Human resource management in general practice: survey of current practice

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SUMMARY

Background. *The organization and management of general practice is changing as a result of government policies designed to expand primary health care services. One aspect of practice management which has been under-researched concerns staffing: the recruitment, retention, management and motivation of practice managers.*

Aim. *A study set out to find out who is routinely involved in making decisions about staffing matters in general practice, to establish the extent to which the human resource management function is formalized and specialized, and to describe the characteristics of the practice managers.*

Method. *A postal questionnaire was sent to a stratified random sample of 750 general practices in England and Wales in February 1994 enquiring about the practice (for example, the fundholding status and number of general practitioner partners), how the practice dealt with a range of staffing matters and about the practice manager (for example, employment background and training in human resource management). Practices were classed as small (single-handed and two or three general practitioner partners), medium (four or five partners) or large (six or more partners).*

Results. *Replies were received from 477 practices (64%). Practice managers had limited authority to make decisions alone in the majority of practices although there was a greater likelihood of them taking independent action as the size of practice increased. Formality in handling staffing matters (as measured by the existence and use of written policies and procedures) also increased with practice size. Larger practices were more likely than smaller practices to have additional tiers in their management structure through the creation of posts with the titles assistant practice manager, fund manager and senior receptionist. Most practice managers had been recruited from within general practice but larger practices were more likely than smaller practices to recruit from outwith general practice. Three quarters of practice managers reported having received some type of formal training in staff management.*

Conclusion. *This study shows that practice size is a major factor associated with differences in the organization and management of staffing. Any initiatives which increase the scale of primary care functions and services would have to address the issues of communication and coordination that might be associated with such a change.*

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Introduction

THE reforms of the National Health Service in 1991 and subsequent government health policies have brought about a large number of changes in the organization and management of general practice. New funding arrangements and new functions and services, together with new supporting infrastructures, are transforming the simple family practitioner services into complex primary care organizations which are increasingly seen as, and see themselves as, small businesses.

Like other service-providing organizations, general practices are labour intensive and their outputs, as with any 'people' business,[1] depend on the recruitment, retention, management and motivation of staff at all levels. As Irvine has said:

> 'The quality of care is critically dependent on the attitudes, skills, and knowledge of each individual, working separately and together, and on the way these are combined in the organization as a whole.'[2]

Such coordination can only be achieved by some form of personnel management. Personnel management along with the character and style of industrial relations in general, has changed considerably over the last decade or so. One indication of change has been the emergence of new terminology: organizations are now more likely to refer to their human resource management function than to use the more familiar term personnel management. The precise meaning of the new term is a matter of debate among employment relations specialists[3,4] but it is generally meant to signal a style of managing people which has a major concentration on individual employee development in addition to what are seen as the more administrative concerns of traditional personnel management. Some versions of human resource management include a more strategic focus for personnel policy by attempting to integrate this role more fully with the overall direction of the organization.[5]

Whatever human resource management actually is, the traditional personnel functions need to be performed in most organizations. Thus, it is still incumbent on all organizations to devise ways of recruiting, deploying, rewarding and developing staff. Although the policies and procedures used in commerce and industry are widely documented,[6] little is known about human resource management in general practice. It might be assumed that many practices do not regard personnel matters as a distinct aspect of the general management function, but there is no clear evidence for this assumption. Furthermore, there may be important differences between large and small practices, and between fundholding and non-fundholding practices.

A three-year investigation (from 1993 to 1996) of human resource management in general practice was undertaken. This paper reports the findings of the first phase of this investigation, from October 1993 to October 1994. The aims of the first phase were: to find out who was routinely involved in making decisions about personnel matters; to establish the extent to which the human resource management function was formalized and specialized; and to describe the characteristics of the people involved in human resource management tasks.

Method

A sample of 750 general practices was randomly selected from lists supplied by 23 family health services authorities in the following way. The sample was drawn in two stages: first, 33 family health services authorities were randomly selected from an alphabetical list of 98 authorities in England and Wales in 1993. Each of the selected authorities was asked to provide a list of general practices and 23 did so. Secondly, from these lists, 2966 practices were stratified into four size bands: single-handed practices, practices with two or three general practitioner partners, those with four or five partners (medium size practices), and those with six or more partners (large practices). As one focus of attention was on possible differences between fundholding and non-fundholding practices, a variable sampling fraction was used in each band ranging from one in nine in single-handed practices to one in two in medium and large practices. The final sample consisted of 86 single-handed practices and 102 practices with two or three partners (these were grouped together and classed as small practices), 388 medium practices and 174 large practices.

In February 1994 a postal questionnaire was sent to the practice manager in each practice. Reminders were sent to non-respondents after three weeks and again after a further three weeks. The questionnaire consisted of three sections.

One section contained questions about the practice: number and age of the general practitioner partners, its fundholding status, and number and employment status of other staff (clinical and non-clinical). Results are presented for practice size (number of partners) and fundholding status.

Another section sought details of how the practice dealt with a range of staffing matters:

- Who routinely had the authority to make decisions on 12 hypothetical issues (Appendix 1). The 12 issues were chosen by the three authors following discussions. A draft questionnaire was commented on by a small project advisory group consisting of a Royal College of General Practitioners administrator, a general practitioner researcher and an Advisory, Conciliation and Arbitration Service (ACAS) officer.
- Formality of procedures, that is, how precisely rules, policies and procedures specified the way in which 11 staffing issues were dealt with and whether written policies existed in the practice.
- Specialization of roles, that is, whether and how frequently the practice manager's role was performed by someone else in the practice and whether additional tiers existed in the management structure, for example with the creation of assistant practice manager, fund manager or senior receptionist posts.

The third section asked for information on the person completing the questionnaire, that is, the practice manager or person with similar job title: sex, age, hours of work, salary, employment background, length of time in post and training in human resource management.

Statistical analysis of the data was performed with the *SPSS* package. All statistics were derived from the chi square test at the 5% level of significance.

Results

Replies were received from 477 of the 750 practices (63.6%), from 142 small practices, 224 medium practices and 111 large practices according to the practice size classification using responses to the question on number of general practitioner partners. The response rate thus ranged from 57.7% in medium practices to 75.5% in small practices.

Of the 477 practices that responded, 188 (39.4%) were fundholding and 287 (60.2%) were non-fundholding; data missing for two respondents.

Authority to make decisions on human resource management

Table 1 shows which members of staff routinely had the authority to make decisions on 12 hypothetical staffing matters. Practice managers generally had the authority to make decisions alone in only five of the 12 areas (health and safety, and non-clinical staff appraisal, discipline, grievance, and training). Otherwise, the typical pattern for most human resource management issues was one of joint decision making between the practice partners and practice manager. As the size of practice increased there was a greater likelihood of practice managers taking independent action on all issues except health and safety,

Table 1. Practice managers' reports on which members of staff routinely had authority to make decisions about 12 hypothetical staffing issues.

	% of practices with authority for issue held by			
Issue[a]	GP partners only	Practice manager only	GP partners/ practice manager	Other staff member[b]
Conditions (n = 473)	*69.3*	*0.8*	*28.3*	*1.5*
Equal opportunities (n = 472)	*28.2*	*18.9*	*51.7*	*1.3*
Health and safety (n = 472)	*6.4*	*70.8*	*17.2*	*5.7*
Recruitment (n = 471)	*13.0*	*37.2*	*42.5*	*7.4*
Clinical staff				
Appraisal (n = 458)	*60.9*	*3.1*	*15.9*	*20.1*
Discipline (n = 472)	*34.1*	*14.0*	*47.9*	*4.0*
Non-clinical staff				
Appraisal (n = 470)	*12.3*	*56.0*	*27.0*	*4.7*
Discipline (n = 473)	*13.1*	*43.6*	*38.9*	*4.4*
Dismissal (n = 468)	*31.6*	*14.7*	*51.9*	*1.7*
Grievance (n = 471)	*5.9*	*64.8*	*22.7*	*6.6*
Promotion (n = 472)	*18.0*	*24.2*	*54.4*	*3.4*
Training (n = 472)	*8.9*	*55.7*	*29.2*	*6.1*

n = number of practices with practice manager respondent. [a]Issues described fully in Appendix 1. [b]Categories of personnel that had too few occurrences to mention individually.

and non-clinical staff appraisal. For example, on the issue of deciding to dismiss a secretary for stealing from a petty cash box (non-clinical staff dismissal), 7.1% of 141 practice managers in small practices, 14.9% of 222 in medium practices and 24.8% of 105 in large practices routinely had authority to act alone.

Approximately half of the practices (245, 51.4%) said that they had one general practitioner partner with a special responsibility for human resource management. However, this partner had a low involvement in decision making. Of the 245 practices with a partner designated in this way, the proportion of practices that were reported to leave the decision on each of the 12 staffing issues to this partner ranged from 1.6% (health and safety) to 18.8% (clinical staff appraisal) whereas the proportion that were reported not to include this partner in the decision at all ranged from 58.0% (clinical staff discipline) to 87.8% (conditions). Decisions were reported to be left to both the partner with special responsibility for human resource management and other staff in 4.1% to 37.1% of practices, on conditions and recruitment, respectively.

A total of 110 of the 188 fundholding practices (58.5%) and 134 of the 287 non-fundholding practices (46.7%) were reported to have a general practitioner partner with special responsibility for human resource management.

Formality of procedures

Respondents were asked to report how precisely (on a three-point scale: 'very precisely', 'to a moderate extent' and 'not at all', with the option to state 'not applicable') formal rules, policies and/or procedures specified the way in which staffing matters were handled. They were also asked to report whether written policies existed, as a possible confirmation of their assessment. Table 2 shows the proportion of practices reporting 11 staffing matters as being 'very precisely' dealt with by formal rules, policies and/or procedures.

In a high proportion of practices, maternity leave, grievance, health and safety, and discipline were reported to be dealt with very formally. For each of these four issues formality (as measured by the proportion of practice managers reporting 'very precisely') increased with the size of practice. Some issues, such as staff appraisal, staff development and promotion were generally reported to be dealt with less formally (as measured by the proportion of practice managers reporting 'to a moderate extent' or 'not at all') but there was a similar, although less pronounced, tendency for formality to increase with the size of practice.

A large proportion of practices reported that the issues of trade union recognition and redundancy were not applicable (54.5% and 32.5%, respectively). A higher proportion of small practices than large practices reported that the other nine issues were not applicable.

Reports that certain issues were dealt with in a formal way were backed up by statements that written policies existed on these matters. Smaller proportions of practices reported having written policies on matters that were not dealt with formally or were not applicable than on matters that were dealt with formally. For example, on the issue of trade union recognition fewer than 14% of practices were reported to have written policies whereas nearly 90% of practices were reported to have written policies on grievance and discipline.

Specialization of roles

Practice managers were asked whether and how frequently (frequently, occasionally or never) their job was performed by someone else in the practice, and whether there existed separate posts of assistant practice manager, fund manager and senior receptionist.

The practice manager role was reported to be performed by someone else: frequently, by 23.2% of small practices, 10.3% of medium practices and 7.2% of large practices; occasionally, by 50.0%, 59.8% and 63.1%, respectively; and never, by 26.8%, 29.9% and 29.7%, respectively.

Table 3 shows that a higher proportion of large practices than medium or small practices reported having created posts with the titles assistant practice manager and fund manager. In each of the three practice size groups, a large proportion of practices reported having a senior receptionist post; this proportion was highest (82.7%) in the large practices. A higher proportion of fundholding practices than non-fundholding practices were reported to have created these posts. For example, 53.7% of the 188 fundholding practices had created an assistant practice manager post compared with 34.1% of the 287 non-fundholding practices; $P<0.001$.

Information on practice managers

A total of 409 of the 477 practice managers were women (85.7%) and 65 (13.6%) were men; data missing for three respondents. Approximately three quarters of the practice managers (77.3% of 475 respondents) were aged between 40 and 59 years.

About half of respondents (52.0% of 475) estimated that their hours of work were between 30 and 39 hours per week but over a third (35.1% of 475) reported working between 40 and 49 hours per week. Of 475 practice managers, 36.2% reported receiving an annual salary of between £10 000 and £15 999. There was a statistically significant difference between salaries in the small

Table 2. Staffing issues reported by practice managers to be dealt with 'very precisely' in formal rules, policies and/or procedures, by size of practice.

	% (no.) of practices in which issue dealt with very precisely			
Staffing issue	Small	Medium	Large	All
Maternity leave	*64.7* (90)	*73.5* (164)	*83.3* (90)	*73.2* (344)
Grievance	*59.0* (82)	*70.7* (157)	*80.7* (88)	*69.6* (327)
Health and safety	*64.7* (90)	*61.4* (137)	*70.6* (77)	*64.5* (304)
Discipline	*52.9* (73)	*66.7* (148)	*74.3* (81)	*64.4* (302)
Equal opportunities	*44.6* (62)	*44.6* (99)	*50.0* (54)	*45.8* (215)
Recruitment	*39.7* (54)	*37.7* (83)	*46.7* (50)	*40.4* (187)
Redundancy	*34.1* (46)	*45.0* (99)	*38.0* (41)	*40.2* (186)
Staff appraisal	*21.7* (30)	*26.0* (58)	*33.9* (37)	*26.6* (125)
Staff development	*16.5* (23)	*18.0* (40)	*22.9* (25)	*18.7* (88)
Promotion	*19.6* (27)	*15.2* (34)	*22.9* (25)	*18.3* (86)
Trade union recognition	*10.9* (15)	*15.4* (34)	*15.9* (17)	*14.2* (66)

Table 3. Practice manager reports of practices having created assistant practice manager, fund manager and senior receptionist posts, by size of practice.

	% of practices with post created		
Job title	Small (n = 141)	Medium (n = 223)	Large (n = 110)
Assistant practice manager	*27.0*	*38.1*	*56.4*
Fund manager	*14.9*	*30.5*	*58.2*
Senior receptionist	*56.7*	*70.9*	*82.7*

n = number of practices with practice manager respondent.

and large practices, with 25.4% of 142 and 2.7% of 111, respectively, reporting to receive an annual salary of less than £10 000 ($P<0.05$). Responses indicated that fundholding practices paid higher salaries to their practice managers: 9.0% of 188 fundholding practices paid annual salaries of £26 000 or more to their practice managers compared with 0.3% of 287 non-fundholding practices; $P<0.001$.

Most practice managers had been recruited from within general practice: 32.0% of 475 respondents reported having been promoted from the practice where they presently worked and 21.1% reported having been recruited from another general practice. Responses indicated that 14.9% of the 475 respondents had been previously employed outwith general practice in private sector management (the proportion rose to 20.2% of the 188 practice managers in fundholding practices) and 12.4% had been in a managerial post in the public sector. Large practices were significantly more likely than small or medium practices to recruit practice managers from outwith general practice: 38.7% of 111 managers in large practices reported having been recruited from public or private sector management posts compared with 28.6% of 224 and 16.2% of 142 in small and medium practices, respectively ($P<0.05$). The length of time that the practice managers had been in their present post was evenly spread: 10.3% of 477 respondents reporting this as being less than one year, 35.2% from three to five years and 15.3% over 11 years.

About three quarters of practice managers (76.8% of 474) said that they had received some type of formal training in human resource management. Diplomas and short courses accounted for the majority of training received. In the 245 practices that reported that one general practitioner partner had a special responsibility for human resource management, fewer than one fifth of these partners had formal training in human resource management. A significant difference was found between general practitioner partners with special responsibility for human resource management in fundholding practices compared with those in non-fundholding practices, with 20.0% of 110 partners and 13.4% of 134 partners, respectively, being reported as having received such training ($P<0.05$).

Discussion

The overall response rate of 64% was satisfactory for a postal questionnaire, although the low response rate from medium practices (58%) suggests some caution in interpreting the results from medium practices. More confidence can be attached to the results from small practices where the response rate was 76%.

Practice size (as measured by the number of general practitioner partners) is a major factor associated with differences in the organization and management of staffing matters. Responses in this study indicated that as the size of practices increased so did: the practice manager's authority to take independent action; the degree of formality in the handling of staffing issues; the specialization of the practice manager's role; and the likelihood that the practice manager had been recruited from outwith general practice. There appeared to be some confusion, however, about the distribution of authority for human resource management decisions in some practices, with general practitioner partners responsible for human resource management having low involvement in decision making. The discrepancies could have arisen from careless completion of the questionnaires or from genuine confusion about the distribution of authority for human resource management in the practices.

Related to practice size but perhaps exercising an independent influence on organization is fundholding status. The findings suggest that fundholding practices were more likely than non-fundholding practices to have recruited people to 'middle management' positions, such as assistant practice manager, particularly from the private sector. In order to recruit such persons it might be necessary to offer salaries comparable to those in the private sector and this might account for the payment of higher salaries to managers in fundholding practices.

The findings in relation to size are consistent with those reported in other settings.[7] It is now well established that as organizations increase in size so do the complexity and formality of their internal structures. Thus, as size increases so do the number of levels in the management hierarchy, the specification of procedures, and the specialization of functions.[8] Other consequences which tend to flow from these changes are increasing problems of delegation, communication, and control within and between the different levels in the hierarchy. Essentially then, large organizations tend to be more bureaucratic than small organizations.

Bureaucracy is a term that is often used pejoratively, to refer to inefficiency, obstructiveness and rigidity. A more objective analysis might, however, see bureaucracy as a system of administration characterized by hierarchical division of labour, continuity (positions in the system are defined posts with a career structure), impersonality (work being conducted according to prescribed procedures without arbitrariness or favouritism), and expertise (office holders being selected according to merit and trained for their role).[9] Looked at in this way, bureaucracy becomes less of a problem and more a rational way of organizing work activity.

This perspective is more likely to be of encouragement to those who see the NHS as being primary care led than to those who would wish to maintain the character of general practice as personal, small scale and informal. The latter group will have to consider their ability to maintain such a culture in an environment heavily influenced by government-initiated change away from personal, small-scale, informal practice. It is clear from experience with other initiatives such as fundholding and hospital trust status that such government-initiated change develops considerable momentum. In the case of fundholding, for example, the government has announced its intention to extend the options for general practices to participate in the scheme.[10] If this anticipated expansion occurs, larger scale primary care organizations will be required to consider all areas of their working strategies, including with regard to their human resource management.

The term human resource management is used to refer to a style of management which flourished in the changed industrial relations climate of the 1980s where intense competition required organizations to pay close attention to customer needs and requirements via individualized contracts, flexible working and team building. As the results of the present study indicate that general practices do not yet regard 'personnel matters' as a distinct management function, it might be concluded that they are a long way from adopting such 'state-of-the-art' management styles. Even so, competitive pressures and the increasing amount of budget setting might encourage a new breed of practice manager in the larger practices to push for changes in staff management. Their ability to succeed in such initiatives would depend mainly on the nature of their relationship with the general practitioner partners in these practices. It is not easy to foster a sense of corporateness in organizations dominated by a professional 'core'.[11] This is not so much a case of managers and professionals being unable to 'get together' but of medical professionals being so preoccupied with their work tasks that they are unable to develop a sense of the practice as a whole requiring strategic direction.

Appendix 1. Twelve hypothetical staffing issues: practice managers were asked who in the practice routinely had authority to make decisions on each of the issues.

Conditions: make a final decision on extending surgery hours.

Equal opportunities: decide appropriate action when a candidate for a job alleges to have been the victim of sexual or racial discrimination.

Health and safety: decide to introduce new system for recording minor accidents in the practice.

Recruitment: make the final decision on the candidate selected for a receptionist post.

Clinical staff

Appraisal: make the final assessment of performance of a district nurse in an appraisal exercise.

Discipline: decide appropriate action when a practice nurse has allegedly been rude to a patient.

Non-clinical staff

Appraisal: make the final assessment of the performance of a member of non-clinical staff in an appraisal exercise.

Discipline: decide appropriate action when a non-clinical member of staff has allegedly been rude to a patient.

Dismissal: decide to dismiss a secretary for stealing from petty cash box.

Grievance: decide appropriate action when a grievance is raised by a cleaner.

Promotion: decide to promote a receptionist to senior receptionist post.

Training: decide to introduce a training course for practice staff.

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