



HEALTH REFORM EVALUATION PROGRAMME – NEWSLETTER NO 3

Autumn 2011

Welcome to the third newsletter of the Health Reform Evaluation Programme.

The Health Reform Evaluation Programme (HREP) aims to provide independent scientific evaluation of the impact of the NHS health reforms.

Evaluations are undertaken by researchers from a range of British universities and research centres. The programme is funded by the Department of Health Policy Research Programme.

It contains updates from the second and third wave studies. The previous newsletter focused on the findings of the first wave of studies, 2006-10. The second wave was commissioned specifically to cover developments to NHS commissioning including the move towards 'World Class Commissioning'. Two studies of commissioning commenced in September 2008 and are reported here.

The programme was then extended to a third wave of research, designed to evaluate the initiatives set out in *High Quality Care for All*, the Darzi review of 2008. These projects have focused on Care Planning, the CQUIN hospital quality payment framework, personal health budget pilots and cultural change in the NHS associated with the reforms.

More information on the Health Reform Evaluation programme can be found at <http://hrep.lshtm.ac.uk>.

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Evaluating PCT commissioning: identifying which commissioning processes produce successful outcomes

In 2006 the Department of Health (DH) set out a framework to strengthen commissioning in order to drive health reform, improve health, improve health care, and improve the financial health of the NHS. The DH identified a range of changes that commissioning, and practice-based commissioning, should deliver.

The aim of our research is to identify the key factors that lead to effective commissioning by studying the outcomes of commissioning initiatives, and the processes related to successful outcomes, for three conditions: diabetes, chronic obstructive pulmonary disease, and coronary heart disease; and one service: emergency and urgent care.

Methods

We are undertaking a controlled before and after study of commissioning initiatives in the 152 PCTs in England. This involved a telephone survey of commissioning managers in 2009 (survey A), and again in 2010 (survey

B), to describe any commissioned changes to care in each of the tracker conditions/services that had started in the previous financial year. We then ask about the processes of commissioning these initiatives (e.g who instigated the initiative, who was involved in developing and shaping the initiative, the extent of continuity of management of the initiative etc). We will then collate routinely available data on outcomes over the period 2004/5 – 2009/10 and study the change in these outcomes over time in PCTs with initiatives compared to those without, for each tracker condition/service. Outcome measures will include the rate of hospital admissions and disease-specific outcome measures (e.g HbA1C control for diabetes). Sources of outcomes data will include Hospital Episode Statistics (HES), and Quality and Outcomes Framework (QOF).

Progress to date

We have completed both surveys A and B. The response rate was 51% (77/152 PCTs) for survey A. For survey B a further 13 PCTs agreed to participate, increasing the response rate to 59%.

Overview of results of the 2009 survey (survey A)

PCTs had commissioned changes to care in the tracker diseases/services in 79% of interviews. The size of investment varied enormously between PCTs.

Initiatives or investments included £91,000 to improve access to diabetic eye screening and £900,000 to establish a community matron scheme to manage 'revolving door' patients with COPD.

The most commonly reported expected primary outcomes for these initiatives were a reduction in emergency hospital admissions (48% of initiatives), improved disease-specific health outcomes (44%) and increased access to care (22%). For the reduction in emergency hospital admissions, 77% of respondents expected to see the changes in outcomes immediately or within a year and 28% were able to quantify approximately the size of change in outcome anticipated. For improved disease-specific outcomes, the changes in primary outcomes were expected slightly later, with 52% reporting that changes would be expected immediately or within a year and 22% expecting to see changes after two years. For improved disease-specific health outcomes only four respondents could quantify the size of change expected in outcomes.

The initiative was instigated by the PCT in 51% of cases, by practice-based commissioners in 13% and by the provider in 5%. In a third of cases the initiative was instigated by a combination of all three.

Specialist clinicians and GPs who are usually involved in the PCT (e.g. on the PEC) were largely or fully involved in developing and shaping the initiative in two-thirds of initiatives, with practice based commissioners being largely or fully involved in 35%. This varied depending on the disease/service area. Local patients were largely or fully involved in just under a third of initiatives. We will measure the extent to which involvement of particular groups in the development of initiatives affected outcomes.

There was a wide variation in the processes used to develop and manage the initiatives. Most of these initiatives were reported to be based on research evidence of effectiveness but a fifth were not (Figure 2). This variation in processes will allow us to consider which processes are associated with outcomes.

Update of preliminary results from 2010 survey (survey B)

There were a total of 337 datapoints once surveys A and B were combined. PCTs had commissioned changes to care in the tracker diseases/services in 62% of interviews in survey B. In total, 86% of PCTs gave us details of initiatives that had been commissioned

between 2006/7-2009/10. Again, the size of investment varied considerably between PCTs, with a slight increase in the number of zero cost initiatives (i.e. reconfigurations) in 2009/10.

The primary and secondary outcomes reported in survey B were very similar to those reported in survey A, with no significant differences in any expected outcomes.

There were no significant differences in the processes of commissioning used, nor the people involved in developing and shaping the initiative, with only small increases in the proportion of initiatives where patients or specialist clinicians were involved in the development of the initiative. There was a decrease in the proportion of initiatives that were instigated by the PCT alone, with an increase in the joint commissioning across PCT/PBC/provider and other clinical networks.

Conclusions to date

The surveys have been successful at identifying variation in the size of investments and the processes of making those investments. Most of the initiatives were expected to achieve outcomes that we should be able to measure using routine data (e.g. reducing emergency hospital admissions).

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Implementation of the World Class Commissioning Competencies: A Survey and Case-study Evaluation

This project recently issued their final report and is available on the Health Reform Evaluation Programme website.

The World Class Commissioning (WCC) programme was introduced into the English NHS in 2007 to develop primary care trust (PCT) commissioning. Following the election of the Coalition Government in May 2011, WCC has been withdrawn as part of its package of changes to modernise the NHS in England. There has been limited evaluation of health commissioning initiatives over the years and in particular little is known about how commissioners interpret and implement initiatives and guidance intended to strengthen commissioning. This research explores the development and implementation of WCC and draws implications for future commissioning arrangements.

This research draws on interviews with key informants (n=6) and a literature review to analyse the aims of and stimulus for WCC. In-depth interviews (n=39) were conducted across three PCT sites in the North of England to analyse the interpretation and implementation of WCC.

Results indicate that the aims and rationale of WCC, in particular the specification of commissioning skills and the aspirations to improve health outcomes, were largely welcomed and supported by key informants and case study participants. However, the implementation of WCC was subject to a number of challenges, including: availability of resources and

knowledge, lack of supportive organisational culture and networks, and the dominance of central control.

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Care planning in the treatment of long term conditions

The Department of Health in England is committed to personalised care planning for patients with long term conditions. Care planning is an approach that involves a focus on shared decision-making and the production of a written plan.

The overarching aim of our project is to provide a comprehensive evaluation of the implementation and outcomes of care planning in the NHS. In this newsletter we report from one stream of this evaluation: an analysis of data from the General Practice Patient Survey on the prevalence and benefits of care planning among patients with long term conditions.

Results from secondary analysis of data on the implementation and impact of care planning

This part of the project analysed data from the 2009/2010 General Practice Patient Survey (a cross sectional survey of 5.5 million patients in England). Outcomes were patient reports of care planning discussions; and perceived benefit from care planning discussions and resultant care plans. Patient and practice variables were included in multilevel logistic regression to investigate predictors of each outcome.

Half the respondents (49%) reported a long-term condition and were eligible to answer the care planning questions. Of these, 84% reported having a care planning discussion during the last 12 months and most reported some benefit. Only 12% who reported a care planning discussion also reported being told they had a care plan. Patients who reported having a care plan were more likely to report benefits from care planning discussions. Several factors predicted the reporting of care planning and care plans of which the most

important was the patients' reports of the quality of interpersonal care.

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Learning about and learning from the implementation and impact of the Commissioning for Quality and Innovation (CQUIN) payment framework

Beginning in April 2009, hospitals and other NHS organisations providing care to NHS patients had to agree plans for achieving higher levels of quality with Primary Care Trusts, which pay for these services. A portion of this payment is conditional on achieving agreed quality goals. This initiative is called the Commissioning for Quality and Innovation payment framework (CQUIN). This study provides an evaluation of the CQUIN initiative during the early years of its introduction.

The study consists of 3 linked strands as follows:

1. Construction of a national picture of CQUIN schemes containing information regarding the content of all CQUIN schemes in England for 2010/11;
2. In-depth case study research in a number of SHAs following through the CQUIN process; and
3. Quantitative analyses testing whether changes over time, using measures of quality derived from national databases are related to the contents of the locally-agreed CQUIN schemes.

Findings to date

Quantitative findings

There was little evidence within stroke care that this choice of topic and the associated goals were closely associated with indications of particular quality problems. However, for maternity and VTE risk, inclusion in the content of local CQUIN schemes seemed to be better aligned with local quality issues. There was no evidence that the inclusion of stroke goals or a goal to reduce Caesarean section rates achieved their aims, but there was some weak evidence that inclusion of process and/or outcome improvement goals to reduce VTE risk may have led to a reduction in readmissions for VTE.

Qualitative findings

Generally there was support for the principle of rewarding quality improvement and agreement that CQUIN had been very successful in terms of focusing attention and action around the quality improvement agenda. However, commissioners tended to be more unequivocal in their support for CQUIN compared with providers. Whilst it may be difficult to argue with the principle of incentivising quality, when participants were asked about a hypothetical scenario in which CQUIN was abolished, providers expressed less regret than commissioners.

Participants were unanimous in their opinion that the increase in the percentage of income linked to CQUIN goals from 0.5% of contract income in Year 1 to 1.5% in Year 2 had been significant in terms of the impact on the process, with CQUIN receiving greater attention at all levels of the organisation as a result. Attitudes towards CQUIN appeared to be influenced by a number of factors. Many of these related to experiences of local implemented and the context of implementation relative to existing relationships between commissioners and providers.

The content of schemes was also important. It is not surprising that those indicators perceived as feasible and realistic by providers were more likely to receive their support. However, there were some differences of opinion with regard to feasibility. The tendency to include broader 'public health' goals such as delivery of smoking cessation advice was reported by providers to be problematic due to the failure of some staff to accept that such activities are a legitimate and necessary part of their role. Additionally, there were some goals which providers viewed as inappropriate (for example, goals to reduce staff sickness levels) since they were perceived as attempts to micromanage, rather than to commission high quality service. There was general agreement that a smaller number of goals were preferable, allowing providers to better focus

their efforts. Views differed as to what this number might be.

Interviewees reported that there had not been enough time to establish meaningful goals in the first year; particularly problematic was insufficient clarity of goal definitions and payment rules. Underperformance only came to light at year end, due to inadequate or non-existent in-year performance measures and monitoring processes. In most cases providers received full payment for Year 1, even where goals had not been achieved. Greater effort was expended on defining goals and agreeing to in year monitoring measures and processes for Year 2, although the research team's meeting observations may suggest that there are still problems related to this.

Some participants suggested that CQUIN was not an appropriate vehicle for incentivising innovation due to its link to performance within fixed timescales and measures and the constraints of non-recurrent funding. Efforts to tightly specify CQUIN goals and increase in-year performance measures were perceived by some as likely to exacerbate this problem. In many cases during Year 2, CQUIN schemes were not agreed prior to the contracting year. Observations and interviews suggest that many providers will not receive their total CQUIN payment for Year 2 due to underperformance on CQUIN goals.

The view that CQUIN was improving quality was a relatively common one and whilst many participants talked about this in general terms, many also gave concrete examples of quality improvements arising from CQUIN goals. In Year 2 the CQUIN guidance was amended to stop payment to acute providers for collecting data, with the emphasis placed on payment for improved performance. This has since been changed to allow CQUIN to reward data collection. Commissioners and providers welcomed this and many commissioners reported that they were incentivising data collection in 2010/11. (This is also evident from our national picture of CQUIN schemes). This was seen as a necessary first step to quality improvement in areas where baseline data were not routinely available.

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Evaluation of the Personal Health Budgets pilot

The potential of personal health budgets has been reinforced in the 2010 White Paper *Equity and Excellence – Liberating the NHS*. This White Paper outlined how the new initiative has the potential to improve outcomes, transform NHS culture by increasing choice and control among personal health budget holders and encourage the integration of health and social care services.

However, this new way of delivering health care represents a major cultural shift within the NHS, which needs to be fully evaluated to inform future decisions about the development of this policy.

Aims and objectives of the evaluation:

- Explore the process of implementing personal health budgets for patients and carers;
- Investigate the short and longer term impacts of personal health budgets on different groups of patients and carers (for example, changes in health and social care-related outcomes; changes in satisfaction);
- Investigate the impact of personal health budgets on professional workplace outcomes;
- Assess the cost-effectiveness of personal health budgets for different health conditions compared to conventional service delivery. In addition, to assess the costs and benefits of different models of personal health budgets and for different groups of patients, including age, ethnicity and socioeconomic status;
- Explore the short and longer term impact of personal health budgets on organisations, staff and the wider health and social care system (for example, in demand for services);
- Assess the wider impact of personal health budgets on the NHS, and NHS values (especially underpinning equity principles);
- Assess the long term effects in terms of using the information gained from the pilot programme to explore what might happen were personal health budgets to become the norm.

This evaluation uses mixed methods which include in-depth case studies of 20 pilot PCTs and a non-randomised controlled trial of personal health care

budgets (n=2000). In this newsletter we report on the early experiences of a small subsample of budget holders. In-depth interviews were undertaken with 58 people from 17 PCTs, around three months after the offer of a personal health budget.

Findings

Some interviewees had already experienced positive outcomes from their personal health budget. These included being able to access treatments, services or equipment not available through the NHS; having greater choice and control over when their care and support is provided; and being able to employ specialist staff. Many other interviewees anticipated similar benefits once their personal health budget was operational.

These outcomes were expected to lead to better health, improved morale and motivation, and enhanced social inclusion. Sometimes other family members were also expected to benefit, if their care responsibilities were reduced.

Personal health budgets could also bring indirect benefits, for example if assessment processes led to medication reviews or in-depth discussions of health problems with a health professional.

The characteristics of people offered personal health budgets varied widely. Some had very complex health conditions affecting all aspects of their daily lives; others had stable, well-managed health problems. These differences affected their experiences of the personal health budget.

Some interviewees had been offered personal health budgets in response to a specific unmet need; they sometimes had little interest in the wider aims of the pilot or in considering alternative uses for the budget. Others who were familiar with social care personal budgets were aware of the policy aims of increasing choice and control; they tended to use their budget to maintain an existing support package.

Information about how personal health budgets could be used was crucially important for prospective budget holders. People intending to use their budget for a specific unmet need were sometimes unaware that other uses were possible; others needed considerable encouragement to think how the budget might best be used.

Few interviewees knew how much their budget was before they began planning how to use it, or how the

level of the budget had been calculated. Many reported they had not been given a choice of how their budget would be managed.

The project is due to report in October 2012.

More interim findings can be found at

www.phbe.org.uk.

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Quality and safety in the NHS: an assessment of behavioural and cultural change

The focus on improving quality and safety in the NHS by engaging frontline staff in the implementation of solutions is intended to: make decision-making more local and accountable, encourage the use of local knowledge, create shared responsibility and a sense of ownership, and foster effective leadership from the frontline. Identifying how the “sharp end” and the “blunt end” of NHS organisations can work together optimally to achieve high quality care is an important goal.

The Quality and Safety in the NHS (QSN) Research Project seeks to identify sustainable, long-term strategies for retaining a focus on patient quality of care and safety in the health service. The study draws upon the perspectives of NHS staff, patients, and others connected to health care delivery to build on the objectives of the Darzi Report (2008) and coalition government NHS White Paper (2010) for a service that is locally led, clinically driven, patient-centred, and delivers value for money. This project will:

- identify lessons that will help ensure sustainability in quality and safety improvements;
- assess how staff practices can best be supported to facilitate such improvements;
- identify leadership processes that motivate staff engagement;
- explain how quality and safety improvement happens, how change can be accelerated, and how innovation can be facilitated based on practical lessons and solutions;
- access the views of patient and carer organisations to inform our understanding of quality and safety;
- and translate findings into terms that allow policy-makers to recognise those processes and

behaviours that facilitate (or hinder) the achievement of high quality care and patient safety.

There are six elements in the study as follows:

- Views of patient and carer organizations, using interviews, surveys and focus groups
- Pilot interviews with 10 lay representatives from patient and carer organisations across England, which are now complete.
- Views of 150 stakeholders across the NHS and beyond, using interviews.
- Staff across the whole of the NHS in England, using surveys.
- Trust board members are being recruited as part of the main team working assessment study process.
- Assessment of team working, using questionnaires in up to 1000 clinical teams across the NHS

Together, these strands will provide detailed case studies, using qualitative methods, to assess how the “blunt end” and the “sharp end” of organisations can best work together to improve quality and safety.

Preliminary analysis from our early data collection (subject to further verification) points to: opportunities and challenges in using routine data to drive quality improvement efforts; the importance of effective channels of communication between ‘sharp end’ and ‘blunt end’ staff; the importance of an emphasis on organisational learning, and a cautious, evaluative approach to innovation; and the need for sharing solutions across the NHS, but the importance of attending to context at the same time.

The key output from the project will be a final report, including integrated results from all the strands, due at the end of June 2012. We will identify practical actions that can help promote behaviours and cultures that support high quality care, and will provide real-time feedback to organisations involved in the research to enable practical learning.

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