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Discussion paper

Improving the quality of primary care

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ABSTRACT

Background This paper considers the role of teaching primary care trusts (tPCTs) at the turn of the century. A retrospective evaluation of a complex intervention is used. The evaluation has three perspectives. These are (1) a commentary on tPCTs in health policy in England, (2) the authors' reflections as senior members of a tPCT in Northern England and (3) a look-back exercise with tPCT members.
Results It outlines the achievements and reflects on the experience of the tPCT and its relationship with its stakeholders. The resultant themes and challenges experienced by the tPCT members working at their organisational boundaries with their stakeholder both provide organisational developmental insight for the emergent primary care commissioning groups (Health and Social Care Bill 2011) and highlight the continuing need for organisational cultural change within general practice.
Conclusion Quality criteria for acceptability, accessibility, appropriateness, equity, clinical effectiveness and cost-effectiveness can only be truly addressed by a learning organisation approach. This was one of the original remits for tPCTs.

Keywords: general practice, learning organisations, primary care, quality, teaching PCT

How this fits in with quality in primary care

What do we know?
Teaching primary care trusts (tPCTs) were locally driven learning organisations responsible for commissioning services and improving quality.

What does this paper add?
This paper reflects on the experience of tPCTs and their relationship with stakeholders to provide both organisational and developmental insight for the emergent primary care commissioning groups.

Introduction

This paper has two main aims. The first is to describe, retrospectively, a broad outline of a government-directed initiative which was designed to improve the quality of English primary healthcare. The creation of teaching primary care trusts (tPCTs) is placed in a wider policy context of healthcare policies from the Westminster UK government at the turn of this century.[1,2] The second aim is to offer a reflection from the authors and narrative data from former tPCT members, who worked together in one tPCT between 2003 and 2007, about the limits of success of this policy initiative. That reflection offers some wider lessons for the future of British primary healthcare in the current context of incipient organisational changes in the wake of the Health and Social Care Bill (2011). Thus, the paper is both policy analysis and a statement from reflective practice.

Background

Primary care trusts (PCTs) were established at the beginning of the century to purchase approximately 80% of NHS services, in particular secondary care, and to provide primary care services through support for general practice and direct provision of community services. This focus on primary and community care resulted from a growing realisation about the financial and medical unsustainability of acute services and a greater understanding of the role effective primary care could play in improving health outcomes.

It is perhaps unsurprising then that the concept of a tPCT was envisaged as a quality driver analogous to teaching hospitals. However, tPCTs were mandated as an explicit public health initiative to be established as a service boost for areas of severe deprivation, with their manifest health inequalities and workforce recruitment and retention problems. There were other striking differences between PCTs and their teaching counterparts, in conception, construction and operation, which often gave rise to tension, confusion and ultimately lost opportunities to maximise the initiative. Box 1 summarises these differences.

tPCTs first emerged with three pilots established in 2001, then in three waves with eight in 2002, a further 11 in 2003 and nine in 2004, making 31 in total. From the outset tPCTs were a locally driven concept with no national template and considerable variation in size, structure, remit, skill and experience of (dedicated) staff and internal resources. Additional national funding was distributed to all three waves, but was considerably reduced from the original £25m pledged by Prime Minister Tony Blair at their inception. For example, cuts were made before the 2003 to 2004 tPCT allocations. Moreover, there was a logical and systemic tension about tPCTs related to their usefully broad, but consequently vague, rationale. Without explicit performance management, evidence of effectiveness and understanding of function could be problematic, and without formal evaluation these new organisations might fail because of 'hard' outcomes to justify their existence. Moreover, as a natural policy experiment they were not random (and so their performance could not be judged against non-tPCTs) for the very reason that they were selectively targeted in the ways, noted above, about identified deprivation.

In this ambiguous context, some clarity of purpose across the tPCTs was negotiated by a network of colleagues nationally being established in 2003. This was dominated by northern organisations, but other English participants from Essex, the Midlands and East Anglia soon joined this national network. Its legitimacy was strengthened through discussions and endorsements in 2005 from John Hutton (then Secretary of State for Health), who had been the main champion of tPCTs within government at the outset. Eventually, the national network differentiated in regional networks were successfully formed and eventually grouped into three, North, Midlands and South regional networks, which met regularly. The work of these groups was presented to the Department of Health in 2007. However, in the first five years of their existence no outcome of their functioning, impact or 'added value' was formally documented. The reflective account below then is one attempt, in the absence of such an overview report, to present learning points from one of the 31 tPCTs established during the 'noughties' in England.

It is offered within the spirit of *An Organisation with a Memory*[3] and as a retrospective account of a complex intervention which triangulates the experience from three perspectives. The authors and tPCT members were participant observers.

First it reflects on tPCTs in their healthcare policy context and secondly the organisational development and emergent issues with its constituent PCTs. Finally it offers a 'look-back exercise' relating to the organisational culture within the tPCT and its interface with its constituent PCTs.

Box 1

Attribute	PCT	tPCT
Funding	Mainstream DoH	Startup (DoH), project, short term
Functions	Purchasing/providing/QA GP	Workforce development, education and learning, some R&D,
Governance	Statutory, national template	tPCT specific
Size	Single organisation	Single, group or clusters of PCTs
Operation	Bureaucratic, hierarchical	Organic, situation specific
Priorities	National policy, e.g. clinical frameworks	Locally determined. Coordinating, influencing networking
Staffing	National template for organisational structure and functions	Local organic development, no prescribed structure, considerable variation

tPCTs in their healthcare policy context

Initially, the focus for tPCTs was on general practitioners, and 'under-doctored' areas, but this soon spread to the wider workforce, with a particular emphasis on organisational development and cultural change management. The latter emphasis included the processes of getting research into practice and the spread of more confident reflective practitioners. This policy initiative was not in isolation though. For example, more widely the Department of Health encouraged the NHS to become a 'learning organisation', as well as the aspiration to become an 'organisation with a memory'.[3] However, these threads of policy about quality improvement that were orientated towards reflection and learning were jostling with some counter-currents. These included some aspects of audit, which was a potential source of learning for clinical practice. If applied mechanistically and too heavily, these led to defensive 'back covering' and 'box ticking'. This was the price being paid for the 'rituals of verification'[4] that were emerging as part of a *New Public Management* model in the NHS.[5] Ever since the Griffiths Report under Margaret Thatcher had determined that the NHS should not just be administered but managed,[6] each successive British government, including New Labour after 1997, had pursued that policy trajectory. As a result, local personal trust and policy acceptance or compliance, negotiated between clinical staff and their managers, became a field of contention. That field was the pragmatic setting of daily life in the NHS, which was both adapted to and to some extent resisted by clinicians. In primary care settings this meant by predominantly and historically being subcontracted and thus not directly managed by doctors. The latter were co-opted into the structures of PCTs by the establishment of practitioner panels or committees (typically called *Professional Executive Committees*, medically dominated with some representation from local leading non-medical practitioners). As Sheaff *et al*[7] noted, such co-option led to a culture of *soft governance* in primary care, with clinical leaders themselves being appointed to pursue local managerial goals, many of which were flowing from central government.

Thus, the specific ideological thrust and expectation of the tPCT initiative from government and those specifically employed to enact and effect the policy aspiration (including these authors) can be sited in a complex political mix. The latter involved wider supportive policies about learning and reflection to ensure quality improvements, as well as a dominant power struggle that was being played out between two communities of interest: clinicians and their managers. This complex mix created an inherent turbulence and set of contradictions about defensiveness and distrust, alongside authentic efforts to learn from experience and improve service quality in both 'camps'. These tensions were amplified further by a plethora of government initiatives (what at the time the *Health Service Journal* editorials were dubbing 'New Labour initiative-itis', and policy analysts, more coolly, were calling *policy churn*), that were themselves disrupting service stability and thus the capacity of the NHS to become a *learning organisation*.[8]

The single retrospective case study below from one tPCT in Northern England illuminates some of the processes and consequences of that central and local policy complexity.

Reflective account of a tPCT in Northern England

The tPCT was established in 2002, comprising the three PCTs in the local area. Box 2 outlines the team development.

From 2003, with these appointments, the team became a visible entity in the local health economy. However, for reasons to be explored below the activity soon became constrained by a number of local processes.

The objectives of this integration were reflected in concepts such as *growing our own workforce* and developing *learning environments*. Boxes 3 and 4 reflect

Box 2

Year	tPCT development
2002	Project director appointed (A-MC)
2003	Clinical Dean (DP) and Academic GPs (3) appointed Project managers, Pathways to Work, Condition Management Programme staff appointed Development of two teams' Organisational Development and Condition Management programme. Managed in tandem and synergies identified
2007	tPCT team dispersed

Box 3 Boundary projects between health and social care sectors

Working with and running learning events with PCTs and tPCTs across the new NW SHA

Producing an Evaluation Framework for local tPCT activity (linked to national developments)

Support for the Clinical Services Review of acute provision in the health economy through facilitating service and role redesign and the shifting of provision where appropriate from secondary to primary care

Developing strategic links with HEIs and medical schools to provide common approaches to medical and inter-professional education

Mainstream development of the unregistered health and social care workforce, e.g. healthcare support workers, practice managers

Box 4 Organisational and workforce development in primary care

Developing multidisciplinary training and 'learning environments' within primary care (e.g. from 14 learning environments in 2005 to 25 in 2007)

Development of role and workforce in primary care (e.g. first contact)

Commissioning '*Educating the educators*' to increase training capacity and competence across the health and social care economy

Supporting the development of learning organisations through learning events and facilitation of workplace learning

Modelling evidence and knowledge-based practice

Development of knowledge workers at practice-based commissioning locality to gather and disseminate informal knowledge currently shared in a narrative unstructured way and contained within single organisations (e.g. within general practice)

the wide range of projects where the tPCT team were successful at working at the health and social care boundaries within the locality. With this came concomitant success in recruitment and retention of GPs and other staff in primary care in the health economy, reflecting the original remit of teaching PCTs.

In the midst of these specific, on-the-record initiatives, driven and sustained by the tPCT team, two separate cultural processes were becoming evident. Firstly, these projects created conditions amenable to working in new and improved ways, which were consistent with national policies and those espoused by the constituent PCTs for local benefits (such as improving service efficiency, reducing clinical risk or increasing access to clinically marginalised populations). Conversely, the team increasingly felt ghettoised in its efforts, and two major dynamics were identified in this process and are recalled now by us and through a *look-back* exercise conducted with tPCT members after their redeployment in 2007.

Firstly, although the executive officers and boards of the constituent PCTs in theory all owned the public title of being a 'tPCT', in practice the work of the tPCT *team* was viewed as external to their general concerns about commissioning clinical services in the secondary care sector, and financial 'book balancing', for each monthly and annual round of scrutiny by the SHA and ultimately the Department of Health. Secondly, the inherently variegated nature of primary care, created by the subcontracting tradition in the NHS, meant that GPs' and their immediate parochial colleagues' level of engagement was highly variable with the projects and initiatives being developed by the tPCT team. Some were enthusiastic participants, whereas others ignored offers made to them about participation.

However, it is the first dynamic that dominates our awareness of what we could call the 'micropolitics' of our tPCT. In our case, substantial respect and support were given about the efforts of the tPCT team in one of the constituent PCTs but not the other. In 2003, as the team was beginning to grow, the less supportive organisation wanted to subordinate the work of the tPCT to the brief of one of its directors, who dealt with training. This would have reduced our wider cultural ambitions and limited our status to a subsystem within that organisation. Moreover, this message was reinforced by concerns that the tPCT team was enjoying too much autonomy.

Clearly then an ideological tension was emerging between two higher-order health policy currents. Firstly, the spirit of the NHS being or becoming an 'organisation with a memory'[3] or a 'learning organisation' was present and the tPCT team and its sup-

porters and advocates within the PCTs and local clinical settings were endeavouring to live according to that intention. Conversely, the powerful logic of the New Public Management model[5] also evinced by the Department of Health could support or subvert that spirit of reflective practice in various ways.

We provide some examples of the tensions between the two cultural processes in Box 5.

When we reflected on these tensions, it became obvious that apart from the discretion of each PCT manager at different points in the organisational hierarchy to embrace or curtail the local activities of the tPCT team, there were some inherent *logical and normative* discrepancies between what managers in the NHS routinely manifest and what the team was trying to achieve. Broadly, these discrepancies could be framed within the notion from the organisational development literature on 'tame' and 'wicked' problems.[10,11] The first of these are dealt with by routines, policies, procedures and protocols: they are ripe for and come to constitute bureaucratic subordination. However, wicked problems are new and are not solvable by bureaucratic subordination. They require innovation, imagination and flexibility of approach, depending on what the challenge is (e.g. growing the work force, becoming more patient-centred in clinical work, learning how to learn in clinical teams, etc.). The logical and normative difference between a learning approach to NHS activity and one regulated by managed routines is outlined in Box 6. Using actual examples we kept a cumulative record of the tensions within the tPCT.

The complex interplay between managing tame problems and dealing with the ubiquitous wicked challenges of organisational learning was evident in our experience. Moreover, just as a structural policy initiative at the start of the 2000s had brought tPCT into existence, their demise was also marked by a structural shift. PCTs had become the focus of substantial political criticism for being too small and parochial. For example, the Health Select Committee in 2009 complained that 'PCTs lack analytical and planning skills and the quality of their management is very variable ... We consider this to be striking and depressing' (Health Select Committee of the House of Commons, 13 January, 2009). By 2010, under a new

Box 5 Differences between tPCT teams and constituent organisations

Issue	tPCT team	Constituent organisations
Management relationships	Based on equality and respect for learning from experience	Strictly hierarchical
Norms	Risk-taking tendency	Risk-averse tendency
Working environment	Flexible, high trust, weekly meetings to share and reflect on projects	Rigid and routinised
Outcomes	Proactively specified locally	Broadly set by national priorities
Funding	Mainly external/short term	Mainstream
Workstreams	Self-defined/identified, practitioner autonomy	Top-down national priorities create prescribed local roles

Box 6 Tame and wicked problems of tPCTs

Tame	Wicked
Training	Workforce Development
Research governance	R&D
Part funding of posts in higher education	Achieving true synergies with HE and joint workforce development
Condition management	Condition management 'extra'
Modernising medical careers (MMC) current	MMC+ in the future
Mission statement about becoming a learning organisation	Becoming a learning organisation in actual daily practice
Current training arrangements	Oracle learning management
Commission and provide services based on past routines and information	Managing in practice the separation of commissioning and providing to balance competition and collaboration
Health inequalities as short-term project-managed issue	Health inequalities central to funding, commissioning and rationale for the organisation's existence

coalition government, the days of PCTs looked numbered.

Look-back exercise with tPCT team members

Following the redeployment of the tPCT team in 2007, *a look-back exercise* was arranged. Organised in 2008, and in the spirit of *Organisation with a Memory*,[3] the aim was to reflect on and evaluate the experience and effectiveness of the tPCT members in their roles across the primary health care locality. Eight team members were able to attend. Their roles included senior manager, clinical, project manager and administration roles (A-MC and PM attended as past team members but did not facilitate). Out of necessity this was a pragmatic exercise and internally facilitated. The resultant themes were analysed using a social learning paradigm (Activity theory[12–14]) in order to focus on the perspective of the tPCT team itself as a learning organisation and its boundary working with its stakeholders. The themes are summarised in Box 7 and have been categorised as enabling or inhibiting their former tPCT roles.

In broad terms, these mirror the authors' reflections with perceived tensions at the boundary between the internal learning organisation tPCT culture and that of the constituent PCTs characterised by disjunction within 'rules and regulations' of this paradigm and contrasting with an innovative internal tPCT organisational culture.

Discussion

In this paper we sought to demonstrate the issues related to the implementation of a government initiative designed to improve the quality of English primary health care through the perspectives of reflections on health policy current during the history of the tPCT, from senior tPCT management and reflections from some tPCT members. The authors accept the

Box 7 Enabling and inhibiting factors for tPCTs

Rules and regulations (external and internal to the tPCT team)	Community of practice	Division of labour (who does what)
Enabling Lack of hierarchy (within the tPCT team)	**Enabling** *'Networking, room for innovation part of something new'* *'Ability to cross boundaries, building relationships'* *'Acknowledging learning'* *'Shaping quality in primary care (nursing)'* *'Supportive environment for a project with a steep learning curve'* *'Permission to take forward own ideas, permission to innovate, non-competitive'* *'Chance to use and add to skills* *'Determination, tenacity'* *'Unofficial mentoring'* *'Wide diversity within the team'* *'Team building'* *'Safe environment, no blame culture'* *'Felt appreciated'* *'Wanted to leave grey world behind'*	**Enabling** Change from previous hierarchical structure ('before joining the tPCT I was task driven, aware of bureaucracy')
Inhibiting Unconnected policy, ambiguity between PCTs and tPCT team Reconfiguration of SHA Temporary contracts Lack of 'buy-in' from stakeholders	**Inhibiting** Perceived 'negativity' towards the organisation from stakeholders	**Inhibiting** Perceptions of lack of support from stakeholders middle management Under-utilisation of skills because of need to innovate (within the tPCT team)

limitations of a study in which the evaluation of a complex intervention is retrospective and limited to a small number of narrative accounts, but would suggest that there are valuable lessons for future NHS organisational development. These will include the difficulties of facilitating cultural change in organisational structures driven by the 'mantras' of national performance management targets; the problems arising from developing a policy which encourages innovation (and as in this case the notion of a learning organisation) anticipate the complexities in all their dimensions of managing change at the multiple boundaries for all stakeholders.

The structural changes, associated with the rise and fall of tPCT, leave behind some clear challenges for those of us interested in genuinely improving the quality of primary health care. Under the new arrangements of primary care commissioning,[15] there are two distinct organisational scenarios, one internal and the other external. The first is that local health centres and practices as primary care *providers* will still be faced with the challenge of learning how to learn. The second is that the new commissioning groups may wish (but are not obliged) to make explicit that a learning organisation approach is being truly manifested in the plurality of service providers they *commission*. These services will be purchased by clinical commissioning groups (CCG) run by GPs and primary healthcare professionals and will be designed to reflect patients' needs in the CCG localities. All practices in the CCG will be expected contractually to participate in these difficult decisions.

If commissioning is shaped only by cost-minimisation criteria, then a learning organisation approach will be ignored. However, the abiding claim of politicians of all hues in the recent past is that the *patient experience* is at the top of their policy agenda. If that is the case, then the quality criteria for acceptability, accessibility, appropriateness, equity, clinical effectiveness and cost-effectiveness can only be truly addressed by a learning organisation approach, which is prepared to deal with wicked not just tame problems.[8] TPCTs were one policy experiment that exposed this necessity, and their absence now, in the midst of the current NHS primary care organisational change, will be missed, given their expertise to take forward and model the reform agenda.

Our experience was that this exposure was useful, but the difficulties with the structures and cultural norms of the stakeholders that were revealed in the experiment were left unresolved at the point of their demise. This paper is one attempt to learn the broad lessons we can from a first post-mortem.

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