Primary care in Bradford: from group to trust and beyond

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In April 1999, four primary care groups were set up to cover the district of Bradford in England.[1] The four groups were Bradford City (population 146 600, 54.1% from ethnic minority communities; 44 practices, 28 with one partner and eight with two partners), Airedale (population 116 450; 70 general practitioners in 19 practices), Bradford South and West (population 147 100; 92 general practitioners in 23 practices) and Bradford North (population 91 850; 54 general practitioners in 13 practices). In October 2000, keeping the same geographic boundaries, all four groups achieved primary care trust status. In April 2001, Bradford City became one of the first three primary care trusts in Britain to be awarded teaching status.

Using the observations of a small group of key staff (mostly general practitioners), we describe how the four primary care groups decided to become trusts, and we examine the process that followed the decision. We look at the early experience of group members once trust status had been achieved and consider issues of continuity and change during this eventful time.

Summary points

Advantages can be gained by multiple primary care groups in one area applying for trust status at the same time

The biggest challenge in the transfer from group to trust is the timetable

The work needed to compile the submission document can detract from everyday duties, but it can also help to maintain the momentum

Primary care trusts need a different organisational structure to groups

General practitioners can be reassured by the trust focusing on strengthening the practice as a unit of care

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Methods

We asked colleagues for comments for this article. We also analysed and interpreted quotes from discussions involving 100 professionals during Bradford University's conference "Primary care groups—one year on" (April 2000) and from questionnaires completed by 40 professionals who met to look at research in the trusts (February 2001). Unattributed quotes come from these discussions and questionnaires.

Deciding to apply for trust status

At the time the decision to apply for trust status was made, Bradford was undergoing citywide changes, and there was a sense of innovation throughout the city. For some group members**,** the decision to become a trust was a result of the attitude in the city; for others, transferring to a trust was one reform too many or the decision was made in haste, representing, not innovation but a loss of independence: "it's a government agenda, it isn't mine." For some group members, the change occurred too quickly—"resulting in a group that had been at the cutting edge becoming a laggard" or the move was "way down the road to the loss of independent contractor status." Becoming involved in the process of applying for trust status did not feel like a choice freely made, but "felt like a self-fulfilling prophecy"—it was the "only way to go under the political circumstances."

In the Bradford North group, there was a sense that a "corporate decision had been made (that trust status would be sought) even before we were a primary care group … there were enough people who were 'gung-ho' about going for trust status and the remainder did not want to miss out" (Dr Peter Rennie, North). "There were a lot of ardent non-fundholders—for political reasons—and they felt that they had not done the best for their patients by being this way. Anything coming along that would benefit their patients, they wanted to be part of" (Dr John Bibby, North).

What being a group had achieved

In each of the four primary care groups, there was a strong sense of achievement in setting up the group, developing its organisational capabilities, and being in a position to move to trust status. Ms Lynnette Throp, chief executive of the Bradford City group, saw this phase as like moving "from kindergarten to university."

Achievements that were identified by group members, excluding that the groups were viable enough from an organisational point of view to transfer to trusts, were maintaining a sense of locality, being a local service for local people (Airedale), winning significant extra resources for health care (City), making

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fundholder services available to all (North), and providing innovation services such as general practitioner specialists and locality centres (South and West).[2 3] Although members from all four trusts said that achieving geographical integrity and extra resources to combat deprivation, promoting equality, and providing a context for service innovation were aspirations, a difference in emphasis for each group shows contrasting socioeconomic and practice configurations that may influence future strategy.

Consultation

Advantages arose from all four primary care groups seeking trust status at the same time. Some elements of the consultation could be done jointly, commonality between the consultation documents could be achieved, people would be reassured that district-wide services would be looked after, and all staff who were moving to the new organisations could move at the same time. "If one goes, we all would go," said Dr Maggie Helliwell (Airedale).

Waiting until the "proper" time to consult risked being too late. "By the time (staff) arrived at the formal discussion, they had got through the anger, denial, depression … they had got through the bereavement cycle, and they were quite prepared to talk sensibly about the detail" (Peter Rennie).

Once it was decided to apply for trust status, contact and meetings were arranged with other professional groups, voluntary sector organisations, patient groups, and neighbourhood groups. The experience of consultation for all four primary care groups was similar: "Don't expect too much from public consultation—people will not be very interested. Not surprisingly, restructuring of primary care is not high on their agendas" (Lynnette Throp). One attempt to seek patients' views used a well established group at a practice within the Bradford North group. After presenting and discussing the issues, the end result was the patients saying "well if you feel this is best for us" (John Bibby).

Costs and benefits

The work of consulting, drafting, and redrafting the submission for trust status was carried forward by small groups of enthusiasts on the boards of the four groups. For some of these board members, there was a sense that the work required was at a cost to everyday work and effective commissioning. Others believed that "we still managed to get services out and to develop things even while doing all the work" (Peter Rennie). Dr Barbara Hakin (South and West) goes further: "As part of the application process, you had to produce the document that showed you were fit for the purpose; this involved identifying structures, functions, and aspirations of the organisation, and it created a pace of change within the group that would not have occurred had we not been going for trust status."

Early days of the new trusts

The biggest challenge in the transfer to trusts was the timetable—"you had to move as quickly as you could … if anything had gone wrong in those first few weeks, and we had taken the scenic route to get the board and the professional executive committee established, then we would have been very exposed" (Barbara Hakin).

Looking at the experience of the first few months of trust activity, "the most interesting point is the tension between the two sorts of organisation … the group was an organisation that flew by the seat of its pants, was protected by being a subcommittee of the health authority, didn't have to have a major, cumbersome decision making process. But, that all allowed innovative, quick, decisions, responsiveness … on the other side [the trust], being a freestanding, statutory authority with a board … has to start doing things properly and demonstrating probity. The biggest challenge is for the trust to hold the line between the two so that you ensure you don't end up down the route that will have someone in court … but not stifling all the good things that have been done by turning into a new health authority" (Barbara Hakin).

Continuity and change

Is the primary care trust a different sort of organisational entity to the primary care group? Does it deliver a different sort of primary care? The fact that the answer might be yes to the former question, but no to the latter shows that people may believe that organisational structure has undue importance. When trying to understand health policy, we need to recognise that the timescales of service development and of changing philosophies of practice are much longer than the epi-

The immediate agenda—the example of Airedale Primary Care Trust

- New staff had to be integrated effectively, in part, by developing and implementing a nursing strategy
- The vision of the trust—the specific or different contribution it would make—had to be addressed
- The chair of the board, chief executive and chair of the professional executive committee had to be happy with their working relationship
- As with the group, the practices and practice managers had to feel involved in developing the organisation
- A health improvement programme for the trust had to be developed
- Teams needed to be established to take forward clinical governance agendas, to develop an education strategy, and to lead on national service frameworks

sodic restructuring of the means by which service is organised. At a time when a number of changes are occurring simultaneously, or in quick succession, it is hard to assess which has the most importance in the long term. For example, clinical governance, professional re-accreditation and the fast developing reality of personal medical services may, in retrospect, represent more significant changes in primary care than the transfer to a primary care trust.

The case for emphasising continuity involved acknowledging that "there was a body of work that led up to the magic date of being a trust and that just carried on. It's like a spectrum. On the day of becoming a trust there were huge organisational changes, but the people who were working at the rolling out of services, and so on, they carried on" (Peter Rennie). "People were doing the same thing with a different title and a different hierarchy above them. There was also a continuity in that the [group] board became the professional executive committee. The belief system, and the people delivering it, has been a consistent theme throughout" (John Bibby).

The case for the importance of recognising the impact of the organisational change and seeing how possibilities for new practices, and even philosophies, can result can also be made. "I think the key message [to people embarking on the shift to trusts] is 'don't underestimate the difference between a group and trust. If your trust ends up being just a slightly different group then you haven't cracked it'" (Barbara Hakin).

Is it worth becoming a primary care trust?

The direction of change to transfer from a primary care group to a trust—although, in these early stages, not the timing—is imposed from above. But is it approved by the group members? The opinions in this paper were mainly given by enthusiasts for the transfer to trusts, but considerable concerns have been expressed, even from them.

One way of reassuring general practitioners was to ensure that the trust focused on strengthening the general practice as the unit of care (other professions contributing to the primary care team might not be best reassured in this way). If general practices are given priority, then something of a federal structure is created. This structure positions general practices as viable and, within limits, independent "states," each with its own "culture" and a centre that (through personal medical services contracts and clinical governance procedures) can define the required level of quality.

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Scientific spirit

Taking fruits of development to primitive tribal societies is an onerous assignment, one that we tried in the Andaman Islands. The tribal huts, made of timber, straw, and dry leaves, withstand torrential rains and gales for generations. The smoke and soot of the firewood from traditional stone stoves accumulates in these huts over years, leading to red eyes and respiratory ailments. Eliminating the cause was expected to prevent further illness. We installed smokeless stoves with chimneys in a few huts. The recipients coughed less, had less watery eyes, and cooking became a pleasure. Soon most of the villagers took to this new idea. Smug in our philanthropic achievement, we returned to the urban comforts.

Visiting a year later, we expected to find healthier eyes and lungs. However, the old village was deserted. Puzzled, we probed farther into the jungle, and, a couple of miles ahead, we found them in a poor hutment compared with their old village. Soon an angrily shouting mob surrounded us.

"You brought evil spirits to our homes and village. Our forefathers built strong houses, but you destroyed them in no time. Our children now suffer from fever and sickness. We have been devastated. Our ancestral village is ruined. Go back, we don't need you."

Despairing, we retreated, but the scientist within us could not accept defeat so easily. We examined the huts of the old village: wooden posts hollowed by white ants, buckled roofs, huts in various stages of disintegration were the evidence of nature's devastation. Insects mined and bored every bit of wood and leaf, while centipedes and millipedes crawled all over. Hordes of mosquitoes and flies buzzed around us. In the middle of each hut stood our gift, the smokeless stove, with its metallic chimney still proudly spouting. Astonished at the extent of destruction, we returned to our camp.

"You look worried, sir. What's the matter?" our wizened old handyman inquired on our return. He had witnessed many enthusiasts like us, a few improving the lot of the tribal villagers but most failing.

"I just can't understand it," I lamented, and recounted the day's activity, including our unceremonious ousting by the villagers. "Can I accompany you to the village tomorrow?" he asked. I shrugged. "Then try to get some sleep, sir. You had a bad day." The only soothing words since that morning were a welcome relief.

The next day, we collected samples of insects, worms, etc, from remains of the huts for our museum. The old man followed us, his rheumy eyes missing nothing. The ugly scene of accusing villagers replayed in my mind, and I turned to the old man. "I tried to help them, but they accused me of leaving evil spirits behind. How distressing. You are tribal. Do you think I left evil spirits here? Am I a sorcerer?"

"No, sir. You didn't leave evil spirits." His words soothed my ego, but not for long. "Unfortunately, you took away the good spirits." I was dumbfounded.

"Sir, cooking on fire is sacred. It brings good spirits and health in the hut. The smoke and soot are as essential for our huts as food for our bodies. The spirit of smoke keeps the ants, mosquitoes, flies, and other insects out. Your stove drove the good smoke spirits out. The evil spirit filled in the vacuum, called insects, destroyed the house, and spread sickness."

When someone labels an illiterate man as uneducated and traditional beliefs as unscientific superstition, I remember this experience. Is science taught and learnt only in plush schools, colleges, and universities?

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