CIVITAS: DATA BRIEFING

Re. GOVERNMENT PLANS TO TRANSFER COMMISSIONING RESPONSIBILITY FROM PCTs TO GPs

EMBARGO: 0001hrs Saturday 10 July 2010

James Gubb, July 2010

EXECUTIVE SUMMARY

The government's plan to hand control of the bulk of the commissioning of health care in the NHS – potentially as much as £80 billion of resources – from Primary Care Trusts (PCTs) to consortia of GPs have been widely trailed in the press, with a White Paper due imminently.[1]

This short briefing aims to provide insight on the scale and nature of the financial risk posed by such a move, by looking at the impact of the last reconfiguration of commissioning on performance. This occurred in 2006 when the number of PCTs was reduced in size from 302 to 152, through merging 222 PCTs and leaving 80 PCTs unchanged.

Looking at Healthcare Commission Annual Health Check ratings on 'quality of services' and 'use of resources' pre-and post-mergers, the following effects were observed:

1. **An absolute drop in performance on 'quality of service' and 'use of resources' lasting *at least* one year in PCTs that were merged.**

    - Where PCTs were merged in 2006 'quality of services' dropped sharply the year after, with the percentage of merged PCTs rated 'good' or 'excellent' falling from 34% in 2005/06 to 12% in 2006/07. The percentage of merged PCTs rated 'good' or 'excellent' on 'use of resources' also fell, from 5% to 4%.

    - This compares with significantly improved performance in 80 PCTs that were not merged. In terms of 'use of resources', the number of PCTs that were not merged rated 'good' or 'excellent' jumped from 15% to 34% between 2005/06 and 2006/07. In terms of 'quality of services', the number rated 'good' or 'excellent' improved from 35% to 39%.

2. **A period of three years before the *relative* performance of PCTs that were merged reached pre-merger (i.e. 2005/06) levels against those that were not.**

    - Ultimately, merged PCTs did subsequently catch-up with those that were not on 'quality of services', but it took three years to do so. As of 2008/09, merged PCTs

remain further behind PCTs that were not merged on 'use of resources' than they were in 2005/06.

This is consistent with other evidence on central government restructuring and hospital mergers.

It is also worth noting the potential dangers when such re-structuring goes wrong. In 2006, South Staffordshire PCT was formed from the merger of five PCTs: Burntwood, Lichfield & Tamworth, Cannock Chase, East Staffordshire and South Western Staffordshire PCTs. Of the failure of South Staffordshire PCT to provide proper oversight of quality of care at Mid Staffordshire NHS Foundation Trust, the Francis Inquiry reported 'several comments criticise the national reorganisation of PCTs in 2006/07, along with the resultant lack of capacity and organisational memory'.

The restructuring of commissioning currently proposed by the government, i.e. moving responsibility for commissioning from PCTs to new GP consortia, is widely seen by policy experts as a major and radical change – potentially the most far-reaching since 1974.

At the same time, the NHS is facing the most austere time in its 62-year history. The Secretary of State for Health has acknowledged this by reaffirming the previous government's commitment to driving £20 billion's worth of efficiency savings in the NHS by 2014.

If the kind of performance drop seen with the merging of PCTs in 2006 – a comparatively minor change – is repeated with current government plans, the NHS will have a major problem. The bulk of proposed NHS efficiency savings rely on efficiencies driven by commissioning, yet the evidence presented suggests that these would not be made.

Ruling out the fiscally implausible possibility that large extra spending on the NHS would follow, this would mean only one thing for patients: a return to explicit rationing, either by increased waiting times or by reductions in services.

INTRODUCTION

The government's plan to hand control of the bulk of the commissioning of health care in the NHS – potentially as much as £80 billion of resources – from Primary Care Trusts (PCTs) to consortia of GPs has been widely trailed in the press, with a White Paper due imminently.[2]

At the NHS Confederation's annual conference in June, Andrew Lansley, Secretary of State for Health, stated:

> *'We want to give GPs control of commissioning, creating a direct relationship between the management of care and the management of resources.'*[3]

The change in structure of the NHS that such a move would represent should not be underestimated. Nigel Edwards, director of policy at the NHS Confederation, outlined the likely challenges in a recent article for the *Health Service Journal* entitled 'don't doubt the government's commitment to radical NHS reform'.[4] Kieran Walshe, professor of health policy at Manchester Business School, told the *Financial Times*:

> *"This has to be the biggest reorganisation of the NHS since 1974. Apart from the existing NHS foundation trusts, there is very little of the existing architecture that will be left unchanged. This is a massive structural upheaval, and it looks to be very expensive, and very risky to do it so quickly."*[5]

For such reasons, it has been reported that both HM Treasury[6] and the Coalition Committee[7] – that was set up to tackle 'unresolved issues' between the coalition partners – have thus far blocked the proposals, or at least stalled them until their financial risk can be properly assessed.

This short briefing aims to provide insight on the scale and nature of the financial risk posed to the NHS by the government's plans to hand control of commissioning to GPs. It does so by looking at the impact of the last reconfiguration of commissioning on the performance of commissioners. This occurred in 2006 when the number of PCTs was reduced in size from 302 to 152 – a relatively minor change when compared with that currently being proposed.

The briefing then discusses the implications of the findings for the NHS, given the government's plan and the tight financial climate.

THE IMPACT OF THE MERGING OF PCTS IN 2006

In the Department of Health document *Commissioning a Patient-led NHS* (2005) the then Labour government signalled its intention to reduce the number of PCTs – regional bodies with overall responsibility for the commissioning of health care for their respective populations – predominantly on grounds of efficiency.[8]

After a period of consultation, the number of PCTs was subsequently cut in half from 302 to 152 in the months following 1 October 2006. This was achieved by merging 222 neighbouring PCTs (typically in twos or threes, occasionally fours or fives). Eighty PCTs remained the same, i.e. retained the same name, structure and remained responsible for the same geographic area. Details can be found in the attached spreadsheet.

The fact that just less than three quarters of PCTs were merged and just over a quarter were not provides a unique opportunity to analyse the effects of re-configuration on the performance of commissioners. This is relevant in assessing the likely impact of the government's current plan to transfer commissioning responsibility from PCTs to GPs.

Annual Health Check

The best available comparative performance data on PCTs from 2005/06 to the present is the then Healthcare Commission's (now Care Quality Commission) Annual Health Check (now Periodic Review).

The Annual Health Check has traditionally assessed PCTs against two overarching criteria, quality of services and use of resources, with PCTs receiving overall ratings of 'weak', 'fair', 'good' or 'excellent' on each. Between 2005/06 and 2007/08, the quality of services criteria assessed performance against: core standards (i.e. the DH's *Standards for Better Health*); existing national targets; and new national targets. The use of resources reported Audit Commission assessments of performance against: financial reporting; financial management; financial standing; internal control; and value for money. All standards were broadly consistent across years, except the addition or removal of one or two indicators.[9]

In 2008/09 the Annual Health Check was changed for PCTs to account for the separation of their role as commissioners and providers of care. The 'quality of services' criteria was re-named 'overall quality score' and split between 'quality of commissioning' and 'meeting core standards' in provision.[a] 'Use of resources' was re-named 'financial management', and is derived from the 'managing finance' section of new Audit Commission assessments of PCTs.[10] The reader should

[a] 'Quality of commissioning' is judged by the relevant core standards, 'existing commitments' (formerly 'national targets') and 'national priorities' (formerly 'new national targets').

thus be aware that comparability of performance for the years 2007/08 and 2008/09 is not what it is for the years between 2005/06 and 2007/08.

Method

The aim, as stated in the introduction, was to analyse the effects of the merging of PCTs in 2006 on their performance. Data was extracted from the Care Quality Commission website on the ratings of PCTs on 'quality of services'/'overall quality score' and 'use of resources'/'financial management' from 2005/06 to 2008/09, a four year period.[11] The 80 PCTs that were not merged in 2006 were then separated from those that were. For each year the number of PCTs not merged and rated 'weak', 'fair', 'good' and 'excellent' on 'quality of services' and on 'use of resources' was totalled and expressed as a percentage of the whole. The same task was performed for the PCTs that were merged. The performance of those merged and not merged was then compared over time.

Results

All results presented here are expressed first in percentage form, for ease of comparison. Raw numbers are shown in brackets.

Quality of services

Results strongly suggest that the merging of PCTs in 2006, at least initially, had a negative effect on quality, as judged by Healthcare Commission ratings on 'quality of services'. Whereas the overall performance of PCTs that were merged was marginally worse than those that were not before mergers took place (i.e. in 2005/06, though more PCTs that were merged were rated 'excellent', as in shown in fig.1), following the mergers, performance diverged significantly.

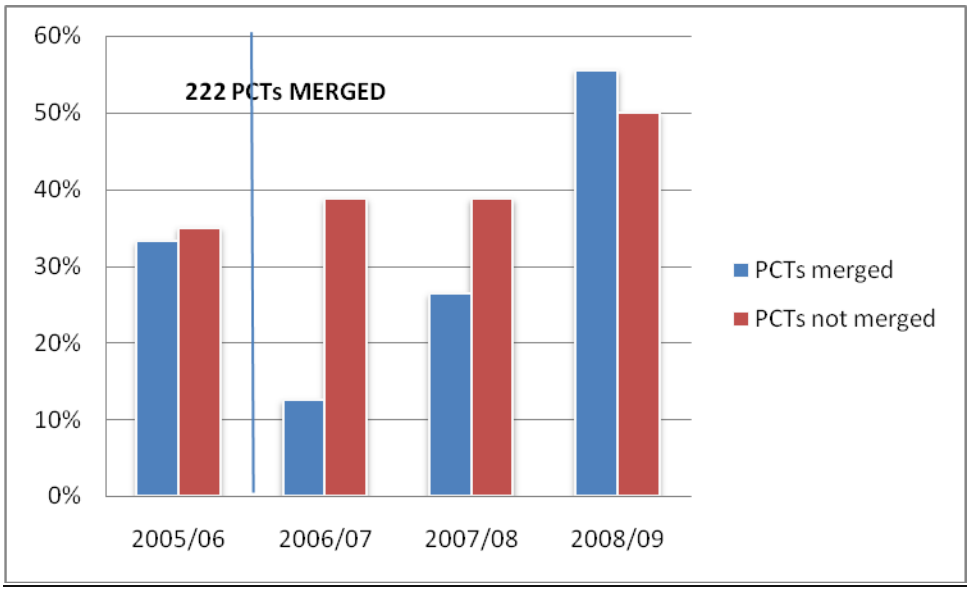
Fig. 1. The impact of the merging of PCTs on quality of services

Year	Quality of services	Merged	*Not* merged
2005/06	WEAK	9% (21)	4% (3)
	FAIR	57% (127)	61% (49)
	GOOD	31% (68)	35% (28)
	EXCELLENT	3% (6)	0% (0)
2006/07	WEAK	19% (14)	5% (4)
	FAIR	68% (49)	56% (45)
	GOOD	11% (8)	38% (30)
	EXCELLENT	1% (1)	1% (1)
2007/08	WEAK	7% (5)	4% (3)
	FAIR	67% (48)	58% (46)
	GOOD	21% (15)	33% (26)
	EXCELLENT	6% (4)	6% (5)
2008/09	WEAK	0% (0)	5% (4)
	FAIR	44% (32)	45% (36)
	GOOD	51% (37)	50% (40)
	EXCELLENT	4% (3)	0% (0)

Source: Healthcare Commission (2009), calculations by author

This is best represented in fig. 2 which shows that whereas the percentage of PCTs rated 'good' or 'excellent' *increased* from 35% to 39% between 2005/06 and 2006/07 for those that were *not* merged, it *decreased significantly* from 34% to 12% for those merged.

Fig. 2. Percentage of PCTs merged and not merged rated 'good' or 'excellent' on quality of services



Source: Healthcare Commission (2009), calculations by author (vertical blue line shows when PCTs merged)

Subsequently the performance of PCTs that were merged improved faster and caught up (and, in 2008/09, actually slightly overtook) those that were not – perhaps suggesting some benefits in terms of economies of scale – but this took until 2008/09 to happen. In other words, it took three years for the original parity between the two groups of PCTs to be restored (albeit at a higher level).[b]

Use of resources

Results similarly suggest that the merging of PCTs in 2006 had a negative impact on 'use of resources', at least compared with the performance of those that were not merged.

Fig. 3. The impact of the merging of PCTs on use of resources

Year	Use of resources	Merged	*Not* merged
2005/06	WEAK	47% (105)	24% (19)
	FAIR	47% (105)	61% (49)
	GOOD	5% (12)	15% (12)
	EXCELLENT	0% (0)	0% (0)
2006/07	WEAK	39% (28)	20% (16)
	FAIR	57% (41)	46% (37)
	GOOD	4% (3)	28% (22)
	EXCELLENT	0% (0)	6% (5)
2007/08	WEAK	4% (3)	4% (3)
	FAIR	57% (41)	35% (28)
	GOOD	39% (28)	51% (41)
	EXCELLENT	0% (0)	10% (8)
2008/09	WEAK	1% (1)	1% (1)
	FAIR	53% (38)	40% (32)
	GOOD	46% (33)	59% (47)
	EXCELLENT	0% (0)	0% (0)

Source: Healthcare Commission (2009), calculations by author

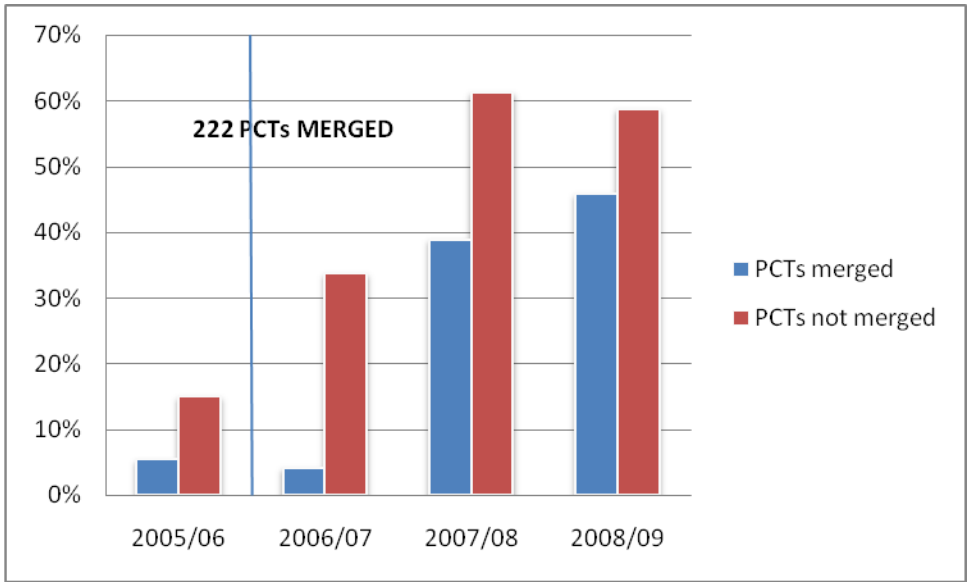
Here, it is important to note that – unlike with 'quality of services' – in the year prior to merging (2005/06), PCTs that were merged in 2006 typically had *worse score*s on 'use of resources' than those that were not merged.

However, following reconfiguration in 2006, the performance of PCTs that were not merged improved significantly faster than those that were merged. This is clearly shown in fig. 4. Whereas the percentage of PCTs rated 'good' or 'excellent' *increased significantly* from 15% to 34% between 2005/06 and 2006/07 for those that were *not* merged, it *decreased* from 5% to 4% for those

[b] It will be interesting to see whether those that were merged continue to improve faster in CQC rating for 2009/10.

merged. In 2007/08, 61% of PCTs that were not merged were rated 'good' or 'excellent', compared with 39% of those that were merged.

Fig. 4. Percentage of PCTs merged and not merged rated 'good' or 'excellent' on use of resources



Source: Healthcare Commission (2009), calculations by author

In 2008/09 – with the new system for rating 'financial management' in place – the performance of PCTs that were merged started to catch up (similar to 'quality of services'). In fact, the percentage of PCTs that were not merged rated 'good' or 'excellent' actually *decreased* by 2 percentage points on the year 2007/08 to 59%, whereas those merged *increased* by 7 percentage points to 46%. However, the difference of 13 percentage points is *still higher* than the difference between the two groups of PCTs in 2005/06, pre-mergers. In other words, after three years the relative parity between the groups in 2005/06 had not been restored.

Discussion

There are limitations to the findings presented here. As with any quantitative work, particularly minus the use of regression analysis, it is difficult to establish causal relationships between one factor and another (in this case the merging of PCTs with performance). There are also ongoing debates as to how indicative of quality and use of resources 'on the ground' the Annual Health Check actually is.[12] Moreover, strict comparison should not be made between 2007/08 and 2008/09 on an individual PCT level.

However, the fact this analysis has the advantage of a 'control' group of 80 PCTs that were not merged in 2006, and the fact the difference in performance between 2005/06 and 2006/07 in PCTs that were and were not merged is so large, means the results – while anecdotal – can be taken

heed of. The Annual Health Check, for all its flaws, also contains the best comparative data available.

To summarise the results, where PCTs were merged in 2006, 'quality of services' dropped sharply the year after (2006/07, as judged by the Annual Health Check) and performance on 'use of resources' remained largely static. This compares with significantly improved performance in PCTs that were not merged, particularly in terms of 'use of resources' where the number of PCTs rated 'good' or 'excellent' jumped from 15% to 34%. Ultimately, PCTs that were merged did subsequently catch-up on 'quality of services', but remain further behind on 'use of resources' than they were in 2005/06 before reconfiguration.

In other words, there was:

1) **An absolute drop in performance on 'quality of service' and 'use of resources' lasting *at least* one year in PCTs that were merged.**
2) **A period of three years before the *relative* performance of PCTs that were merged reached pre-merger (i.e. 2005/06) levels against those that were not.**

Such findings are consistent with other evidence on re-structuring and mergers. In separate publications, for example, the National Audit Office and Institute for Government found two-year delays in benefits accruing where central government restructuring is concerned.[13] Naomi Fulop and colleagues, in a study looking at hospital mergers, found few benefits were observed after two years.[14]

It is also worth noting the potential dangers when re-structuring goes wrong. Although clearly not the only contributing factor, in looking at the failure of South Staffordshire PCT to provide proper oversight of quality of care at Mid Staffordshire NHS Foundation Trust, the Francis Inquiry reported 'several comments criticise the national reorganisation of PCTs in 2006/07, along with the resultant lack of capacity and organisational memory'.[15] The written submission from *Cure the NHS* said the following:

> *'… the first function of a newly reconfigured organisation should be to take stock of the services that it was providing: to understand what it was commissioning and how well this was being delivered. This does not seem to have happened at the PCT.'*[16]

In 2006, South Staffordshire PCT was formed from the merger of five PCTs: Burntwood, Lichfield & Tamworth, Cannock Chase, East Staffordshire and South Western Staffordshire PCTs.

IMPLICATIONS FOR GOVERNMENT POLICY

Put simply, the trends unearthed in this paper should fire a loud warning shot at the current government proposals to reconfigure commissioning by handing responsibility to GPs are concerned, if not put the brakes on them completely. While conceding the current performance of many PCTs leaves much to be desired, the risk of pursuing such a *fundamental* re-structuring to 'solve' this is an even greater time-lag and short-term dip in performance than with the merging of PCTs in 2006 (a relatively minor change by comparison).

These concerns are multiplied by three further points. First, that the financial risk of, and accountability arrangements for, shifting commissioning responsibility to GPs apparently have not been thought-through properly.[17] It is imperative that this is put right, for there are numerous potential conflicts of interest that arise from GPs acting as independent 'businesses' involved in both the purchasing and provision of care – not least of GPs over-paying themselves or spending over-budget.[18] The effects of GP commissioning on integration between primary and secondary care is also a worry. As one participant in a recent qualitative study carried out by Civitas said:

> *'It's like setting up a football team and asking the defence [primary care] to fight the forwards [acute care] [on the same team]'.*

Second, it is not clear that GPs will be better at commissioning than PCTs. Those who are enthusiastic to do things differently could well be, but many – who are less enthusiastic – probably will not. The bulk of evidence on the effectiveness of GP commissioning in the context of the NHS comes from GP fundholding in the 1990s. This suggests GP fundholding was associated with: improvements in speed, access and responsiveness of secondary care; reductions in waiting times; slight reductions in referral rates and costs; and widening the range of available services.[19] A review by the King's Fund think tank suggested GP fundholding was 'the most promising' of the 1990s market-based reforms.[20]

However, we should err on the side of caution in interpreting this. Important in the current financial climate is that GP fundholding failed to reduce costs as much as expected. Little effect on the rate of innovation was observed and fundholding was associated with lower patient satisfaction with services. Little research, too, was carried out on the impact of fundholding on health outcomes.

Most importantly, GP fundholders were self-selected volunteers for the programme, tending to be well-organised practices in middle-class areas, enthusiastic about taking on commissioning budgets.[21] There is no evidence to draw on to support GPs *across the country* taking on commissioning as consortia, as is proposed by the government. Indeed, the current incarnation of GP commissioning, practice-based commissioning, is proving ineffective in most areas. In a

recent survey of practice-based commissioners by the Department of Health, for example, 41% of respondents indicated that practice-based commissioning has not influenced (i.e. neither 'a great deal' nor 'a fair amount') the clinical practice of the GP practices within their group.[22]

Third, we should not forget the current context of decision-making on the NHS. The stark reality is that the NHS is facing the most austere time in its 62-year history. In late 2009 the King's Fund/IFS estimated that, with near-static real-term increases in funding, *to do little more than maintain existing standards of care* (in the face of inflation and rising demand) the NHS will have to get in the region of 4-6 per cent more for its money year-on-year over the next five years.[23] The Secretary of State for Health has acknowledged this by reaffirming the previous government's commitment to driving £20 billion's worth of efficiency savings in the NHS by 2014.[24]

The proposed restructuring of the NHS, moving responsibility for commissioning from PCTs to new GP consortia, is widely seen by policy experts as a major and radical change. Evidence from the merging of PCTs from 2005-6 onwards – a comparatively minor change – **shows that merged PCTs suffered a one-year absolute drop in quality and efficiency, and that it took merged PCTs three years to use resources as efficiently as unmerged PCTs.**

If this kind of performance drop is repeated under the proposed restructuring, the NHS will have a major problem. The bulk of proposed NHS efficiency savings rely on efficiencies driven by commissioning, yet the evidence presented suggests that these would not be made. Ruling out the fiscally implausible possibility that large extra spending on the NHS would follow, this would mean only one thing for patients: a return to explicit rationing, either by increased waiting times or by reductions in services.

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CIVITAS: Institute for the Study of Civil Society, 8 July 2010

[1] Timmins, N, 'NHS set for massive structural upheaval', *Financial Times*, 17 June 2010. Available at: http://www.ft.com/cms/s/0/dc1eee7c-7a25-11df-aa69-00144feabdc0.html
[2] Timmins, N, 'NHS set for massive structural upheaval', *Financial Times*, 17 June 2010. Available at: http://www.ft.com/cms/s/0/dc1eee7c-7a25-11df-aa69-00144feabdc0.html
[3] http://www.dh.gov.uk/en/MediaCentre/Speeches/DH_117081
[4] Edwards, N, 'Don't doubt the government's commitment to radical NHS reform', *HSJ*, 17 June 2010. Available at: http://www.hsj.co.uk/comment/opinion/dont-doubt-the-governments-commitment-to-radical-nhs-reform/5015712.article
[5] Timmins, N, 'NHS set for massive structural upheaval', *Financial Times*, 17 June 2010
[6] Ramesh, R, 'Treasury sends back Lansley plan to give GPs control of £80bn', *The Guardian*, 25 June 2010. Available at: http://www.guardian.co.uk/society/2010/jun/25/nhs-review-treasury-stonewalls
[7] Timmins, N, 'Doubt cast on Lansley's NHS plans', *Financial Times,* 4 July 2010. Available at: http://cachef.ft.com/cms/s/0/65dad086-87aa-11df-9f37-00144feabdc0.html
[8] Department of Health, *Commissioning a Patient-Led NHS*, London: TSO, 2005. Available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4116717.pdf
[9] http://www.cqc.org.uk/_db/_documents/0708_annual_health_check_performance_rating_scoring_rules.pdf
[10] http://www.cqc.org.uk/_db/_documents/2008_09_scoring_methodology_for_quality_of_services_and_quality_of_financial_management.pdf
[11] http://www.cqc.org.uk/guidanceforprofessionals/nhstrusts/annualassessments/annualhealthcheck2005/06-2008/09.cfm. Accessed 6 July 2010.
[12] BBC News, Dirty Essex hospitals prompt call for system reform. *BBC News,* 27th November 2009 http://news.bbc.co.uk/1/hi/health/8382036.stm.
[13] National Audit Office, *Reorganising central government*.,London:TSO, 2003; Institute for Government *Making and breaking Whitehall departments*., London: Institute for Government, 2010. See also: Edwards, N, *The triumph of hope over experience: Lessons from the history of reorganisation,* London: NHS Confederation, 2010
[14] Fulop N, Protopsaltis G, Hutchings A, et al 'Process and impact of mergers of NHS trusts: multicentre case study and management cost analysis', *BMJ*, 2002, 325: pp246–9
[15] Francis, R, *Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005-March 2009*, Vol 1., London: TSO, 2010, p.374
[16] Ibid.
[17] Timmins, N, 'Doubt cast on Lansley's NHS plans', *Financial Times,* 4 July 2010. Available at: http://cachef.ft.com/cms/s/0/65dad086-87aa-11df-9f37-00144feabdc0.html
[18] Nuffield Trust, *Giving GPs budgets for commissioning: what needs to be done?*, London: The Nuffield Trust, 2010
[19] For a summary of all the evidence see: Brereton, L, and Vasoodaven, V, *The Impact of the NHS Market: A overview of the literature*, London: Civitas, 2010, pp.16-19 http://www.civitas.org.uk/nhs/download/Civitas_LiteratureReview_NHS_market_Feb10.pdf
[20] Le Grand J, Mays N, Mulligan J, eds. Learning from the NHS Internal Market. London: King's Fund, 1998.
[21] For a summary of all the evidence see: Brereton, L, and Vasoodaven, V, *The Impact of the NHS Market: A overview of the literature*, London: Civitas, 2010, pp.16-19 http://www.civitas.org.uk/nhs/download/Civitas_LiteratureReview_NHS_market_Feb10.pdf
[22] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_117071
[23] Appleby, J. Crawford, R. Emmerson, C. *How cold will it be? Prospects for NHS funding 2011-2017*, London: King's Fund/IFS, 2009
[24] http://www.dh.gov.uk/en/MediaCentre/Speeches/DH_117081