Primary care groups

Tackling organisational change in the new NHS

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This is the first in a series of five articles

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The organisational centrepiece of the Labour government's reforms of the NHS was the establishment of 481 primary care groups in England in April 1999 and their anticipated progression to trust status.[1 2] For the first time since the founding of the NHS in 1948, primary and community health services have come together in a single organisation that controls a unified budget for delivering health care to and improving the health of communities of about 100 000 people.[3] Although they will initially operate as subcommittees of health authorities, they will become freestanding primary care trusts as they show that they can manage budgets and services. As trusts they will have full control of their budgets and be responsible for providing and managing a wide range of community based services as well as for commissioning hospital services on behalf of their patients. Seventeen trusts were established in April 2000, a further 23 in October 2000, and 124 in April 2001. It is anticipated that all groups will become fully fledged trusts within the next two years.[4]

The establishment of primary care groups and trusts represents a break with the market culture of the early 1990s, replacing general practice fundholding with a corporate culture that emphasises partnership and collective responsibility. Establishment of the groups is also an attempt to foster local ownership and control.[1] General practitioners and other health professionals working with NHS managers are responsible for shaping local policies and priorities as well as for implementing national policy. Primary care groups and trusts have a crucial part to play in modernising the NHS under the terms of the government's national plan, which was published in June 2000 (box).[4]

In their first year most primary care groups concentrated on establishing an infrastructure, developing their organisation, dealing with the abolition of GP fundholding, and developing a corporate culture of working.[5–7] At the end of their second year we can assess how well they are performing in terms of their principal functions and their own aspirations. Will primary care trusts deliver the modernisation that is expected of them by the government? In the first of five articles we examine how they are managing the process of organisational change. Other articles in the series will assess their performance in modernising primary care, improving quality, working in partnership, and improving health.

Summary points

- The establishment of primary care groups and trusts in England represents a major change from the internal market that characterised the NHS in the 1990s
- The national tracker survey is evaluating the progress of 72 of the 481 primary care groups established in 1999
- Most primary care groups and trusts report that they have inadequate resources to manage change
- Many primary care groups are merging to increase managerial resources and prepare for becoming trusts
- Most primary care groups aim to become trusts by April 2002 to achieve greater integration of primary and community services
- The demands of rapid organisational change being undertaken with limited managerial resources may divert attention from the tasks of modernising services and improving health

Key points of the NHS plan

- All primary care groups will become trusts by 2004
- 500 one stop health centres will be established by 2004
- 2000 more GPs will be practising by 2004
- 3000 surgery premises will be upgraded by 2004
- Up to 1000 GP specialists will be taking referrals from fellow GPs by 2004
- Four million outpatient appointments with consultants will be provided in primary care by 2004
- A third of all GPs will be working under new personal medical services contracts by 2002
- Singlehanded GPs will sign new contracts designed to protect clinical standards by 2004
- 5000 extra beds will be available for intermediate care by 2004

National tracker survey

To review the progress of the groups we draw on results from the longitudinal national survey of 72 of the 481 primary care groups established in England in 1999.[6 8] Details of the survey and response rates are summarised in the box. Information and opinions were provided by health professionals and managers who are closely involved in developing these new organisations and are thus likely to present a more positive assessment of their achievements than those who are not directly involved. Two of the primary care groups in our original sample had merged with each other by the time we did the second survey in 2000, and six had become primary care trusts.

Corporate culture and resources

The NHS internal market of the 1990s promoted competition and, through general practice fundholding, encouraged practices to develop services in isolation, sometimes at the expense of other practices and their patients.[9] The Audit Commission concluded that apart from a small number of notable exceptions, most fundholding practices had brought about only modest improvements in health care and that these were probably insufficient to justify their higher cost.[10] Variants of the original fundholding scheme, including "multi-funds," total purchasing pilot schemes, and locality commissioning groups, began to develop a more collaborative approach to commissioning after 1995. However, these schemes were mostly confined to practices that volunteered to implement them and were concerned primarily with commissioning hospital services and community health services.

The establishment of primary care groups is changing the organisational and cultural climate of primary care. The three achievements most commonly cited by chief executives of primary care groups in their first year were building relationships with primary care professionals, getting the board to work as a corporate group, and developing the organisation.[6] By December 2000 most chief executives felt that their boards were working well, and most primary care groups were working hard to consult with and involve professional stakeholders. As a result, the chairs of primary care groups reported that both general practitioners and nurses were more positive and supportive of their organisations by the second year. Altogether, 62% of the 72 primary care groups surveyed reported that at least half of the general practitioners were supportive, compared with 40% in the first year. Two thirds felt that at least half of the practice nurses and community nurses were supportive, compared with 39% in the first year. However, work remains to be done to engage the professional stakeholders: 30% of chief executives identified apathy among general practitioners as an obstacle to progress. Despite the announcement of additional funding for general practice,[11] the serious crises of workload and morale[12] will continue to make it difficult for primary care groups to secure the full commitment of general practitioners.

The ability of primary care groups to manage organisational development at the same time as improving services will be affected by their management capacity—that is, the capacity of the organisation to manage its business—and the availability of professional staff and support staff. Tables 1 and 2 show the wide variation in the managerial, financial, and administrative resources available. Apart from the chief executive, 16% of primary care groups and trusts had three or fewer staff. At the other end of the spectrum, 16% had 10 or more. For organisations responsible for budgets in excess of £100m ($140m) each year, it was surprising that 15% had no specialist finance staff. Staffing levels reflected the budgets for management, which were influenced by the recommendation that they should be set at £3 per person for the population served. However, the actual allocation varied from less than £3 to more than £6. Two thirds of chief executives reported that current staffing levels were inadequate, and 62% identified inadequate resources (money or staff, or both) as obstacles to progress.

National tracker survey of primary care groups and trusts

Aims
To describe how primary care groups and trusts tackle their core functions (health improvement, developing primary and community services, and commissioning hospital services); to evaluate their achievements against national and local goals; to identify features associated with successful delivery of core functions

Sample
Random sample of 72 (15%) of the 481 primary care groups established in England in 1999, stratified by health region

Design and methods
Annual surveys (October to December 1999 and October to December 2000) of key informants using face to face interviews (1999 only), telephone interviews (2000 only), and postal questionnaires

Telephone interviews and postal questionnaires in 2000 discussed organisational development, budgets, primary care development, commissioning, clinical governance, prescribing, health improvement, and working partnerships

By the 2000 survey two primary care groups in the sample had merged, leaving a total of 71, of which six had become primary care trusts

Response rates for 2000 survey
71 key informants responded, except for health authorities where 48 responded

Telephone interviews—97% of chief executives responded, as did 97% of chairs and 100% of health authorities

Postal questionnaires—82% of those in charge of clinical governance responded, as did 80% of those in charge of prescribing, 70% of those in charge of information management and technology, 72% of those in charge of commissioning, 61% of social services representatives, and 66% of community health council representatives

Table 1 No of staff in primary care groups and trusts, 2000[8]

	No of staff* (n=68)				
	<1	1-1.9	2-2.9	3-3.9	⩾4
Managers†	7 (10)	13 (19)	24 (35)	8 (12)	16 (24)
Finance staff	36 (53)	16 (24)	10 (15)	5 (7)	1 (2)
Secretarial or administrative	5 (7)	12 (18)	24 (35)	16 (24)	11 (16)

*Whole time equivalents.
†Excluding chief executives.

Table 2 Funds allocated for management, 2000-2001[8]

	Funding for management (n=66)				
	<£200 000	£200 000-299 000	£300 000-399 000	£400 000-499 000	⩾£500 000
No (%) of groups and trusts	6 (9)	15 (23)	17 (26)	10 (15)	18 (27)

Mergers

The government felt strongly that primary care groups and trusts should retain a more local focus than is possible for existing health authorities. For this reason, the 1997 white paper recommended that they should typically serve around 100 000 people[1]; the average number of people served by the 481 primary care groups established in 1999 was 105 000. However, the results of our survey in 2000 show that two thirds are planning to merge with their neighbours by April 2002, pushing the average number served up to 193 000. Altogether, 13% of all primary care groups and trusts in our sample will care for populations of more than 300 000.

The most common reasons given for planning to merge were to increase management capacity or to achieve economies of scale in management; these were mentioned by 48% of those planning mergers. The large number of planned mergers should not be surprising considering the perceived inadequacy of existing staffing levels and the allocation of management budgets on the basis of the number of people served. Altogether, 37% claimed to be merging in order to become a trust, perhaps reflecting a view that smaller trusts would not be viable. Health authorities were playing an active role in promoting mergers: 40% of primary care groups planning mergers said that their health authorities had promoted mergers and 17% said that the health authority had forced them to merge.

Although the recommended number of 100 000 patients per group was not based on a systematic review of evidence, there is also no evidence to support the increases in size that will result from the present round of mergers.[13] Indeed, for some of the core functions of primary care groups—such as developing clinical governance and community based services—there are arguments for smaller units of aggregation. Furthermore, there is considerable evidence that mergers make additional demands on managers and staff and that any benefits take time to be realised.[14 15]

Table 3 Reasons for changing from primary care group to trust and time frame for transition[8]

Decision about becoming a trust	No (%) respondents
Timing of bid to become a trust (n=70)	
Became a trust in April or October 2000	6 (8)
Application submitted for April 2001	29 (41)
Aim to become a trust in April 2002	28 (40)
Do not expect to become a trust until after 2002	7 (10)
Reasons for becoming a trust (n=66)	
Integrate primary and community services	51 (77)
Focus on local needs and services	38 (58)
Exploit capacity to innovate and develop new services	28 (42)
Increase control over resources	17 (26)
Gain autonomy from health authority	17 (26)
Services expected to be provided by trust (n=61)	
Community nursing	58 (95)
Community based therapies (for example, physiotherapy, occupational therapy, chiropody)	47 (77)
Community based services for specific groups of clients (for example, children, older people, drug users)	39 (64)
Specialist services previously provided in hospitals	16 (26)
Community mental health services	10 (16)

Becoming a primary care trust

Virtually all of the primary care groups in our survey expect to become primary care trusts by April 2002 (table 3). Three quarters cited the potential for achieving greater integration of primary and community health services as a reason for wishing to become a trust. Most were aiming to achieve this by becoming providers of community nursing services and other community based services. They will thus take on substantially greater management responsibilities as they acquire direct responsibility for additional staff and services. However, 36% of primary care groups said that inadequate management capacity was an obstacle to becoming a trust, and 36% said that lack of resources was an obstacle to becoming a trust.

Many primary care groups are seeking to become trusts as a way of achieving greater independence and developing greater sensitivity to local needs, but there is tension between local autonomy and central control. In the NHS white paper[1] and in subsequent guidance[16] the government has asserted its commitment to placing general practitioners, nurses, social services, and local communities at the forefront of developing and providing services. In practice, however, many primary care groups are finding that their scope for achieving local autonomy is limited by central directives and targets and by the degree of control exercised by health authorities. A quarter cited problems in their relations with health authorities as an obstacle to progress; problems included autocratic or paternalistic management, a reluctance to delegate, and the imposition of financial constraints. They believe that becoming a trust will give them greater control over resources and decisions.

Discussion

Primary care groups and trusts have made significant progress in implementing the changes necessary to transform the culture and organisation of primary care and community health services. However, our survey suggests some causes for concern; these need to be addressed to ensure success in delivering improvements in services and health outcomes in the medium term and longer.

The wide variation in management capacity and the perceived inadequacy of the infrastructure of management and support for primary care groups and trusts may put a brake on their ability to tackle the challenges set out in the NHS plan.[4] They are adopting

a variety of strategies to tackle the problem, but the root cause lies in the constraints imposed on budgets for management. There are only two ways of increasing resources: by merging with a neighbouring group or by becoming a primary care trust and thus acquiring additional staff and greater control over the budget. However, neither of these is likely to solve the underlying problem since both will generate additional demands on management.

There is no evidence that economies of scale will be derived from increases in size beyond 100 000 people,[13] and the additional responsibilities of managing services and dealing with hospitals will mean that any additional management resource will soon be used up. Furthermore, both mergers and the transition to trust status generate additional demands in terms of managing the process of organisational change among staff and stakeholders. What little evidence is available on the costs of management indicates that these are likely to be much higher than £3 per person. Using evidence from evaluations of the total purchasing pilot scheme, under which groups of practices controlled the total budget for hospital and community services, management costs have been estimated to be in the region of £17 to £18 per person[17]; a detailed study of the likely costs of managing one primary care trust estimated them to be around £11 per person.[18]

There is continuing tension between centralised policy and management and local autonomy and initiative. Over the past decade, successive governments have grappled with the problem of how to devolve decision making to frontline health professionals while retaining control over NHS policy and managing performance.[19] Primary care groups and trusts were promoted as putting local health professionals "in the driving seat" to develop services and increase sensitivity to local needs and circumstances.[1] The reality has proved rather different: there has been a demanding stream of central directives and performance targets. Many primary care groups have been disappointed by their inability to pursue locally defined agendas and are looking to becoming trusts as a way of reclaiming autonomy. If, as seems likely, primary care trusts are just as tightly managed in terms of performance as primary care groups, there is a danger that local health professionals will become disillusioned and disengaged. A recognition of the need to empower frontline staff has been reflected in proposals for further structural reform.[20] However, the upheaval associated with creating 30 new strategic health authorities could weaken support for primary care groups and fledgling primary care trusts.

For the NHS the importance of primary care groups and trusts lies in their potential to improve local services. While many have begun to introduce changes designed to deliver these improvements, there is a danger that the demands of managing complex mergers, preparing to become a trust, and managing the inevitable upheavals that will follow, will divert attention from the real business of raising quality standards, improving access to services, building partnerships, and improving health.

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One hundred years ago

Hospitals and antivivisectors

It used to be said that if a man would stand at the foot of Nelson's monument and look at the tail of the lion which stood on the top of old Northumberland House he would in a short time gather a crowd which would block the traffic in Whitehall and the Strand. Mr Stephen Coleridge seems to have taken this to heart, and is endeavouring by taking up a conspicuous position and pointing his finger at the medical schools and laboratories, to block the flow of donations and bequests to the hospitals. His latest effort is to issue a large quarto pamphlet, entitled *The Metropolitan Hospitals and Vivisection: A Guide for the Charitable in the Disposition of their Gifts and Bequests.* The body of the pamphlet consists of a long table in which those "hospitals that have vivisectors on their staffs and have attached to them medical schools licensed for vivisection are printed in red ink. Hospitals that have licensed vivisectors on their staffs, but have no medical schools licensed for vivisection attached to them are printed in italics," while those "that are now entirely free from any connection with vivisection are printed in ordinary type. Intending benefactors," Mr Coleridge says, "can therefore see at a glance what hospitals foster and what hospitals are free from vivisection." *(BMJ* 1901;i:104)