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Commissioning high quality care for people with long-term conditions – an action research study

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1. *Aims/Objectives*

This study investigates how commissioning can improve care for people with long term conditions (LTCs). In doing this we will examine the organisation and processes of commissioning (e.g. needs assessment, service planning and specification, design of incentives and performance management) and other influences that are known to shape success (e.g. local clinical leadership) alongside outcomes. We will focus on three sites that are demonstrably at the forefront of effective commissioning and adopt an action research approach. We will focus on commissioning for people with diabetes and at least one other LTC.

Overall aim

•· to explore the ways in which NHS commissioning can be enacted to assure high quality care for people living with long-term conditions.

Objectives

•· to identify and develop the organisation and processes that are associated with effective commissioning (good outcomes);

•· to identify and measure an appropriate set of outcomes, some developed with commissioners;

•· to draw on experience from other sectors and international health systems in developing commissioning within study sites;

•· to develop and disseminate good practice guidance as a result; and •· to consider how the learning from this research could be more widely applicable in the health service.

There is more than sufficient research evidence in the UK about what facilitates or inhibits effective commissioning at a macro policy level (e.g. Ham, 1996; Mays et al, 2001; Smith and Goodwin, 2002; Smith et al, 2004; Baxter et al, 2007; Russell, 2008; Ham, 2008b; Lewis et al, 2009) but much less at local level.

We will focus on (a) in-depth and rapid research that can ‘get under the skin' of local commissioning practice; and (b) an area which is a high policy priority - improving quality of care for people with LTCs. Our proposal addresses the following: the organisation of commissioning (4.2); the processes of commissioning (4.3), including an exploration of the relationships between doctors, managers, user representatives and others; the incentives and mechanisms used in commissioning (4.4); and commissioning for LTCs (4.5).

We will work with ‘commissioning communities' (mainly PCTs, and other local partner organisations) that are competent commissioners and known innovators in order to understand and develop activity that is most likely to improve quality of care. Our intention is that study be intensive, to enable close collaboration between commissioning practitioners, clinicians, service users and researchers, and focused on improving the practice of commissioning in ‘real time', and then learning from this process to develop good practice guidance.

We aim to develop a conceptual framework that explores commissioner-provider integration, processes of commissioning, and social interactions and networks. This should contribute to a broader understanding of commissioning in a range of settings within health and social care. In line with our action research approach, we are committed to exploring possibilities of collaboration with existing researchers and practitioners in the field and those commissioned to investigate other aspects of commissioning under this call.

2. *Background*

NHS context: policy on commissioning

The commissioning function in the NHS in England has its origins in the introduction in 1990 of the 'purchaser-provider split' (Le Grand et al, 1998), established as part of the NHS internal market. From 1997, the Labour government abolished GP fundholding, yet retained the purchaser-provider split at health authority, then later at primary care trust (PCT), level. From 2002, the government created a more vigorous quasi-market, hoping to improve efficiency and quality through stronger commissioning (Lewis et al, 2009).

Department of Health policy has signalled a need for PCTs to focus on commissioning services that help improve health and well-being (DH, 2006a, 2007) and for PCTs and PBCs to become 'World Class Commissioners' (Hewitt, 2007). This was further underlined in the Darzi Review (DH, 2008) and in recent guidance (DH 2009) on commissioning care for LTCs.

Theoretical framework for exploring the practice of commissioning

Our approach is informed by three related frameworks. The first concerns previous research carried out by this team (Smith et al, 2004, p6) describing a 'continuum of commissioning' that illustrates the range of actors within NHS commissioning and the organisational levels at which they are situated, from individual patient through to national level. We will build on this, developing a matrix where the level of commissioning organisation is explored alongside the degree of commissioner-provider integration. This will enable us to investigate the complexity where, for example, PBCs and PCTs often find themselves as both commissioners and providers of services, and the impact of this on the commissioning and ultimate provision of care for people with LTCs.

Secondly, we will draw on recent analysis of the processes of commissioning, which builds on the 'cycle of commissioning' developed by Ovretveit (1995) and adapted by the DH (2003). This includes: identifiying needs; developing commissioning plans; developing effective relationships with providers; acquiring and analysing information about provider performance; shaping payments and incentives; and facilitating effective clinical and user engagement in commissioning (see Annex 1). Ham (2008) has highlighted various characteristics that are associated with success in commissioning, including organisational size, skill mix, managerial competence and effective use of data. Also, effective commissioning for LTCs involves clinicians to take up evidence-based practice (Singh and Ham, 2005). We will examine the influence of these factors and work to develop them and others with relevant key actors. Thirdly, to study these interactions and effects, we will adapt the theory and methods used by Bate et al (2008) in their study of quality improvement in health care. This approach links a descriptive account of the factors considered to shape success (e.g. aligned or perverse incentives, strong leadership, political pressure) with a chronological account of commissioning processes and the dynamics of change. Bate *et al*'s work draws heavily on Process Theory (e.g. Langley 1999), which explains phenomena in terms of sequences of events that lead to an outcome and the interactions between different events and influences on them over time. We will draw on this and elements of social network theory (Wasserman & Faust, 1994; Scott 2000) to identify and map the relationships and activities that link clinical and managerial leaders from the PCT with the wider clinical community. This will enable us to explore the role of leaders within and outside the commissioning process in supporting effective commissioning and/or changed clinical practice.

3. Need

Benefits of research to NHS

This project will examine what facilitates and inhibits the everyday practice of commissioning, exploring the organisation, processes, and relationships involved; reporting on factors that enable change to be made to the quality of service for people with LTCs; and developing recommendations for good practice in commissioning. In summary, this research will:

1. add substantially to practitioner and academic understanding of an under-researched component of healthcare commissioning;

2. develop understanding of the experience of clinician managers more generally;

3. extend the potential of action research as a tool for researching the 'physiology' of commissioning;

4. identify and disseminate organisational, process- and network-related enablers and barriers to commissioning for LTCs;

5.describe practical, research-informed, experience of seeking to enhance local commissioning practice; and

6. identify priorities and actionable recommendations to improve NHS commissioning for LTCs.

4. *Methods*

Phase One: Site selection and preliminary fieldwork (months 1-6)

Initial (unfunded) work will be carried out to make contacts, identify information to inform selection of ‘commissioning communities'. The first six months of the study will then involve:

(a)Preparation of frameworks for structuring evidence

Preparatory work will be done to identify, collect and collate information relating to a range of commissioning processes and outcomes (clinical and financial). The sources of information are detailed in Annex 2. This will be used primarily to inform selection of case study sites (see (b) and also as contextual background to shape initial discussion with sites (see (c) below).

(b) Site selection and recruitment

Selection will focus at two levels: (i) overarching ‘commissioning communities' and (ii) commissioning sub-groups centred on LTCs.

(i)‘Commissioning communities '

We will purposively select three ‘commissioning communities' (PCTs and associated PBCs and providers) following a three-stage process:

- Identifying a list of potential PCTs based on a combination of the views of national experts and findings for a number of different national metrics (see (a) above).
- Inviting applications from shortlisted organisations, asking them to undertake basic screening to categorise the local commissioning arrangements according to the Smith et al (2004) matrix. We will make explicit what our ‘offer' is to prospective sites, over what time period, our expectations and any resource implications.
- Selecting three PCTs on the basis of the following four factors:

1) willingness to participate in the action research and work with the research group to develop, extend and share their commissioning experience and expertise.

2) known innovators (as indicated by SHA commissioning leads), with a sound historical record of

commissioning (indicated by metrics in Annex 2).

3) a good record in relation to a set of process and outcome metrics of the quality of commissioning. We will analyse data to identify areas where ‘performance' appears greater than would be expected when compared to similar organisations.

4) At least one site using a mix of NHS / private sector capacity in commissioning and one not.

We will exclude PCTs that have been (or are) the focus of previous (or current) extensive study and/or are not sufficiently distinctive from each other in terms of basic variables.

(ii) Sub-groups focused on LTCs

'Commissioning communities' will be selected as our main ‘cases' but we will ultimately focus our ‘site' analysis on two sub-case studies within each PCT focused on LTCs. We will seek to balance the benefits of comparing the same LTC across study sites (preselecting one LTC for investigation in each site), with a formative action research methodology (selecting one or more supplementary LTCs or commissioning initiatives).

Our preference for the pre-selected LTC in all three case study sites is diabetes - a high prevalence / high expenditure condition for which there exists extensive epidemiological data, evidence-based guidance on good practice, a national service framework, NICE guidance and the *Diabetes commissioning toolkit* to support effective commissioning. Diabetes is of sufficient importance that it is likely to have been prioritized in at least three shortlisted PCTs. If this is not the case we will consider COPD as a valuable second option.

Selection of the additional 3 sub-case studies will be informed by the orientation set out in (c) below. We will identify commissioning work on a LTC or care group (e.g. frail elderly) for which there is a specific local commissioning or service development initiative being undertaken by the PCT and/or a local PBC group (e.g. commissioning for integrated care pathway or innovative use of data/ IT). Every effort will be made to ensure that the same LTC or initiative is selected for each of the three PCTs. By undertaking ‘sub-case studies' within each site and mapping them using the theoretical approach described above, we will develop an understanding of PCT-wide factors which remain constant across different LTCs and those which vary according to the context of the specific condition.

(c) Commissioning community orientation and mapping of activities

We will conduct a two-week (equivalent) immersion within each commissioning community, shadowing a small number of stakeholders (e.g. director of commissioning, lead commissioning clinician). The purpose will be to develop rapport, observe meetings (formal and informal), and facilitate further access to information for investigation. Our focus will be on exploring how sites do their commissioning work for LTCs, and the outcomes that result. We will use the structured evidence (see Annex 2) to prompt discussion of past experience of commissioning.

We will use annotated field notes to record observations and, supplemented by structured evidence, use these to develop profiles for each site that map (a) the individuals, institutions, interactions, events and documents that make up each 'commissioning community', and (b) innovative commissioning activities relevant to LTCs, (c) outcome metrics used locally to help inform selection of additional LTC or commissioning initative sub-groups (i.e. other than diabetes) for each site.

Phase Two: Fieldwork - exploring and supporting commissioning (months 7-18)

(d) Community case studies

We will work with local commissioning team(s) at PCT or PBC level to see what can be achieved by consciously tackling the principal obstacles to effective commissioning of services for people with LTCs. The research objectives in individual sites will be focused on these obstacles and explored in relation to the commissioning cycle set out in Annex 1. Whilst objectives will necessarily be set in liaison with sites, these will include key areas such as those set out in Table 1, along with related data collection activities. Where appropriate, we will provide technical assistance during the above activities/cycle. For example, the team has particular expertise in linking and manipulation of routine data, risk profiling of patients with LTCs, costing of individuals' care packages, and setting individual budgets for LTC services.

5. Contribution to existing research

Previous research

Reforms in the 1990s led to research on purchasing models including fundholding, total purchasing, GP commissioning groups, and primary care groups and trusts (e.g. Le Grand et al, 1998; Mays et al, 2001; Audit Commission, 1996, 2000; Dowling and Glendinning, 2003; Smith and Goodwin, 2006). International studies (e.g. Mays and Hand, 2000; Ashton et al, 2004; Figueras et al, 2005; Ham, 2008) highlight that health purchasing is an under-developed activity in many countries, requiring a high level of technical, managerial and political skill, supported by sophisticated information management systems. Renewed policy interest in making commissioning effective has led to a series of review studies (e.g. Smith and Goodwin, 2002; Smith et al, 2004; NERA, 2005, Wade et al, 2006, Goodwin, 2007, Curry et al, 2008), that support the view that commissioning has yet to reach maturity.

Current research

Ongoing research into commissioning in the NHS includes: two projects in the DH PRP Health Reform Evaluation Programme; PRP studies of World Class Commissioning and PBC; the NPCRDC evaluation of PBC (Checkland et al, 2008; Coleman et al, 2007); and the SDO-funded study of contractual governance in the NHS.

The theories and methods underpinning our proposed research have much in common with these projects. However, much ongoing research examines how nationally designed elements of commissioning affect provider behaviour and provider/commissioner relationships. Our project is rooted in (i) the *local practice, capability and capacity* of commissioning; (ii) the micro-level relationships between key players; and (iii) the extent to which local commissioners can influence quality of care for people with LTCs.

6. Plan of Investigation

Plan of investigation

We will take an action research approach (Lewin 1946) seeking to generate knowledge about the social system of commissioning, whilst at the same time working with local commissioners to try and change it where deemed necessary (Meyer 2000; 2001). We will work with stakeholders in each case study to identify how to gather local accounts of commissioning services for people with LTCs, with an emphasis on ensuring consistency of methods to enable cross-case analysis of the three sites and associated LTC sub-groups involved in the action research.

We propose a three-phase, mixed-method study, in which the findings of earlier phases, combined with on-going engagement with stakeholders, will influence detailed design of later phases. The phases are: (1) initial site selection and preliminary fieldwork, including a period of intensive orientation; (2) case studies of three commissioning communities including data collection, interviews, observation of commissioning activities, mapping of social networks; and (3) analysis, synthesis and reporting.

Table 1: Linking site project objectives and data collection

	OBJECTIVES (to be agreed with sites)	**PROPOSED DATA TO BE COLLECTED**
ASSESS NEEDS	1. To help commissioners use routine data analysis to inform needs assessment.	• information on local health needs (for the PCT population and specifically in relation to the selected LTCs) • exploration with commissioners of what additional health needs data might be collected • description of current service patterns and spending in relation to specific LTCs • comparative analyses of historical and current patterns of expenditure by LTC care group
PLAN	2. To help commissioners reduce the asymmetry of information between themselves and providers in relation to the nature and quality of services. 3. To map local interactions involved in the Commissioning process, and to feed back on notable patterns. 4. To support commissioners in connecting these analyses with plans to improve services	• support commissioners in identifying and refining (feasible) objectives for commissioning for diabetes and other selected LTCs • participant observation and recordings of strategic and operational commissioning meetings • semi-structured interviews with local clinicians, managers, and user representatives, with a particular focus on review of previous commissioning exercises for diabetes and other selected LTCs; potential for improvements; and perceptions of the extent to which they feel their involvement has an influence on planning, service specification and contracting at PCT and/or sub-group level.

CONTRACT	5. To support commissioners in determining how best to structure their contracts.	• examination of contract datasets and information collection, and what use is made of these by commissioners; • participant observation and recordings of contract negotiation and review meetings, with subsequent feedback to participants
MONITOR	6. To assist commissioners in how they might assess the quality and outcomes of commissioned services.	• analysis of service use by patients with the combination of LTCs chosen for sub-group examination; • provision of support about how they might monitor contracts, including reporting to the local community; • interviews (as above) with a particular focus on how service quality is (or should be) monitored, reviewed and acted upon.
REVISE	7. To support commissioners in reviewing performance, monitoring data and discussing, with local stakeholders, how best to revise the commissioning process.	• identification of constraints on effective commissioning and recommendations for change to policies and priorities; • research feedback sessions with local stakeholders, including discussion about changes to be made.

Data collection

We will collect data from multiple (qualitative and quantitative) sources across a 12-month period of fieldwork and capturing one full commissioning cycle (see Table 1).

We plan to observe approximately 60 activities (across the three PCT commissioning communities) associated with the different stages of the commissioning cycle (on average 2 activities per stage of the commissioning cycle, for each LTC sub-group). These observations are likely to equate to a half-day each (20 days per PCT, 60 days total). We will finalise selection of observations on completion of the orientation phase. This will be a partly emergent process as we learn of particular meetings or processes put in place during the (not always linear) commissioning process. Researchers will keep fieldwork diaries, recording ‘conversations-on-the-hoof' (Willis, 2000) throughout periods of observation, and typed up as soon as practicable thereafter.

We plan to undertake 15 semi-structured interviews in each PCT, at the planning and again at the review/revision stage of the commissioning cycle (30 per PCT, 90 overall).The majority of interviews will be face-to-face (with some by telephone to facilitate access and efficient use of research time). Interviews will be recorded and transcribed with consent.

We will update our contextual quantitative information (developed in Phase 1) in-year with new intelligence as it arises. In addition we will focus our investigation on the selected LTC sub-groups to explore the extent of any changes over time with respect to indicators of the quality and quantity of services commissioned. We will also look at the risk profile of patients and information on estimated costs of care. This analysis will assess the extent of changes against historical patterns and (where possible) compare with similar areas.

Though some of these analyses can exploit aggregated data sets such as collected by the DH; we may require access to extracts from some routine hospital-patient level data sets from the secondary users' services (SUS). This information will be reviewed with the sites themselves to explore the relative importance of such information within commissioning decisions. We estimate that for each LTC there will be of the order of 10 comparative metrics to be explored and where possible we will look at the past 5-10 years' activity against 3-5 comparable areas elsewhere in the country.

Documents relevant to the different stages of the commissioning cycle will be collected and reviewed (e.g. commissioning plans, minutes from meetings, local policy documents, commissioning plans and contracts).

Feedback to stakeholders

Emerging analysis will be fed back to stakeholders in a way that enables them to reflect on their practice and make changes for the next phase, changes that we will track at the mid-point and final stage of the research. Informal feedback will take place through ad hoc discussions with stakeholders throughout fieldwork. We will hold:

- one half-day workshop in each PCT to present and share emerging findings across the different LTC groups; and
- two project-wide workshops bringing together stakeholders from the three commissioning communities, LTC sub-groups, and advisory group, along with international experts and people skilled in commissioning within private health care. Workshops will focus on using findings, together with the experience of local stakeholders, to draw conclusions about effective commissioning practice in relation to LTCs, and how these can be developed into research-based good practice guidance.

e) Exploring commissioning relationships

We will gather data on social networks within each site through a social network questionnaire of all GPs in each of the three sites. We will develop a structured questionnaire asking GPs what and who influences their practice in relation to diabetes care. This questionnaire will be standard for all three sites, but will be accompanied in each site by an *aide memoire* listing relevant clinicians in that site. The questionnaire will be emailed to GPs wherever possible, and posted to any GPs for whom we cannot obtain an email address. A repeat mailing will go to GPs after a few weeks. We will also take advantage of opportunities such as GP training days to promote the questionnaire to practitioners and encourage response. With the support of a researcher at Manchester University with expertise in social network analysis, we will use the responses to the questionnaire to map networks of influence in each of the three study sites.

In addition to the survey, we will explore commissioning relationships and social networks through qualitative data from observations (see above).

Phase Three: Analysis, synthesis and reporting (on-going, month 7-24)

Within action research, there is an onus on researchers to ensure space for the generation of theory from findings. We will hold regular quarterly full-day workshops of the advisory group (comprising the full research team, expert advisors and representatives of those living with and caring for people with LTCs). This will feed into our on-going reflection and analysis.

We will analyse data within and across cases and sub-groups in the context of:

a) the three theoretical frameworks outlined above

b) our emerging research evidence on the organisation, processes, and relationships associated with commissioning.

The research will be written up as three in-depth case studies, along with overall thematic analysis of with-in case and cross-case study learning (i.e. within and across selected commissioning communities and sub-groups) and how this can be applied as good practice guidance. As described by Hammersley et al (2000), the case studies of action research will be used to uncover causal processes that seek to link inputs and outputs within a system. In this case, we will seek to link different mixes of organisational and process factors associated with effective commissioning, and draw conclusions (overall and/or at the various stages outlined in Annex 1).

Social network data will be analysed at individual actor level and, where appropriate, at sub-group level (for example, a PBC group may be analysed as a sub-group). We will map the links and associations between GPs, between and within the sub-groups identified in each case study, and between GPs and the wider local clinical community.

We will link social network data with qualitative data on the commissioning process. In doing so, we will obtain novel information on the nature and style of clinical leadership and subjective views on its influence on commissioning for LTC services.

One element of the quantitative analysis will be to assess the outcomes of commissioning in the three case studies for people with diabetes and other selected LTCs, in particular the extent of preventable emergency admissions (a proxy measure for health) in this population and the costs of this care relative to comparable PCTs (comparable with respect to deprivation, urbanity and numbers of people registered via the quality and outcomes framework (QOF) in the PCT with a particular LTC). This will be done by (a) using local SUS data to identify emergency admissions in the PCT population for the specific LTCs (in order to calculate an age-sex standardised rate of emergency admission for comparison with other PCTs) (b) using emergency admissions (SUS data) as the numerator of a rate but using as the denominator population those registered with the disease in the PCT as part of the QOF dataset).

Plans for dissemination of results

The Nuffield Trust has a track record in national and international dissemination via a number of means, including peer-reviewed papers (management, clinical, professional and academic), website materials, conferences and other events, and regular meetings with key policy-makers. The Trust has ready-nurtured networks in the NHS, in national professional and regulatory bodies in government and internationally on issues such as commissioning, primary care, integrated care and the management of LTCs. This will enable us to tailor messages to professional, lay and academic audiences, and is enhanced by the multidisciplinary nature of the research team.

The final project report will set out the three case studies of PCT commissioning communities, exploring in each case the experience of commissioning for people with selected LTCs. It will set out how commissioning could be improved generally and to improve care for specific LTCs. The report will conclude with a discussion of overall learning about the organisation, process and relationships inherent in commissioning, and good practice guidance. The final report will be accompanied by a stand-alone executive summary, and a 2-3 page briefing for use with practitioners and others wishing for a ‘quick and clean' summary.

7. Project Management

Proposals for the involvement of stakeholders

This action research study is concerned with ‘working with members of an organisation over a matter which is of genuine concern to them and in which there is an intent by the organisation members to take action based on the intervention' (Eden & Huxham, 1996). We intend the research to inform commissioning practice within the three sites, as well as adding to knowledge about commissioning at a national level. Local stakeholders will take part in shaping project focus and fieldwork plans during the orientation/shadowing period and at an initial workshop, be part of a local feedback workshop, and participate in two project-wide meetings where overall learning will be distilled.

The project advisory group will meet 8 times and will include NHS commissioners, private sector commissioning expertise, and user/carer representation, together with academic and international input. The advisory group will peer review research plans, tools, briefings and reports. We will additionally seek three international peer reviewers to ensure our work is not overly parochial and NHS-focused.

8. Service users/public involvement

We will include representatives of patient organisations on the advisory group.
Will work with local patient and public involvement organisations and structures in each of the three study sites.

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