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Research

From primary care groups to primary care trusts in the new NHS in England

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The establishment of primary care trusts (PCTs) is a radical reorganization of the NHS. This paper examines primary care groups (PCGs) making an early change to trust status, comparing them with those adopting a longer timetable for the change. The data are derived from the National Tracker Survey of primary care groups and trusts (random sample of 72 PCGs, 15% of the 481 PCGs in England, and five purposively sampled early PCTs) conducted in 1999 and 2000. The main source of data consisted of interviews with Chief Officers (response rates: 1999, 100%; 2000, 97%). In total, 43% of PCGs had become PCTs by April 2001, and 90% expect to become PCTs by April 2002. Integration of primary and community health services, focusing on local needs and innovation in service development, were common reasons for wanting to become a PCT. These trusts were more likely to cite autonomy as a reason, and were also more likely to believe that they had the support of professional stakeholders, but a substantial minority reported that they did not have the active support of GPs and other primary care staff. Although early trusts had slightly more experience of GP-led commissioning, there was no evidence that they were performing better than later trusts in their core functions of developing primary care, improving quality and commissioning services. The rapid progress from PCGs to PCTs does not seem to reflect the process of developmental learning and building on experience initially envisaged by government. Evidence from earlier NHS reforms indicates that time taken to build capacity, develop relationships and secure stakeholder support is associated with success. There appears to be a tension between central control over the implementation of NHS reforms and the desire to devolve budgets and responsibilities to local level.

Key words: health care reform; organizational development; primary care trusts

Introduction

Since 1948, primary health care has been both the cornerstone and the Achilles' heel of the National Health Service (NHS) in the UK. By creating a tripartite division between hospital, community and family practitioner services, with open access to family practitioner services but controlled access to specialist services, the architects of the NHS created a service available to all at relatively low cost. However, the tripartite structure, combined with the independent contractor status of general practitioners (GPs), has resulted in a service which suffers from problems of poor communication and coordination, an inability to plan comprehensive services to address health needs, and wide variations in provision. The reforms introduced by the Conservative Government in the early 1990s tried to address these problems through the creation of an internal market. In primary care, the focus of attention was on the purchasing role of GPs through GP fundholding and its variants (multifunds, extended fundholding, total purchasing, etc.), but little attempt was made to develop closer integration of primary and community services.

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The publication of the Labour Government's White Paper on the NHS in England (Department of Health, 1997) formally announced the demise of GP fundholding and the internal market. However, the agenda set out in the White Paper was potentially far more radical than the simple abolition of market mechanisms. It placed the emphasis squarely on the role of the NHS in improving health, set out a renewed commitment to equity of access and provision, and proposed a system of quality improvement through clinical governance. The organizational centrepiece of the reforms introduced in the last 2 years is the formation of primary care groups (PCGs), with the expectation that these would in due course become freestanding primary care trusts (PCTs). A total of 481 PCGs were established in April 1999. Typically PCGs are responsible for around 100 000 people. Each PCG has a Chief Officer, support staff and a Board containing up to seven local GPs, two nurses, one lay member, one social services representative and a nonexecutive member of the health authority. PCGs act as subcommittees of the health authority, having delegated responsibility for primary, community and hospital services. PCGs have three principal functions:

1) improving the health of the population and addressing health inequalities;
2) developing primary and community health services;
3) commissioning a range of community and hospital services.

PCGs are expected to develop over time, learning from existing arrangements and their own experience. This developmental learning process was reflected in four proposed levels of operation:

- *Level One*: supporting and advising the health authority in commissioning care for its population;
- *Level Two*: taking devolved responsibility for managing the budget for health care as a subcommittee of the health authority;
- *Level Three*: becoming established as a freestanding body accountable to the health authority for commissioning primary and secondary services (PCT);
- *Level Four*: becoming established as a freestanding body accountable to the health authority for commissioning care with added responsibility for the provision of community health services (PCT).

All PCGs were established at Level One or Level Two in April 1999. A total of 17 PCGs became PCTs in April 2000, a further 23 in October 2000 and 124 in April 2001. The NHS Plan (Secretary of State for Health, 2000) announced that all PCGs are expected to become trusts by April 2004. PCTs will have a Board containing a majority of lay members which is responsible for overseeing the work of a professional Executive consisting of GPs, nurses, social services representatives, managers and other professionals. They will have a unified budget for the provision of health care to their populations, combining the resources previously allocated separately to primary, community and hospital services. At Level Four, they will be able to provide an agreed range of community-based services (i.e., employ and manage staff) and commission services from other providers (principally NHS trusts).

The establishment of PCTs represents a radical change in the funding, organization and governance of health care provision in the NHS. For the first time since 1948, there will be a single budget for health care provision, including general practitioner services, community health services and hospital services, with flexibility to shift resources between sectors and services. Although most GPs are likely to remain independent contractors in the short term, local contracting, increasing use of salaried service and the fact that the PCT is responsible for the quality and quantity of primary care provision represent a major shift in the organization of primary care. GPs and other primary care professionals will play an increasingly important role in managing local health care through the PCT Executive, including shaping services commissioned from other NHS trusts. As they take responsibility for the provision of services, PCTs will play a leading role in managing local health care provision. In short, they represent an English version of comprehensive managed care organizations.

Evidence from early research on PCGs indicated that most of them were making rapid progress towards taking on their new responsibilities (Audit Commission, 2000; Smith *et al*., 2000; Wilkin *et al*., 2000). However, this research also suggests

that many PCGs will require more time to develop the organizational and managerial capacity necessary to take on the responsibilities of becoming fully-fledged PCTs. This conclusion is also supported by earlier research on total purchasing and locality commissioning schemes in the late 1990s (Smith and Shapiro, 1996; Regen *et al*., 1999; Wyke *et al*., 1999).

This paper draws on the results of the National Tracker Survey of PCGs and PCTs to examine how PCGs are approaching the transition to trust status. It examines their reasons for wanting to make the transition, the services that they plan to provide, and their readiness to take on the additional responsibilities of becoming a trust. We examine the characteristics of early PCTs and assess the extent to which they are building on success and a process of developmental learning by comparing them with PCGs which have opted for a slower pace of change.

Methods

The National Tracker survey is evaluating the performance of a random sample of 72 (15%) of the 481 PCGs established in England in April 1999. An additional five PCGs which expected to become early trusts were purposively sampled to ensure adequate representation of early PCTs.

The first survey was conducted between October and December 1999 (Wilkin *et al*., 2000), and the second survey was conducted between October and December 2000 (Wilkin *et al*., 2001). Data were obtained through interviews with Chief Officers, Chairs and health authority leads, and postal questionnaires to other key informants. Questionnaires covered all of the principal functions of PCGs, as well as organizational and financial information. Health improvement plans, primary care investment plans, joint investment plans and accountability agreements were also collected.

The evidence presented in this paper is drawn from the structured interviews with Chief Officers of PCGs and PCTs (100% response rate in year 1 and 97% response rate in year 2) and health authority leads (98% response rate for both years). The first survey used face-to-face interviews. These were replaced with telephone interviews in the second survey.

Results

Most PCGs began work in April 1999 at Level Two, but by April 2001 43% of the PCGs in our random sample had become Level Four PCTs (see Table 1). Only one opted for Level Three (commissioning only) in 2000, and this has now moved to Level Four. By April 2002, 90% of our original sample expect to have become PCTs. Many PCGs are also planning to merge with neighbouring PCGs in preparation for becoming a PCT. Four (6%) of the PCGs in our sample had merged by October 2000 (two of these had merged with each other, reducing the total sample to 71), and a further 51 (71%) were planning mergers. If all of these mergers proceed, the average population of PCGs/PCTs will rise to 193 000, compared with the initially recommended figure of 100 000.

Table 1 Actual and planned transitions from primary care group to primary care trust ($n = 71$)

Trust in April 2000	Trust in October 2000	Trust in April 2001	Trust in April 2002	Trust after April 2002
3 (4%)	3 (4%)	25 (35%)	33 (46%)	7 (10%)

The results presented in the remainder of this paper are based on our random sample together with the five 'early PCTs' purposively sampled to increase the representation of PCTs. Three of these five became PCTs in 2000, and the remaining two in April 2001. The analysis compares early trusts (April 2000, October 2000 and April 2001) with later trusts (mostly aiming to become PCTs in April 2002).

Size of PCG/PCTs

Assuming that the planned mergers take place, the early trusts are somewhat smaller in terms of populations served than the later trusts (see Table 2). Later trusts were more likely to be planning mergers which will take their populations above 200 000, more than twice the size originally envisaged.

Reasons for becoming a trust

Chief Officers were asked why the PCG had decided to become a trust, and what changes to local services being a trust would enable them to

Table 2 Estimated population of primary care groups and primary care trusts following anticipated mergers

	Population size following merger		
	<150 000	150 000–199 999	⩾200 000
Early trusts ($n = 36$)	13 (36%)	12 (33%)	11 (31%)
Later trusts ($n = 40$)	10 (25%)	8 (20%)	22 (55%)

make. Integration of primary and community health services, focusing on local needs and services and service development were the most commonly cited reasons for becoming a PCT (see Table 3). It is notable that autonomy and the ability to manage their own resources were more often mentioned by early trusts, while the later trusts appeared to be more concerned about integrating service provision. The wish to be more independent was summed up in our first survey as 'ability to determine our own future', 'independence and influence in the local health economy', 'we will feel more in control of the local process once we are a trust' and 'don't have health authority culture looming over you the whole time'. However, it was notable how few of them explicitly linked their aspirations to trust status with a broader strategy for improving health and reducing inequalities. A few Chief Officers of early trusts indicated that they anticipated advantages in being among the first wave, with comments such as 'it will happen anyway, and those in the first wave will get more support', 'not to be left behind with regard to other PCGs and trusts' and 'good to be one of the first . . . rather than one of the last'.

Changes to services

When asked what changes to services would be made possible by becoming a trust, most Chief Officers again emphasized the integration of primary and community health services, combined with a stronger focus on local needs and improved access to primary and community services (see Table 4). In our first survey, more than half of the Chief Officers identified initiatives at the interface between primary and secondary care as priorities, but by the second year it was evident that transferring care from hospital to community settings was less of a priority than improvements in primary and community services themselves.

Support for trust status and obstacles

Health authorities are perceived by many PCGs as playing an important role in supporting the move to trust status, and in some cases setting the agenda. In total, 13 (35%) of the later trusts said that their health authorities had set the agenda, compared with five (19%) of the early trusts. This is consistent with the finding that the early trusts were more likely to be actively seeking autonomy and independence through the change. Perhaps

Table 3 Reasons for becoming a primary care trust

Reasons	Early trusts ($n = 34$)	Later trusts ($n = 37$)
Autonomy/independence from health authority	12 (35%)	6 (16%)
Focus on local needs/services	20 (59%)	20 (54%)
Manage own staff and services	8 (24%)	5 (14%)
Integration of primary and community health services	22 (65%)	31 (84%)
Control over budget and resources	9 (27%)	9 (24%)
Integration of health and social services	4 (12%)	10 (27%)
More flexible working	8 (24%)	5 (14%)
Innovation and service development	16 (47%)	15 (41%)

Table 4 Changes to services enabled by becoming a primary care trust

Changes to services	Early trusts ($n = 34$)	Later trusts ($n = 37$)
Integration of primary and community health services	26 (77%)	33 (89%)
Focus on local priorities	19 (56%)	15 (41%)
Integration of health and social services	7 (21%)	14 (38%)
Improved access to primary and community services	19 (56%)	20 (54%)
Moving specialist services to primary care	5 (15%)	8 (22%)
Improved services for priority groups	12 (35%)	9 (24%)
Improvements in quality of primary care	10 (29%)	11 (30%)

more important to the ultimate success of PCTs will be the extent of support from key stakeholders (see Table 5). Among professional stakeholders, the early trusts were more likely to believe that they had the support of general practitioners, nurses and other primary care staff. Nevertheless, it is notable that almost a third of the early trusts were embarking on such a major change without the active support of local GPs, and the majority of the later trusts had still to win the support of GPs. Although most respondents felt that the key institutional stakeholders were supportive, it is clear that many still have a considerable amount of work to do in order to secure active support from key stakeholders.

Perceived obstacles to becoming a successful PCT included lack of resources, GP resistance and inadequate management capacity. In all cases, the later trusts were more likely to see these as obstacles to their progress. In total, 15 (41%) Chief Officers of later trusts cited lack of resources as an obstacle, compared with nine (27%) of those in early trusts. It was found that 43% (16) of later trusts cited GP resistance or apathy as an obstacle, compared with 27% (9) of the early trusts, and 46% (17) of the later trusts said that lack of management resources was an obstacle, compared with 27% (9) of the early trusts.

Preparedness for trust status

Early trusts had somewhat more experience of GP-based commissioning among their practices, and more of them had existing or approved personal medical services (PMS) pilot schemes (see Table 6). These allow new practice-based contracts, the provision of a wider range of services and the employment of salaried GPs. The greater experience of GP fundholding and innovative PMS pilot schemes suggests that some of the early trusts were building on a stronger base of experience in commissioning and practice-based innovation among their GPs and other practice staff.

Table 5 Numbers of Chief Officers rating stakeholders as supportive of move to primary care trust status

Stakeholders	Early trusts ($n = 34$)	Later trusts ($n = 37$)
General practitioners	22 (65%)	13 (35%)
Nurses	28 (82%)	16 (43%)
Other primary care staff	18 (53%)	11 (30%)
Local authority/social services	23 (68%)	26 (70%)
Acute trust(s)	21 (62%)	17 (46%)
Community trust(s)	21 (62%)	22 (59%)
Community health council	25 (74%)	21 (57%)

Table 6 Previous experience of commissioning and PMS pilots

	Early trusts ($n = 32$)	Later trusts ($n = 38$)
Eight or more standard fundholding practices	11 (34%)	6 (16%)
Practices involved in multi-funds	4 (13%)	5 (13%)
Practices involved in total purchasing pilots	6 (19%)	6 (16%)
Practices involved in locality commissioning groups	9 (28%)	9 (24%)
First-wave PMS pilots	6 (19%)	2 (5%)
Second-wave PMS pilots	8 (25%)	7 (18%)
Multi-practice PMS schemes	6 (19%)	2 (5%)

In terms of the infrastructure of the PCGs themselves, there were no systematic differences between early trusts and other PCGs in the number or type of staff employed, premises and equipment, the formation of Executive groups, use of organizational development plans, development of information management and technology (IM&T) systems, etc. Most PCG Boards were working well together, but there was no evidence that early trusts had made more progress towards a corporate style of working. Indeed, only 58% of Chief Officers in early trusts said that they were working well in terms of a shared vision and common purpose, compared with 74% in the later trusts. It seems possible that the process of change may undermine the corporate culture, at least in the short term.

We compared the priorities and performance of early trusts and other PCGs for each of the core functions of PCG/PCTs. There were no systematic differences in reported progress in the development of primary and community services, improving quality through clinical governance, commissioning hospital and community services, developing partnerships with local authority services or improving health and reducing inequalities. To obtain an independent assessment of PCG performance, we asked health authorities to rate the performance of each PCG during the first 18 months in each of five key areas (see Table 7). These ratings do not suggest

Table 7 Health authority rating of how well PCG/PCT is performing core functions

	Early trusts ($n = 36$)		Later trusts ($n = 39$)	
	Performing poorly	Performing well	Performing poorly	Performing well
Improving health of the population	3 (8%)	9 (25%)	10 (26%)	5 (13%)
Improving primary care services	1 (3%)	18 (50%)	0	23 (59%)
Clinical governance	1 (3%)	20 (56%)	4 (10%)	26 (67%)
Commissioning hospital services	5 (14%)	15 (42%)	3 (8%)	16 (41%)
Developing partnerships with local authority	3 (8%)	22 (61%)	4 (10%)	20 (51%)

that the early trusts had convinced the health authorities that they were making more rapid progress than other PCGs. Although the differences between early and later trusts are small, it is interesting that slightly more of the early trusts were felt to be doing a good job in areas such as health improvement and developing partnerships, where the ability to act as an autonomous organization may bring advantages. In contrast, more of the later trusts, which were continuing to operate as PCGs, were doing well in primary care development and clinical governance, which tend to require stronger networking with local practitioners. However, when we asked health authority respondents to give an overall rating for each PCG/PCT in terms of whether they were at the 'leading edge' of development, 'average' or 'below average', they were more likely to rate the early trusts as being at the leading edge (see Table 8). This may simply reflect an assumption that early trusts must be more advanced because they are making an early move to trust status.

Discussion

Only 18 months after the establishment of PCGs, 43% of our representative sample have become Level Four PCTs. This suggests that the process of developmental learning and progression through different levels of responsibility set out in the White Paper (Department of Health, 1997) has already been left behind. Although Government Ministers and the NHS Executive have not explicitly exerted pressure on PCGs to become trusts, there has been a widespread perception among those working in PCGs of pressure to increase the pace of change. The NHS Plan (Secretary of State for Health, 2000) makes it clear that all PCGs will become PCTs by April 2004. At a local level, the fact that a quarter of our respondents stated that their health authorities had set the agenda for becoming a trust indicates a strong steering towards rapid progress to PCT status.

Table 8 Health authority lead's overall assessment of performance

Performance	Early trusts ($n = 36$)	Later trusts ($n = 40$)
Leading edge	17 (47%)	8 (20%)
Average	17 (47%)	27 (68%)
Below average	2 (6%)	5 (13%)

Our comparison of early and later trusts found little evidence that the process is being driven by building on success and developmental learning. There were few differences between earlier and later trusts in terms of either their preparedness for making the change or their performance as PCGs in their core functions. Although the Chief Officers of early trusts were more likely to report that they had the support of key stakeholders, there was still a substantial minority who felt that they had not yet secured the active support of key professional stakeholders. Evidence from the evaluation of total purchasing pilot sites suggests that the more successful sites took time to develop relationships, build managerial capacity and invest in a process of organizational development (Mays *et al*., 1998; Wyke *et al*., 1999). Although some of the early trusts are able to build on their previous experience of GP fundholding and other innovative developments, it is important to recognize that PCTs will be taking considerably greater responsibilities for

managing budgets, employing staff and providing high-quality services. Unlike total purchasing pilots or PMS pilots, they do not have the advantage of restricting their membership to a small group of enthusiastic general practices. All practices within the geographical area of the PCG or PCT are members, regardless of their interest or enthusiasm.

The fact that a third of early trusts cited 'independence from the health authority' as a reason for wanting to become a trust suggests a continuing tension between the traditions of centralized command and control in the NHS and a desire to devolve budgets and responsibilities to local level. On the one hand, some health authorities were perceived to be setting the agenda for transition to trust status, but on the other hand many PCGs saw this as an opportunity to exert more local control over decision making. As in other areas of New Labour policy (e.g., regional devolution and the creation of elected mayors), the Government has given contradictory messages. PCGs and PCTs are seen as a means of engaging local stakeholders in shaping policies and decisions (NHS Executive, 1998), but they are also part of a hierarchical NHS structure which is characterized by centralized policy making, regulation and guidance.

Although most of the early trusts had agendas for introducing changes to local service provision and increasing the integration of primary and community health services, it was not clear that trust status was a necessary condition for bringing about these changes, except in so far as they assumed that direct management of community services was a necessary condition for closer integration. More importantly, it was not evident that early trusts had clarified how trust status would enable them to deliver better services and improved health. There is a danger that the task of managing large and complex services (community nursing, therapies, mental health, etc.) will divert attention away from their longer-term goals. Many PCGs, including some of the early trusts, had too few staff and too little management experience (Wilkin *et al*., 2000). It was not surprising, therefore, that many of them cited lack of resources or lack of management capacity as obstacles to making the transition to PCT status.

PCTs differ from existing NHS trusts in a number of important ways. They combine commissioner and provider functions in a single organization, the roles of the Board and Executive are very different, and professional stakeholders have a much stronger role in decision making. The involvement of professional stakeholders, particularly GPs who will not be employees of the PCT but contractors to it, is a crucial difference. The engagement of and 'ownership' by professional stakeholders will be crucial to PCTs' ability to deliver the modernization of primary care that is expected of them.

Representation of key health professions on the PCT Executive is an important step towards securing the commitment of the larger body of professionals, but it will not guarantee this. The evidence from our research indicates that many GPs and nurses were not yet felt to be committed to the trust agenda. Most of the early trusts believe that they have secured this commitment, but these judgements should be treated with a degree of scepticism, coming as they do from Chief Officers. Those who have yet to make the change will need to work hard to secure positive commitment as they go through the process of consultation.

Although early progress to trust status should not be taken as an indication of success, we had expected to find that the early trusts were building on past experience and that they would have made more progress than other PCGs in developing their capacity to deliver on the core functions. The evidence that early trusts tended to contain more general practices with experience of fundholding and PMS pilots did suggest that they may be exploiting a capacity for innovation and change locally. However, there was no evidence that the early trusts were performing any better than other PCGs in organizational development, managing budgets, developing clinical governance, commissioning or developing partnerships with other agencies. Rather than having fully exploited their potential to bring about change as a PCG and building on this experience in making the transition to trust status, they may have decided that their interests were best served by completing the process of organizational change as quickly as possible.

The establishment of PCTs creates the structural conditions for major changes in the way in which health care in the NHS is delivered. However, although structural change was necessary to bring about a more integrated and cost-effective service, it is by no means sufficient to guarantee improvements in services and in the health of the popu-

lation. These require changes in culture and behaviour which will take time. PCTs will be judged by users and by government on whether they deliver a better service and improved health.

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