures. Never before have primary care practitioners and social services representatives been formally integrated within the NHS. The new organisations are patently different to the old district health authorities, despite some similarities of function and size. Research suggests that those participating in PCG boards, as well as representatives from other key agencies such as health authorities and NHS Trusts, support the approach. Inevitably there are concerns - about resourcing, the potential dominance by GPs and the medical model of health care, tensions between roles as board members and representative agency agendas, the sheer organisational development work required, and the difficulties of achieving public involvement and accountability. Despite this it would appear that the immediate future will see new collaborative developments which should provide the basis for improved services. In the short term the emphasis on organisational development is likely to be retained.

There are, though, a number of key problem areas which are relevant to both collaboration and participation. A key challenge is to develop appropriate accountability structures between the NHS and local authorities and also with (and to) communities. This will not be easy, particularly given the intense centralist pull within the NHS in terms of performance management, national service frameworks, NICE guidelines and policies on cancer, waiting lists etc. These are also predominantly medical agendas which may not fit easily with local SSD or community agendas. Health and social care still operate in very different value systems and issues such as funding streams can create real problems. There are also still major difficulties around charging for social care which generates real tensions for service providers and users alike. Pooled budgets can only address part of this problem.

Like their TPP predecessors, these new primary care organisations are likely to spend little time on a wide range of service developments. Their capacity to develop new collaborative services will depend on the type and strength of the partnership and the speed with which organisational calm can be found. The evidence from TPP and simulation exercises with PCG board members suggests the focus will be on developing primary and community care services. These types of development will certainly have a more supportive framework with the freedoms promised in *Partnership in Action* and the introduction of joint investment plans. It is likely, however, that many will be focused at a practice rather than at a PCG level (SSI, 1999). Commissioning activity at a PCG level will probably remain fairly low-key and targeted at specific areas - predominantly those identified as national priorities. This would suggest that little progress will be made on improving public health - the first goal for PCGs set by the government. In addition, in the push towards PCTs, organisational upheaval will remain a constant challenge for developing primary care/social services partnerships.

Finally, the limited research evidence on public involvement suggests that this area of activity will, despite government policy and the appointment of lay members, remain a low priority and predominantly a secondary activity. Lay members are often
relatively isolated and unsupported, and generally neither represent nor provide an adequate conduit to local communities. However, they are an important lay voice. Patient and public involvement remains, however, a major challenge for PCGs and their counterparts. Again centralist directives and management are at odds with a local, community focus. PCGs and PCTs are likely to be a focal point for managing these tensions - a new role for many in primary care. In the immediate future organisational priorities are likely to mean that patient and public involvement are low on the agenda - although PCGs will need to do something in order to 'tick the box'. Thus developments will probably continue to be patchy. However, the seeds of a new way of thinking about primary care and public involvement have been planted and, particularly where a stronger public health model of primary care is developed, primary care organisations of the future may indeed become more community focused.

The key ingredient which will lead to improvements in collaboration and participation is probably the enthusiasm of the individuals involved, especially PCG board members, operating in a policy framework that is generally seen as positive. However, individual enthusiasm can easily be sapped if there are few successes in the short term and if new arrangements are not seen to bring benefits to the constituent stakeholders. As things are currently developing, the local flexibility (as limited as it may be) does provide a facilitative framework for PCGs - although how long this will continue is difficult to foresee. It is worth remembering too, that these developments do not operate in a policy vacuum. Primary care initiatives continue apace with Healthy Living Centres, Walk-in-Centres, PCT status and further Primary Care Act Pilot projects. How far these will divert, strengthen or subvert partnerships between PCGs and SSDs only time will tell. In looking to the future we need to think much more broadly about primary care organisations, their roles and the extent to which they can develop a pivotal role in the local health system. A case of watch this space.

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