From collaboration to commissioning: developing relationships between primary health and social services

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Since the publication in 1989 of the white paper, *Caring for People*, the benefits of collaboration between primary health and social services have been emphasised—albeit with little guidance on how to achieve this.[1 2] The success of emergency initiatives to reduce pressure on hospital beds and, in future, health action zones,[3] will also depend on good relationships between agencies. The recent NHS white paper also emphasises the importance of partnerships, and proposes that local authority representatives are involved in both primary care groups and health authority meetings.[4]

Collaboration is important, particularly since the 1993 changes in community care, because general practitioners and social services staff act as gatekeepers to other services. General practitioners control access to secondary and community health services through patient referrals. Social services departments manage funding for home care services and residential and nursing home places and control access through assessment and care management. When one professional or organisation depends on another professional or organisation to obtain services, their ability to achieve their own professional or organisational objectives is affected crucially. Thus, general practitioners depend on social services' funding of nursing home places or intensive domiciliary services to avoid admission to hospital for some patients or to support other patients after discharge home.

For many general practitioners, closer links with their social services department are a high priority. Some writers have argued that the surgery is an ideal base for social services because of the universality that characterises primary care.[5] Others have suggested that general practitioners should be given an integrated budget from which they can purchase both health and social services.[6] Although some studies have indicated a lack of success in achieving collaborative working, this may reflect a lack of clarity and realism about the goals and barriers associated with joint working.[7 8]

We describe several initiatives designed to improve collaboration between primary health and social services. We have drawn on two data sources. Firstly, we searched databases such as BIDS, HELMIS, CARE-DATA, and DHS-DATA and professional journals for publications about collaboration between primary health and social services (excluding initiatives focusing only on children's services) since 1990. Secondly, we investigated a number of joint primary health/social services initiatives through site visits, interviews with key stakeholders, and scrutiny of project documents.[9]

Summary points

- Basing a social worker or care manager in a general practice improves relations between primary health and social services
- Joint needs assessment and service commissioning are also needed if patients are to have speedier access to a wider range of services
- Joint assessment and commissioning do not require new legislation or pooled budgets
- Health and social services are likely to benefit appreciably, but the benefits for patients are largely unevaluated
- Success of joint commissioning initiatives depends on a commitment to joint ownership and equal involvement of primary health and social services staff

"Outposting" social services staff

The most common initiative involves the outposting, on a full or part time basis, of a social worker or care manager to a health centre or general practice. He or she takes referrals from practice staff, carries out assessments, and arranges services funded by the local authority for practice patients, from either a central or devolved budget.[10–18] Process evaluations of these initiatives have found widely acknowledged improvements in the sharing of information and in mutual understanding of the different professional roles, responsibilities, and organisational frameworks within which social and primary health services are delivered. These gains seem to be even greater if the outposting is preceded by joint training or team building exercises. Better communication and collaboration between practice based nurses and social workers were thought to be particularly valuable, possibly more than those between general practitioners and social workers.[11 15] Closer collaboration led, in turn, to quicker referrals

from primary health care to social services,[12] fewer inappropriate referrals,[10] and routine feedback on the outcome of referrals.[11]

However, these schemes are not without their problems. Care managers based in general practice risk isolation from both their peers and the managers who provide essential professional supervision.[10 12 17] Many general practitioner lists are smaller than the populations covered by the area office of a social services department, so a social work attachment to every practice and health centre is unrealistic, particularly with the very tight control on local authority community care expenditure.[2 16 19] Moreover, social services departments are likely to be concerned about the equity implications of having social services staff based in some practices but not others.[18] Finally, few schemes have had rigorous summative or case-control evaluations, so the potential benefits for patients, such as faster access to better coordinated services, have yet to be confirmed.[11]

Collaboration to commissioning

Some initiatives have gone further and have developed joint needs assessments and service commissioning between primary health and social services teams. Joint planning and purchasing has had a rather variable history, and has not generally included primary health services.[20–22] However, the new primary care groups are expected to have a strategic role in purchasing and commissioning a broad range of health services, and all NHS organisations will have a clear duty to work in partnership with local authorities.[3] What can be learned from the involvement of primary health services in joint commissioning to date?

The use of the term "commissioning" is deliberate. It denotes a strategic as well as an operational involvement in service planning, without necessarily controlling budgets or setting contracts.[23] Three different models of joint commissioning between primary health and social services can be identified.[9]

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Area or locality as basis for joint commissioning

Since 1972, Northern Ireland has had integrated health and social services authorities; in 1990 these became integrated purchasers, with community health and social services provided by integrated trusts. The extension of total purchasing to Northern Ireland has therefore given general practitioners in total purchasing pilot schemes (TPPs) access to budgets that include responsibility for mainstream social services. However, these potentially extensive new purchasing powers are constrained by the statutory responsibilities which remain incumbent on the area directors of social services. The North Downs total purchasing pilot, for example, operates as a subcommittee of the Eastern Health and Social Services Board, on which the director of social services sits. Nevertheless, it has begun to consider how to improve relations between general practices and trust based social work services. Measures include having a named social worker for each patient and attaching social workers to practices, as happens with community health staff.

Joint commissioning based on area or locality

As exemplified in the box, primary health services may participate in joint health and social services commissioning forums based on the area or locality. This can also provide opportunities for primary care staff to work with the main voluntary sector organisations, which are frequently members of joint commissioning forums.

Developing opportunities for discussions with local authorities about new service developments will be an important priority for primary care groups. Moreover, the involvement of community nursing professionals (who hitherto have often been excluded from area or locality based joint commissioning) in primary care groups is a major new opportunity to contribute their knowledge to discussions on joint commissioning. Involvement in partnerships at locality level will also enable primary care groups to contribute to health action zones.[3]

Joint commissioning at practice level

A second model, illustrated in the box, is joint commissioning at the level of the general practice. Here, practice and social services staff together assess needs and develop new services, typically to fill gaps at the interface between local health services and social care. Some of the total purchasing pilot projects have been able to facilitate this by contributing funds for joint funded social work posts and new services.

Practice as basis for joint commissioning

At Bromsgrove total purchasing pilot, Worcestershire, the primary care manager and social services development manager together identified problems in obtaining respite care for patients. The scheme now purchases respite beds for practice patients, regardless of whether these are needed for health or social reasons; funding responsibilities are sorted out afterwards. Similarly, the Arley Joint Commissioning Project, Warwickshire provides, with health authority funding, intensive home and respite care services for patients to prevent admission to hospital.

Patients as basis for joint commissioning

The Malmesbury Integrated Community Care Team, Wiltshire, includes district nurses, social workers, and occupational therapists. An assessment carried out by a district nurse is accepted as the basis for allocating local authority home care services; conversely, a social work assessment can form the basis for allocating community nursing or other health services.

Joint commissioning at the level of a practice or group of practices allows both health and social services professionals to contribute their expertise to assessing local needs. If new services are developed, they are likely to make transfer across the interface between health services and social services easier for patients with complex or changing needs. This is important if primary and community health services are to be able to deal appropriately with the consequences of shifting patterns of hospital admission and discharge. However, there is a risk with this model that health related concerns will dominate and undermine the contribution and commitment of social services staff. In addition, it may increase inequities between the patients of different general practitioners, some of whom may come to have access to more services than others; this may in turn have implications for patient registration, list size, and income related to capitation.

Joint commissioning at patient level

A third model, shown in the box, is joint commissioning for individual patients. Here, different professionals—district nurses, social workers, and occupational therapists—form a single practice based team, carrying out assessments, recommending services, and providing continuing management of care.

This model reduces the risk that people with complex needs receive repeated assessments for different services. However, it offers fewer opportunities for more strategic action in developing new services to fill local gaps. Health professionals may also feel uncomfortable carrying out the financial assessments required for social services.

Discussion

These models of joint commissioning can all take place within existing legislative frameworks—none requires pooled budgets or other radical changes. All offer opportunities for closer working relationships, so that primary health and social services professionals can better understand each other's responsibilities, professional perspectives, and organisational frameworks. They therefore all provide opportunities to reduce the frustrations that primary health staff may experience in negotiating the changing priority frameworks and resource allocation processes that determine access to local authority services. Joint service commissioning between primary health and social services is therefore as likely to improve communication and teamwork between professionals as the more common models of attaching outposted social workers to general practices.

However, joint commissioning between primary health and social services goes much further. It allows both health and social services professionals to contribute their respective experiences, expertise, and insights to assessing local problems and needs and, where resources are available, to develop or purchase new services at the margins of both health and social services responsibilities. For general practitioners and community nurses, joint commissioning with social services staff offers the same benefits as co-location but with the additional opportunity of contributing to service developments that meet patients needs better.

The importance of equal involvement and shared ownership cannot be overestimated. Local authority staff may have anxieties about the medical approach to social problems or about the diversion of pooled resources into the acute hospital sector. It will be important to show that these fears are groundless. The model of general practitioner fundholding, in which practitioners use their purchasing leverage to make changes in other services that they think are required, does not acknowledge the expertise of social services staff in assessing non-medical needs, prioritising risk, and working with networks of specialist provider organisations.[24] Moreover, social workers based in primary healthcare teams need to maintain close links with their employing organisations. Social services managers provide professional supervision and regulation and most social services departments allocate services according to priorities and procedures with which outposted staff need to keep up to date.

Realism about what can be achieved is essential. Closer working—whether through basing social services staff in general practice or joint commissioning—will almost certainly increase general practitioners' understanding of local authority priorities and speed up formal referral procedures. However, neither is likely to enable formal procedures to be circumvented or additional local authority resources to be allocated for the patients of one particular practice.

The same conclusions apply in respect of those projects where health authorities or total purchasing pilots have been able to contribute towards the costs of a social work post based in a practice. Again this will undoubtedly lead to easier communication and better working relationships between agencies. However, local authorities have their own views about democratic accountability and equity. It is therefore unlikely that NHS funding for additional practice based social work posts will lead to the allocation of extra local authority services for the patients of those particular practices. But if some resources at practice level can be contributed to the development of new joint service initiatives at the interface between health and social services, real benefits for practice patients may occur—albeit at the cost of greater inequity for others in the locality.

Finally, all these initiatives still require careful evaluation to determine whether, and which, benefits claimed by primary health and social services staff are also shared by service users. Which model of joint commissioning delivers most gains for patients? How easy is it for them to find out about services? Are services better coordinated? To what extent are patients' preferences taken into account? What are the consequences for equity and citizenship? These questions will be particularly important for primary care groups. As discussion of pooled budgets gains ground, it is vital that the lessons from today's experiences are taken into account.

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Primary care: core values

Developing primary care: gatekeeping, commissioning, and managed care

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If Nye Bevan were around today, he might be surprised to find that the basic features of British general practice, not least its administrative separation from hospital care, are still in place half a century after the genesis of the NHS. But primary care has not stood still over that period—both its structure and role have developed continuously.

This development has not been part of an orchestrated grand plan. Rather, it has been characterised by incremental change in response to wider pressures. In this article we examine briefly how some of these pressures have recently influenced the shape and direction of primary care in the UK, and reflect upon the direction of further change in future.

Pressures influencing the shape of primary care

Of the pressures outlined above, two of the greatest at present are the imperative to control the rising costs of health care and improve quality. Consequently, some of the prime movers shaping the development of health systems in the United Kingdom and other countries in recent years have been funders of health care, whether public or private.

Three related changes have resulted. Firstly, there has been greater investment in, and expansion of the role of, primary care, and more emphasis on its gatekeeping role. Secondly, general practitioners, and to a lesser extent other primary care staff, have been given more opportunity to shape services that are provided in secondary care, particularly through directly

Summary points

Primary care is being shaped incrementally by external pressures, especially the need to contain costs and demonstrate improved quality

As a result, primary care professionals, particularly general practitioners, have been encouraged to take more responsibilty to influence health services, rather than just their own professional practice

In recent years general practitioners' influence has increased through being involved in commissioning, or being directly responsible for purchasing care, from providers

In future, primary care will be required to take a bigger role in managing resources for primary and secondary care

Scrutiny of quality and cost of care will become more intense

This is the fourth in a series of six articles reflecting on the core values that will underpin the development of primary care

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managing a budget. Thirdly, incentives and rules have been applied to providers in secondary and primary care to encourage cost conscious behaviour, reduce inappropriate or ineffective care, and promote good quality care. Each of these aims is an essential element of managed care[1 2] and is referred to in the recent white paper, *The New NHS*.[3]

Greater investment in primary care and the gatekeeping role

Unlike many other countries, the United Kingdom has developed a strong system of primary care. Firm central direction has ensured universal access to a general practitioner, a healthy balance of general practitioners to hospital doctors, and greater average annual real growth of expenditure on family health services compared to hospital and community health services—3.7% compared with 2.9% over the past 20 years. The solo general practitioner working out of two rooms has been replaced largely by group practice, multidisciplinary teams and multipurpose health centres. The roles of primary care staff, especially nurses, have expanded and teamwork is encouraged.[4] The two recent primary care white papers emphasise both the development of primary care organisations to replace the independent general practitioner, and primary care as the main locus for healthcare activity.[5 6] In the 1990s there has been some limited attempt to influence the services provided in general practice—for example, through the national general practice contract—and this is likely to continue.

Other countries are belatedly learning the value of these types of arrangement, particularly in terms of efficiency, and are rapidly reshaping their healthcare systems. For example, in the United States there are new incentives for doctors to train as primary care physicians and for hospitals not to train more specialists.[7] Payment scales have been adjusted to favour primary care physicians over specialists,[8 9] reimbursement for providers has shifted from fee for service to capitation, and payers are increasingly insisting that patients seeking care make first contact with a primary care gatekeeper rather than a specialist. There is thus a worldwide push to promote investment in primary care above specialist care.[10 11]

Greater opportunity to shape services provided in secondary care

The underlying aim of initiatives in this area is not simply to give primary care providers greater influence over secondary care. Increasingly, the government wants to encourage greater cost control and efficiency at the point where many key decisions relating to subsequent expenditure are made—in primary care. The NHS has done this through increasing the influence of the general practitioner, rather than of other members of the primary care team or patients.

Three overlapping developments are increasingly being pursued in Britain[3]: greater contact between general practitioners, health authority purchasers, and secondary care providers; giving general practitioners and primary care organisations direct purchasing power; and, most recently, encouraging vertical and "virtual" integration of providers in primary and secondary care.

Greater contact between general practitioners, purchasers, and secondary care providers

General practitioners and other primary care staff have always had opportunities to influence care provided by other providers. They have been able to do this informally through professional networks and formally through representation on the boards of health authorities and hospitals.

The NHS reforms of 1991 channelled general practitioners' influence into the purchasing process instead.[12] General practitioners have been encouraged to influence providers indirectly through the health authority via locality commissioning and variants such as general practitioner led commissioning, or through the new primary care groups.[3] The existing initiatives have had some impact, particularly in developing services at the interface between primary and secondary care.[13–15] General practitioners who purchase care (for example, through fundholding or total purchasing[16]) can influence providers directly through purchasing services.

The reforms in 1991 offered little to encourage greater direct links between providers in primary and secondary care, other than through purchasing, possibly because efficiency was a higher concern than quality of care. Yet these links remained and have grown, despite the incentives of the internal market and other policies such as the requirement to increase hospital productivity.[17] Hospital at home, shared care, and outreach schemes are widespread, and some trusts are making efforts to work jointly with general practitioners on a wide range of issues.[18] The 1997 Primary Care Act and the recent white papers for England, *The New NHS*,[3] and Scotland, *Designed to Care*,[19] mark a break with the recent past because they explicitly encourage links of this kind.

Giving general practitioners and primary care organisations direct purchasing power

The general practitioner fundholding scheme, introduced in 1991, and its subsequent variants—community fundholding, extended fundholding, and total purchasing—gave general practitioners the opportunity to influence secondary care providers directly and provided modest incentives to shift costly hospital care to community settings. Currently around 55% of people in Britain are registered with practices operating some kind of fundholding scheme.[19]

If hard outcome measures of efficiency, equity, effectiveness, and choice for patients are used as a measure, the impact of fundholding has been uncertain.[20–23] There may be at least five reasons why the impact on curbing costs or demands, where appropriate, has been modest.

- Fundholding practices, at least in the early days, may have had relatively generous budgets that provided weak incentives to scrutinise expenditure.[24]
- Peer review of clinical behaviour is undeveloped, and adequate information to support it is often lacking.
- The scope for reducing hospitalisation for elective surgery may be limited, since there is little opportunity to shift it into primary care; in any case fundholding

offers no significant remuneration for taking on extra work.

- NHS trusts may obstruct change because they see nothing positive in greater general practitioner power for general practitioners, share no mutual sense of mission, and have incentives to increase hospital activity while general practitioners try to reduce it. On soft outcomes such as increasing general practitioners' sense of empowerment and ability to influence other providers, fundholding has had more obvious success.[20 25]
- Finally, fundholders and total purchasers as organisations may be too undeveloped and weak to have had much impact.[20]

This apparent lack of impact so far, plus the higher administrative costs of devolved purchasing, raise important questions about the future impact of different forms of purchasing or commissioning. The new primary care groups, covering a population of around 100 000 (set out in *The New NHS*), which will largely replace existing forms of general practitioner purchasing and commissioning, will need considerable support and help from health authorities to develop into robust and cohesive organisations. Will they be strong enough to manage demands effectively and appropriately and persuade providers to make necessary changes? Other, more fundamental, questions also need urgent answers, such as the accountability and purchasing competence of primary care groups and the future role of health authorities,[26] only hinted at in *The New NHS*.

Regardless of the pros and cons of existing models, greater incentives to use resources for NHS care more efficiently and to manage demand must be here to stay. The current proposals seek to draw all general practitioners into the mainstream task of managing NHS resources. No one model will suit all areas, however, and the umbrella term primary care groups will probably cover a range of organisations.

Encouraging vertical and virtual integration

Since 1991 the NHS has tried to separate purchasers and providers and, to some degree, push purchasing into primary care. While primary and secondary care have worked together there was no push to merge them into one "vertically integrated" organisation—until the 1997 Primary Care Act and the recent white paper, *The New NHS*.

Vertically and "virtually" integrated organisations linking primary and secondary care (box) are most strongly developed in the United States (particularly in California). They have developed largely in response to the pressure to control costs and to reduce cost shifting between different providers.[27]

In the United Kingdom, local vertical partnerships between hospitals and community services and primary care have developed at the interface between primary and secondary care. Examples include hospital at home schemes, outreach, shared care, general practitioners working in accident and emergency departments, and community staff attached to general practices as part of the primary care team. These have developed mostly to improve the quality and seamlessness of services provided, and in response to new technologies that allow more treatment at home and easier communication with hospital. Recently, the potential of such partnerships to contain costs by reducing unnecessary hospital use has become important.[28]

Linking primary and secondary care

- *Vertical integration* usually comprises large networks of primary care physicians and their teams working with secondary care providers in one single organisation. The organisation receives capitated payment for patient care, bears all the financial risk, and shares the benefits of any reduction in use of resources (such as fewer admissions to hospital) among employees, who are thus encouraged to work towards the same broad mission.
- *"Virtual" integration* is where primary care organisations (often large networks of primary care physicians) receive capitated payment for patient care, bear the financial risk of that care, and contract with preferred secondary care providers (often entering into long term relationships) without being part of the same organisation.[27]

The 1997 Primary Care Act provided the opportunity for further vertical integration. The act allowed NHS trusts (acute or community) to employ the primary team directly, including the general practitioners, and allowed the merger of budgets for general medical services and hospital and community health services.[29–31] But the underlying aim of this legislation is not clear—is it to promote more seamless care and teamwork,[32] facilitate a shift of care from hospital into the community, ease recruitment of general practitioners and practice staff, or protect the income of NHS trusts? If a main aim is to contain costs by shifting care into the community, then there may be insufficient incentives for secondary care providers to change spots and become more primary care led. But strong and stable partnerships could develop between providers in different settings under these arrangements.

The New NHS and Scotland's version, *Designed to Care*,[19] both encourage primary care staff and community trusts to team up to form a single primary care trust. Hinted at in *The New NHS*, and made more explicit in *Designed to Care*, is the possibility of primary care organisations linking up more closely with hospitals through innovative local arrangements. Possible developments include vertically integrated disease management packages (for example, for chronic diseases),[33] as well as schemes to pool resources and share financial incentives to keep patients out of hospital where appropriate.

In many ways virtual integration already exists in the NHS. Through fundholding and its variants, purchasers with capitated budgets, who are also primary care providers, have entered into long term contractual relationships with other providers. This has already encouraged greater efforts to provide seamless care and curb costs. For example, many of the new total purchasing pilots have made a priority of attempting to reduce both length of stay and medical admissions where appropriate[16] in order to be able to use the resources elsewhere. Some have employed "tracker" nurses to work in provider units to encourage prompter discharge for patients,[34] and others have persuaded NHS trusts to employ specialist nurses to help manage patients with chronic disease in the community. It remains to be seen whether these schemes will be effective, or whether the new primary care groups will develop them further. This partly depends on whether hospitals will have strong incentives to increase inpatient activity or whether they will develop wider roles for themselves.

More incentives and rules to improve efficiency and quality

Policies to encourage efficiency have mostly been heavily directed by the NHS Executive; for example, the discipline of living within the means of a global budget, and achieving the targets of the purchaser efficiency index[35] and cost improvement programmes. The NHS reforms of 1991 aimed to increase the incentives for efficiency at a more local level through introducing the purchaser-provider split and, in particular, by devolving budgets to primary care.

The incentives operating locally are still weak, however, and this may be one reason why purchasing seems to have had a modest impact on effective management of demands. Although there are early signs that general practitioner fundholders and total purchasers are beginning to think about peer reviewing their colleagues, health authorities have been reluctant to investigate or act even on gross variations in clinical practice. Through the research and development initiative, more information is becoming available on the costs of treatments and on the effectiveness of care, yet there are few direct incentives, as well as inadequate help, to use this knowledge. Proposals in *The New NHS* are designed to strengthen scrutiny of clinical performance and variations and to make much more information on the costs and effects of treatment available. The proposed Commission for Health Improvement, the nomination of a senior professional in each primary care group who will be responsible for the quality of clinical care, and the publication of a list of reference costs for hospital treatments should all help to improve monitoring of performance. But whether the new primary care groups will act on these initiatives depends on how far they will be supported by health authorities, who are already stretched.

Even greater scrutiny of clinical behaviour is likely if resource constraints become tighter in future, if the incentives set up by different forms of purchasing through the primary care groups do not result in demands being managed more effectively, and if patients' demands for information increase. Such scrutiny may take a more aggressive form, as seen in the United States: retrospective or prospective authorisation of care before payment, utilisation review and physician profiling, and more direct financial rewards for doctors to provide high quality and cost effective care as well as sanctions for those who do not.[36] Sanctions could include exclusion from networks of providers or purchasers. These developments raise many important questions, such as who would set the criteria for, and conduct, utilisation reviews, what will be done about providers who perform poorly, and whether the national GP contract will stand.

Conclusion

Primary care will develop in response to several key pressures, as it has in the past. The latest developments push the NHS only into the foothills of fully formed managed care. Unless the reforms result in better management of demand and increasing quality, they may curtail the freedom of primary care professionals as providers and purchasers. Direct and powerful tools to scrutinise and control clinical behaviour may become the norm, such as utilisation review with sanctions and rewards. The lesson for doctors may well be "manage or be managed." In the United States some of these changes have resulted in doctors having greatly diminished control over the healthcare delivery system; these doctors are described as being "still in shock,"[37] something that would have surprised Mr Bevan.

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