



PRUComm Research Review August 2015

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 continued to expand culminating in a new phase of work examining co-commissioning of primary care by CCGs and NHS England and additional short research projects on primary care to include new projects on the public health system in England and research on competition and collaboration. We have also continued our research on aspects of the functioning of the health care system with work on contracting and competition and also continued to examine the developing public health system. This is our third 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 and with NHS England. PRUComm to work 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 im-



proved 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 continued to focus on examining how the changes to the English NHS and public health system have developed. We continue to examine the development of clinical commissioning groups and the new commissioning structures. 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 GP retention and recruitment and a national survey of general practice.

We continue to publish copies of reports and papers on the PRUComm website and publish in high quality academic journals. As well as papers arising from our CCG research we have recently published well received articles on primary care and community health services integration and primary care led commissioning.

Professor Stephen Peckham
Director.

Engaging with policy makers, practitioners and researchers

In May 2014 PRUComm jointly 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. PRUComm researchers presented the findings of our work on CCGs related to clinical engagement.

PRUComm also ran a workshop session at the Medical Sociology conference in September 2014 and ran a panel session at the Health Services Research Network Conference in July 2015.

As in previous years PRUComm ran its own research day in March 2015. Here we presented findings from our research on CCGs and clinical engagement, contracting, competition and co-operation and from Phoenix, our public health systems project. Given the current interest in developing primary and community care following the publication of the *Five Year Forward View* in 2014, we also presented the findings of our review on integrating primary care

and community health services. The seminar was attended by over 60 policy and decision-makers and academic researchers. The event started with an overview of current policy developments by Dr Sara McCafferty from the Department of Health.

During the year PRUComm staff have also made presentations to NHS England and Monitor on aspects of the research units work. PRUComm staff have also attended a number of conferences and panel discussions where we have been able to discuss our research and publicise our findings.

Dissemination to practitioners,

policy makers and academics remains a key element of our research programme. We value the close liaison with national and local health organisations. We make our research reports available on our website and are committed to publishing our research findings in academic journals. During the year findings from our research have been influential at a policy level. For example, the contracting project findings fed directly into the drafting of the 2015/6 version of the National Standard Contract.

Also perhaps that Monitor used findings on pricing as part of their rethinking on NHS pricing policy.



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Continued turbulence affects public health developments

During the year we commenced the first round of detailed case study work for our study focusing upon the transition of public health into local government. We undertook interviews in five geographical areas involving 14 local authorities and relevant health agencies. We also undertook two national surveys – one of Directors of Public Health and one of lead councillors for public health. An interim report was produced in February 2015 and submitted to the Department of Health with a full report of the surveys of Directors of Public Health and Lead Councillors will be available soon.

While we focused attention on the models of organisation for public health within local authorities, our findings suggest that the inter-organisational arrangements and relationships between local authorities are important. Local context is also important on a number of different levels: structural context; financial context; ‘attitude’ (to public health and the transition); ‘political’ context. The increased linkage between public health staff and local councillors is generally seen

as positive by both public health staff and councillors.

Our findings, highlight the fragmentation of the new system, and the continued state of change as structures and processes find their feet, and as roles and relationships are developed. This is occurring in the context of wider change, as local authorities (and others) continue to adapt to deal with financial pressures.

In addition to fragmentation, our case study findings pointed to a sub-optimal system design (with sometimes negative feedback and unintended consequences), and current prematurity of organisations. There were some tensions related to the resulting lack of role clarity which have, in some cases, influenced relationship building amongst system actors. Governance of such an emerging, fragmented system is a huge challenge.

The changes in roles across the system do seem to lean towards consequent changes in approaches to public health and activities for health improvement. We have seen windows of opportunity opening. However, it is not yet clear how long those windows will be

open for – particularly given the current requirement to cut budgets – and it is not yet clear what public health teams, working with others across the system, will make of those opportunities.

It is also possible that the new duties and responsibilities for public health will shape councils in different ways – if directorates/ departments and ways of working become ever more cross cutting and integrated (rather than based on specific individual services), elected members will also have to start rethinking their portfolios and ways in which they have traditionally worked. In addition, elected members will have to reconcile their roles in improving health with their roles in promoting economic development, or even in supporting other local political priorities.

We have commenced a second round of interviews and observations exploring internal and external relationships related to three areas of activity for tackling obesity – school based services, clinical pathways and planning and transportation. A second round of national surveys is being planned for September 2015.



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Clinical Commissioning Groups

The Health and Social Care Act 2012 (implemented from 2013) introduced Clinical Commissioning Groups (CCGs) to replace Primary Care Trusts (PCTs) as commissioners of healthcare for their local populations. These organisations were designed to unleash the potential of involving a broad range of clinicians in commissioning. Groups of GPs were invited to volunteer to form CCGs, initially in ‘shadow’ form, taking over statutory responsibility in April 2013. PRUComm was

commissioned by the Department of Health to undertake research following the development of CCGs in England since their inception in 2011.

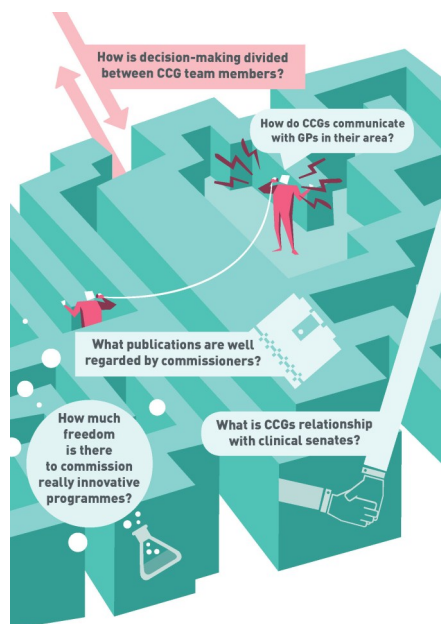
The first phase of our study (January 2011 to September 2012) reported an early evidence from the development of CCGs prior to their authorisation. During this phase, we gathered a number of claims from participants about the ‘added value’ that clinicians (particularly GPs) bring to the commissioning process.

These claims 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 explored these claims in more depth in the second phase of the study (April 2013 to March 2015). We used ‘Realist Evaluation’ (Pawson & Tilley, 1997) to seek out the participants ‘programme theories’ as to how a particular policy or programme will bring about the desired outcomes; explore the extent to which these programme theories ‘work’ in the real world; and examine in detail the mechanisms and contexts

which underpin them. The approach is often said to be exploring ‘what works, for whom, in what circumstances?’

We explored our findings in the context of official aspirations and previous initiatives involving GPs in commissioning, and uncovered a number of detailed mechanisms which underpin the success or failure of GP input to commissioning. Thus, for example, we found that whilst it is possible for clinicians to engage productively with colleagues from providers to challenge performance and influence care pathways, this only occurs if there is careful preparation, with rehearsal of the issues in advance and active planning as to who will do what in the meeting.

The third phase of the study (June 2015 to December 2017) aims to explore the significant change to the work of CCGs as they take over varying levels of responsibility for commissioning primary care services from April 2015. This represents a further development of CCGs and the study will provide NHS England with formative evidence to support them as they work with CCGs in developing their new roles. This phase of the study will build on the understanding of CCGs that we have developed over the first two phases of the work and will allow us to reflect longitudinally on the process by which CCGs have developed and taken up a range of new responsibilities.



Competition and Co-operation

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.

This project commenced during 2013/14 with data being collected in four case study sites alongside the data on CCG commissioning. An interim report was produced in October 2014 and submitted to the Department of Health. The report focused on the understanding of the rules regarding use of competition and cooperation in commis-

sioning by commissioners and providers. In the first year of the study we have found that despite 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) commissioners and providers were confused about the rules governing the use of competition.

During the second phase of data collection, which is ongoing, we aim to re-interview

senior commissioners about any changes in their understanding of the rules and their approach to commissioning local services. The final report is due in 2015/16.



Contracting

Since 2007 there has been a detailed form of standard national contract issued by the Department of Health (recently NHS England) for use by commissioners. Pricing for acute services consisted of a mix of a cost per case system using National Tariffs and some locally negotiated prices. Block contracts were sanctioned for mental health and community services. There are provisions for commissioners to impose financial penalties for poor quality care, and financial incentives for quality improvement (mainly a framework called 'Commissioning for Quality and Innovation').

This project, which ran from 2011 to 2014, aimed to investigate how commissioners negotiated, specified, monitored and managed contractual mechanisms to improve services and allocate financial risk in their local health economies.

Most of the contractual relationships between NHS acute providers and commissioners were char-

acterised by the use of general annual financial settlements outside the terms of the National Tariff rules and the contract. This behaviour was increasing over time, due to commissioners being unable to afford the contractually specified sums.

Moreover, increasing numbers of commissioners and NHS acute providers were agreeing to abandon the National Tariff at the outset and settle on a block contract (i.e. a fixed budget) in order to limit the financial risk to the commissioners. Financial incentives to improve quality contained in contracts were in widespread use. But not all commissioners withheld money from poorly performing providers.

Overall, the findings of the study indicate that the provisions of the national contract need to be revised to take account of the changing situation in respect of the allocation of financial risk in local health economies. Our interim report is available on the

PRUComm website and final report will be available shortly.

The next phase of research aims to investigate the increasing use by commissioners of more complex forms of contractual arrangements to achieve NHS policy aims. The relevant aims often include the improvement of both quality and efficiency of local services by their reconfiguration.

The current policy environment is dominated by the several different permutations of service reconfiguration set out in the *Five Year Forward View* (2014). The new (to the NHS) types of contractual arrangement include ways of coordinating between several providers, such as alliance contracts, partnerships, and prime contractor models; and explicitly contracting for outcomes. Many new forms of contract include both aspects.

Some of the new forms of contract also involve the entry of independent providers into the NHS quasi market.

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 an important intelligence resource for decision-makers in the Department and in the NHS. 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.

A key focus of this work has been on primary and community health services. Our most recent reviews are examining the impact of differ-

ent funding mechanisms on primary medical care and examining the evidence on general practice and community health services integration.

The focus on primary care continues with two further pieces of work. Working with Professor Matt Sutton at the University of Manchester we are conducting the latest in a number of work/life survey. These national surveys of GPs' working conditions and attitudes to primary care reforms were undertaken 1998, 2001, 2004, 2005, 2008, 2010 and 2012. We are currently running the survey for the 8th time, asking more than 5000 GPs to tell us about their working lives. The surveys provide a robust assessment of the current state of the GP

workforce in England, covering not only overall job satisfaction and workload, but also perceived job stressors and intentions to quit. This evidence will be a vital tool for the Department of Health and NHS England, who, along with the Royal College of GPs and Health Education England are currently working on strategies to improve retention and recruitment in the GP workforce. The results will be available in the autumn.

We are also undertaking a review related to GP recruitment, retention and re-engagement. This work will draw on published literature and evidence as well as recent reviews to provide policy advice and support to NHS England and the Department of Health.



PRUComm Reports

(Available from www.prucomm.ac.uk):

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

Reports waiting publication:

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

PHOENIX: First survey report.

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

The future of primary care Creating teams for tomorrow

Report by the Primary Care Workforce Commission



"With its highly skilled workforce, effective multi-disciplinary teams and well-developed IT systems, the NHS is in an unparalleled position to develop a modern primary care system that is truly world class."

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Recent journal articles**In press:**

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