Stakeholder Perspectives on the Formation of Primary Care Trusts: Implications for the Merger of Social and Health Care

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Abstract

Although both fundholding and locality commissioning failed to achieve more than small scale changes at practice or hospital level, devolved commissioning remains central to the government's plans for the NHS in the form of primary care trusts (PCTs) in England and Wales, and local health care co-operatives (LHCCs) in Scotland. In this paper we present the results of an analysis of the views of key stakeholders on the likely success of PCTs/LHCCs and assess how previous experience of devolved commissioning might guide future developments. We used data collected at the time of the foundation of the pre-cursors of Primary Care Trusts, the Primary Care Groups and LHCCs. We found very significant disparities in perspectives between stakeholders at health authority, trust and general practice levels. All Health Board and Authority members interviewed were guardedly optimistic about the future, Trust managers were more sceptical about the future and general practitioners (with the exception of some ex-fundholders) were the most negative in their views. The concerns identified were: the absence of mechanisms for promoting change; the continuing fragmentation of services and planning; lack of resources; the complexity of needs assessment; the absence of both collaborative working and strategic thinking from the culture of general practice ; powerlessness; responsibility for rationing; and the enforcement of a salaried service in general practice. Subsequent events have shown that Health Authority respondents, and to a lesser extent those of the hospital Trusts, were too optimistic about the durability of their organisations, and the slow rate of evolution of Primary Care Trusts. The pattern of views and attitudes which we found is consistent with results from other studies, and suggests that a period of considerable upheaval is likely as PCTs form. These findings contradict positive presentations of current developments and raise questions about the concordance of current policy with evidence. We draw conclusions about the implications for social services of integration with PCTs in such an organisational climate, to stimulate discussion with colleagues from social care.

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Introduction

The National Health Service Research and Development strategy acknowledges the importance of making practice and policy more evidence-based. As we have shown elsewhere, however, fundholding failed to achieve more than smallscale changes at practice or hospital level (Craig et al, 2000). Nor was it effective in encouraging fundholders to adopt a strategic perspective in their commissioning or role (Drummond et al, 2001). Locality commissioning was similarly unsuccessful in producing major changes in contracts or services (Hudson Hart et al, 1999).

Despite the modest achievements of the various forms of devolved commissioning it remains central to the government's plans for the NHS (Department of Health 1997, HMSO 1997), in the forms of Primary Care Trusts (PCTs) in England and Wales and Local Health Care Co-operatives (LHCCs) in Scotland. The political significance of the changes that have occurred since 1997, in terms of a re-orientation of health and social care from a retail market model to a managed market, should not be underestimated (Iliffe and Munro, 2000) but nor should the discontinuities of structure be overstated (Iliffe, 2001). The main difference between fundholding and these two new forms of devolved commissioning are the withdrawal of responsibilities for holding funds (in LHCCs and some forms of Primary Care Group only) and the larger population groupings covered by the new commissioning organisations. Much of the rhetoric surrounding LHCCs and PCTs nevertheless remains the same. Like fundholders before them, they will be expected to receive support from (reorganised strategic) health authorities or health boards, collaborate with acute and community trusts and local authorities, get involved in health strategy formulation and increase the responsiveness to the public of the community health services which they manage (Department of Health, 1997).

The PCTs require general practitioners and primary care teams to improve the health of their communities by addressing the health needs of their population, promoting the health of that population and working with other organisations (particularly with social service departments) to deliver effective and appropriate care (Department of Health 1998). The argument in favour of this joint working is clear, for the highest users of health and social care are people with complex and long-term needs. They experience health, social, economic and environmental difficulties, inextricably linked, whose amelioration lies outside the remit and competence of existing primary health care (Glendinning and Wilkin 1999).

However, there are significant obstacles to changing the organisational culture of the NHS which have to be overcome before joint working, in the format anticipated in the PCTs, becomes possible. Potential problems include the likely negative impact of compulsory enrolment of potentially reluctant general practitioners (Smith 1998), the wide variations in prescribing and referral that will impede the introduction of capitation based funding (Majeed, 1998), the tendency of the NHS to undervalue the motivation of practitioners and overvalue sanctions (Ham, 1999), and the risk that the whole process of change will degenerate into a bureaucratic 'name and shame' culture (Thames Region, 1998). The majority of general practitioners (in Scotland at least) are not motivated to consider needs assessment as a core task (Murie et al, 2000), whilst mergers of smaller organisations into larger ones, like PCTs, seem to be driven more by the shortage of management resources than by benefits to the public (Wilkin et al, 2001). Tensions between facilitating development in local services and policing practice seem likely to increase as PCTs take on both roles (Campbell et al 2001), local agendas may be overwhelmed by central ones, and the demands of change will divert attention from service provision (Wilkin et al, 2001).

Nevertheless, current policy analysis remains largely positive, especially in the interpretation of findings from the National Primary Care Centre's tracking study, funded by the Department of Health (Wilkin et al, 2001; Campbell et al, 2001). Significant signs of progress, active involvement of social care in the PCT precursors, the Primary Care Groups (PCGs) are claimed (Glendinning et al, 2001; Wilkin et al, 2001), the main perceived threat being underfunding of management (Wilkin et al, 2001).

In this paper, we analyse the views of key stakeholders in the early phase of the shift from fundholding, during the formation of PCGs and LHCCs, to try and assess how experience of devolved commissioning might influence the future development of Primary Care Trusts. In effect we talked to those involved in the birth of the new organisational structures about the prospects for their growth and development. Our aim in presenting these results is to stimulate discussion about the likely impact of PCT development on social and health care integration, and the contribution that social care can make to the stabilisation of new organisations.

Methods
Four health authority areas, two health boards in Scotland and two health authorities in North Thames Region, England, were selected for fieldwork on the basis of their being broadly comparable in terms of demography, their history of health care organisation and their experience of commissioning and fundholding.

Within each health authority, interdisciplinary triangulation (Janesick, 1994) was pursued by interviewing a purposive sample of senior health authority staff, senior NHS Trust management and senior clinical staff, and general practitioners participating in the several commissioning and purchasing initiatives. A random sample of general practitioners from large, small and single-handed practices not taking part in any of the commissioning experiments was also interviewed.

Face-to-face interviews were selected as the optimal method for eliciting insider perspectives and frameworks of meaning (Britten, 1995). A semi-structured interview schedule was constructed using themes derived from a review of the literature on commissioning and the shift to primary care. Interviews lasted up to an hour and were audio recorded. Respondents were assured of

anonymity and asked to discuss the existence of strategic shift of activity and resources from secondary to primary care, in relation to different types of commissioning. Interviews took place between December 1998 and September 1999.

An analytic, inductive approach to the data allowed identification and classification of recurring themes. Each theme was appraised to ensure that it was corroborated by at least two respondents. Individual themes were combined to produce models which could be applied to the data in order to produce a critical and consistent interpretation of the data.

Results

Interviews were conducted with 86 individuals, 18 from health authorities and boards (including finance, public health, commissioning and primary care), 42 from trusts (including finance, nursing, consultants in medicine and surgery, and community trust managers) and 26 from general practice (including all types of fundholding and locality commissioning as well as general practitioners not involved in either).

Views of Future Organisational Development in the NHS

When considering future organisational development in the most general terms, it was striking that across the sample as a whole the potential benefit of integrating services was a recurring theme. Integration was seen as beneficial both in terms of internal NHS structures:

'there are lots of professionals working in primary care who have a voice which should be heard, around how to make the system better. I think the real problem is that we missed out getting their voice into the discussions, therapists, ... everybody, not just nurses but all the other staff, they have an awful lot to offer, to contribute'
Director of Commissioning, London Health Authority

and between health and social care agencies:

'the boundary between health ..., local authority ..., voluntary sector, if we get that right and we get everyone working, singing from the same sheet'
Public health consultant, London Health Authority

An important part of the solution to what was perceived as a current lack of integration was thought to lie in resolving the structure and management of social services. For example, respondents suggested that because social service departments are directly accountable to politically-controlled local authorities, they tended to be responsive to local political pressures and short-term influences, to the occasional detriment of patient care:

'you get a very experienced multi-disciplinary team making a recommendation, having looked after and treated the patient for months, and that recommendation being queried or overturned by a Social Work Committee who have never clapped eyes on the patient and who simply do not have the kind of expertise that we have'
Consultant geriatrician, Scottish Hospital Trust

In primary care in particular, revising the general practitioner contract and making primary care a salaried service were judged by some (particularly in health authorities and trusts) to be an aid to future integration:

'if we could find a way of doing away with the national contract .... I think there is a realisation that that seems to be the way that it is heading, but [general practitioners] will fight tooth and nail either to keep it or to be reimbursed for losing it and I suspect that they will just fight to keep it .... It is one of the ways you can guarantee you bring them within the NHS.... Bringing them within the formal structure is important. I don't think they are within it at the moment'
Nurse manager, London Hospital Trust

When the views of people in different sectors of the NHS are examined separately, however, differences in emphasis emerge.

Perspectives from Health Boards and Health Authorities

All Health Board and Authority members interviewed were *guardedly optimistic* about the future, although the problems that the new organisations would face were not underestimated.

> *'We are perfectly able…to undertake a strategic shift, although whether the overall product can be as good as it might be if budgets are limited is (another) question.'*
> Director of Public Health, Scotland

They hoped that PCTs would give general practitioners a local perspective on working together to develop strategies and joint protocols, and to encourage cultures to merge. Different *mechanisms for change* received different emphases. Those at the Health Boards in Scotland suggested that the Joint Investment Fund might be the vehicle for changing the focus of health care delivery. Participants in both London and Scotland suggested that clinical governance could be the mechanism for improving the quality of both staff and practices.

The *prospects for change* were seen less positively.

> *'I wish we had more intellectual power in the health service to make these things happen - we are under-planned, under-managed and under-resourced…'*
> Director of Commissioning, Scotland

However, although the hope was that joint agreement on the locus of provision would enable funding to be redistributed, concern was voiced that it would be almost impossible to move finances even if services could be shifted to the primary care sector. In London the demographics of local general practice, the lack of suitably talented staff and the need to involve the voluntary sector and local authorities were all perceived as potential problems that would have to be resolved by the emerging PCTs. The *fragmentation and contradictoriness* of the fundholding era was not seen as a past problem, but rather a continuing one:

> *'…the inertia is enormous, the purchasers are very fragmented…it just seems like a system that is designed not to work'*
> Director of Finance, London

Respondents in all areas noted that there appeared to be overlap between the responsibilities of the new organisations and the established bodies of the Trusts and Health Authorities and Boards, with the potential to compromise future planning strategies.

Concerns about funding the new organisation were widespread. In Scotland the LHCCs had a cash-limited prescribing budget only, but any resulting savings in overall NHS revenues may take some time to accumulate. Acute services in Scotland will be ring fenced but in England Primary Care Trusts will have a large budget and the responsibility that that entails. In London however it appeared unlikely to the participants that many PCGs would evolve to become trusts, although they would be allocated funding and power to shift some services.

The *complexity of needs assessment* was not seen as a major problem compared with organisational and developmental issues. Only in one Scottish city was the diversity of local populations seen as a problem for service planning, the culture and needs of the 'mink belt' being dramatically different from those of the large deprived housing estates. *The existing structures were seen as durable.* In the other three study sites all respondents thought that power would remain in the hands of the Board or Authority for a considerable time. In one London Health Authority it was believed that general practitioners were happy to remain under the auspices of the Health Authority in a highly structured and focused way:

> *'(The PCGs say) we are not ready (for separate accommodation) yet, we still need to stay warm and cuddly with the health authority, we have so much to learn from you.'*
> Director of Commissioning, London

Perspectives from Trusts

Trust managers were more sceptical about the future than their Health Authority and Board peers. In Scotland the prospect of re-engineering existing services through the mechanism of the Joint Investment Fund was considered naive, and according to Finance Directors there was no *financial slack* that would permit this. Although everyone recognised the potential of the new organisations to develop joint protocols and a

seamless service, one manager (from a London Trust) hoped that they would maintain a purchaser/ provider split and give secondary care a 'jolt'. The new structures were seen as *embryonic*. The rules and framework of PCTs were still at an early stage of development and all managers thought that these would take a long time to evolve and become efficient and effective. Perceptions of general practice were negative, in the sense that *neither collaboration nor strategic thinking were part of the culture*. Some doubted the determination of general practitioners to work together in a structured way:

> *'I don't think that GPs have given a moment's thought to how they are going to work together'*
> Director of Finance, London Trust

Primary Care Trusts will be very large organisations. Respondents from acute trusts in one Scottish city and both London study sites all expressed doubts as to the ability of primary care groups to form unified cohesive groups. If and when they did so everyone recognised that the power they could wield would make it essential for all trusts to increase and improve dialogue. Hospital Trust respondents in one London area expressed concerns and doubts as to the ability and will of local general practitioners to allow the evolution of Primary Care Trusts. Trust staff from London and Scotland expressed the concern that they may well become internally focused or, according to one Trust's staff, crisis-driven and reactive to emergency pressures.

Medical specialists in the existing acute trusts were less aware of developments. Five of the consultants interviewed knew nothing of PCG/Ts and could make no comment as to their influence on future developments. Two, however had already written proposals for joint working and hoped their formation would generate interest among general practitioners to discuss future developments with secondary clinicians. No consensus emerged from the interviews as to how Primary Care Trusts would develop. Some felt that general practitioners would develop their own spheres of interest which may well influence purchasing, and for that reason improved communication should be encouraged. *Specialist interests* were reflected in respondents' aspirations

for the governance of PCTs. For example, stroke consultants felt that stroke was a disease that readily crosses organisational and professional boundaries and all argued that its care ought to be led by experts and managed by a multidisciplinary team. Such stroke teams could be readily developed by Primary Care Trusts. Two consultants suggested that they would not alter the present ethos of colleagues speaking to each other about individual patients. As one stated:

> *'we all work for the same NHS so it shouldn't matter where we work'.*
> Hospital consultant, Scotland

Perspectives from General Practice

General practitioners were the most negative in their views of PCG/Ts and Trusts. Seven general practitioners in Scotland demonstrated a marked lack of enthusiasm for and knowledge of them, while another felt that they had all been:

> *'rolled up in a ball and skewered'*
> GP, Scotland

Apart from some fundholders very few welcomed the new organisation. In Scotland the lack of financial control made some general practitioners concerned that the new structures would *lack power* and become talking shops. The minority which did welcome the change hoped for increased and integrated dialogue with general practitioners taking a global and strategic lead in health care. They may well be able to improve nursing provision but a cash-limited prescribing budget would ultimately lead to *rationing* of prescribing of some drugs. Some general practitioners in Scotland and one London study site acknowledged the difficulty posed by the traditional culture of general practice, although the influence they could wield should they become a unified force was seen as being considerable. *Lack of resources* was a common theme. Finding time to become actively involved would be problematic not only for the general practitioners concerned but also for their partners; it would require a large proportion of their time, something no one felt was in large supply. Some general practitioners in both Scotland and London felt (with regret) that the current changes were the first steps to enforcing a *salaried general practitioner* service.

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We have attempted to summarise how the different stakeholders perceived each other as participants in the process of NHS change, in Table 1. The absence of specific views about the contribution of Hospital Trusts and Health authorities amongst general practitioners is striking.

Table 1: Stakeholders' views on the implications of current policy for existing structures

		STAKEHOLDERS		
		Trust staff	Health Board/ Authority staff	GPs
STRUCTURES	Trusts	No financial slack to respond to changes in commissioning		
	Boards and Health Authorities	Sceptical about change JIF unlikely to work as mechanism for change	Guarded optimism but prospects for change are limited JIF a mechanism for change Existing structures (eg Boards) durable Complexity of needs assessment not a major problem	
	PCGs and PCTs	Collaboration and strategic thinking not in GP culture Structures embryonic Inward looking, crisis driven	Fragmentation and contradictoriness persist Funding a problem	Not welcomed by majority Powerless, but may become rationing agents Resources limited May enforce salaried general practice

The table shows the results more starkly than the text does - GPs do not have a complex view of future developments (two boxes empty). Trusts have the widest perspective (even though the consultants were often unaware of what was going on).

Discussion
These findings are consistent with the results of other studies, contradict the previous positive presentation of current developments and raise questions about the concordance of current policy with evidence. The long list of tasks for practitioners and managers to understand and carry

out has not stopped some commentators from being optimistic about the prospects for PCTs, but only in a descriptive report without an explicit methodology (Proctor and Campbell, 1999). The National Primary Care Research and Development Centre is more balanced in its views, but sees the process of change as positive and emphasises the gains that have been made, mainly from a managerial perspective (Wilkin et al, 2001; Campbell et al, 2001). We will discuss our findings in the light of subsequent events, compare them with the results of other empirical research, and speculate on the implications of what we have learned for the integration of social and health care. We do this with the knowledge that our results derive from urban areas with particular characteristics, and that they may not apply in small towns or rural settings.

Health Authorities and Trusts The first striking finding is that those who were most optimistic about the prospects for change – the respondents from Health Authorities and Hospital Trusts – were the least accurate in their predictions about PCT development. Their expectations for the timescale for change, and their beliefs about the reluctance of general practitioners to allow the emergence of PCTs now read like wishful thinking about slow evolution. The reality is that PCT development is well underway in the London areas studied, consistent with the finding from the national tracker study that virtually all primary care groups were moving to PCT status (Wilkin et al, 2001). The overlapping roles noted by Health Authority respondents are set to disappear as health authorities merge into strategic health authorities serving larger populations.

Nevertheless, the disparities in perspectives between stakeholders at health authority, trust and general practice levels, suggest that the tensions between centralised planning and local incrementalism may continue to undermine the development and implementation of health policy (Wainwright, 1998), even in a reconfigured structure in which guarded optimists from Health authorities are distributed across PCTs. This redistribution of managerial expertise not only raises the questions of dilution of managerial skill and subsequent pressure for PCT merger as noted by Wilkin et al (2001), but also suggests that local

variations in service development may become evident. Inevitably there is a political dimension to the model of commissioning chosen, dependent on the balance of power in the decision-making process, but the current top-down approach to rapid evolution of PCTs may promote one model uncritically at the expense of others, with potential dislocation of service planning and provision (Chappel et al, 1999). On the other hand, a number of different models of PCT governance may emerge from the varied power relationships and mixes of expertise in different areas, perhaps collapsing later into hierarchical or quasi-market arrangements (Sheaff, 1999).

Facilitating evidence-based change is difficult and complex, but policy makers need to openly acknowledge this complexity (Harries et al, 1999). The assumption that improvements in the systems and processes of management can mean only greater synergy in the relationships between different professions and different tiers of the health service administration is not necessarily borne out in experience, which suggests that greater disparity is also a possible outcome (Coe, 1996). Social service departments aligning themselves with PCTs will need to map their local health service organisations and chart courses carefully, because of the risk in a turbulent climate of losing sight of the quality of services provided.

General Practitioners The tracker survey suggests that general practitioners are slowly becoming more positive towards the process of reform, including PCT formation, although this is based on the perceptions of managers required to bring changes about (Wilkin et al, 2001; Glendinning et al, 2001). Other empirical studies are less comforting. Our findings suggest that general practitioners have the least developed view of the different roles of NHS management, and feel the most apprehensive about the change to PCT status. A postal survey of a one in two sample of Scottish general practitioners supplemented by semi-structured interviews with other stakeholders revealed concerns over general practitioner commitment, lack of skills and training, increases in workload and pre-occupations with budgets at the expense of needs assessment (Hanlon et al, 1998). Different disciplines have similar anxieties about short timescales, lack of skills, confusion

over roles, with insufficient start-up funding to initiate change and lack of incentives to sustain it (Wilson, 1998). Increased workload due to shifts in the balance of care is difficult to measure and has not been researched adequately (Scott and Vale, 1998), but is reputed to be a widespread experience.

Interviews with a 20% sample of general practitioners in one district revealed disquiet about the potential conflict between rationing and patient advocacy (Ayers, 1996), a concern reinforced by international experience (Majeed and Malcolm, 1999). Incentives that offset workload changes might be important, but externally imposed incentives could have negative effects on general practitioner involvement in and motivation towards commissioning (Hausman and Le Grand, 1999). Extensive investment in organisational development will be necessary if the problems experienced in the brief pilot of total purchasing are to be avoided (Goodwin et al 1998), a message reinforced by a study of needs assessment at practice level (Ruta et al, 1997). This investment is not only needed at Primary Care Trust level, but in the administrative tier immediately above them, for there is evidence of a complete lack of comprehensive planning mechanisms at health authority level for some services (Webb et al, 1996). Mergers of organisations require investment in management capacity, staff morale and time to realise benefits (Bojke et al, 2001).

Pessimism about the possibility of positive development in primary care through PCT formation may have an impact on efforts to promote joint working at any level. Collaboration between general practitioners themselves may or may not prove to be problematic, but we know that at the level of specific services the views of general practitioners and nurses can differ significantly (Barclay et al, 1999). The role in commissioning offered to nurses poses problems for them (Kaufman, 1998) and, without a framework for engaging in debate on commissioning, their influence on service development is likely to be limited (Antrobus and Brown, 1997). Collaboration between general practitioners and specialists, on the other hand, is well established with a foundation of mutual respect and established mechanisms for conflict

avoidance (Marshall, 1998). By comparison, the traditional professional inequalities between social work and medicine are seen even by optimistic observers as a threat to recent gains (Glendinning et al, 2001). Our findings of caution and apprehension amongst general practitioners do not suggest that innovative ways of working are high on the profession's agenda. Social workers becoming engaged in PCT development may find that they have much in common with community nurses in their ability to influence commissioning, and are no less in competition with secondary care over priorities and resource allocation than previously.

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Conclusions

The similarities between American managed care and the rationing role of PCTs have already been pointed out, together with the public displeasure and professional disillusion found in American primary care (Koperski, 2000). The potential for PCTs to act as levers for privatisation of health care (Pollack, 2001) has to be taken seriously, in this light, although there are strong counter arguments (Appleby, 2001). Yet it is also arguable that, in a health system now widely acknowledged as inevitably finite and 'rationed', what is important is that the values which inform rationing decisions, and the methodologies through which they become actualised, should be transparent. PCTs may be better placed to ensure such transparency than national government or health authorities (Drummond et al, 2001). The issue may be whether general practitioners and others in PCTs are prepared to accept the responsibility for rationing decisions, in a culture where expectations for health care are already extremely high. The question for social care may be: what can its culture contribute to this process?

Acknowledgements

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