PRUComm

POLICY RESEARCH UNIT IN COMMISSIONING AND THE HEALTHCARE SYSTEM

PRUComm Research Review August 2017

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 Faculty of Biology, Medicine and Health, Division of Population Health, Health Services Research, and Primary Care,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*

Making a difference through research

This is our fifth annual review of research and provides a brief overview of our research activities. Following confirmation last year of our extension until the end of 2018 we have now agreed a programme of work with the Department. This sees a stronger shift towards exploring the impact of system changes on commissioning. The introduction of Sustainability and Transformation Plans and new meta-practice organisations creates a rapidly shifting landscape for the commissioning and delivery of healthcare in England.

We continue to enjoy a close working relationship with the NHS Commissioning Policy and Sponsorship, NHS Group within the Department's Policy Group and with NHS England. Over the last year PRUComm's research activities have continued to expand culminating in a new phase of work examining new forms of contracting such as alliance contracting and prime organisation contracting which a number of NHS commissioners have been exploring. Our research on primary care co-commissioning by CGGs and NHS England was completed and a final report has been prepared which will be published on our website in the next few months.

We also undertook two shorter projects. One examined the evidence on the costs of community health services which we hope to follow up with a larger study over the next couple of years. The other was a review of the Quality and Outcomes Framework to assess whether it supported more recent policy developments. This work is reported on more fully in this review.

Our main aim remains the same — to develop a programme of research on commissioning and health systems that supports the Department of Health's policy development and analysis functions. We support the Department of Health to manage the challenges associated with developing commissioning for health and wellbeing.

Our key objectives remain:

- Developing high quality research programmes that support healthcare commissioners and policy makers
- Providing a national resource, holding evidence and research on commissioning
- Bringing together academics regarded as experts in health services, organisational and commissioning research with those responsible for policy in order to foster relationships and exchange information.

We continue to publish copies of reports and papers on the PRUComm website, publish in high quality academic journals and undertake other related research which adds value to the commissioned work we undertake for the Department of Health, NHS England and other national organisations.

Finally I would like to pay tribute to Dr Julia Segar who died this year. We were all very sad to lose Julia from cancer. Julia worked with PRUComm for a number of years and was a trusted colleague and a friend. Always able to provide an anthropologist's insights into what are often complex organisational idiosyncrasies of the NHS she also brought a smile and sense of humour to the team.

Professor Stephen Peckham
Director

Engaging with policy makers, practitioners and researchers

PRUComm continues to work with policy and decision-makers in a number of ways. We work closely with the policy groups in the Department of Health to agree our work programme and liaise with them on individual research projects. We also have good links with NHS England — especially on projects such as primary care co-commissioning, for the GP recruitment and retention review and most recently for the review of the Quality and Outcomes Framework. We value these links enormously as they ensure that our work has direct policy relevance.

However, our research has a wider audience having been used by policy makers in developing guidance, being used by NHS decision-makers and used as evidence for the Health Select Committee and Kath Checkland gave evidence at the House of Lords on 6th Sept on demand management at the NHS Sustainability Committee.

Our research on primary care co-commissioning project mentioned at NHS England Board meeting and various NHS England events. We also continue to promote PRUComm's research through conference workshops such as the HSRUK and British Sociological Association (BSA) conferences. We have high-level contacts with the NIHR HS&DR programme, and insights from PRUComm work have informed the process of research priority setting. We have responded quickly to responsive requests, and delivered reports which have been widely disseminated within NHS England. Our research on clinical engagement in commissioning has been extensively referred to in the NHS Clinical Commissioners report on leadership (http://www.hunter-healthcare.com/news/thought-leadership/docs/HH_WHATMAKESATOPCCLEADER_V05[5].pdf) and our primary care co-commissioning report was used by Dr Michael Dixon in his speech at the Westminster Health Forum event on commissioning.

Our responsive project continues to be driven by immediate policy needs and work in the last year has included our project looking at the fit between QOF and current policy reported overleaf and a short project on community health services costs. This latter project was to help inform policy decisions on the shape of community health services but we identified a significant gap in economic and costing evidence. We are currently discussing with the Department of Health a new research project designed to gather cost data from community health services.

Two of our studies influenced policy directly with the GP recruitment study used to inform the development of the GP forward View and the GP worklife survey used by the pay review board, as well as policy makers and professional organisations to inform their work. Given the value of the survey PRUComm has been asked to undertake a further ninth survey round this year.

Primary care co-commissioning

Since 2014 we have been examining the development of the co-commissioning of primary care between CCGs and NHS England. We completed field work during the year and a final report has been completed and submitted for peer review by the Department of Health. This final report will be available on our website in the autumn.

The study provides a snapshot of the development of primary care co-commissioning bringing together of evidence from senior policy makers as to the overall objectives for the policy with both telephone survey and case study evidence as to how it is playing out in practice. In addition, the study looked longitudinally at the development of CCGs hence the evidence we present rests upon a deep understanding of the context. Our case study approach, which combined observational evidence with interviews means that we have not only captured evidence about issues voiced by interviewees, but we also watched these issues unfold in real time in a variety of meetings. This detailed observational evidence has provided insights which would not have arisen from interviews alone. The ethnographic approach does, however, mean that we were only able to collect data in four case study sites. The generalisability of our findings from these sites rests upon two things: the two rounds of telephone survey data, which confirmed that the issues arising in our case studies were also issues relevant more widely; and a theoretical generalisation arising from our broader engagement in organisational theory.

Our study suggests that CCGs have taken to primary care co-commissioning with varying degrees of enthusiasm, but with a clear sense that the commissioning of primary care services requires local knowledge and involvement of trusted managers with expertise in primary care.

We identified two programme theories as to why primary care co-commissioning by CCGs was desirable. Firstly, it would bring clinicians with relevant local knowledge and expertise back into the commissioning process, supporting the development of locally-relevant plans. Secondly, it would allow a 'place-based approach', with the potential to move money between budgets and to facilitate integration between primary, secondary, and community care.

Our case studies show that the first of these arguments has significant resonance. The importance of local knowledge and the involvement of known and trusted managers with expertise in primary care was cited in interviews and observed in meetings. However, the development of local-relevant plans could be affected by potential conflicts or lack of alignment between plans made at CCG level and the strategic plans of individual GP practices as independent businesses and between national initiatives/requirements and local plans. There was also concern about the lack of visibility of primary care services in local Sustainability and Transformation Plans.

The concept of a 'place-based' approach to services, although has gained currency, often not clearly defined. However, there was a common understanding of 'place-based' as encompassing joined-up commissioning of services for patients in a geographical area, with associated shifts of resources between primary, community and hospital services. In practice, we did not find significant evidence that CCGs were able to use their new primary care commissioning powers to facilitate this type of integration and resource-shifting.

New models of care are being developed, and commissioners were keen to invest in community-based alternatives to secondary care services. However, investments were coming from existing primary care sources rather than from disinvestments in other sectors or from pooling of resources across sectors. We found no evidence of an appetite amongst GPs for any change in their base contracts. Thus, investments were occurring via 'add on' contracts funded from existing sources. The pressures felt by primary care providers across the country meant that the focus of all of our sites was on sustaining, developing and supporting primary care, rather than in developing new approaches.

We found some evidence that the need to keep primary care co-commissioning structures and processes separate to the wider work of the CCG to minimise conflicts of interest may act to limit opportunities for taking a truly place-based approach.

Factors affecting how CCGs have taken on their new role:

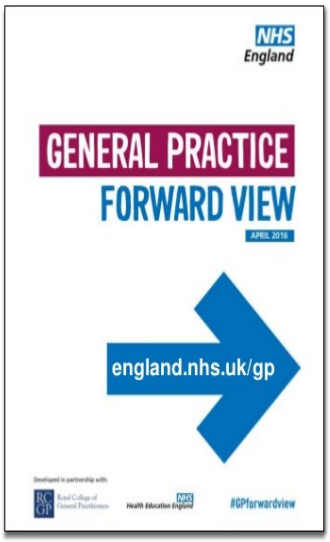
- The speed at which change occurred. These issues were generally short-lived, but were significant at the time, requiring considerable work and taking up significant amounts of managerial and clinical time.
- Ongoing practical issues such as personnel spread thinly and there are areas of work (e.g. estates, primary care finance) in which the relevant expertise has been lost in the significant down-sizing of the managerial workforce following the Health and Social Care Act 2012, problem with accessing information, and conflicts of interest.
- Problems generated by the current legislative context, which was seen as a 'workaround'. NHS England retaining statutory responsibility for primary care commissioning continues to generate significant issues such as cumbersome governance arrangement, fragmentation of responsibilities with respect to performance management of GP practice, and lack of clarity over who is responsible for what.

Review of the Quality and Outcomes Framework in England

The Quality and Outcomes Framework (QOF), an incentive scheme in general practice, was introduced across the UK in 2004 to link payment to delivery of primary medical care. Drivers for its introduction included the recognition that there were variations between general practices in the quality of care and the need to increase investment to improve morale and recruitment in primary care. QOF, in the early years, led to a reduction in inequalities in delivery of those aspects of care that it incentivised. Currently, there is little variation in QOF achievement between practices - most derive maximum, or near maximum income from it.

The QOF had other effects, encouraging nurse-led multidisciplinary management of chronic disease to deliver incentivised services, and better practice computerisation, so that delivery could be recorded.

However, the extent to which high QOF achievement means a higher quality service in general practice is not clear. Quality in primary care is difficult to define, but it certainly encompasses more than is measured by QOF. It is now explicit NHS policy to improve other aspects of primary care – in particular, to deliver better integrated, holistic and patient-centred care and more effective primary prevention in primary care. Whether QOF can deliver these policies has been questioned, as have its role in reducing inequalities and its ability to deliver better population health.



NHS England commissioned the Centre for Health Services Studies at the University of Kent, on behalf of the Policy Research Unit in Commissioning and the Healthcare System, to review the evidence of effectiveness of QOF in the context of a changing policy landscape. We examined the most recent evidence that QOF influences behaviour in general practice and health outcomes, taking a broad view of primary care quality. We also considered the evidence that QOF helps sustain changes in primary care and effects of withdrawing QOF indicators using recent patterns of QOF achievement and the published literature.

Our key findings were:

- most QOF indicators are unlikely to promote in any meaningful way the aims of the Five Year Forward View most relevant to primary care, that is, better holistic care, integrated care or patient-centred care
- QOF may motivate practices to maintain performance on QOF indicators, although these represent a limited, biomedical view of health and the quality of primary care; it is not clear, however, what would happen to the elements of care incentivised by QOF if the current indicators were retired
- QOF may divert practices from other aspects of providing high quality of primary care and from prioritising those patients with the greatest needs, for example, with difficult-to-manage problems, multiple morbidity or those that are hardest to reach
- there is no definitive evidence that QOF has an important impact on population health or emergency admissions.

Competition and Co-operation

Originally due to end Dec 2015, at which point a final report was submitted*. It was agreed that data collection would continue to track the effects of later policy developments, such as Sustainability and Transformation Plans (STPs) and new models of care (NCMs) following the Five Year Forward View (5YFV).

This project aimed to investigate how commissioners in local health systems managed the interplay of competition and cooperation in their local health economies, looking at acute and community health services. Our research questions included: how do commissioners and the organisations they commission from understand the policy and regulatory environment, including incentives for competition and co-operation? ; and in the current environment, which encourages both competition and cooperation, how do commissioning organisations and providers approach their relationships with each other in order to undertake the planning and delivery of care for patients? These questions continue to be important as there has been no legislative reform of the competition regime for the NHS despite the increasing policy emphasis on collaboration and integration as evidenced in the NCMs, STPs and developing Accountable Care Systems across the country.

Our earlier findings concerning the understanding of the regulatory context of the NHS market by both commissioners and providers of care indicated that that the 'rules of the game' were not clear to all 'players'. This continues to be the case in 2016 onwards as policies originating from the 5YFV evolve. While most commissioners have welcomed the advent of NCMs, STPs and the opportunity to collaborate with other commissioners and local providers, there still appears to be an appetite for using competition in certain circumstances. Collaborative planning involving key local providers and other commissioners, creating a sense of shared ownership of problems faced by the local health economy had been, and continues to be, the preferred way for CCG commissioners to approach large scale service reconfiguration.

A final report of this additional research will be submitted in December 2017.

New forms of contracts

Over the past few years the need to find new ways to integrate services has become an important policy priority in the English NHS. The formation of new organisational configurations in local health economies announced in the *Five Year Forward View* entails separate organisations working closely together to improve the integration of local services and allow the better use of resources. One way to achieve collaboration across organisational boundaries is through the adoption of new models of contracting, such as alliance contracting, prime provider contracting and outcome based contracting.

Despite their relative novelty in the English NHS, these models have a history of use in other sectors such as construction and defence, as well as in the commissioning of public services in the UK and overseas. This report summarises the findings of a literature review of the available evidence concerning the characteristics of these new contractual models and their implementation in other sectors. The available evidence is considered in order to draw out the lessons which may be learnt to aid the implementation of these models in the English NHS.

Although the models are conceptually distinct, they share defining characteristics. They all, to a degree, shift risk from the commissioner to the provider, and in doing so, seek to incentivise providers to seek innovative ways to achieve the aims of the principal, such as to improve integration, value for money or particular outcomes.

In order to inform our current research on contracting models we reviewed the literature on their use in a wide variety of settings. We found that whilst alliance contracting, prime contracting and outcomes based contracting are popular models which have a history of use in other sectors they are undertheorised in the literature, and there is a lack of empirical evidence particularly regarding the benefits of the approaches. he ability of these models to improve integration is taken for granted in much of the literature. A small number of prime provider studies suggest increased sharing of good practice and better co-ordination of services.

There is more evidence that alliance contracting and prime contracting may result in cost savings including a reduction in capital costs, the development of innovations and benefits in relation to time. The evidence base regarding improvements in the quality of services is not convincing.

A key aim of these new contractual models is a reduce opportunism. Evidence suggests that opportunistic behaviour has been observed in relation to outcome based contracting. However there is some evidence that opportunistic behaviour is reduced in alliance contracting.

Key findings are that the models are likely to incur high transaction costs relating to the negotiation and specification of outcomes and rely heavily on the relational aspects of contracting. There is also found to be a lack of convincing cross-sectoral evidence of the impact of the models, particularly in relation to improving co-ordination across organisations. The paper questions the reconciliation of the use of these new contractual models in settings such as the English NHS with the requirements of public sector governance for transparency and accountability. The models serve to highlight the problems inherent in the New Public Management/post New Public Management agenda of the transfer of risk away from commissioners of services in terms of transparency and accountability.

Little is known about models of contract such as alliancing and outcome based contracting, both of which are new to the NHS. Due to complete in mid 2018, the research questions for this study are:

- why commissioners choose particular models of contracting, and what they think such models can achieve
- in detail the characteristics of these new contractual documents, in particular how outcomes are specified and how financial risk is shared between the parties
- how the contracts are used in practice, in particular whether the contractual documentation is adhered to, and if not, in which ways it is not
- the strengths and weaknesses of the different contractual models, both in respect of encouraging cooperation between providers and achieving better outcomes
- how the NHS standard contract is used in conjunction with the new models of contracting, and whether any problems arise in attempting to do so
- how the new contractual models contribute to reconfiguration of services in local health economies

The first stage of the project was a literature review, completed in July 2016*. Field work is now underway in three case study sites each of which is experimenting with a new model of contract such as a multi party alliance or an outcome based contract. An interim report will be submitted in the autumn of 2017.

PRUComm Reports

(See www.prucomm.ac.uk):

December 2016: Review of the Quality and Outcomes Framework in England.

August 2016: GP recruitment and retention: an evidence review

July 2016: New contractual models: an evidence review

July 2016: PHOENIX: Public Health and Obesity in England – the New Infrastructure Examined—Final report

July 2016: PHOENIX: Second survey report

June 2016: Commissioning through Competition and Cooperation: Final report.

January 2016: Understanding primary care co-commissioning: Uptake, scope of activity and process of change

November 2015: Eighth national GP worklife survey. *University of Manchester*.

October 2015: PHOENIX: First survey report.

July 2015: Study of the use of Contractual Mechanisms in Commissioning: Final Report

April 2015: PHOENIX: Public Health and Obesity in England – the New Infrastructure Examined—Second interim report

March 2015: Exploring the GP 'added value' in commissioning: What works, in what circumstances: Final Report

January 2015: The Role Of Local Authorities In Health Issues: A Policy Document Analysis.

January 2015: PHOENIX: Public Health and Obesity in England–the New Infrastructure examined First interim report: the scoping review.

October 2014: Commissioning through Competition and Cooperation: interim report.

October 2014: GP payment schemes review

August 2014: Moving Services out of hospital: Joining up General Practice and community services?

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

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Recent publications 2016 - 2017

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