

# Commissioning high quality care for people with long-term conditions

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### ***Contribution of authors***

Dr Judith Smith (Director of Policy) was the Principal Investigator, developed the research proposal, provided expert advice and facilitation within case study sites, carried out interviews, was involved in data analysis and report-writing, and edited this final report.

Dr Sara Shaw (Visiting Senior Fellow) developed the research proposal, carried out interviews and observations, was primary contact for one site, and was involved in data analysis and report-writing.

Dr Alison Porter (Senior Researcher) carried out interviews, literature review and observations, was primary contact for two sites, and was involved in data analysis and report-writing.

Dr Rebecca Rosen (Senior Fellow) provided expert advice and facilitation within case study sites, undertook the social network analysis, and was involved in report-writing.

Ian Blunt (Senior Research Analyst) undertook quantitative data analysis, provided specialist data analytical advice to colleagues within case study sites, and was involved in report-writing.

Dr Alisha Davies (Specialist Public Health Trainee) undertook appraisal of public health evidence and literature review within case study sites, and was involved in report-writing.

Elizabeth Eastmure (Project Manager) carried out project management, ethics and research governance, and supported report-writing.

Professor Nicholas Mays (Professor of Health Policy, LSHTM) provided methodological advice and strategic direction, took part in analysis, and acted as critical reader of the final report.

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# Executive Summary

## **Background**

Commissioning is the term used to describe the process of aligning resources to the health needs of a population (within a defined budget), putting in place cost-effective services to meet those needs, and monitoring the quality of services to ensure that they fulfil the standards set out in contracts.

One of the most influential pieces of analysis of health care commissioning is Øvretveit's (1995) commissioning cycle, in which the stages of needs assessment, planning, contracting, monitoring and review are repeated annually. This model has been promoted by the Department of Health to the primary care trusts (PCTs) which were responsible for commissioning health care at the time of this study. Other analyses have examined the continuum of agencies which carry out commissioning, placing PCT commissioning at a mid-point between personal health budgets and specialised commissioning at national level (Smith et al, 2004), and the need to balance formal, transactional aspects of commissioning with more relational processes.

Much of the existing research and literature focuses on the organisation of commissioning and specific aspects of the commissioning cycle, such as contracting. Less attention has been paid to the practice of commissioning, although relevant literature exists on three themes, concerned respectively with practice (how people make sense of institutional requirements within real situations), networks (how different parties work together to plan and manage services), and management (how commissioning skills are applied).

## **Aims**

The aim of this research was to explore how NHS commissioning could be enacted to improve care for people living with long-term conditions. The objectives were to:

1. identify the organisation and processes associated with effective commissioning;
2. identify an appropriate set of outcomes, some developed in association with commissioners themselves;
3. draw on experience from other sectors and international health systems in developing commissioning within study sites, developing and disseminating good practice guidance as a result; and

4. consider how the learning from this research could be more widely applicable in the NHS.

## **Methods**

A cohort of 'high performing' PCT areas was identified, from which three were selected as case study sites: Calderdale, Somerset and Wirral. Within each PCT area the study examined the whole 'commissioning community', including provider organisations. The research focused on specific developments in relation to two long-term conditions: diabetes in all three sites, to allow cross-site comparison; and one other condition selected by local commissioners (stroke in Somerset and dementia in Calderdale and Wirral).

An initial orientation and mapping phase was followed by a main data collection phase lasting 15 months. Seventy-one semi-structured interviews were carried out to examine commissioning practice, and a further 21 focused on the impact on local commissioning of wider health service reforms. An additional 20 telephone interviews with lead contacts in sites tracked developments on a regular basis. Twenty-seven commissioning meetings were observed, and over three hundred documents analysed. Where possible, quantitative data were collected on service provision, activity levels, costs and patient experience at the start and close of the fieldwork.

A questionnaire survey was used to carry out a social network analysis of patterns of influence on GP clinical practice in relation to diabetes care, this being an attempt to explore how far the activity of commissioners influences the clinical practice of GP giving care to people with long-term condition.

The study was a comparative multi-case study project, within which the researchers offered supportive intervention and consultancy in sites as part of the research process. Interventions included facilitating meetings and workshops, evidence review, and data analysis. These interventions aided the establishment of collaborative working relationships between the research team and sites, especially given the rapidly changing policy and organisational context.

Qualitative and quantitative data were analysed within and across sites and service areas, to develop an understanding of the day-to-day practice of commissioning, including what factors facilitated or inhibited progress.

Emerging findings were presented for validation at two workshop events (in May and November 2011) bringing together representatives from each study site with members of the research team and advisory group.

## Results

The practice of commissioning was studied in relation to six specific service developments:

1. The development of a strategic plan for diabetes care in Calderdale
2. A transformation of dementia services in Calderdale
3. Redesign of the Somerset Diabetes Service, including a new intermediate tier of nurse-led care
4. Establishment of an Early Supported Discharge service for stroke patients in Somerset
5. Review of the diabetic podiatry service in Wirral
6. Establishment of a new Memory Assessment Service in Wirral

Seven cross-cutting themes emerged:

*The scope of commissioning* – findings challenged the model of a ‘commissioning cycle’ of sequential tasks. Developmental commissioning, over many years, was running in parallel with annual contractual aspects of commissioning. Deciding the scope and scale of commissioning work was an essential first step. Co-ordination and support for implementation were significant parts of commissioning practice.

*The labour of commissioning* – an extraordinary amount of effort went into commissioning across all six service areas, made up of technical and relational tasks. Effective commissioning required a combination of senior strategic leadership and day-to-day project management input from dedicated commissioning staff. This labour seemed often to be disproportionate to the anticipated or actual service gains.

*Identifying the commissioners* – commissioning tasks were undertaken by managers and clinicians from providers, GPs, and representatives of third sector organisations, as well as by PCT commissioners. The contribution of different parties varied according to the stage in the commissioning process. Clinicians had a role as experts and champions for change, and GPs’ role as decision-makers was evolving.

*The question of money* – the role of money in commissioning practice was observed to be intermittent and at times peripheral. The organisational structure of PCTs encouraged a separation of financial and contractual aspects of commissioning from developmental processes. A limited role was observed for NHS financial incentive schemes, but the

majority of spending on the services studied was absorbed in block contracts. Anticipated cost savings from service redesign in relation to long-term conditions were in some cases hard for commissioners to reconcile with pressure for immediate efficiencies.

*The scale and pace of change* – the change brought about through the commissioning processes observed tended to be incremental rather than radical – it was cautious, carefully paced and non-disruptive. Success seemed to come where commissioners were tackling 'bite-sized' commissioning tasks as part of a wider local plan for service delivery.

*External drivers of commissioning* – external drivers played a powerful role in shaping commissioning practice in each of the six service areas. National 'guidance' provided top-down impetus to get things done, presented templates for services, and provided a national framework to facilitate local decision-making and identification of priorities. External support organisations were available for commissioners to call on to help their work. External drivers were mediated by local circumstances, particularly existing patterns of service provision.

*Working in a context of uncertainty* – the study took place at a time of significant change to the structure of the National Health Service in England, as plans were being put in place to shift commissioning responsibilities from PCTs to GP-led clinical commissioning groups. Commissioning of care for people with long-term conditions managed to continue in the face of loss of PCT management and analytical capacity and a sense of uncertainty about the future.

The social network analysis of influences on GPs' practice in diabetes care had a low response rate (21%) overall, although higher in Calderdale (44%). The main sources of advice and influence on diabetes care were found to be GP colleagues, specialist nurses, and hospital consultants. PCTs were only occasionally cited by GPs as an influence on their practice.

As previous research has found, tracking the impact of commissioning through quantitative data (concerning activity levels and clinical outcomes) proved challenging, because of long time lags between intervention and change, and because of difficulties in attributing impact to commissioning rather than other factors.

## **Conclusions**

Commissioning for long-term conditions seems to differ from elective services, and requires an approach which represents a blurring of the purchaser-provider split. However, the effort involved in commissioning has to be worth the outcomes, and relational aspects of commissioning work must leave room for transactions that assure such outcomes (e.g. contracting, review, decommissioning).

The research suggested that the following activities, amenable to measurement, were associated with effective commissioning:

- Commissioners acting as convenors of multiple local interests and stakeholders
- Focus by commissioners on overall setting of priorities for health spending, rather than a few services at the margins
- Commissioners getting the right balance between relational and contractual aspects of commissioning
- A strong focus on monitoring of activity, financial performance and quality, and using this to inform review
- Shared risk across providers and a long timescale for development in relation to delivery of care for long-term conditions
- Support for commissioning managers
- Adequate clinical involvement in commissioning
- Specific and measurable objectives for any newly commissioned or re-commissioned service
- A programme of review and re-commissioning of the services that cost most money