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Relationships between the key players in primary care groups and trusts: some lessons from total purchasing pilots

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Primary care groups (PCGs) and primary care trusts (PCTs) are the way forward for primary care in the UK. These groups of general practitioners (GPs) and community nurses, organized along geographical lines, will need to forge relationships with other organizations and key players to a much greater extent than has been necessary hitherto. Currently PCGs most closely resemble the total purchasing pilots (TPPs), which have been the subject of a national evaluation. This paper reports on the evidence collected by interviewing key stakeholders – lead GPs, health authority (HA) leads, project managers and social services representatives – about how relationships developed in TPPs and how this might be relevant to PCGs and PCTs. The importance of good relationships with HAs was recognized by the TPPs, and the HAs were seen as having an important strategic role. Relationships with social services were slow to start for historical reasons, and had not progressed particularly far by the end of the study. Similarly, involving patients and the wider public in TPPs was problematic, and there was a lack of guidance about the most appropriate ways of proceeding. The evidence suggests that progress will be slow and the problems encountered by TPPs are likely to become apparent as PCGs develop, and with the transition to trust status. There is much for the primary care groups and trusts to learn from the TPPs.

Key words: general practitioners; health authorities; primary care groups; primary care trusts; relationships; social services; total purchasing

Introduction

The NHS White Paper entitled *The New NHS: Modern, Dependable* (Department of Health, 1997) and the Green Paper entitled *Our Healthier Nation* (Department of Health, 1998a) introduced wide-ranging structural reforms into the NHS. Together, the various policy initiatives are expected to form an integrated programme of action. One of the most significant structural changes, reflecting the government's commitment to enhancing the role of primary care, is the introduction of PCGs. Health service guidance recognized the scale of change and emphasized the importance of good working relationships between all 'stakeholder' groups:

> the transition to Primary Care Groups is a major change; the process needs to be inclusive, with decisions based on the involvement of primary care and community health services professionals, as well as consultation with the wider NHS, public and voluntary organisations (and) the goals of Primary Care Groups include a contribution on improving health, as described in 'Our Healthier Nation'. (Department of Health, 1998b: 4)

The programme of change proposed is radical and broad, but it reflects an evolutionary and not a revolutionary process in the development and

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implementation of health policy. Primary care now lies at the very heart of health service commissioning and health care provision. This is in line with the broad thrust of policy towards a 'primary care-led NHS' (NHS Executive, 1994). The role of GPs has evolved considerably from that of individual independent contractors providing general medical services to their registered populations, to being key players in PCGs and the emerging primary care trusts (PCTs), responsible for planning health services to meet local needs. GPs have been involved in purchasing and commissioning in various forms since 1990 as a result of successive government policies, including fundholding and locality commissioning. These represented two quite distinct approaches to purchasing. Fundholders were independent of their host health authorities and purchased selected services directly. In contrast, locality commissioners generally did not aspire to hold their own budgets, and worked more closely with their host health authorities in planning the range of local services.

The introduction of TPPs along with community fundholding and extended fundholding in 1994 introduced further diversity into the practice of devolved commissioning (NHS Executive, 1994). At that time TP was an initiative:

> where either one general practitioner practice, or a consortium of practices, were delegated money by the relevant health authority to purchase potentially all of the community, secondary and tertiary health care not included in standard fundholding for patients on their lists.
>
> (Total Purchasing National Evaluation Team, 1997: 5)

TPPs were subcommittees of the HA, to whom they were accountable, usually through their project board (Leese and Mahon, 1997). However, although originally introduced as an extension to fundholding, total purchasing (TP) emerged as a 'hybrid' model combining the characteristics of both locality commissioning and fundholding. Thus, prior to the election of the new Labour government, 'a considerable convergence of views . . . on the future configuration of the commissioning and purchasing function' had emerged (Mays and Dixon, 1996: 24).

The introduction of PCGs brought together formally and, indeed, replaced those diverse approaches to purchasing and commissioning, and there is enormous potential to learn from past experiences. TPPs were introduced into the NHS as a pilot scheme and were subjected to a comprehensive and extensive evaluation. There is therefore a body of research evidence on which PCGs can draw. Furthermore, the proposed PCGs bear fundamental similarities to TPPs. The most important similarities are that both TPPs and PCGs involve groups of general practices being delegated a budget to purchase potentially all hospital and community health services (HCHS) for their populations, and they will combine a population perspective with service development at the individual patient level (Mays *et al*., 1998a).

PCGs are made up of groups of general practices and community nurses within a defined geographical area. They are managed by a board consisting of GPs (who may be in the majority), community or practice nurses, and individuals representing social services, the HA, the public and the PCG chief executive (Department of Health, 1998c). Four distinct but developmental models of PCGs are set out in the White Paper (Department of Health, 1997). The first level of PCG will support HAs in commissioning care for its population and act in an advisory capacity, akin to the role played by GP commissioning groups. At the second level, responsibility for managing the health care budget is devolved to the PCG. This model most closely resembles total purchasing. At the third level, PCGs become established as free-standing bodies accountable to the HA for commissioning care. The Primary Care Trust option (level 4) allows PCGs to be responsible in addition for the management of primary and community health services. Whilst the independent contractor status of GPs remains unaffected by the reforms, PCGs replace the current range of primary care organizations established after the last major reform of the NHS in 1990–1991 (Crail, 1997).

PCGs service natural communities of approximately 100 000 individuals. They hold a single unified budget (covering HCHS, prescribing by GPs and nurses and the GMS budget for GP infrastructure) which is cash limited, although PCGs are free to decide how to allocate the budget. PCGs must work strategically and in a way that complements the local Health Improvement Plan (HImP). HAs are the accountable bodies under

which the PCGs will operate, as well as providing an important supportive environment within which they will develop. The relationship between PCGs and HAs is vital and:

> the benefits of PCGs will only be achieved if GPs, nurses and other health professionals, managers, social services, HAs, NHS Trusts and the public are able to develop an effective partnership.
>
> (Department of Health, 1998d: 6)

GP fundholding and total purchasing (and the range of other purchasing and commissioning models in primary care) ended as PCGs went 'live' in April 1999. For PCGs to become fully operational, certain key issues need to be addressed, including relationships with HAs, social services and patients and the public.

Thus, whilst the TPPs are in many ways comparable to PCGs, there are also some fundamental differences. Perhaps the most important difference relates to the potential Trust status of the PCGs as they progress from groups with delegated budgets (as in the TPP model) to devolved power for the budget from the HA (level 3) and, ultimately, to level 4 where PCGs operate as free-standing bodies accountable to their host HA. A second important difference relates to the size of TPPs compared to PCGs, with TPPs being generally smaller and with a greater range in population covered by the pilots. Furthermore, unlike standard fundholding and TP, which were voluntary, PCG participation is compulsory. This has important implications for how to engender the motivation of all practices to participate in spirit, if not in a proactive way. Furthermore, the involvement of other agencies such as social services, of which GPs have little direct working experience, introduces another facet into the collaborative effort required within PCGs.

The TPP experience should prove valuable to PCGs and PCTs, and can be regarded as a natural progression which will hopefully fulfil standards of effectiveness, efficiency and equity that are not evident in the fundholding and locality commissioning models.

The primary focus of this paper is on the relationships between the TPPs and the health authorities, since they are of great significance not only to TPPs but also to PCGs and PCTs. At levels 1 and 2, PCGs are subcommittees of the health authority and therefore have to work closely together. Data are also presented about the relationships between the TPPs and social services, and also with patients.

Methods

This paper describes research conducted by members of the Total Purchasing National Evaluation Team (TP-NET), consisting of researchers from the Universities of Manchester, York, Southampton, Bristol and Edinburgh, and co-ordinated by the King's Fund. The findings are based on the analysis of face-to-face, semi-structured interviews conducted with project managers, lead GPs and health authority leads from most of the 53 first-wave TPPs in the first live year, namely 1996–1997. An initial set of interviews was also conducted in the preparatory year (1995–1996). By the time of the second round of interviews, four projects had dropped out of the scheme (Mays *et al*., 1998b), leaving a maximum of 49 possible responses to each question.

Although many of the questions asked were open-ended and were analysed using thematic coding techniques, in other cases it was possible to quantify the results. An example of the latter is a question which asked of the project managers, '*Overall, how would you describe your relationship with the local HA? Was it (1) paternal/dictatorial, (2) collaborative, (3) co-operative, (4) begrudging/hostile, or (5) adversarial/competitive?*'.

In addition, face-to-face interviews were conducted in the preparatory year with social services representatives for those TPPs which had been in contact with their local social services department in connection with total purchasing. These were followed up by means of telephone interviews early in the second live year only if any service changes had resulted. The authors led the field work in 14 TPPs, and the results obtained from these projects will be discussed in this paper.

Finally, GPs and project managers were asked, during their preparatory and first live years, about their attempt to involve patients and the wider public in their decision to become a TPP and in their purchasing intentions. Data are available from 47 of the 53 projects in the preparatory year and from 44 of 49 projects in the first live year.

Table 1 Some characteristics of the TPPs in the study

Characteristic	First wave
Number of projects	53
Number of single-practice projects	16
Number of practices	191
Number of GPs	960
Median number of practices per project	2.0
Mean number of practices per project	3.1
Mean population of projects	33 327
Range of project populations	12 310–84 700

Results

Characteristics of the TPPs

Detailed information about the characteristics of the initial 53 projects is described in an earlier publication (Total Purchasing National Evaluation Team (TP-NET), 1997) and is summarized in Table 1. A typology of TPPs was drawn up by TP-NET (Mays *et al*., 1998b) and is reproduced in a modified format in Table 2. It was based on a review of their progress against six basic developmental criteria, namely (1) staying together as a group, (2) purchasing directly, (3) changing service provision, (4) shifting the location of care, (5) making effective external links and (6) staying within budget. Type 1 TPPs (under-performing) had not achieved any changes in TPP-related service areas. Type 2 TPPs (developmental) were at a preparatory stage and emphasized developing their infrastructure and undertaking needs assessment before active purchasing. Type 3 TPPs (co-purchasing) did not hold a budget or purchase directly, but were attempting to change HA purchasing. Type 4 TPPs (primary care developers) were developing services in TP-related areas within primary care, but had not made any changes in secondary care. They were either co-purchasing or had independent contracts. Type 5 TPPs (commissioning) had their own budgets and independent contracts. They were purchasing to achieve change in secondary as well as primary care. This typology of TPPs has been used throughout this paper to identify any association between the developmental stage reached and the relationship with the host HA.

Table 2 A typology of TPPs

Description	Type	Number	Percentage
Underperforming	1	2	4
Developmental	2	11	21
Co-purchasing	3	8	15
Primary care developer	4	8	15
Commissioning	5	23	44
Fully integrated	6	0	0
Total	—	52	100

Relationships between the TPPs and the health authority

Collaboration or co-operation?

At the time of the interview, 35 site project managers (83%) and 36 GP leads (86%) indicated that the relationship with the HA was either collaborative, co-operative or both, but that in some cases this had not always been so. Seven site managers indicated that the relationship was adversarial, dictatorial or wary, as did six GPs. However, despite these observations, the overwhelming response from the site managers and GPs was that the relationships between the HA and their TPP had strengthened in the previous year (see Table 3). This was the view of 25 (66%) of the site managers and 27 (69%) of the GPs who responded. Only five GPs and four site managers considered that the relationship had weakened, and the remainder indicated that there had either been no change or that there had been some ups and downs. In some cases, of course, although the relationships had strengthened, there was still considerable work to be done in achieving the type of relationship which would sustain effective and efficient purchasing in the future. The assessment of the situation differed little among the HA leads, site managers and GPs.

Table 3 The nature of the relationship between the TPP and the HA

Relationship	Site manager	GP
Strengthened	25 (65.8%[a])	27 (69.2%)
Weakened	4 (10.5%[a])	5 (16.7%)
Unchanged	6 (15.8%[a])	4 (10.3%)
Mixed	3 (7.9%[a])	3 (7.7%)
No response	11	11
Total responses	38	39

[a]Percentage of responders.

In total, 29 HA respondents (74%) described relationships between the HA and the TPP as collaborative, co-operative, or a combination of both. The general impression given was that relationships were improving, albeit slowly. In only 10 instances (26%) was the relationship described as being in conflict. Even where conflict was evident, this was likely to be seen as an improvement. Interestingly, 5 of these 10 TPPs were described as 'developmental' (Type 2), and themselves represented only 21% of all TPPs, the important implication being that a greater proportion of the TPPs at the less developed levels in the typology (see Table 2) had conflicting relationships, perhaps suggesting that good relationships with the HA were important enabling factors for the development of TPPs.

The TPP as an elaboration or an alternative to the HA

Of the 39 HA leads who were asked whether they considered TPPs to be an elaboration or an alternative to the HA, 13 (33%) chose 'elaboration', the remainder giving other views. The choice of 'elaboration' or 'alternative' was intended to indicate a greater or lesser reliance, respectively, on the HA, a distinction which was instantly recognized by the respondents. Concern was expressed that the TPPs should not simply replicate the HA, but needed to be different, leaving the HA with a more strategic role. Six were definite that the TPPs were not an alternative to the HA, since they did not purchase all services and would, in any case, find it difficult to operate in isolation from the HA. Furthermore, smaller TPPs could never fulfil the same role as the HA. The need for a strategic overview was emphasized, with the HA being the appropriate organization for this, whereas GPs were regarded as less appropriate in this respect, although they have the advantage of more detailed local knowledge. The HA was overwhelmingly regarded as being essential to TPPs, even where relationships were strained.

Using the typology set out in Table 2, 31 of the 52 TPPs fulfilled the criteria for being the most highly developed (types 4 and 5 in Table 2), representing 59% of all the TPPs in the study. Furthermore, 13 TPPs were described as HA alternatives and six as elaborations by the HA leads. Although nine of the 13 TPPs regarded as alternatives were types 4 and 5, only two of the six described as elaborations were in this group. In the case of the 20 TPPs that gave alternative responses, 12 (60%) were of types 4 or 5. This small sample suggests that as TPPs develop they are increasingly likely to be regarded as alternatives to the HA, rather than as elaborations, the former implying less dependence on the HA.

The key individual and key decision-making

Typically, a single GP was the entrepreneurial influence and innovator, and this was the viewpoint of the health authority leads, project managers and GP interviewees, for whom GPs were overwhelmingly regarded as the key individuals, closely followed by GPs and site managers together, and site managers individually (see Table 4). In some cases opinion was strongly dependent on the standpoint of the individual, with some being reluctant to name themselves as the key person. However, up to one-third of projects had no single key individual identified, indicating a group responsibility for this role.

Entrepreneurs have been typically associated with the private sector, but with the introduction of a quasi-market in health care, and particularly of fundholding, it has been possible for entrepreneurial individuals or 'product champions' (Stocking, 1985; Huntington, 1996; Ennew *et al*., 1998) to take the lead in the new primary care organizations. Whether this will be possible or indeed desirable in the much larger primary care groups remains to be seen. However, for the TPPs no link was found between the person(s) identified as key individuals and the developmental stage of the project.

The overwhelming impression given by the HA leads, the site managers and the lead GPs was that the GPs, the practice team or the TPP team was the place where key decisions were made, indicating that in most cases the GPs had a high level of control over the decisions made in the TPP. The executive board (Leese and Mahon, 1997), which may have had representatives from the HA as well as from the TPP, was also regarded as an important place for decision-making, but the subcommittee was essentially a rubber-stamping structure necessary by statute. PCG guidance states that, although PCG boards will be directly accountable to the Chief Executive of the HA, they may choose to organize themselves along management subgroup

Table 4 The key decision-makers

Key individual	HA response	Site manager response	GP response
GPs	17 (40.5%[a])	13 (32.5%)	13 (35.1%)
GP(s) plus site manager	6 (14.3%[a])	6 (15.0%)	6 (16.2%)
Site manager	4 (9.5%[a])	3 (7.5%)	7 (18.9%)
No single person	10 (23.8%[a])	15 (37.5%)	11 (29.7%)
Other	5 (11.9%[a])	3 (7.5%)	0
No response	7	9	12
Total responses	42	40	37

[a]Percentage of responders

lines as did the TPPs (Department of Health, 1998e).

The stimulus of TPPs for the development of other models of local purchasing

Of the 47 HA leads interviewed, only 16 (34%) were unequivocal in their view that the TPP had been a stimulating influence on HA deliberations about future developments. The general impression given by this group was that TPPs had stimulated thought and the development of new ideas. Other HA leads were rather less positive. There was some indication that the TPP had been a catalyst, but that changes were happening anyway, and in some instances GPs were already working well together. In seven cases, the view was that the TPP could be a stimulus for other models, but that this had not yet happened. Reservations were expressed by six HA respondents, where more time was required to decide how influential the TPP really was locally. This was particularly the case for the single-practice projects which, in some instances, were considered to be too small to have had very much impact, at least in the short term.

At the time of the interviews, PCGs were not on the agenda, and locality commissioning was regarded as the way forward. In some cases the TPP did fit into the direction in which the HA wanted to go. In other cases, HAs did not want to 'miss out' on having a TPP, but it did not necessarily fit into the planned strategy particularly well, although these HAs were in the minority.

There was a strong indication that the more developed TPPs were more likely to be seen as a stimulus for further developments locally than were the less developed TTP's. The TPPs were also credited with having new ideas and generally influencing the 'culture' of the HA by introducing new and hitherto unconsidered and less traditional ways of thinking. The fact that so many of the more highly developed TPPs were thinking strategically in terms of the stimulating effect they had on other local developments augurs well for PCGs which can harness the experience of such local TPPs. With the introduction of Health Improvement Plans (HImPs) (Department of Health, 1998f) which provide the overarching direction for PCGs, the experience of the TPPs and their relationships with their host HAs will be relevant for the smooth implementation and running of these new structures.

The future role of the HA

Almost without exception, the HA view was that there would still be a strategic role which they were in the best position to fulfil. The need for a body to be responsible for a broad overview of services within an area was considered to be of paramount importance, and one which TPPs and other GP groupings were not qualified to undertake. Resource allocation would also need to be undertaken centrally and, since practices had different approaches, equitable provision of services would be an area that the HA would be in a good position to oversee. Other issues which were regarded as likely to remain the preserve of the HA included risk management, being responsible for the public health agenda, and audit and accountability where whole budgets were devolved to GPs. Depending on the size of the TPP or evolving locality commissioning groups, joint commissioning and selected purchasing for those services which it would be impractical to purchase on a small scale would also be appropriate for the HA. Clearly, however,

many of the responsibilities mentioned by the respondents will eventually be devolved to the more advanced PCGs, although the time taken to achieve this may well be longer than anticipated if the experiences of the TPPs are to be heeded. Furthermore, since PCGs are considerably larger than most of the TPPs, this may help them to undertake more than the TPPs, which were essentially selective purchasers. Such eventualities could not have been foreseen by the interviewees.

Relationships between the TPPs and the social services departments

Collaboration been social services and the TPPs was shown to be limited mainly to improving relationships and getting to know each other's ways of working, rather than making any lasting service changes or working jointly. Three of the 14 TPPs for which results were analysed had no contact with social services at all during the preparatory and first live years. In others, contact had been limited to perhaps a few meetings each year at which possible joint ventures might be discussed without anything concrete actually being established. Even in such circumstances, meetings were considered to be valuable in that they allowed staff to become more aware of the differing viewpoints and perspectives of professionals with very different ways of working.

In some cases it proved difficult to find common ground. Furthermore, where local councils were Labour controlled, opposition to fundholding sometimes spilled over to TPPs, although in most cases initiatives were not discouraged, but neither were they encouraged. There was general agreement that TPPs had been a 'good thing' in that they changed viewpoints and alerted individuals to different standpoints. There was much emphasis on developing a strategic approach to services, and it was felt that TPPs had provided the opportunity to think about improved ways of delivering primary care.

The local knowledge of GPs was welcomed by social services staff at the director level. Issues of particular importance to the TPPs included improving mental health services and having a dedicated social worker associated with the TPP. Social services departments were generally willing to help, but were also concerned that TPPs should not be treated more favourably than other practices. As a result of these conflicts, progress was slow. However, continuing to discuss issues of mutual interest was considered to be important as a first step towards increased joint working.

More specifically, one TPP had a named social worker dedicated to the project, but although relationships improved, the anticipated benefits in continuity of care were not realized. The TPP switched to looking at achieving closer liaison in domicilary care assessment. However, although this initiative showed that social services staff could work in a primary care setting without difficulty, there was little joint working, and there were still two groups – namely the primary health care team and social services staff – working in parallel.

Relationships between the TPPs and patients

The accountability framework (NHS Executive, 1995), which applied to both standard fundholding and total purchasers, stated that patients and the wider public should be involved in service planning and review, but it said nothing about which mechanisms could or should be in place to achieve this.

In total, 34 of 47 TPPs (72%) attempted to involve patients and the public in a variety of ways. Only one project reported that they had consulted their patients before deciding to become a TPP. Information-giving and public relations were the predominant rationale for most forms of patient and public involvement. Few ventured beyond one-way information-giving towards a more active approach to involvement, and indeed many felt that more active participation was inappropriate. However, there was some (albeit limited) evidence of a more positive and imaginative approach to involving patients in decision-making, and this appeared to be most successful when the focus was on specific rather than general issues, and when the purpose of involving patients and the public was made explicit, both within the project and to patients and the public. For example, when service or disease-specific user groups were involved (e.g. the Alzheimer's Disease Society), the aim was often to comment, advise on or to develop specific plans for this group of patients, and a greater and more meaningful degree of involvement was achieved. However, the extent to which the various approaches *actually* influenced decision-making is still unknown.

Overall, there were very few developments in

the nature and extent of patient and public involvement in TP during the first live year. Although many projects reported some form of contact with their local CHC, this was often described in terms such as 'contact' or 'keeping them informed'. In total, 12 of 41 TPPs, representing 25% of those who responded, had some contact with the CHC, and this had risen to 18 of 44 TPPs (40%) during the first live year. Furthermore, although many projects pointed to CHC attendance at project board meetings, their status at these meetings was often unclear and their active involvement in management was likely to be limited. For example, only 10% of project managers identified a CHC representative on the executive (decision-making) board, compared with half this number (4%) in 1995–1996, indicating slow progress and low levels of official representation, despite the rhetoric noted above.

During the preparatory year, 13 of 46 TPPs, representing 28% of those responding, had made no attempt whatsoever to consult with patients, patient representatives or the public. Although some project managers felt that, in principle, patient and public involvement was a 'good thing', they simply did not know how to start the process of implementation. The absence of any mechanism whereby patients could be involved in TPP decisions was apparent and was a major hindering factor.

Methods for involving patients and the public tended to be selected in isolation from any consideration as to why patients were being approached or what TPPs wanted to achieve. Most of the interviewees felt frustrated at their limited success, and they typically blamed this on features of the patient population or the public, most notably apathy, rather than on their own inappropriate choice of methods. Many projects were aware of these problems but, in the absence of any specific guidelines or mechanisms, felt that they were difficult to overcome. Four TPPs specifically referred to difficulties in achieving representativeness as a reason for failing to attempt any form of patient involvement, either because of the difficulties associated with getting a 'representative view' or because they felt that this was unattainable and therefore not worth pursuing at all. However, concerns about representativeness did not prevent many other projects from pursuing some form of patient and public involvement. Perceived features of patients themselves resulted in a failure to consult in some TPPs. It was felt that patients did not understand the issues, they tended to get 'emotional or irrational', or it was the patients with 'bugbears' who tended to get involved in initiatives aimed at promoting involvement. This reluctance to involve patients prevailed in the first live year, when 9 of the 45 respondents (representing 20% of the total) had made no attempt to involve patients with regard to the range of services purchased by the TPP and eight (18%) had made no attempt to measure patient satisfaction with services.

Discussion

The enhanced role of GPs in the purchasing and commissioning process has coincided with the enhanced status of purchasing and commissioning in the NHS from the 'poor relation' (with the exception of fundholding) to the powerful key player (Higgins and Girling, 1994). The 'New NHS' endorses the continuation of the purchaser provider split 'building on what has worked, but discarding what has failed' (Department of Health, 1997: 8). However, as in the case of TPP:

> the guidance provides advice but is not a detailed blueprint. Health authorities, primary care groups, and other local stakeholders will need to work together to fashion an organisation appropriate to the local circumstances in which it operates.
>
> (Department of Health, 1998e: 3)

TPPs highlighted a number of problems and weaknesses associated with the current system, many of which will be replicated unless lessons are learned. The findings from the TPP evaluation are relevant to an understanding of the issues that PCGs and other NHS organizations face in translating and formulating the policy agenda in the new NHS. The need to develop and maintain collaborative relationships with other organizations and initiatives is recognized in the guidance on the establishment of PGCs and, in particular, the role that social services have to play in informing and shaping the decisions that PCGs will need to make (Department of Health, 1998c). PCGs will operate within the overarching strategic direction set by their local HImP – the government's way of tack-

ling the fragmentation associated with previous models of primary care purchasing and commissioning.

Although key individuals or 'innovators' are important for generating enthusiasm and driving projects forward in the initial stages, this study emphasized the requirement for group responsibility in PCGs and the need for co-operation and collaboration.

The role of the health authority is clear. There is both a need and a willingness to relinquish 'control' and to take on a strategic role in overseeing service development and ensuring that equity prevails in constituent PCGs and PCTs.

Our research illustrates the fundamental importance of relationships, and indeed the nature of the relationships between professionals and managers are quite fundamental to the success of PCGs. There have been warnings of 'a serious communications deficit' among primary care practitioners, and a limited knowledge and understanding of the NHS changes and their implications (Hunter and Marks, 1998). However, at the same time there is, in some PCGs, an acute recognition of the importance of relationships. Participants in an education and training programme undertaken by the PCG Resource Unit in Oxford identified team-working, team-building, understanding the roles of others, co-operation and conflict management, communication and influencing skills as being important for effective PCG creation (Wilson *et al*., 1998). A recent survey of PCG Chief Executives found firm and considered views about their current and future relationships with their HA, but their views about their relationships with other organizations and with patients and the public were more formative, speculative and less specific (Mahon and Garrod, 1999).

Although the shift towards a primary care-led NHS is equated with a shift towards a patient-led service, the evidence from our research suggests this is more rhetoric than practice, and the emphasis is more on information-giving and promoting good public relations than on more sophisticated models of patient involvement that will enable them to contribute to the development of PCGs. PCGs will struggle at the technical level with regard to how and when to involve patients and the community unless they begin to debate their own attitudes and values about the significance of the patient or lay perspective. Success might be attainable if there is emphasis on patient contributions to specific services or disease groups where patients have an important role to play.

PCGs are not simply an extension of TPPs, and new roles and relationships will need to be forged. Appropriate organizational structures and processes are considered to be important prerequisites for success (Mahon *et al*., 1998). There remains enormous scope for organizational development in health care organizations in general and in PCGs in particular. The new NHS is changing the role and the function of all existing NHS organizations, and in particular how they relate to others in their health system. Strategies to develop PCGs and PCTs must therefore link with strategies to develop the whole system. It is hoped that the findings presented in this paper and in other TP-NET publications will feed into that process to produce new organizations that are fit for their new purpose.

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References

Crail, M. 1997: News focus, modern times? *Health Service Journal* 11 December, 10–11.

Department of Health 1997: *The new NHS: modern, dependable*. London: The Stationery Office.

Department of Health 1998a: *Our healthier nation*. London: The Stationery Office.

Department of Health 1998b: *Better health and better care*: *implementing 'The New NHS' and 'Our Healthier Nation'*. HSC 1998/021. London: Department of Health.

Department of Health 1998c: *The new NHS: modern and dependable. Governing arrangements for primary care groups*. HSC 1998/230. London: Department of Health.

Department of Health 1998d: *The new NHS: modern and dependable. Establishing primary care groups*. HSC 1998/065. London: Department of Health.

Department of Health 1998e: *The new NHS: modern and dependable. Developing primary care groups*. HSC 1998/139. London: Department of Health.

Department of Health 1998f: *Health improvement programmes*. HSC 1998/167. London: Department of Health.

Ennew, C., Whynes, D., Jolleys, J. and **Robinson, P.** 1998: Entrepreneurship and innovation among GP fundholders. *Public Money and Management* 18, 59–64.

Higgins, J. and **Girling, J.** 1994: Purchasing for health: the development of an idea. In Harrison, A., editor. *Health Care UK*. London: King's Fund, 50–56.

Hunter, G. and **Marks, L.** 1998: *The development of primary care groups: policy into practice*. Birmingham: NHS Confederation.

Huntington, J. 1996: From invention to innovation. In Meads, G., editor. *Future options for general practice*. Oxford: Radcliffe Medical Press, 211–22.

Leese, B. and **Mahon, A.** 1997: Management issues in total purchasing pilots. *Primary Care* 7, 7–9.

Mahon, A. and **Garrod, D.** 1999: *Primary care groups – the first six months*. Manchester: The Manchester Centre for Healthcare Management, University of Manchester.

Mahon, A., Leese, B., Baxter, K., Goodwin, N. and **Scott, J.** 1998: *Determining success criteria for total purchasing pilot projects*. London: King's Fund.

Mays, N. and **Dixon, J.** 1996: *Purchaser plurality in UK health care*. London: King's Fund.

Mays, N., Goodwin, N., Kiloran, A. and **Malbon, G.** 1998a: *Total purchasing. A step towards primary care groups*. London: King's Fund.

Mays, N., Goodwin, N., Malbon, G., Leese, B., Mahon, A. and **Wyke, S.** 1998b: *What were the achievements of total purchasing pilots in their first year and how can they be explained?* London: King's Fund.

NHS Executive 1994: *Developing NHS purchasing and GP fundholding*. EL (94)79. London: Department of Health.

NHS Executive 1995: *An accountability framework for GP fundholding. Towards a primary care led NHS*. London: Department of Health.

Stocking, B. 1985: *Initiative and inertia: case studies in the NHS*. London: Nuffield Provincial Hospitals Trust.

Total Purchasing National Evaluation Team (TP-NET) 1997: *Total purchasing. A profile of national pilot projects*. London: King's Fund.

Wilson, T., Butler, F. and **Watson, M.** 1998: View to a skill. *Health Service Journal* 24 September, 24–25.