Public Health Governance and Primary Care Delivery: a Triangulated Study

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Executive Summary

Background

Government commitments to improving health and addressing inequalities are reflected in a range of policies, standards and targets, but shifting the focus of the NHS towards prevention has proved difficult to achieve. Much depends on how commissioners interpret and prioritise health and well being and the extent to which a preventive ethos is reflected throughout the commissioning cycle. Governance arrangements are intended to promote effective decision-making and reflect underlying principles and values. However governance arrangements are complex, conflicting incentives are layered into the health care system and there are many competing priorities. This study explored the extent to which governance structures and incentive arrangements acted as enablers or barriers to a preventive agenda.

Aims

The aim of the study was to identify the impact of governance structures and incentive arrangements on commissioning for health improvement and on the health improvement activities of practices. This raised specific research questions. What is the impact of performance management regimes? How are commissioners deploying their contractual flexibilities or using incentives to promote health and well being? How is public involvement in commissioning being achieved and to what extent is prevention prioritised? We also explored the concept of stewardship as an underlying principle of governance.

Methods

In order to provide a conceptual framework and inform fieldwork we mapped elements of performance management regimes, scoped approaches to governance, assessed prioritisation tools and reviewed economic theory on incentives of relevance to commissioners. Public health governance was discussed in three focus groups, one with national stakeholders and two with regional stakeholders. Fieldwork involved 99 semi-structured interviews in ten purposively selected case study sites across England. Interviewees included PCT Chief Executives and Executive Directors, practice-based commissioning (PBC) leads, members of the voluntary and community sector (VCS), and Chairs of Local Involvement Networks (LINks) and of Overview and Scrutiny Committees for Health. An on-line survey of PCTs provided a national context for case study findings.
Results

Commissioning organisations differ in the extent to which they reflect a preventive ethos. Commissioning for health and well being was often viewed as synonymous with commissioning, spanning prevention and hospital care. Practice-based commissioners were often poorly integrated with the commissioning cycle and few had influenced their local Joint Strategic Needs Assessments (JSNAs).

There are different approaches to governance, including procedures for managing risk within organisations, participatory governance and governance between organisations. Leadership for health and well being involved negotiating these arrangements and encouraging a public health perspective. Many commissioner interviewees focused on processes of governance within PCTs and performance management regimes were also largely geared to single organisational performance. Performance management of joint targets by Strategic Health Authorities and Government Offices was often poorly integrated. There was a hierarchy of targets and health improvement targets were not always prioritised.

Changes in regulatory arrangements through the Comprehensive Area Assessment encouraged a shift towards cross-agency governance which better reflected the breadth of a public health system. However, partnership governance arrangements for a preventive agenda required development. Separate themed partnerships under Local Strategic Partnerships for areas such as safety, environment or economic development, tended to fragment the health and well being agenda.

Policy and commissioning guidance emphasises public accountability through patient and public involvement throughout the commissioning cycle. Initiatives in PCTs ranged from formal involvement to large stakeholder events. In practice, engagement often fell short of an influential role in decision-making anticipated by members of the VCS and potential synergies between VCS activities and partnership strategies were not adequately exploited. Public involvement in PBC was limited. While LINks could provide a route for engaging with local communities, commissioners needed to clarify their role in formal decision-making structures. Scrutiny committees were typically focused on health care, often responding to public concern. Commissioners considered it difficult to engage the public in a longer term health and well being agenda and public interest was skewed towards health care services.

Commissioners can incentivise provider performance through contracts, local reward schemes and enhancements to the Quality and Outcomes Framework (QOF). They can also reward behaviour change through individual incentives. Local Enhanced Services, a locally agreed element of the GMS contract, were the most widely cited incentive for the provision of preventive services. These were viewed as an effective and flexible approach to meeting targets and addressing gaps in the QOF. However, they were also optional and piecemeal, vulnerable in times of economic
downturn and had the potential to increase inequalities. Contract specifications and performance management were often weak.

Other incentives included resources associated with Spearhead status or Freed up Resources (FUR) for successful demand management through PBC. Additional Spearhead resources formed part of baseline allocations, and seemed to have exerted little independent influence. FUR were contingent on the financial situation of PCTs and annual funding made it difficult for practices to demonstrate success. Some PCTs had introduced recurrent funding or pooling of resources in order to address this. There were shifts towards more rigorous performance management of primary care, deployment of contractual flexibilities, and clustering of LESs, which encouraged a more collaborative approach across practices. There were also attempts to devise local budgets which incentivised outcomes rather than activity. Commissioners considered it important to collaborate and not rely on transactional approaches.

Prioritising investment is a key task for commissioners. Methods for prioritising investment within the NHS or across partnerships were under-developed. Historically, growth money had been used for investing in health promotion. Interviewees emphasised the importance of demonstrating the business case for prevention, although few were optimistic that preventive services would be protected in a period of economic downturn and much would depend on how acute sector demand was managed. However, economic stringency could also spur radical restructuring and whole system investment. Although monitoring preventative health spend could clarify changes in the balance of investment, commissioners considered it difficult to measure.

Programme budgeting was commonly used to investigate outliers in terms of costs, but there were concerns over the timeliness and quality of data. Many were developing their own prioritisation matrices but a comparative analysis of tools available demonstrates that tools vary in the extent to which they assess inter-sectoral aspects, changes over time, or equity.

**Conclusions**

The extent to which a public health ethos is embedded in the commissioning cycle is reflected in the use of incentives and contractual flexibilities for preventive services, methods for prioritising investment in health and well being and the emphasis accorded to partnership governance. Our study shows variation in almost every aspect of commissioning practice, leading to the following recommendations.

1. Commissioning organisations should ensure that the underlying principle of stewardship of the health of the population informs governance structures and decision-making processes and is integrated into each aspect of the commissioning cycle.
2. Governance structures influence decision-making and priority-setting. Commissioning organisations should assess governance structures for their impact on decision-making in relation to health and well being.

3. Governance processes within organisations predominate and commissioners, working in partnership, should also direct attention to governance across a local public health system.

4. PBC is largely focused on demand management with limited involvement in the JSNA, health and well being partnerships or assurance for WCC. PBC will require further development if it is to address all aspects of the commissioning cycle.

5. Local Enhanced Services are widely used by PCTs as financial incentives for GPs to provide preventive services but are optional and fragmented. A more strategic approach to the use of incentives by commissioners could build on evidence of pitfalls and potential areas of benefit and should also take account of the interplay of incentives across a health care system.

6. Further research is needed on the use of prioritisation tools and their applicability for prioritising investment in health and well being over the longer term and across all spend.

7. VCS involvement in commissioning strategies should be developed by local commissioners and ways of increasing public involvement in a preventive agenda explored. PCTs, PBC and local authorities should clarify the role LINks are to play in influencing commissioning decisions.

8. Further research is needed on the cost-effectiveness of public health interventions over the longer term in order to strengthen the business case for public health investment.

9. In each of the topic areas studied we found examples of innovative practice. We also found PCTs working independently on key topics, such as prioritisation methods, which would benefit from collaboration. We therefore suggest that methods for knowledge exchange in relation to the preventive agenda are given more priority by policy makers and researchers and that knowledge exchange spans the range of organisations involved in the health and well being agenda.

The report was completed just before a new coalition government signalled substantial changes to commissioning in the NHS, including the eventual abolition of PCTs. However the study raises generic issues related to commissioning for health and well being, exploring the complexity of governance for public health which goes beyond the governance arrangements of any single organisation.
Addendum

This document is an output from a research project that was commissioned by the Service Delivery and Organisation (SDO) programme, and managed by the National Coordinating Centre for the Service Delivery and Organisation (NCCSDO), based at the London School of Hygiene & Tropical Medicine.

The management of the SDO programme has now transferred to the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton. Although NETSCC, SDO has conducted the editorial review of this document, we had no involvement in the commissioning, and therefore may not be able to comment on the background of this document. Should you have any queries please contact sdo@southampton.ac.uk.