PRUComm

POLICY RESEARCH UNIT IN COMMISSIONING AND THE HEALTHCARE SYSTEM

PRUComm Research Review July 2014

Making a difference through research

PRUComm:

- PRUComm was established in 2011
- It is one of a number of Department of Health Policy Research Units
- PRUComm is a collaboration between the Service Delivery and Organisation Research Group at the London School of Hygiene and Tropical Medicine; the Health Policy, Politics and Organisation Group in the Institute of Population Health, University of Manchester and the Centre for Health Services Studies at the University of Kent.
- Research projects cover a broad spectrum of healthcare commissioning and health system issues
- PRUComm aims to deliver high quality, timely research to support healthcare practice and policy

Over the last year PRUComm's research activities have expanded to include new projects on the public health system in England and research on competition and collaboration. We have also continued our research on the progress of Clinical Commissioning Groups and undertaking responsive research for the Department of Health. This is our second annual review of research and provides a brief overview of our current research activities.

The past year has seen PRUComm develop a close working relationship with the NHS Commissioning Policy and Sponsorship, NHS Group within the Department's Policy Group. PRUComm also now works to a programme of work agreed with a newly formed Advisory Group chaired by the Department of Health key policy lead.

PRUComm's aim is to develop a programme of research on commissioning and health systems that supports the Department of Health's policy development and analysis functions. PRUComm also informs how approaches to health services commissioning 'work', both as organisational processes in themselves, and as instruments to secure policy objectives such as improved services, greater equality of access, greater responsiveness to patients, and improved effectiveness. The unit serves as a key source of research on commissioning and the healthcare system providing support to healthcare commissioners and policy makers. We support the Department of Health to manage the challenges associated with developing commissioning for health and wellbeing

Our key objectives are to:

- Develop high quality research programmes that support healthcare commissioners and policy makers
- Provide a national resource, holding evidence and research on commissioning
- Bring together academics who are nationally and internationally regarded as experts in health services, organisational and commissioning research with those responsible for making and implementing policy in order to foster relationships and exchange information

The past year has, understandably focused on examining how the changes to the English NHS and public health system have developed. We have continued to examine the development of clinical commissioning groups and the new commissioning structures. We have also started exploring how issues of competition and collaboration are being managed within the new system. While most media attention has understandably been focused on changes to the commissioning and delivery of healthcare, the shift of public health to local authorities was a major part of the reforms introduced in April 2013. PRUComm is researching progress and developments in the public health system with a particular emphasis on how governance and organisational structures develop and whether being embedded within local councils changes the way that public health services are provided.

We are also more focused on examining issues related to primary and community health care with two current projects examining funding and integration. Given the increasing policy emphasis on this area of healthcare we anticipate that we will be increasingly involved in further research on primary and community care.

Professor Stephen Peckham

Director.

The new English Public Health System—one year on

The PHOENIX project has been exploring the impact of structural changes to the health and care system in England on the functioning of the public health system, and on the approaches taken to improving the public's health.

In 2013 we completed a scoping review involving an analysis of Department of Health policy documents (2010-2013), responses to those documents from a range of stakeholders; conducting semi-structured interviews with key informants; and analysing the oral and written evidence presented at the House of Commons Communities and Local Government Committee on the role of local authorities in health issues. We gathered data from local authority (LA) and Health and Wellbeing Board (HWB) websites and other sources to start to develop a picture of how the new structures are developing, and to collate demographic and other data on local authorities. A number of important themes were identified and explored during this phase. The key points related to three themes - governance, relationships and new ways of working.

The reforms have had a profound effect on leadership within the public health system. Whilst LAs are now the local leaders for public health, in a more fragmented system, leadership for public health appears to be more dispersed amongst a range of organisations and a range of people within the LA. At national level, the leadership role is complex and not yet developed (from a local perspective).

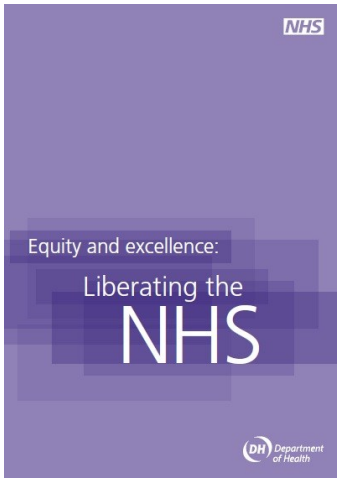
Accountability mechanisms have changed dramatically within public health, and many people still seem to be unclear about them. Some performance management mechanisms have disappeared, and much accountability now appears to rely on transparency and the democratic accountability that this would (theoretically) enable.

The extent to which 'system leaders' within PHE are able to influence local decisions and performance will depend on the strength of relationships principally between the LA and the local Public Health England centre. These relationships will take time to develop.

Many people have faced new ways of working, in new settings, and with new relationships to build. Public health teams in LAs have faced the most profound of these changes, having gone from a position of 'expert voice' to a position where they must defend their opinions and activities in the context of competing demands and severely restricted resources. Public health staff may require new skills, and may need to seek new 'allies' to thrive in the new environment.

HWBs could be crucial in bringing together a fragmented system and dispersed leadership.

The next phase of data collection began in March with the initiation of case study work in a range of local authorities. National surveys will also be conducted in June/July this year and again in 2015.



Clinical Commissioning Groups

The first phase of our study (September 2011 – May/June 2012) reported an early evidence from the development of Clinical Commissioning Groups (CCGs). During the first phase, we gathered a number of claims from participants about the 'added value' that clinicians (particularly GPs) bring to the commissioning process. These claims have generally centred on the value of having clinicians present in negotiations with providers and the ability of clinicians to influence their colleague's behaviour. We are exploring these claims in more depth in the second phase of the study (September 2013 - December 2015). The aim of phase two of the project is to explore the impacts of CCGs, with a particular focus upon the claims about clinician 'added value' and to elucidate the contexts and factors that enable or inhibit the delivery of these benefits. The 8 case study sites from phase one of the study have provided an excellent coverage of different contexts and characteristics. Therefore in phase two we continue working with these sites. We have undertaken interviews (July 2014 - January 2014) with 42 GPs and Managers. From the interviews we found that the claims made by respondents highlight two aspects of GP's knowledge and experience that are important for commissioning i.e. that they are *fine-grained* and *concrete*. As front-line clinicians seeing significant number of patients, GPs are able to aggregate their knowledge about individual patients allowing them to provide an overview of the whole systems. Their knowledge is also based upon real experiences of particular services rather than statistical evidence. In the next stage of data collection, we will use observational method to explore the extent to which the new system enables and facilitate the mobilisation of this knowledge and the impact this mobilisation has on the commissioning process. An interim report is available from http://www.prucomm.ac.uk/assets/files/exploring-ongoing-development.pdf

Clinical Commissioning Groups: one year on

Following on from initial research on developing CCGs, PRUComm has been examining the "added value" provided by having clinicians rather than managers leading the process of commissioning. We have also been collaborating with The Nuffield Trust and King's Fund to share research results and disseminate these to decision-makers

In May 2014 PRUComm joint hosted a well attended seminar in collaboration with The Nuffield Trust and the King's Fund at The King's Fund, London. Those attending included academics, policymakers and practitioners.

In April 2013 clinical commissioning groups (CCGs) took over responsibility for £65 billion of the NHS budget. One year on, the seminar reflected on progress made by CCGs during their first year in operation, and discussed key issues for their future development.

Three presentations were given at the seminar:

Exploring the 'added value' clinicians bring to commissioning: views from the ground

This presentation was given by Dr Katherine Checkland of PRUCOMM. She presented evidence from an on-going study of CCGs as to what knowledge; skills and abilities clinicians (especially GPs), bring to CCGs. The research found that GPs believed they have a knowledge from working on the' front-line' and see their patients on a regular basis and thus know the problems and difficulties they encounter. They are able to feed back such experiences to managers, and the wider bodies of the CCG. Furthermore, GPs clinical knowledge is needed to inform service provision, pathway development and contextualise policy etc. It was being claimed that GPs bring a *concrete* knowledge of how the NHS actually performs in practice to the commissioning process, based in the real experiences of patients. Furthermore, that knowledge is *fine-grained*, distinguishing in detail between the experiences of different categories of patients and between services. Dr Checkland argued that although such knowledge is valuable, it may be not be used in a systematic and joined up manner and there is a danger that the focus on the value of this type of knowledge may crowd out more systematic population health knowledge and data.

CCGs: engaging members and supporting primary care development

Holly Holder, Fellow in Health Policy, Nuffield Trust and Ruth Robertson, Fellow, Health Policy, The King's Fund. They reported on the latest findings from their study.

One year on, CCGs have managed to broadly maintain overall levels of engagement, although fewer GPs remain highly engaged. CCGs were the organisation reported as having the greatest influence over GPs' work; fewer said health and wellbeing boards were influential at this stage. GPs increasingly accepted that their CCG has a role in primary care development, and many saw the CCG as more effective at this than the previous PCT.

There were signs that CCGs are influencing general practice. Some GPs reported their CCG has improved relationships between GPs, promoted multidisciplinary team working, and changed referral and prescribing behaviours. Fewer reported a positive impact on the overall quality of care they provide.

Commissioning health care: comparing theories, policies and practice

Professor Rod Sheaff, is a Professor in Health Services Research, Plymouth School of Government, Plymouth University. He presented the results of a recent NIHR-funded study which compared commissioning across three European countries. The team spent some time investigating the 'programme theories' underlying the English NHS reforms, and then compared these with the reality on the ground. The study report will soon be published on the NIHR website.

After the presentations a discussion followed, chaired by incoming Chief Executive of the Nuffield Trust, Nigel Edwards. The discussion covered what should CCGs focus on in terms of member engagement and primary care development; which CCG activities should GP board members and other GPs with a formal role in their CCG focus their efforts and what policy changes would make CCGs role easier?

The audience included CCG staff, academics, policy makers, staff from NHS England and representatives from the voluntary sector. The discussion was lively, and there was a general agreement that CCGs most of all need a period of policy stability to allow them to focus on the financial challenges facing the NHS. There was also a clear consensus that CCGs have an important role in supporting primary care development.

Competition and Collaboration

We are in the process of investigating the way in which Clinical Commissioning Groups (CCGs) use the range of commissioning mechanisms at their disposal to ensure that cooperative behaviour can appropriately coexist with competition between providers both of which are being encouraged by the Health and Social Care Act 2012.

We are using theories of 'co-opetition' (i.e. strategies by which organisations compete and co-operate simultaneously to mutual benefit), along with other theoretical concepts such as new institutional economics, networks and relational contracting to understand how and why CCGs decide whether to use competition or more co-operative processes in their local health economies.

The research questions are:

How do commissioners and the organisations they commission from understand the regulatory and policy environment, including incentives for competition and co-operation?

How do commissioning organisations and providers approach their relationships with each other in order to undertake the planning and delivery of care for patients?

How do commissioning organisations use or shape the local provider environment to secure high quality care for patients? This entails examining how CCGs' commissioning strategies take account of the local configuration of providers and the degree to which they seek to use or enhance competition and/or encourage cooperation to improve services.

There has been a large number of guidance documents and regulatory decisions issued by the regulators (Monitor, the Office for Fair Trading, and the Competition Commission) and other NHS bodies (mainly NHS England). In the first year of the study, we have found that both commissioners and providers are confused about the current rules governing the use of competition.

Contracting

This project was developed in response to the Department of Health's need for research to investigate how the NHS standard contract document is being used in practice. In particular, the operation of contractual financial levers designed to improve quality of care and pricing mechanisms in the contract are of interest.

We are investigating how commissioners negotiate, specify, monitor and manage contractual mechanisms to improve services and allocate financial risk in their local health economies, looking at both acute services and community health care. The latter is a particularly under researched area, where contracting will become increasingly important as provider services become increasingly separated from commissioning organisations and more diverse types of providers develop.

The research questions are:

What is the range of formal provisions, including positive and negative financial levers in respect of quality of care in contracts across the English NHS?

How are contractual financial levers negotiated, specified, monitored and enforced in practice?

How does contracting at local level relate to and dovetail with any national level contracting undertaken by NHS England.

How are prices set? In particular, how are prices for services not included in current tariffs negotiated?

What payments are actually made to providers?

How do these relate to the prices agreed at the outset?

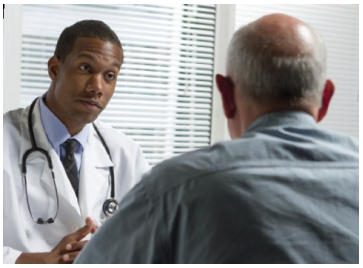
What are the effects of the use (or non use) of contractual mechanisms on service improvement and allocation of financial risk?

Our interim report http://blogs.lshtm.ac.uk/prucomm/files/2013/01/PRUComm-Contracting-study-interim-report-December-2012final1.pdf shows that while commissioners are happy to use financial levers to encourage improvement in the quality of care, in some areas it has not been possible to adhere to the national pricing rules in respect of 'payment by results', due to financial constraints in some local health economies.

These findings were used by Monitor to help them design the new national pricing rules for the contract year 2014/15.

Responsive research

PRUComm has continued to respond to requests from the Department of Health and NHS England for discrete pieces of research. These are normally in the form of short-term evidence reviews or drawing specific data from our current research projects. In this way PRUComm provides and important intelligence resource for decision-makers in the Department and in the NHS.



A key focus of this work has been on primary and community health services. Our most recent reviews are examining the impact of different funding mechanisms on primary medical care and examining the evidence on general practice and community health services integration. This responsive research is designed to meet the specific needs of policy makers and analysts in the Department of Health as well as NHS England in a timely fashion.

Other research

In addition to research commissioned by the Department of Health as part of PRUComm's core research activity, our researchers are involved in many other relevant projects. The following give a brief overview of current and recent research undertaken by PRUComm researchers:

EVOC: Patient and public engagement in commissioning for people with long term conditions. http://www.netscc.ac.uk/hsdr/projdetails.php?ref=08-1806-261

RAPPORT: ReseArch with Patient and Public invOlvement: a RealisT evaluation (RAPPORT) http://www.netscc.ac.uk/hsdr/projdetails.php?ref=10-2001-36

Evaluation of the Community Foundation Trust Programme http://hrep.lshtm.ac.uk/publications/CFT%20final%20report.pdf

To explore the approaches to tackling health inequalities developed by local Health and Well-being Boards and associated organisations as they are established http://www.population-health.manchester.ac.uk/primarycare/research/HiPPO/researchprojects/?ID=2579&Control=TagList1

Primary care factors associated with unplanned secondary care: An observation and interview study' http://www.bristol.ac.uk/primaryhealthcare/researchthemes/unscheduledcare.html

Measuring quality in community nursing: a mixed methods study http://www.nets.nihr.ac.uk/projects/hsdr/1220902

To explore the development of local health policy relating to health inequalities as new NHS structures are implemented, focusing upon the development of GP Commissioning Consortia http://www.population-health.manchester.ac.uk/primarycare/research/HiPPO/researchprojects/?ID=2581&Control=TagList1

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PRUComm publications

PRUComm reports (Available on www.prucomm.ac.uk):

April 2014: Exploring the ongoing development and impact of Clinical Commissioning Groups

January 2014: Changing the local Public Health system in England: Early evidence from two qualitative studies of Clinical Commissioning Groups

March 2013: Personal Budgets and Health: a review of the evidence

January 2013: Clinical engagement in primary care-led commissioning: a review of the evidence

January 2013: Study of the use of contractual mechanisms in commissioning

November 2012: Exploring the early workings of emerging Clinical Commissioning Groups: Final report

Recent journal articles

Perkins N, Coleman A, Wright M et al (in press) Involving GPs in commissioning: what 'added value' do they think they bring to Clinical Commissioning Groups? *British Journal of General Practice*

Coleman A, Segar J, Checkland K, McDermott I, Harrison S and Peckham, S (In press) Leadership for health commissioning in the new NHS: exploring the early development of Clinical Commissioning Groups in England. *Journal of Health Organization and Management*

Peckham S (In press) Accountability in the UK Healthcare System: An Overview *Healthcare Policy*

Gadsby E, Segar J, Allen P, Checkland K, Coleman A, McDermott I, Peckham S (In press) Personal Budgets, Choice and Health – a review of international evidence from 11 OECD countries. *International Journal of Public and Private Health care Management and Economics*

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