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Partnerships, performance and primary care: developing integrated services for older people in England

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ABSTRACT
The development of health services in England is currently shaped by three key factors: the active involvement of front-line health professionals (particularly family doctors – general practitioners) in decisions about resource allocation and service development priorities; the promotion of 'partnerships' between health and other organisations in order to deliver 'joined-up' services; and the close performance management of organisations and professionals to ensure that they meet externally prescribed objectives and targets. This paper considers the implications and impact of these factors on the development of services for older people. It discusses whether, under these circumstances, health service developments are likely to address some of the most pressing needs of older people.

KEY WORDS – Primary care, partnerships, National Service Framework, performance management.

Introduction

This paper critically examines recent policy developments in England aimed at improving health and social services for older people. Since the election in 1997 of the first Blair Labour government, these policies have been characterised by two distinctive new themes: first, an emphasis on 'partnerships' (between organisations, services and individual service providers), rather than structural reorganisation, as a means of improving relationships between services and sectors; and secondly, a concerted drive to demonstrate improved performance in both the National Health Service (NHS) and local government, as part of a wider endeavour of 'modernising' public sector services in general. A third theme, which reflects substantial continuities with earlier

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policies during the 1990s, is the growing involvement of front-line health professionals (particularly family doctors or, as usually known in Britain, general practitioners (GPs)) in decisions about resource allocation and service development priorities for NHS community and hospital services as a whole.

Using evidence from two linked, longitudinal studies of primary care organisations and their partnerships with other statutory agencies, this paper argues that these three policy themes are together largely shaping the focus of, and investments in, new patterns of health and social services for older people. The priorities of older people themselves, especially for support and services which can help avoid ill health and disability, maintain independence and maximise the quality of life are, in comparison, relatively overlooked. Indeed, the voices of older people are heard only faintly in the processes of service development and implementation.

The first part of the paper summarises the current funding and organisation of services for older people in England, and highlights some key problem areas. This is followed by a review and analysis of current policies and the methods which are proposed for achieving their objectives. The third section of the paper reports recent findings on how local health and social services organisations are responding to and implementing these policies, and the barriers which may impede their progress. The paper concludes with a discussion of the future prospects for service development and the implications for older people and their quality of life.

The organisation and funding of health and social services for older people

The main providers of formal services for older people in England[1] include the NHS, local authority social services and, increasingly, independent (charitable and for profit) service providers, all funded from a combination of public expenditure and user payments. (The contributions of relatives and friends, who are probably the major source of support and care, are not the subject of this paper.) NHS hospital, primary and community health services for older people remain funded from taxation and free at the point of use. Over the past two decades, long-term residential care has largely shifted from the NHS (long-stay hospital beds) and local authority social services departments (care homes) to private sector nursing and care home providers. As long-stay hospital services have contracted and the

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pressure to discharge patients from acute hospital care as quickly as possible have increased, so the range of ancillary rehabilitation services has also contracted (Nocon and Baldwin 1998; Audit Commission 2000; Lewis 2001). Funding for residential and nursing-home care comes from a mixture of local authority social services department purchasers and means-tested contributions from residents themselves: about a third of places are purchased entirely by older people themselves, and many more contribute part of the cost, depending on the means-tested assessment.

For older people living at home, all medical and community nursing services are provided free of charge through the NHS. Home care, day and respite care services funded by local authorities are again subject to means-tested contributions from service users; the criteria and levels of these contributions vary between local authorities across England. Although local authorities remain the major purchasers of non-residential, domiciliary care services, these are increasingly provided through contracts with private sector provider organisations. Local authority home care services are allocated following an assessment of need; there is considerable evidence that these services are increasingly targeted on older people who are most vulnerable or at risk of admission to residential care (Davis *et al.* 1997; Knapp *et al.* 2001). Older people who need less intensive support to remain living at home or who need help with domestic and household (rather than personal care) tasks are increasingly *unlikely* to receive local authority funded home care services, despite growing evidence that such services are both highly valued and sustain older people's independence and social inclusion (Clark *et al.* 1998; Lewis *et al.* 1999; Quilgars 2000).

The boundaries and co-ordination among these different services with their different eligibility criteria and funding regimes – and older people's experiences of moving between them – are increasingly recognised as problematic. Even within the NHS, older people who experience common problems such as hip fracture are likely to encounter considerable discontinuities between the different clinics and professionals involved in their treatment and rehabilitation – despite the fact that the outcomes for such patients, including the likelihood of returning home, are improved by effective joint working (Audit Commission 1995). Indeed, it is arguable that the problems of co-ordinating services were increased by the widespread introduction of quasi-markets across the public sector as a whole during the late 1980s and the 1990s. Quasi-markets require purchasers to manage relationships with a number of different providers, and they encourage competitive and adversarial rather than collaborative relationships

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(Wistow and Hardy 1996). Moreover, the use of contracts as the basis for procuring welfare services encourages close specification of the legitimate 'core business' of front-line health and social services, leaving less scope for flexibility and substitution at the margins (Charlesworth *et al.* 1996). These problems typify 'wicked issues' in social policy (Audit Commission 1998): the complex problems which cross organisational boundaries and therefore, to be tackled successfully, require a collaborative, inter-agency approach. Collaboration and co-ordination are therefore currently the focus of numerous policy initiatives, not only in England but also Australia (Fine 1998) and the United States (Leutz 1999).

The boundary (or 'Berlin Wall', according to a former Minister of Health) between NHS and local authority social services has been identified as particularly problematic. Efforts to encourage joint planning between health and social services organisations during the 1980s had only limited success and were particularly under-developed in relation to services for older people. Renewed attempts during the early 1990s to encourage joint commissioning between NHS and local authority social services organisations attempted to draw into the scope of collaborative activities mainstream service programmes, major contracts and large budgets. Joint commissioning slowly began to embrace wider, more strategic approaches to needs assessment and service provision, although again, joint commissioning of older people's services was less developed than in relation to other groups (Poxton 1999). Most significantly, family doctors (GPs) and other front-line community health services were in the main *not* involved in these collaborative initiatives, which generally took place between health authorities (the NHS purchasers) and local authorities (Glendinning *et al.* 1998; Rummery and Glendinning 2000). As will be argued below, the consequences of this exclusion may take some time to overcome.

Primary care, partnerships and performance in government policy

The Labour government's policies for primary care, provider partnerships, and performance monitoring all have major implications for services for older people. The government came to power in May 1997 and claims to be taking a 'third way' between 'new-right' policies (loosely caricatured as market 'free-for-all'), and traditional Labour approaches (equally loosely caricatured as standardised, state-controlled welfare). Thus in many areas of policy – including for these

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'three Ps' – both continuities with previous administrations and innovations can be detected.

Primary care – bringing GPs into commissioning and collaboration

The new government explicitly condemned the adversarial, fragmented and above all inequitable nature of the quasi-market introduced into the NHS by the preceding Conservative administrations, in which individual GPs were given budgets (as 'fund-holders') to purchase a limited range of hospital services for their patients. The response was to 'universalise' the more successful aspects of fund-holding by establishing 'Primary Care Groups' (PCGs) to which all the GPs in a locality belong (typically covering around 100,000 patients) (Department of Health (DH) 1997). These new organisations have increasing levels of autonomy to spend a newly-unified budget covering almost all primary, community health and hospital services and prescribing. They are responsible for commissioning hospital services, developing integrated primary and community health services, and improving the health of their local populations. As PCGs develop their organisational capacity, they become free-standing Primary Care Trusts[2] (PCTs), which bring together under a single organisational umbrella all primary and community health service provision.

PCG/Ts have been described as the United Kingdom equivalent of United States health maintenance organisations (Lewis and Gillam 2001). They have lead responsibility for the local implementation of all health policy and service developments; for planning and purchasing local health services (including hospital services); and for providing a comprehensive range of primary and community health services in the locality. Moreover, unlike the fragmentation of GP services, PCGs and PCTs provide an organisational vehicle for managing closer collaboration between health and local authority social care services in a local area.

Two important issues arose from this major transformation of primary care. First, PCGs were rapidly established across England following the publication of the government's proposals in December 1997 and first went 'live' in April 1999. A year later, a handful of PCGs had already become autonomous Trusts and all other PCGs will become PCTs over the next four years (DH 2000). Moreover, many PCGs are merging, to achieve economies of scale and enhance their purchasing 'leverage' (Bojke *et al.* 2001). This has required the astonishingly rapid establishment of new organisations, and the equally rapid expansion of both their managerial capacity and their ability to

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steer major organisational and professional changes. Such intensive internal organisational demands may at least temporarily divert attention from more collaborative activities.

Secondly, GPs dominate both numerically and culturally the governing boards of PCG/Ts, while other stakeholders (such as social services and lay representatives) have a much smaller role and less influence (North and Peckham 2001). British GPs have, however, historically been independent contractors, and until very recently remained largely outside mainstream NHS organisations and management structures (Glendinning 1999). The history of GPs' collaborative activities, either with one another or with social services, is not promising (North *et al.* 1999). GPs were not involved in the joint health and social services planning and commissioning that took place from the 1970s, and when they did become involved, during the quasi-market of the 1990s, it was as GP fund-holders, who used their enhanced financial flexibility and purchasing leverage to buy additional social work services for *their* practices and *their* patients (Glendinning *et al.* 1998; Rummery and Glendinning 2000). Even among leading-edge GP fund-holders, engagement with wider strategic planning and inter-agency activities was minimal (Wyke *et al.* 1999). Moreover, inter-professional relationships between doctors and social workers have been regarded by both academics and professionals themselves as poor, being characterised by a lack of mutual understanding and blame and therefore providing an unhelpful basis for collaboration:

> In many ways I think [working with social services staff] could be very useful. I think a lot of learning needs to go on about how we can all work together. There really are some deep-seated prejudices on both sides. (GP quoted in North *et al.* 1999: 413)

GPs are therefore now expected to play a leading role in commissioning health services for older people through PCG/Ts, with other service providers such as local authority social services departments, and in managing the delivery of these services, through close inter-professional front-line working. However, neither the history of general practice, nor the experience and culture of GPs. provide a sound basis from which to work.

Compulsory partnerships

Given the shortcomings of previous attempts to break down the 'Berlin Wall' between health and social care services, current policies place renewed emphasis on 'partnerships'. All NHS organisations are now

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under a statutory duty to work in partnership with other services, while local authorities have a corresponding new responsibility for improving the health of the local population. One illustration of this partnership imperative is the requirement that PCG/T boards must include a representative from the local authority social services department.

Substantial financial resources have been 'earmarked' to support new local health and social service collaborations. Structural barriers to integration have been removed, enabling local authorities and NHS organisations to pool budgets for a specified range of services, to delegate overlapping or contiguous commissioning responsibilities to one 'lead' organisation, and to integrate social care and health services in a single 'provider' organisation (DH 1998; Hudson *et al.* 2001). These new 'flexibilities' are intended to facilitate the configuration of local solutions to local problems of integration. However, they, and other elements of the current policy of promoting partnership, may also enable central government to exercise much closer scrutiny over local health and social care collaboration, and to reward or punish local partners (Clarke and Glendinning, forthcoming).

The government's impatience with the pace of health and social services collaboration in England prompted yet more proposals in 2000 for integrating services (DH 2000). These include a new investment of £70 millions in combined social and health 'intermediate care' services, *e.g.* intensive home nursing, rapid response health and social care teams, and active rehabilitation services, to support early discharge from hospital and to prevent avoidable hospital admissions. PCG/Ts have a major role in commissioning, managing and providing such services, in partnership with local authority social services' home care services and private sector providers. Recent proposals also include plans to move social workers to primary care settings; introduce integrated assessments of individual older people's health *and* social care needs (DH 2001*a*); and the eventual complete merger of local health and social services into a single organisation, a NHS 'Care Trust'. Modelled on Primary Care Trusts, these will bring together existing family physician, community nursing and social services into a single organisation and management structure (Iliffe 2001). Care Trusts will commission and provide integrated services for specific groups of users within a defined geographical area.

The establishment of Care Trusts from 2002 is voluntary and depends on the priorities and preferences of local health and social services organisations. Early applications for Care Trust pilot status suggests that, as with previous collaborative initiatives, services for older people may be less well prepared for closer integration than

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services for, say, people with mental health problems or learning disability. Collaboration is not however optional: when and where 'partnership failure' occurs and collaboration is judged by the central regulatory bodies to be inadequate, legislation enacted just before the 2001 election empowers the government to compel local NHS organisations and local authority social services departments to use the new collaborative mechanisms.

Managing and improving performance

Continuity with previous administrations is also apparent in the overwhelming concern of the current government to maintain and enhance managerial accountability:

> the Labour government has accepted many of the changes made by the Conservatives that have improved managerial accountability and has introduced some of its own. The performance management ethos has become even more pronounced under New Labour. (Rouse and Smith 1998: 250)

Newman (2001: 2) also refers to the intensification of neo-liberal performance management, audit and inspection regimes. This continues a tendency for new policy initiatives to be shaped by, and even restricted to, those activities where targets can be set and where the performance of organisations and individual service providers in relation to these targets can be measured. It is of course far easier to construct performance indicators and regulatory/audit systems around single departmental activities and services than around more diffuse partnership and collaborative activities, or objectives which cross-cut departmental boundaries and core professional activities (Newman 2000).

One aspect of this intensified performance management of the public sector has been the publication of 'National Service Frameworks' (NSFs), which prescribe clinical and service standards in relation to specific clusters of health and other services. The NSFs stem from Labour's political commitment to end the inequities and inequalities which had developed through GP fund-holding, so that 'patients will get greater consistency in the availability and quality of services, right across the NHS' (DH 1997: 57). The first NSFs focused on specific clinical services for heart disease and mental illness. However, the *NSF for Older People* (DH 2001*b*) is much broader. It sets standards across health *and* social services in England, regardless of whether or not these are delivered in hospital, the community or long-term institutional care, or are provided by public or private organisations. The *NSF for Older People* (DH 2001*a*) aims to:

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- prevent age discrimination in accessing NHS and social care services;
- provide individualised 'packages' of care, through single assessment arrangements and integrated service commissioning and provision;
- increase the volume and range of intermediate care services to support early hospital discharge and prevent unnecessary hospital admission;
- improve the quality of hospital care for older people;
- reduce the incidence of stroke and improve diagnosis, treatment and rehabilitation after a stroke;
- prevent falls and provide effective treatment and rehabilitation after a fall;
- promote good mental health and improve diagnosis and treatment of depression and dementia;
- promote general health and sustain independence;
- improve the coherence and quality of prescribing.

Each standard is accompanied by a set of required interventions, and short and longer-term milestones for their achievement. Because of PCG/Ts' extensive responsibilities for all local NHS services (whether through direct provision or commissioning), and their statutory duty of partnership working, they have a major role in implementing the NSF. Moreover, the intensified emphasis on performance means that PCG/T activities in relation to this role will be closely monitored and scrutinised. It is too early to assess what impact the NSF will have on the experiences of older people using health and social care services, although some early responses by key PCG/T and social services personnel are available (and are discussed below). More extensive evidence is however available on the two other policy themes of great relevance to the development of older people's services: the development of the new primary care organisations, and the imperative to engage in partnership and collaboration at all levels. This evidence is also reviewed in the next section.

Developing services for older people: new primary care roles and responsibilities

PCG/Ts now hold the budget for health services for their local populations, are responsible for commissioning acute services and for developing and providing integrated primary and community services, and have a new statutory duty to work in 'partnership'. Their

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activities, including collaboration with other health and social services organisations, are therefore crucially important in the future development of health and social services for older people. Many of the recent initiatives that have been described emphasise objectives and processes, rather than the outcomes for older people. This is not new: studies of previous innovations in primary care have shown that the early priorities are more likely to concern internal systems and managerial capacity than external activities (Regan *et al.* 1999). Nevertheless, indications of priorities, potential barriers and possible outcomes can be discerned.

The evidence comes from two linked, longitudinal studies which aim to evaluate the development and performance of PCG/Ts and in particular the nature and effectiveness of the relationships they are establishing with other organisations, including local authority social services departments. The studies are funded by the English Department of Health and are being conducted by the National Primary Care Research and Development Centre at the University of Manchester. One of the studies is a survey of a representative sample of 15 per cent of English PCG/Ts; fieldwork was carried out in the autumns of 1999 and 2000, respectively six months and 18 months after these new organisations went 'live'. Interviews were conducted with the Chair of the PCG/T Board and Chief Executive, and postal questionnaires sent to the social services department representative on the PCG/T Board, the local Community Health Council and other key stakeholders (Wilkin *et al.* 2000; 2001). The second study involves in-depth case studies of a subsample of four of these PCG/Ts; again, two rounds of semi-structured interviews have so far been conducted with various local stakeholders (Rummery *et al.* 2000). Together, these two studies provide a robust account of how PCG/Ts are approaching the development of services for older people.

As Newman (2001: 111) points out, pressures to create 'joined up' partnerships may be difficult to reconcile with more directive, hierarchical forms of governance. Indeed, PCG/T priorities clearly show the influence of the intensive external scrutiny to which they are subject. In the second round of the PCG/T survey, the most important health improvement priorities cited by PCG/T Chairs reflected exactly those areas subject to National Service Frameworks – heart disease, mental health and older people. Similarly, with regard to priorities for older people's services and partnership working, managers in the case study sites also spoke of goals which reflected national policy agendas, particularly intermediate care and hospital admission/discharge arrangements:

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The main pressure we're coming under is to manage the winter pressures – the emergency admission work – better, and to develop intermediate care services … we are absolutely clear as managers that we have to deliver waiting list numbers, waiting times: we have to deliver managing winter pressures better. (Health authority manager)

Delivering tangible results on key performance targets thus tended to drive service development priorities, possibly at the expense of partnership working:

You have to recognise that partnership and joint working isn't easy, it's a long haul … the real test is when you come under pressure to deliver … because you are accountable for doing things, accountable in a hard way, and that really tests the relationship. (Health authority manager)

Their focus is on reducing bed delays, reducing the amount of time people are in hospital for certain events like a broken neck of the femur or a stroke. They're quite determined to reduce that at almost any cost to us. (Social services manager)

Most of the managers in the case studies expressed a desire to move away from such narrow targets towards the development of holistic and preventative services for older people, with a single point of entry, but were constrained by the need to demonstrate 'quick wins' on high profile political issues such as bedblocking. The external pressures driving the priorities of PCG/Ts were also reflected in the relative lack of influence felt by many of the representatives from local social services departments who sat on PCG/T boards. Even 18 months after PCG/Ts were established, social services representatives still felt relatively marginal to many areas of activity, and both they and other stakeholders rated their influence on decision-making as considerably lower than that of other board members. Forty per cent of PCG/T chief officers described social services representatives as having 'little or no influence', compared to only two per cent for GPs and 28 per cent for lay representatives (Wilkin *et al*. 2001). Social services representatives in the case study sites explained the reasons for this marginalisation:

I am not sure whether it is appropriate, or whether I want to be involved, but some of the areas around clinical governance and prescribing are the areas that I find most difficult to enter into a meaningful debate, because they can turn into quite a clinical discussion, and I feel that's totally appropriate. So there's less from a social services perspective to add to that, but I do wonder whether things like multi-disciplinary assessments come into the clinical governance debate.

Underpinning these uneven patterns of power and influence lie some major differences in the approaches of different professions and

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organisations to the identification of needs and the commissioning of services to meet those needs. Both social services representatives and other PCG/T Board members noted the discrepancies between GPs, who tended still to focus on narrower patient, practice and medical issues, and the broader, strategic perspectives demanded by PCG/Ts' extensive new responsibilities. The dominance of the somewhat narrower concerns of GPs also contributed to the perceived marginalisation of the social services representatives on PCG Boards:

> I would say that [my influence] is not so extensive, and that's related to the capacity of the Board and the people to be able to think more widely than their health care interests, and that's the problem … It's to do with their view of the world. (Social services representative)

> What the GPs on the Board are concerned about is what happens to their individual patients. I don't think they're quite evolved to the stage that they are thinking strategically yet, they're still focused, quite rightly in a lot of respects, on what this is going to mean for GPs in their practice and for their patients. (Social services representative)

> I've used every opportunity to start to increase their knowledge about social services and to identify ways that it's of benefit to them in their general practice, not just in strategic planning terms, but that it's a real benefit for their patients … At first it irritated me that they weren't seeing their role at that strategic management level … Some of the GP Board members had a real difficulty, they were saying, 'I'm looking at this monitoring information, now what do I do with it, that's not my responsibility'. I've been the one that's banging the table saying, 'Yes it is your responsibility!' (Social services representative)

Nevertheless, in most PCG/Ts, some of the traditional mistrust between GPs and social services staff had decreased, with the proportion of social services representatives reporting the attitudes of other Board members as friendly and constructive increasing over time. Somewhat slower progress was evident in the PCG/Ts' capacity to plan and commission services for older people in collaboration with other stakeholders – a key step in the development of integrated services. PCG/Ts were only gradually beginning to conduct comprehensive assessments of the needs of the older people and the adequacy of existing services. By the end of 2000, half (51 per cent) had done this, compared with only a quarter a year earlier. However, professional and organisational perspectives still dominated such assessments (Figure 1). Indeed, the issue of consultation – who is involved and contributes to decisions – on the provision and commissioning of services is much broader. The two studies show a widespread tendency for decisions to be shaped by the priorities and objectives set out in national policy guidance and performance indicators and by the

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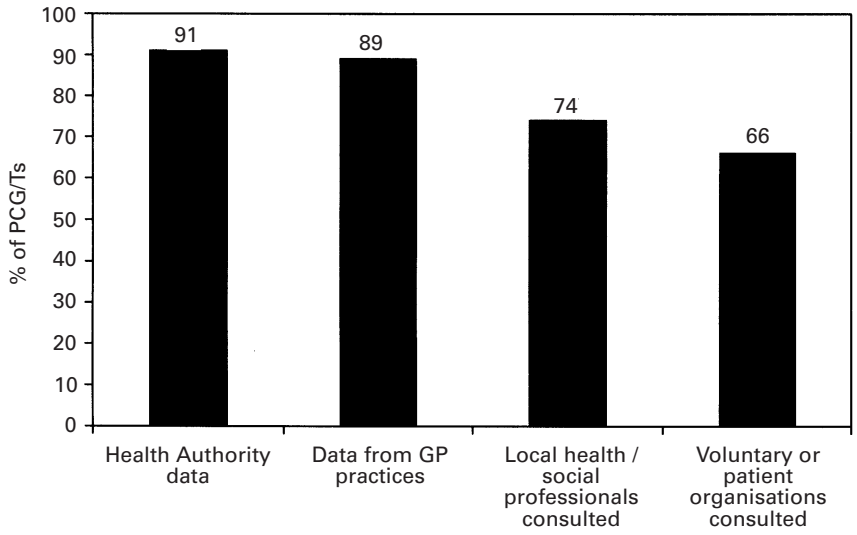


Figure 1. Sources of information used by PCG/Ts to assess the health service needs of older people (N = 35)

perspectives of the GPs who constitute the majority on the PCG/T Board and other clinicians. Thus, few PCG/Ts appeared to involve or consult their social services counterparts when commissioning other health services – despite the fact that poor co-ordination between hospitals, primary and community health and social services in arrangements for admitting and discharging patients from hospital is widely believed to be a major constraint on the efficiency of the acute hospital sector (DH 2000). Nevertheless, when commissioning hospital services, PCG/Ts were far more likely to consult hospital doctors and nurses than social services departments – let alone voluntary organisations, older people or carers. PCG/Ts were more likely to consult their social services counterparts about the commissioning of community health services (district nursing, physiotherapy and other rehabilitation services), but even here 43 per cent of PCG/Ts reported *no* social services consultation (Figure 2).

Nevertheless, PCG/Ts recognised that collaboration with social services in planning new service developments for older people was a high priority. In the latest round of the survey, PCG/T chief officers were asked which services were their top priorities for collaborative working with social services; 91 per cent identified older people's services among their top three priorities. However, given the clear national policy objectives and the close performance management of local activities in relation to those priorities, it was not surprising that

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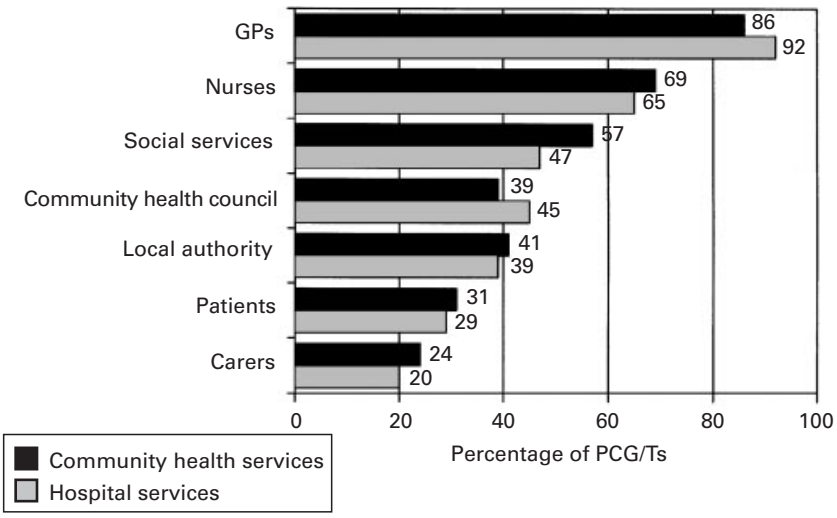


Figure 2. Percentage of PCG/Ts consulting different groups to inform commissioning

TABLE 1. *Priorities for service developments for older people through closer partnership working* ($N = 40$)

Priority	% of Social Services Representatives
Improving front line co-ordination between health and SS	58
Developing community rehabilitation	55
Developing joint/integrated assessments	53
Promoting health/independence	43
Reducing hospital admission	40
Improving range of domiciliary services	33
Improving support to carers	18

Note: Respondents could choose more than one answer.

the types of older people's services which PCG/Ts were planning in collaboration with social services were mainly located at the interfaces between hospital and domiciliary services. They included community-based rehabilitation schemes, intensive and 24-hour rapid response home care services, other intermediate care services and integrated home equipment services. Social services representatives on PCG/T Boards largely endorsed these priorities for joint service developments for older people, with the additional priority of improved co-ordination between front-line health and social services staff (Table 1).

Again, these priorities clearly reflect those set out in the National Service Framework for Older People, the NHS Plan for England and

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other recent policy statements. They also show a distinctively medical orientation; preventive services such as health promotion and help with simple household tasks, which might enable older people to remain independent, or halt the development of physical or mental health problems tend to receive less attention. Health and social services staff in the case study sites endorsed the view that, while the NSF might help to improve the status and importance attached to developing older people's services, it was nevertheless highly prescriptive about the content of those services:

> [The Mental Health] National Service Framework has had a major effect on commissioning development … so I think the main effect will be a more detailed specification of the services we are buying … I think it will provide a clear framework for joint working for older people. (Health authority manager)

> Our priorities are in relation to the NSF for Older People … For example, with regard to community equipment, the NSF tells us that we've got to provide services to 50 per cent more people by 2004, so that is clearly a priority for us … that is clearly a priority that comes from our performance indicators. (Social services manager)

Moreover, the NSF also increased the importance of collaboration between PCG/Ts and social services in relation to older people's services, with the risk that this could come to be viewed as a new performance target in itself:

> I think it is getting easier because the political agendas have changed more to joint working, I feel as though I have been banging away at this for such a long time and now I feel, particularly with the National Service Framework, that our job has been made easier and people are more interested. (Social services manager)

Indeed, PCG/T respondents did report some gradual improvements in relationships between front-line health and social services staff. In the first round of the annual survey of PCG/Ts, relationships between GPs and social workers were often reported to be poor, though relationships between community nurses and social workers were somewhat better. By the second year, relationships between social workers and GPs were reported to have got a lot better in over a third of PCG/Ts, and a little better in a further half; similar improvements were reported in relations between social workers and community nurses. Nevertheless, improved inter-professional relationships do not necessarily signify close operational-level collaboration in delivering services. Indeed, in the second round of the survey, only a third of PCG/T chief officers rated operational-level collaboration between community nursing and

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social services as good, compared to 56 per cent the previous year. Moreover, apart from joint training, other changes in the deployment – the location, organisation, roles and responsibilities – of front-line health and social services staff which might contribute to better collaboration and service co-ordination were not common.

Finally, as suggested above, there was little evidence that PCGs had consulted older people, or even voluntary organisations which might represent their views, in the course of identifying new service priorities, commissioning services or when deciding how to implement these new developments. There were some differences in the attitudes of PCG/T and social services staff over the timing and importance of consultation, with the latter keen to involve service users from the outset in planning services, and the former wanting to develop clear plans prior to consultation:

> I don't think at this moment in time we are in a position to consult on the changes, because we haven't decided yet what they might be (PCG chief officer).

> One area that we consulted with the public in community care was bathing … so we together sorted out a system that isn't wonderfully popular with professionals but is very popular with clients and patients (Social services commissioning manager).

Around three-quarters of PCG/Ts had co-opted representatives from voluntary organisations onto subcommittees or working parties, but only a fifth of these representatives were from Age Concern or other organisations representing older people. Community Health Council (CHC) representatives were also asked in the most recent round of the sample survey about their local PCG/T's consultation on services for older people. Fifty-eight per cent of PCG/Ts were reported to have undertaken little or no consultation with the CHC, and 56 per cent of PCG/Ts had undertaken little or no consultation with local people on this issue. Where consultation had occurred, CHC representatives were asked whether this had had any impact on policies and decisions, but in almost all PCG/Ts the impact was considered to have been minimal.

Discussion and conclusions

Primary care is now the key player in the development of integrated health and social services for older people. PCG/Ts hold unified budgets for virtually all areas of health care expenditure; have responsibility for commissioning hospital and community health services for their locality; and are responsible for the provision of

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comprehensive, integrated primary and community health services. They are under a statutory duty to work in partnership and in a position to ensure that the health services which they commission and/or provide are appropriately co-ordinated with social care and other services. These responsibilities and opportunities extend across the whole range of service organisation, from the planning, purchasing and contracting of services to the development of local integrated home nursing and home care teams and single, comprehensive assessment processes which can be carried out by whichever doctor, nurse, social worker or occupational therapist first receives a referral. PCG/Ts can also use the new partnership flexibilities to pool their budgets with local authorities, delegate commissioning responsibilities to a more experienced 'lead' organisation, and integrate their health and social services in a single 'provider' organisation.

The evidence to date suggests however that a considerable amount of cultural change, organisational development and 'learning' are still required before these opportunities are fully grasped. One reason for this is the continuing domination of what Alford (1975, cited in North and Peckham 2001) terms the 'professional monopolisers' and the associated individualistic, small business culture of general practice, which is not well attuned with population or locality-level needs assessment, 'whole systems' approaches to service commissioning or inter-sectoral collaboration:

> GPs are independent contractors … and have been used to developing their own practices … I think to take on the role of strategic thinkers is really quite a hard job. (Social services representative on PCG/T board)

A second constraint is the very rapid organisational development which PCGs have been – and still are – required to undergo, in developing capacity and becoming Primary Care Trusts. These pressures focus attention on internal activities rather than external relationships:

> It's bigger and bleaker than everyone thinks it is, becoming a Trust from a PCG. There's a lot more organisational work to be done … to be honest, the move to a PCT does create a hiatus in an organisation – you don't do anything when you're doing that. (PCG chief officer)

Thirdly, PCG/Ts' organisational development has been accompanied by intensive performance management of a wide range of activities, many of which are not related to collaborative modes of working or the development of integrated services; inevitably these activities take priority. Indeed, the imposition on PCG/Ts of a range of performance measures and targets carries further threats to the development and

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integration of services for older people. As Newman (2001: 112) points out, problems are often created for local partnerships by the imposition from above of 'best practice' standards and prescriptions, rather than the encouragement of local responsiveness, diversity and horizontal, inter-organisational communication and learning. Thus the standards contained in the *National Service Framework for Older People* include a mix of specific, service-related interventions and milestones (for example, diagnostic facilities and protocols to identify older people at risk of strokes, protocols for the rapid referral and management of those with transient ischaemic attack); and broader, more diffuse objectives (for example, prevention of falls, health promotion programmes and 'action to ensure fair eligibility criteria' which 'do not discriminate against older people'). It is of course far easier to take action on the more specific and concrete service or clinical targets than on those which are diffuse or difficult to measure. This risks marginalising those targets, such as 'providing person-centred care', or maximising choice, which are far harder to operationalise, but which may have major impacts on older people's quality of life.

Both the widespread closure of long-stay hospital services and the contraction of acute hospital services during the 1980s seriously reduced the availability of rehabilitation services which in general were not transferred to the community (Lewis 2001). The current emphasis on re-establishing a wide range of intermediate care services – to prevent admission to hospital or residential care and to support older people after discharge – will therefore certainly help to fill an important gap. Moreover, the imperative on PCG/Ts to develop intermediate care services should also provide a specific focus around which PCG/Ts can develop closer relationships with local authority social services departments.

The intermediate care services which PCG/Ts are developing are however mostly restricted to providing short-term intensive support, particularly in a crisis or immediately after hospital discharge. This comparatively narrow scope is reinforced by the milestones which have been set in the Older People's NSF for developing intermediate care services; these milestones relate to reductions in 'unnecessary' hospital admissions and increases in services to support early hospital discharge. This raises several issues. First, as the Audit Commission (2000: 21) warns, 'intermediate care services should act as an extension to specialist clinical care and rehabilitation, not as a substitute for it'. There is, however, a risk that pressures to clear acute hospital beds may find older people being discharged to 'step down' rehabilitation facilities without the specialist clinical support which some may still

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require. Indeed, there are strong arguments that specialist geriatric services should play a far greater role in supporting frail older people in the community than they currently do (Black and Bowman 1997; Bowman *et al.* 1999; Royal College of Physicians 2000).

Secondly, there is a possibility that no new services will be developed for older people who are not currently at risk of admission to hospital or long-stay residential care or awaiting discharge from hospital. For example, an evaluation of two local rehabilitation services found that nearly 40 per cent of people using them were considered not to be on the threshold of admission to residential care. This was interpreted as evidence of a poorly targeted service, rather than as evidence of the extent to which a wide range of older people in different circumstances might benefit from help to improve their mobility and other daily functional activities (Audit Commission 2000: 24). Lewis (2001), however, cites a number of government and independent academic reports which emphasise the complex mix of medical *and* social interventions which should be included under the term 'rehabilitation'. In contrast, the targeting of resource investments and performance management activities on services at the interface of hospital and institutional care will marginalise many older people who could benefit from preventive services, who need help managing the consequences of long-term illness and disability, or who would simply experience improvements in confidence and quality of life from some active rehabilitation and therapy services. Such services could delay, prevent or reverse the deterioration or loss of independence by older people. The risk of these wider benefits being overlooked is increased by the fact that new intermediate care services will be available only on a short-term, transitional basis, and will thus exclude opportunities for maintaining independence or preventing deterioration.

Furthermore, as is entirely appropriate, many PCG/Ts are developing such services in partnership with local authorities; but this raises new questions about which elements will be subject to local authority means-tested user charges, and suggests the emergence of a new set of boundaries between 'free' health care and means-tested personal care. For example, will such services be free for a short, initial crisis period, with charges introduced after, say, a week or two? Will charges be imposed for the 'personal' care elements of such services, but not for the 'nursing' or 'therapy' elements? Given the low incomes of a substantial minority of older people, coupled with the higher risk of ill-health and disability among less affluent population groups, the issue of service charges may have a major impact on older people's decisions to begin or continue using such services, with negative consequences for their

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independence and quality of life. As Lewis (2001) points out, both partnership initiatives and new investments in intermediate care services may be undermined by the failure to address the financial dimension of the health-social care boundary.

More generally, although current policy emphasises partnerships between PCG/Ts and local authority social services departments in developing and delivering services, the performance of PCG/Ts to date raises questions about the equality of such relationships. Survey and case study evidence both indicate that professional medical perspectives still dominate supposedly 'joint' processes of commissioning and contracting for services, whether intermediate care or otherwise. Both social services partners and user representatives remain relatively marginal to many service development and commissioning activities. Moreover, the proposed new, integrated Care Trusts described earlier in this paper are modelled on NHS organisations and will have delegated autonomy from local authorities; they will be managed through mainstream NHS management and accountability systems. 'Despite attempts to develop cross-cutting performance measures, the structuring of audit and inspection regimes has tended to follow departmental and service boundaries rather than reflect cross-cutting or joined-up objectives' (Newman 2001: 120). It is far from clear how the rather different objectives and contributions of the social services partners in Care Trusts will be sustained under such conditions.

Finally, it is difficult to detect any evidence that the aspirations and wishes of older people themselves are reflected in current policies or proposals for future joint or integrated service developments. This pattern may at least partly reflect the problems of involving users – of any age – in developing new patterns of services which have to be accomplished within a tight timescale and to objectives which are set by central government, thus leaving little scope for local discretion.

The views and perspectives of older people are crucially important in counteracting a policy and service development agenda that may be increasingly medically-dominated. In particular, priorities which are dominated by the rapid development of intermediate care services, and which are audited and performance-managed with narrow targets relating to acute hospital and residential care use, will overlook many developments which can contribute to older people remaining independent, exercising choice and control and maximising the quality of their lives. For the development of the *National Service Framework for Older People*, an independent advisory group of older people was convened to provide a 'user' perspective. The priorities identified by the group differ from those which finally emerged in the NSF, although

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some priorities, such as the ending of unequal treatment because of ageism, are common to both the NSF and the user group's recommendations. Rather, older people themselves complained about delays in receiving health and social services (which could in themselves create further health problems); about the narrow scope of assessments (too geared towards eligibility for specific services, rather than aiming to maximise quality of life); about the lack of preventive services (especially domestic help and support to help older people stay healthy); about charges for local authority home care services (and the continuing charges in England for personal care in nursing and residential care homes); about poor transport and building design; and about the quality of services in hospitals, residential care homes and older people's own homes (HOPe Group 2000). As well as calling for an end to ageism, their priorities were for wider action to improve older people's health; for information, equal access and advocacy services; for their dignity and autonomy to be respected; and for improved training for all professionals working with older people (HOPe Group 2000). Above all, they called for involvement in the planning, organisation and monitoring of services, for 'making a difference to people's lives will mean working in co-operation with older people themselves. Who knows better than older people what results are needed?' (Ellis 2001: 11).

'Integration', co-ordination and partnership are almost sacred mantras in the health and social care policy and service worlds of contemporary England: some may see challenging these goals as heresy. It is however appropriate to question whether they are the most pressing priorities of older people themselves; and to ask whether the pursuit of these objectives risks the expenditure of considerable managerial energy with no prospect of clear, discernible benefits for older people. The current preoccupations with co-ordination and performance ultimately may obscure more fundamental and politically difficult issues about the level of resources committed to sustaining the scope and quality of the services received by older people in England. In the long term, these considerations may have a greater impact on the quality of life of older people than yet another set of service reorganisations.

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NOTES

1 Following political devolution, differences are emerging between the different countries of the United Kingdom, particularly England and Scotland, in the funding and scope of health and social services for older people. The focus of this paper is on services for older people in England.
2 National Health Service 'Trusts' are semi-independent legal and financial entities, and were first introduced to run acute hospitals (and others community health or mental health services) in the early-1990s.

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