NHS Commissioning Practice and Health System Governance

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NHS Commissioning Practice and Health System Governance

1. **Aims/Objectives**

Our **research aims** are to:

1. examine which commissioning practices emerge and are adapted to different organisational and care-group contexts, including health economies with multiple commissioning organisations, so producing evidence-based recommendations to improve NHS commissioning practice.

2. explore what NHS commissioners can learn form commissioning in other health systems

3. contribute thereby to governance theory, institutional economics, organisational sociology and organisational theory.

Focusing on tracer care groups (unscheduled care; mental health; public health), our **research questions** are:

1. How do English health policy makers and NHS commissioners understand the policy aims of commissioning, and how governance over providers can be exercised through commissioning?

2. How will the reconfiguration of commissioning structures occur in practice and what shapes this reconfiguration?

3. How far does current commissioning practice allow commissioners to exercise governance over their local NHS health economies? 
   (a) How much room for manoeuvre do NHS commissioners have? 
   (b) What are the consequences, and how do commissioners try to manage them, when commissioning is distributed across different organisations and when it shifts to being client-based? 
   (c) How do provider managers respond to commissioning activity?

4. How do commissioning practices differ in different types of commissioning organisation and for specific care groups? Which aspects of service provision do different commissioning organisations tend to focus on?

5. What factors, including the local health system context, appear to influence commissioning practice, and the relationships between commissioners and providers?

2. **Background**

Current English policy regards commissioning as the medium for public governance (Rhodes, 1997; Robinson & Le Grand, 1995) of NHS services provided by diverse,
often independent organisations. NHS commissioners are to: ‘manage the local health system’; promote health; be patient advocates; ‘engage’ clinicians with commissioning; ensure providers meet national standards for care (NSFs, quality and safety standards), targets and other national policy objectives (Department of Health, 2004, 2007a, 2007b). The World Class Commissioning (WCC) policy (Department of Health, 2007a) spelt out 11 competencies which PCTs needed to strengthen for these purposes. Our study will provide new knowledge that will contribute to assessing what parts of the WCC remain relevant to NHS commissioning, providing a firmer evidence base for those elements. After the 2010 general election the incoming government announced that (subject to consultation) by 2013 the bulk of NHS commissioning would be done by consortia of general practices. During 2010-2013 these GP commissioning consortia would take over much, but not all, of the commissioning work previously undertaken by PCTs and SHAs. At national level a Commissioning Board will oversee NHS commissioning practice and its development (Department of Health, 2010).

A likely consequence of the shift to GP-led commissioning is a diversification of commissioning organisations or indeed, since general practices will remain independent, commissioning networks (of general practices). The period of transition from 2010-2013 is likely to witness the concurrent operation of diverse modes of commissioning and correspondingly diverse organisational arrangements through which commissioning is carried out. Whilst these unstable circumstances make it practically harder to conduct research the increased variety of modes of commissioning and of commissioning organisation give an opportunity (rare in England) to compare different modes of commissioning and commission organisations concurrently. We anticipate that at least the following variants of commissioning organisation are likely to develop:

1. A ‘standard model’ GP consortium, structured as a network whose coordinating body employs its own commissioning management support staff. This model admits of variants, such as:
   (a) a selective model, which limits its membership to small group of self-selected ‘leading’ general practices (e.g. in Wirral)
   (b) a universal model including all general practices in a locality.
2. Limited liability partnerships
3. Social enterprises (e.g. Sentinel in Plymouth) or a Community Interest Companies commissioning on general practices’ joint behalf.
4. Commercial firms (e.g. UHE in Hounslow) sub-contracted by NHS bodies to commission on their behalf, including the extension of former FESC arrangements.
5. General practices collectively take over the former PCT commissioning infrastructure (proposed for Salford).
6. ‘Polysystem’ networks of (‘federated’) general practices (e.g. in Redbridge).
7. Wide-area commissioning bodies created by merging the relics of former PCTs (e.g. in London).
8. Individual general practices commissioning for themselves, independently (e.g. Radlett).
9. For rare conditions or highly specialised treatments, commissioning undertaken by the Commissioning Board or a regional body on its behalf.

There is a little evidence suggesting that the foci of attention of these different commissioning organisations may differ from those of PCTs. Such evidence (and not only from the UK (Sheaff 1990, Saltman & von Otter 1992, Robinson & Steiner 1998)) also suggests that primary care commissioners focus on managing, and may
therefore destabilise, existing patterns of referral to secondary care with implications for the financial stability of secondary care providers (Department of Health 1992). In contrast, more purely managerial bodies (e.g. PCTs) have in England focused more upon the implementation of national policies and targets.

NHS commissioning for certain care groups is likely to become more distributed, with separate organisations commissioning the same providers in parallel. In certain cases (e.g. NGMS contracting) the commissioning cycle is already distributed across different organisations. Some services (e.g. for children, mental health) are commissioned jointly with local government. During the transition from PCT-led to GP consortium-led commissioning, the commissioning of many services is likely to be distributed across (at least) these two bodies, besides local government for mental health services and public health work. NHS commissioners therefore need to know how to commission collaboratively across organisational boundaries and through other, mediating organisations. Commissioning is also likely to become more client-centred. ‘Payment by results’ will spread to mental health services (Department of Health 2009). Personal care budgets are likely to be piloted in some primary and community care services.

Government will continue to pursue the policy of provider diversification. That policy implies that NHS commissioners will need to understand commercial and third sector modes of commissioning and the practical implications for NHS commissioning. Commercial and third-sector providers are autonomous. Government intends that all NHS Trusts will become NHS Foundation Trusts, which will also exercise ‘earned autonomy’, both 'positive' freedoms (e.g. capital-raising) and relaxation of commissioner controls. Current policies therefore imply defining 'windows' for provider autonomy (Exworthy & Powell, 2004), allowing providers autonomy to innovate, differentiate their services and develop competitive advantage. These conditions raise the question of how to ensure that providers do meet commissioners’ requirements whilst avoiding ‘under-governance’ in matters where commissioners should hold providers to account and ‘over-governance’ (‘micro-management’) through which commissioners’ control unnecessarily restricts provider innovation and service development.

In the days of PCTs an imbalance of power impeded commissioners in fulfilling their governance functions over providers (of all kinds) who possess superior information and bargaining power. PCT mergers strengthened their bargaining position as commissioners but not the concentration of referrals into ever fewer secondary care providers (Dusheiko, Goddard, Gravelle, & Jacobs, 2008). Hitherto, PCTs and general practices lacked the necessary resources for commissioning (Audit Commission, 2004; Audit Commission & Healthcare Commission, 2008) (Ham, 2008), finding difficulty assembling even basic data (patient numbers, case mix) for monitoring specific care groups (Boaden et al., 2006). PCTs had difficulty involving patients and public in decision-making for commissioning (Lupton, Peckham, & Taylor, 1998; Pickard, Sheaff, Sibbald, Marshall, & Campbell, 2002; Sheaff, Pickard, & Smith, 2002). Although primary care contracts became increasingly complete, PCT contracting was still largely relational (Allen, 2002; Exworthy, 1998; Flynn, Williams, & Pickard, 1996) (Sheaff & Lloyd-Kendall, 2000). Until 2010 PBC had limited effects in stimulating medical engagement with NHS commissioning (Davies, Powell, & Rushmer, 2007; Audit Commission & Healthcare Commission, 2008; Checkland, Coleman, Harrison, & Hiroeh, 2008; Coleman, Harrison, Checkland, & Hiroeh, 2007). The question also arises (Berwick, 2008; Jones, Exworthy, & Frosini, 2008) of whether the introduction of GP commissioning risks re-entrenching
professional or provider 'capture' of NHS commissioning. In any health system, conflicting demands from commissioning bodies can 'gridlock' provider development (Sheaff, 2005). English policy tensions include: facilitating entry of new providers versus cost control (Pollock, Shaoul, & Vickers, 2002); promoting evidence based practice versus patient preferences for, say, 'alternative medicine' (Singh & Ernst, 2008); activity based versus need-based funding (Street & Maynard, 2007); and cost control versus case-based units of payment (PBR) (Mannion, Marini, & Street, 2008; Marini & Street, 2007).

Finally, NHS commissioning policy and practice have under-exploited evidence about commissioning in other health systems.

Because NHS commissioners are intended to exercise arms-length governance over health care providers, we will as a theoretical framework develop and test a contingency theory of modes of commissioning, exploring how commissioning interacts with co-existing hierarchical and networked governance (Exworthy, Powell, & Mohan, 1999; Sheaff & Pilgrim, 2006).

Since governance is an exercise of power, we apply Therborn's conceptualisation (Therborn, 1978; Therborn, 1980) to analyse of power, which indicates that NHS commissioners might apply the following the following governance mechanisms, listed in descending order of stringency of the sanctions involved:

1. **Law, para-legal regulations and contracts**, of various degrees of completeness and presentation (Macneil, 1978). NHS bodies, social enterprises, general practices (partnerships) and commercial firms all have different legal personalities, competences and responsibilities.

2. **Competition or contestability** (Baumol, 1982) through: creating a monopsony (Light, 1997); provider selection, including 'make-or-buy' decisions; stimulating new providers or inviting untried providers to tender.

3. **Financial incentives**: choice of units of provider payment (e.g. annual subscription, capitation, DRG-like tariffs) (Iverson & Luras, 2007); use of price vs. non-price competition (for an example see Grumbach, Osmond, Vranizan, Jaffe, & Bindman, 1998); route of payment (e.g. 'cash follows patient' systems intended to incentivise providers to meet referrer or patient demands); and, conversely, financial penalties.

4. Managing conflicts to produce a 'negotiated order' (Strauss, Schatzman, Ehrlich, Bucher, & Sabshin, 1963) and relating long-term collaborations with a few preferred providers (Allen, 1995; Macneil, 1978), although strong relationality (Granovetter, 1983) may inhibit commissioners from radically changing existing patterns of relationships (Exworthy, 1998).

5. **Ideological control**: through discursive 'orders' (Fairclough, 2005) such as EBM, professional 'disciplines' (Flynn, 2002), agenda control (Bachrach & Baratz, 1970), 'non-decision-making' (Lukes, 1974) and 'excommunicating' dissidents.

6. **Managerial performance** of the procurement process (see Cousins & Lawson, 2007), above all how the type and complexity of the procurement is considered (normally, through a supply portfolio approach) (Kraljic, 1984; Cousins, 2005), relationship management and performance measurement.
For these activities, those who manage NHS commissioning must have the required skill set and performance metrics in place. Against this, health care providers have 'impersonal' power (Therborn, 1978; Therborn, 1980) derived from their role as the organisations which actually deliver health care, the main activity upon which the commissioners depend in order to realise their (commissioners') own objectives.

A central managerial question facing NHS commissioners is therefore how to select, combine, adjust and apply the above governance mechanisms given local contextual variations in:

1. Commissioners' role i.e. how wide a range of policies they implement and how decentralised implementation is (Peckam, Exworthy, Powell & Greener, 2008). Possible roles range from policy agent (implementing all policies with health sector implications) to health system planner (Saltman & von Otter, 1992), purchaser (procuring pre-defined 'baskets' of healthcare provision (European Health Management Association, 2007), consumer proxy for patients who lack the technical knowledge to negotiate with healthcare providers (Arrow, 1963), to relatively passive reimbursement of providers' or patients' costs.
2. Co-existence of multiple, perhaps organisationally diverse commissioners in a local health economy.
3. Care groups (contrast health promotion and acute in-patient care)
4. Organisational type of provider. Different mechanisms are apparently required for governance of commercial, third sector and NHS providers (Flynn et al., 1996).
5. Local organisational cultures, micro-politics and history (e.g. histories of antagonism or collaboration between NHS organisations or even personalities).

Contingency theory predicts that for each combination of these circumstances, specific combinations and applications of the above governance mechanisms are necessary for commissioners to exercise governance over providers. We call each such combination a 'mode of commissioning'. We also hypothesise that different types of commissioning organisation (GP commissioning consortia, local government, non-NHS commissioners) are likely to develop different modes of commissioning.

Contingency theory also predicts that observed commissioning practice is likely to evolve by trial and error towards the mode(s) best adapted to commissioners' roles and circumstances. The research aims to accelerate and deepen this learning by critically examining existing commissioning practices and how their current and foreseeable contexts influence their development and use as means of governance over providers.

3. **Need**

Few questions are more important to the NHS than how its commissioners can exercise governance over local health economies and service providers, and what aspects of service delivery the commissioners should focus their attention on. A more strongly evidence-based programme theory of health care commissioning would strengthen NHS commissioners’ managerial practice through a stronger understanding of how to select and apply different modes of commissioning, of how these modes of commissioning work and of how to use them manage the profile and
delivery of NHS services. The study compares NHS modes of commissioning with selected examples of commissioning in the German and the Italian health systems.

4. Methods:
   a. Setting

   In each of four local health economies in England we will study at least one commissioning cycle for each of four tracer groups: older people at risk of unplanned hospital admission; mental health; and public health (focusing on CHD and diabetes prevention); planned inpatient orthopaedics. In England, these commissioning cycles are likely to be distributed across PCTs, local government, GP consortia and (depending on local conditions) further organisations. Also we will study one cycle in a German and in an Italian health economy. A database covering the baseline position for PCT-level (i.e. local health economy level) commissioning across England will also be assembled.

   b. Design

   Multiple-method realistic evaluation comprising:
   1. Content and discourse analysis of policy-makers’ and managers’ interviews and policy documents to elicit their programme theory of NHS commissioning.
   2. Cross-sectional empirical study of current NHS commissioning practice at local health economy level, based on a database which combines existing data and, if necessary as a supplement, new data collected by census of the outgoing PCTs.
   3. Comparison of explanatory case studies of commissioning cycles in different commissioning organisations, the case studies being a purposive maximum-variety sample of commissioning organisational arrangements and care groups.
   4. Comparison of the above case studies with an explanatory case studies of the German sick-fund commissioning of health services and a similar study of commissioning in an Italian health economy.
   5. Review of relevant concurrent research into NHS commissioning.

   c. Data Collection

   Our respective sampling strategies will be:
   1. Policy-makers: snowball from DH, academic and think-tank members known to influence health policy, seeking maximum variety of policy standpoints and aiming at data saturation. Our past experience suggests that returns from further interviewing often diminish after about 20 interviews.

   2. Documents: Because we wish to analyse interested in the policy documents which most influence NHS practice, the relevant sampling strategy is purposive i.e. to identify those most widely-distributed, measured if possible by numbers of downloads to NHS addresses.

   3. Census respondents: From websites, other documents or telephone enquiry, we will identify the commissioning lead manager for each local health
economy (in the short term, the relevant PCT manager). A census requires no sampling strategy, only post-facto analysis of response bias.

4. Commissioning cycles for case study: The sampling unit will be the local health economy, taken as (an entity equivalent in size to) a PCT. The transition between PCT-led and GP consortium-led commissioning will probably give the opportunity to compare diverse organisational forms of NHS commissioner. Because we want to study commissioning as a means of governance under conditions organisational diversity we will make a maximum variety sample of four health economies, chosen for diversity of types of commissioning organisation. Given our aim of deriving practical lessons for NHS managers, we will were possible select these from among the (first wave i.e. December 2010) Pathfinder sites. Depending on what commissioning organisations arise and are accessible to researchers, we will attempt to include health economies which between them contain examples of:

   (a) A 'standard model' site with a GP consortium structured as a network whose coordinating body employs its own managerial support staff.
   (b) commissioning through a social enterprise or community interest company
   (c) and (d) two other kinds of commissioning organisation, such as commissioning supported by a commercial firm, or commissioning through a 'federated Polysystem' or 'Polyclinic'.

In light of the fluid situation we will need to adopt a correspondingly flexible sampling strategy but will consult SDO about any substantial changes to the above. We assume that in all health economies the Commissioning Board or its regional agent will commission rare conditions or highly specialised treatments. As NHS commissioning develops and diversifies unforeseen modes of commissioning and forms of supporting organisational infrastructure may appear. If necessary, we will subject to agreement with SDO also undertake up to four 'mini-case-studies' to explore modes of commissioning in these sites, focusing on just one care group or on a specific aspect of the commissioning cycle.

5. German and Italian study sites. We have chosen:
   (a) Techniker Krankenkasse (TKK) as the largest health insurance fund in Germany with 7.2 million members and with over 100 years experience as a healthcare purchaser. TKK is one of the best German health insurance funds terms of performance and value for money. They are keen to be involved with UK organisations as part of their learning as a leading European healthcare organisation.
   (b) Emilia Romagna health region, as a managerially innovative health region which is outward-looking and interested in exchanging knowledge about commissioning with foreign health systems. This health region has agreed to participate in the study.

6. Concurrent research: we will attempt exhaustive coverage of emerging published findings.

Data collection on the programme theory of NHS commissioning will be:
1. Interviews (approximately 30) with policy-makers and senior managers at DH, sub-national and local health economy level.

2. Collection of printed documents during site visits and download of policy documents (from DH, NICE, Healthcare Commission, NPSA websites), asking web-masters which ones have most downloads to NHS addresses.

As far as possible we will collect data for the database about NHS commissioning practice by collating existing publicly-available data on such points as: character of the local health economy; providers for the four tracer groups; extent of practice based commissioning in 2009-10, external links to other commissioners for the tracer groups; FESC and cross-boundary flows of patients.

To supply data then still missing we will if necessary make a census local health economies beginning with the lead commissioning managers for each local health economy (until early 2011 still a PCT role, so currently approximately 150), developing a structured questionnaire to record factual rather than attitudinal data, supplemented with a small number of open questions to capture any relevant data which the questionnaire design did not anticipate. Data will initially be collected on-line with e-mail, postal and telephone follow-up.

Narrative case study data would be assembled from informant interviews and documents describing how the commissioners undertake the steps described in figure 1, noting:

1. which policies and documents are influential, provider selection criteria, any additional and any omitted commissioning activities, and how the study commissioners coordinate their commissioning with each other and higher-level bodies (in the NHS, DH, Healthcare Commission etc).

2. Which governance mechanisms the commissioners use.

3. Whether the commissioners also line-manage any services and if so, how that affects commissioning.

4. How provider managers describe their organisation’s relationship with their commissioners, including any disagreements between provider and commissioner, and how they are resolved.

5. Whether any service changes have (or not) occurred, which might be attributed to commissioners’ activities.

We will include patient representatives among the interviewees.

d. Data Analysis

We present the plan of analyses by research question.

Commissioners’ Programme Theory (RQ1): Policy objectives and the mechanisms they presuppose will so far as possible be ‘read off’ from interview transcripts and documents. If gaps remain it will be necessary to impute the missing assumptions (Lukacs, 1971) but in doing so we will impute the most empirically plausible and logically coherent assumptions possible so as not to evaluate a ‘straw man’ programme theory. We will make a:

1. Framework analysis, based on figure 1 but elaborated using subsequent publications about NHS commissioning policy and practice.

2. Leximancer analysis which permits, via a software algorithm based on a thesaurus, the mining of text for concepts (Travaglia & Braithwaite, 2007).
3. Cognitive semantic (Nerlich, Dingwall, & Clarke, 2002; Fischer, 2003) and frame semantic analyses (Fillmore, 1982).

Diversification of commissioning organisation (RQ2): For each study site we will write a narrative case study, giving the history of the formation and development of commissioning there during the study period. We will induct patterns of formation within sites, and then (using a common analytical framework) systematically compare these patterns cross-sectionally between the study sites, inducting common patterns.

Commissioning practice (RQ3) The case studies will be systematically compared using a common analytic framework derived by updating figure 1 in light of subsequent empirical research and including fields reflecting the governance mechanisms and contextual variables described above. To check whether the framework omits important data patterns we will also inductively code the qualitative data (Glaser & Strauss, 1967), and add any new themes to the analytic framework. Insofar as the data permit we will also use relatively simple statistical techniques (non-parametric tests; ANOVA; cluster analysis) to categorise the commissioning practices at local health economy level described in the database.

Contingent differences in commissioning practices (RQ4) Analysis will be analogous to that for RQ2, but focusing on categorising patterns of development, and variations found across commissioners; how far these patterns are associated with other characteristics the local health economy and tracer groups' specific healthcare 'technologies'.

Relationships between commissioners and providers, in health economies with different profiles of commissioning organisation (RQ5) We will categorise each case study site's commissioning practice subjectively, in terms of how they describe it; and classify commissioners' commissioning practice objectively, applying (insofar as the data are publicly available and permit) statistical techniques (non-parametric tests; ANOVA; cluster analysis) to categorise local health economies according to their commissioning practices and organisational profiles. We will then make tests suitable for non-parametric, often categorial data (e.g. chi-squared) for associations between these categories and (other) publicly available indicators of provider performance (e.g. access target achievement, financial deficit/surplus).

To explore what mechanisms produce any associations which are found we will systematically compare our case studies for patterns (similarities and differences) between different commissioners' commissioning practices (answers to RQs 3,4). We will similarly compare the German case and Italian studies with the NHS cases to discover any points at which NHS commissioning practice promotes or impedes the governance of provider through commissioning. These comparisons will use the same frameworks as for RQ3, RQ4 and RQ5.

A second framework analysis will then re-collate all the empirical findings above under the standard categories of realistic evaluation, at broadest (though we will decompose them into more specific sub-categories): policy objectives, mechanisms (i.e. commissioning practices) used to realise them, contextual influences, and resulting policy and service outcomes. This framework will allow systematic comparisons in terms of commissioning contexts, mechanisms and outcomes between policy-makers' and managers’ programme theories (answer to RQ1) with
the foregoing empirical findings about commissioning practice. The comparison will produce empirically tested, perhaps revised, programme theories predicting which modes of commissioning are likely to be applicable in which settings.

Empirically, the study is limited to the foci listed. Case studies are inherently open to recall and response bias, but triangulation between informants and other data sources should reduce that risk. The analytic framework rests upon several assumptions but the methods will allow us to verify or correct them during the research. The proposal also rests on assumptions about the current state and purposes of NHS commissioning. These conditions are unstable during 2009-2012 but its theory-based analytic frameworks and research questions enable the research design to accommodate, indeed exploit, such changes.

5. **Contribution to existing research**

This project supports the objectives of the Health Commissioning Programme by producing research evidence that strengthens the evidence available to improve NHS commissioning practice. Of the research questions in §4.2 of the call, our research questions (see below) contribute to answering questions 1, 3, 4 and 6. Of those in §4.3 we contribute to answering "What roles do clinicians play in the negotiating and monitoring of contracts in commissioning organisations?" From §4.5 we deal with the first three out of the four bullet points and from §4.6 we address the last three bullet points but not the others.

Although not our main focus, the work we propose will probably also yield findings about: private sector support to commissioners; public involvement; third-sector involvement; contractual dispute handling; how commissioners incentivise providers and what intermediate outcomes they use; how commissioners use performance data and patient-reported outcome data; contrast of urban and rural contexts; and how commissioners interpret and apply the health and well-being framework (through our public health tracer). The research is also relevant to the SDO's own themes of patient and carer-centred services, public health services and studying health care organisations.

This study excludes: how the effects of commissioning are transmitted within provider organisations from 'boundary-spanners' to clinicians, since other research already addresses that. We complement HREP's 'demand side' perspective by focusing on preventive activities rather than health care for two of the same care groups (CHD, diabetes), and on alternative modes of commissioning and inter-organisational governance rather than managerial competences. We also propose to study non-NHS commissioning. This project is not an evaluation of GP commissioning consortia *per se*, nor an evaluation of personal health budgets *per se*. It focuses on the more general (less institution-specific) of how governance is exercised through the commissioning of health care.

6. **Plan of Investigation**

Given the above research questions, our research design is realistic evaluation (Pawson & Tilley, 1997) using a mixed-method approach like that adopted by Byng,
Norman and Redfern (2005) to test empirically, and as necessary revise, the programme theories underlying NHS commissioning practice. It comprises:

1. Discourse analysis of commissioning policy to articulate more fully and precisely the ‘programme theory’ of NHS commissioning. Discourse analysis of commissioning policy to articulate more fully and precisely the ‘programme theory’ underlying the policy. By ‘programme theory’ we mean policy-makers' and managers’ objectives for NHS commissioning and their assumptions about what commissioning processes and governance mechanisms will realise these objectives, and how. We will analyse key policy documents', policy makers' and managers' accounts of these matters.

2. Cross-sectional empirical study of current NHS commissioning practice, based on a database and census of PCTs, updating the approach of Raftery et al. (Raftery, Robinson, Mulligan, & Forrest, 1996), to:
   (a) describe, so far as data are available, the profile (mix) of commissioning organisation(s) practices and resources in each local health economy, allowing categorisation of local health economies in terms of these variables.
   (b) provide a sampling frame for the case studies described below.
   (c) test for associations between health economies' organisational characteristics (profiles), commissioning practices and published indicators on provider outcomes.

We will create a data-grid in which the rows will be local health economies and the columns data-sets likely to be required for the analyses below. We will obtain as many data-sets as possible from existing sources (e.g. DH, Dr. Foster, NPCRDC, HREP studies), then make if necessary a census of PCTs to fill the remaining gaps.

3. Explanatory multiple longitudinal case studies of commissioning organisations, taking one commissioning cycle (see figure 1) for one tracer group in one local health economy as the unit of analysis ('case') (Yin, 1999) and comprehending both sides of the commissioner-provider nexus and any commissioning distributed over several organisations. We will:
   (a) narrate the commissioning cycle and the governance mechanisms involved.
   (b) describe the relationships between commissioning practice, organisational structures and processes, external networking and provider responses.
   (c) Describe how the commissioning cycle is distributed between different commissioning bodies of the types listed above.

These case studies will ground comparisons of commissioning for different care groups in different contexts, providing a basis for hypothesis testing (Bitektine, 2008).

4. A comparative study of external procurement in other health systems, if possible healthcare commissioning practices in:
   (a) a German local health economy, where multiple commissioners also commission public and private providers, paying them by DRG-like tariffs.
   (b) an Italian health region, in a health system more closely modelled on the British NHS
To maximise comparability we will as far as possible use the same analytic and data collection frameworks as for the English case studies, thereby enabling the researchers to judge whether these modes of non-NHS commissioning, or elements thereof, might provide practical managerial lessons for NHS commissioners.

5. Concurrently we will exploit findings of the literature review which SDO plans to commission, of any later or excluded material (e.g. relevant German and French publications such as G+G Blickpunkt and Pratiques et Organisation des Soins). We will attempt to gather emerging findings on commissioner-provider relations from relevant concurrent studies funded by HREP, NICE and the DH Health Policy Programme, convening inter-project meeting (providing SDO can meet incidental reasonable on-costs) about 18 months after project start as a forum for comparing findings and methods, in particular (as a check on our own methods) any findings which appear to challenge the assumptions and framework on which the present proposal rests. We will use realist synthesis methods (Pawson, Greenhalgh, Harvey, & Walshe, 2005) to combine the findings.

Because contingency theory implies that provider healthcare 'technology' is likely strongly to influence commissioning practice, we select four contrasting 'technologies' as 'tracers' likely to reveal contrasting commissioning practices:

1. Unscheduled care: unplanned admissions of people with chronic conditions
2. Mental health: provision of unscheduled care through home treatment teams.
3. Public health: prevention of diabetes and coronary heart disease through both clinical activity (e.g. statin prescribing) and inter-sectoral action (e.g. to influence diet and exercise).
4. Scheduled orthopaedic in-patient care

7. Project Management

Nigel Charles is the project manager. The necessity, following the reform of NHS commissioning in 2010 to review and adjust this research proposal has required the additional work of updating the database, census materials, policy documents and data collection instruments to accommodate the changes to NHS commissioning, revision of the sampling framework, re-costing and consultation with SDO. The project timetable (table 2) has been revised accordingly.

Table 2: Outline Project Timetable

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<th>Activity</th>
<th>Months</th>
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<tr>
<td>2009</td>
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<tr>
<td>Obtain ethics approval</td>
<td>❌</td>
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<tr>
<td>Design and populate database</td>
<td>❌</td>
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<tr>
<td>Document collection and analysis</td>
<td>❌</td>
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<tr>
<td>Prepare case study data collection and analysis instruments</td>
<td>❌</td>
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<tr>
<td>Analysis of programme theories</td>
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<tr>
<td>Electronically distribute census to PCTs</td>
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<tr>
<td>2010</td>
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<td>Document collection and analysis</td>
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05 January 2011
The project has ethical approval (reference 09/H0206/50) from the South West 2 Research Ethics Committee, but we will check whether making the above changes may involve a revision of our research ethics approval. Recent changes in NHS commissioning do not alter other uncertainties in this timetable i.e. are speed of research governance approvals, any unforeseen conditions attached to them; whether and how swiftly study sites grant research access (which restructuring impedes and delays); and response rates from heavily-loaded commissioning staff.

We propose to submit annual interim reports whose format would follow current SDO practice of combining a standard pro-forma with a free-text report. Contents of the latter would include: update of the policy and scientific contexts; any methodological developments; progress against timetable; stakeholder participation; and emerging findings. We would expect to hold further ad hoc discussions with SDO should additional unforeseen circumstances apparently necessitate substantial changes in the research proposed here.

8. Service users/public involvement

An important - indeed integral - part of this research is involvement of key...
stakeholders (NHS commissioning managers and the involved clinicians) from the outset. As preliminary findings emerge we will share and test them with stakeholders through, above all, an action learning set formed at the start of the project. The action learning set is intended to enhance our research questions, relevance of the findings and dissemination strategies by bringing together managers and researchers. Through action learning managers from different organisations facing different situations and challenges meet on a regular basis as 'comrades in adversity learning from and with each other through discriminating questioning, fresh experience and reflective insight' (Smith, 1997: 721). The strength of action learning is its simplicity; managers can address complex, seemingly intractable problems through personal and collaborative reflection within a learning set (Revans 1980). Action learning is thus uniquely adapted to develop mutual understanding between managers and researchers. (Action learning is not action research (Lewin 1946), a research design which we have not adopted.) We will invite two stakeholders from each of the NHS four study sites, one manager and one clinician per organisation, to join a set meeting three times a year during the project period. One of these meetings will be a 'mini-conference' at which contributors from TKK and Emilia Romagna health region describe their own commissioning practice and its relevance to healthcare. The sick fund representatives could offer 'expert outsider' insights to members of the action learning sets about the focus, processes and expected effects of their commissioning efforts. NC and AM will be the learning set facilitators.

We propose to involve other stakeholders through:

- South West Peninsula CLAHR includes representatives of NHS organisations in the region and aims to help NHS organisations identify research questions of value to them. It also includes an organisation (PenPIG) for consulting patients and public in research development. We will ask them to advise us how they would wish us to elaborate the above research questions and themes. (RS is a member of its Executive.)

- A virtual advisory group of key policy-makers (e.g. Stephen Dunn (EoE SHA), Richard Gleave (DH director of planning), Chris Ham (Kings Fund)), whom we will ask to comment on methods, emerging findings and dissemination.

- Consulting a similar virtual group of clinicians involved in commissioning.

The applicants include a commissioning lead (RB) for Plymouth PCT, who is also a GP and member of a commissioning consortium.

9. References


Disclaimer

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