Policy Research Unit in Health and Social Care Systems and Commissioning

Annual Research Review 2021-2022

About PRUComm

This review covers the work of the Policy Research Unit in Health and Social Care Systems and Commissioning during 2021 and 2022 - the research outlined here builds on our work from the past three years.

We have continued to build on our previous work on Sustainability and Transformation Partnerships (STPs), examine the development of Integrated Care Systems (ICSs), and research Primary Care Networks (PCNs) and community health services (CHS). We have also recently completed a further run of the GP Worklife Survey and continued our evaluation of changes to the Quality and Outcomes Framework (QOF) scheme.

Aspects of our work are now changing to meet the developing needs of the Department of Health and Social Care and the changes to the health and care systems following the *'Integration and Innovation: working together to improve health and social care for all'* White Paper and the recent Health and Care Act 2022.

Our core aim is to further develop our ongoing research programmes to include outcomes and social care system analysis. We aim to understand how contemporary approaches to system level co-ordination, health and social care commissioning, and integrated service delivery contribute to improving population health and wellbeing, as well as maximising system efficiency and ensuring system sustainability in the long-term.

Our key objectives are to:

- Develop a sustainable research unit that produces high-quality and policy-relevant evidence on health and social care systems and commissioning.
- Provide core expertise and a research resource on health and social care systems and commissioning for policymakers, analysts, and others in the DHSC, Arms' Length Bodies (ALBs) and Regulatory agencies.
- Support capacity building and develop new methodological approaches to systems and commissioning research.
- Undertake rapid response research to meet the needs of policymakers and respond to requests for advice and support.
- Work with national and international collaborators to provide a unique repository of knowledge and evidence on health and social care systems and commissioning, and contribute to the growing international literature in this area.
- Undertake knowledge mobilisation with a wide policy, practitioner, public and academic audience.
- Use the core resource provided by the unit as a platform upon which to bid for additional funding for related research, maximising the return on DHSC investment by leveraging additional funding.

We continue to work closely with policy and analyst colleagues in the Department. Over the last year we also undertook a number of very successful webinars for the Department on aspects of our research, reaching over 100 staff members in the Department and other national NHS organisations.

We also continue to publish reports and papers on the PRUComm website, publish in high-quality academic journals, and undertake other related research and impact activities which add value to the commissioned work we undertake for DHSC, NHS England and other national organisations.

Professor Stephen Peckham
Director

The Quality and Outcomes Framework

NHS England has implemented financial reward to general practices for quality improvement activity (QI) since 2019 as part the Quality and Outcomes Framework (QOF) - the English general practice pay-for-performance scheme introduced in 2004 that provides on average 8-10% of practice income. Until 2019, QOF solely rewarded achievement of specific clinical activities or clinical outcomes. Rewarding QI activity is a novel approach aiming to counter some of the unintended effects of QOF.

PRUComm was asked to evaluate this as part of its responsive work programme. Our preliminary evaluation in 2019/20 suggested that practices felt favourably towards financial incentivisation of QI but recognised that greater practice involvement in choice of topic may make it more effective, and highlighted the potential for unintended effects on quality in other areas (1).

The study had to be paused during the COVID-19 pandemic because QOF income was guaranteed to practices, i.e. not dependent on completion of incentivised activities. Work restarted in July 2022 and is due to be completed in March 2023.

The next steps include a literature review, a quantitative survey of general practices, a qualitative interview study of general practice staff and GPs, and a stakeholder workshop with primary care professionals and members of the public.

We will synthesise the findings to:

- Articulate the theory by which financial incentivisation might promote QI and ultimately improve quality of care
- Identify outcomes that could be used to assess value of QI in the QOF
- Identify where support to practices could be improved for QI in the QOF
- Identify how the programme might better meet its objectives

Primary Care Network formation and operation

Primary Care Networks (PCNs) are a mechanism for enhancing co-ordination through collaborative action between GP members and other providers, at Neighbourhood level. They are intended to provide the building blocks of the new integrated NHS.

Collaboration between groups of GP practices is orchestrated through an add-on contract which GPs hold with NHS England to provide services, and involvement is associated with a range of financial incentives, including resources for the employment of certain additional staff.

PRUComm is now in the final stages of this three-year mixed-methods project.

Our work so far has highlighted:

- The multiple policy objectives associated with the PCN policy and the variable extent to which policy mechanisms might facilitate achieving these (2)
- The crucial, and highly variable, role that local commissioners and inter-organisational entities, such as GP Federations, played in supporting PCN operation (3,4)

- The importance of managerial resource and support (3)
- The broad variability of PCN size and constitution, and the extent of geographical overlap of PCN footprints (5)
- The extent to which local history and pre-existing collaborative relationships play a role in shaping network dynamics (3)

Separate from, but related to the project, we have also looked closely at the various funding streams and the implications of these arrangements for addressing health inequities (6).

We have now concluded data collection, including in-depth qualitative case study work with seven varied PCNs in different parts of England. We modified our approach and focus because of COVID-19 to ensure that we were able to capture insights into the role of PCNs in responding to the pandemic, and the consequences of this period for network collaboration (7).

The final report will comprehensively address the following questions:

1. What kind of networks are PCNs, and what are the policy goals associated with them?
2. How have PCNs been established, and what factors have supported or hindered them in their early development?
3. What can we learn from the operation of PCNs about the important building blocks of successful collaboration, and how does this vary across the different policy goals?
4. What outcomes and outputs can be identified as being associated with PCNs, and what factors might influence these?

The National GP Worklife Survey

The National General Practitioner Worklife Survey has been conducted approximately every two years since 1998. The survey explores GPs' experiences of their working lives, including sources of stress and their job satisfaction. In 2021/22 PRUComm carried out the eleventh survey in the series (8). Completed surveys (both online and by post) were received from 2,284 GPs.

The mean level of overall satisfaction decreased significantly from 4.49 to 4.30 (on a scale from 1-7, 1 very dissatisfied, 7 – very satisfied) between 2019 and 2021. Overall satisfaction has now reduced to a level similar to 2015. Respondents reported greatest satisfaction with their fellow workers, and with their physical working conditions, and least satisfaction with their hours of work, with only 37.9% reporting satisfaction with their hours of work and 46.7% reporting dissatisfaction.

There was a statistically significant decrease in the average number of hours worked by GPs from 2019 to 2021 of 1.6 hours (p=0.013) from 40 to 38.4 hours. This is the second survey in a row where we have seen substantial decreases in average hours worked from the previous survey. This is notable because little survey-to-survey variation in average hours worked by respondents was observed from 2008 to 2017. However, it must be noted that average hours still amount to more than a usual full time working week in most industries, despite many GPs describing themselves as working 'part time'.

GPs reported the greatest stress due to increasing workloads, increased demands from patients, having insufficient time to do the job justice, paperwork (including electronic), long

working hours and dealing with problem patients. They reported the least stress with finding a locum, doing patient forms (e.g. Fit Notes, Blue Badges), and interruptions by emergency calls during surgery consultations. More than eight out of 10 GPs reported experiencing considerable or high pressure from increasing workloads and increased demands from patients.

Most worryingly, over a third (33.4%) of GPs said there was a considerable or high likelihood of them leaving 'direct patient care' within 5 years. Amongst those aged 50 or over this figure was 60.5%, with the vast majority of these (47.1%) indicated that the likelihood was high. The corresponding figure was considerably lower for GPs under 50 at 15.5%, with 43.2% of these GPs stating there was no chance of them leaving within the next five years.

This survey provides the most comprehensive longitudinal study of GPs' experiences of their working lives. Current pressure on primary care is very high and increasing. The findings from our survey provide insights which may help in designing policies and programmes to support GP recruitment and retention, and will support policy makers as they consider what is needed to relieve the pressure on practices.

The impact of community health services on hospital use

This strand of work investigates aspects of community health services (CHS) and the links between care in the community and the effect on secondary care. We utilise newly published datasets from NHS digital, where a process of careful data scrutiny is required before the analysis stage. Several reports were produced for the Department of Health and Social care regarding the new data, focusing on contents, limitations and suggestions for improvement.

Objectives:

- Investigate the availability and properties of data on community activity.
- Estimate population-level links between activity and costs in the community and hospitals.
- Undertake economic analyses of community service expansions for specific populations and needs.
- Investigate the effect of the COVID-19 pandemic on community care referrals.

We initially tested the association of care from CHS and hospital services and calculated the net costs of each community activity. We found that CHS services were weak substitutes for hospital services. However, the substitution was insufficient to yield cost reductions in the health care service. We did note that the analysis only accounted for short-term relationships and that in the long term, the presence of CHS within the community may be related to unmet needs, which may reduce system-level costs in the long term. Data within the CHS focussing on activity (contacts) were provided on the aggregated level, where it was impossible to investigate the relationship between different types of CHS, meaning it was impossible with the publicly available data to investigate the relationship of CHS on patients with specific conditions such as mental health services.

An additional work package investigated the effect of the COVID-19 pandemic on community care referrals. The impact of the COVID-19 pandemic on GP appointments and hospital services has been well documented. The volume of health care contacts for GP and hospital services decreased after the first UK lockdown measures for COVID-19 were introduced in March 2020. GP and hospital services were the main avenues for community care referrals for patients, and the impact of the COVID-19 pandemic on CHS should have decreased. This research focused on measuring the amount of CHS referrals dropped, which regions saw the most and least reductions, and how the different areas have or have not recovered.

The unmet needs of older people and the role of community health services

CHS play a critical role in the more comprehensive health and care system and ensuring that older people are well and healthy in communities. These services aim to provide holistic care (including preventative care) as close to home as possible to encourage independence and maximise the quality of life. However, estimates of demand and unmet care needs are minimal, there is little consensus on their definitions and scope, and their scale and distribution are not yet available. This makes ensuring appropriate funding and design of the service very challenging. It also means that if these needs remain unmet in the community, this places burdens elsewhere on the healthcare system, for example, through increased hospital admissions.

This project aims to provide a greater conceptual understanding of what constitutes unmet needs among older people and how they can be measured, to estimate the levels of unmet needs among older people (65+) and the general population profile of this demand, and finally to investigate the relationship between the levels of unmet needs and CHS.

The project adopts a mixed-methodology design, involving:

a. Conceptual/theoretical work to define unmet needs through ongoing national and international research in the area of unmet needs and the role of CHS in meeting such demand, and scoping of indicators and metrics used to measure unmet care needs;

b. Quantitative analysis to create and investigate the measures of unmet care needs and their profile using existing national, individual and survey data (CHS activities data, GPPS, ELSA), and then explore the relationship between unmet care needs and community health services.

In this project, we reviewed the definitions and measures of unmet needs and identified available data sources to provide this information. We produced two analyses - a scoping review of conceptual literature, and a review of measures using existing data (9).

Very few studies explicitly defined unmet needs, stressing the importance of researching this topic and contributing to its foundations. Most reported unmet needs were focused on and defined by Activities of Daily Living, both in conceptual investigations and in quantitative research to date. These insights were used to create measures

of unmet care needs based on GPPS and ELSA datasets at an aggregate level.

We also compared the results from these two datasets, revealing a mix of similarities and differences. The results showed that about 29% of the respondents from both datasets responded that they *Don't require care.* However, the proportion of respondents with unmet care needs varied (37% in GPPS data against 52% in ELSA data). Within this group, the proportion of respondents who reported their *Needs not met*, was 13% in the GPPS data and 42% in the ELSA data. The distribution of long-term conditions and the spread across regions in the UK were similar in both datasets. The differences in surveys' objectives could explain these results, questions asked, and their order, stressing the importance of context in interpreting results.

We also investigated the impact of COVID-19 on CHS activities and its contribution to the accumulation of unmet care needs. Further work on this project involves a more detailed analysis of unmet care needs using GPPS individual-level data and exploring the association between the current measures of unmet care needs (obtained from ELSA data) and CHS activities.

The DHSC has identified that unmet need/demand is a significant issue for CHS and the need for more comprehensive research to provide the level of detail necessary to make policy decisions. This work will inform the design of policy/strategy at a national level that enables CHS to effectively meet current and future demand.

Integrated Care Systems

The publication of our final report (10) marks the completion of a two-year study of the development of Integrated Care Systems (ICSs). The aim of our research was to investigate the development of ICSs in order to find out how effective these new forms of collaboration are in achieving their goals, and what factors influence this.

The research investigated:

- How ICSs were developing locally
- The way system partners were reconciling organisational and system roles
- How collaborations and providers could be held to account
- The way local priorities were being reconciled with system priorities
- Whether ICSs are able to allocate resources more efficiently across sectoral boundaries and bring their local health economies into financial balance

The research was conducted in two phases and used qualitative methods with a small quantitative component. Primarily, we used a case study research design, consisting of three in-depth case studies, each consisting of a system and its partners. The first phase of fieldwork was undertaken between December 2019 and March 2020 and focused on studying ICSs (and their predecessor Sustainability and Transformation Partnerships). Fieldwork was interrupted in March 2020 by the COVID-19 pandemic. The second phase of fieldwork took place between January 2021 and September 2021 and focused on a more detailed examination of one place within each of our case studies.

Our research suggests that the move to a more collaborative ethos has been welcomed, and system partners widely support the development of system working, and the opportunities for improved planning and provision of services which they believed system working offers. Local actors felt that collaboration in systems led to improvements to service planning and delivery in ways that did not occur previously.

However, our findings also suggest that there are a number of key themes which need to be considered in relation to the capacity of systems to achieve their aims, including bringing their local health economies into financial balance. These are: the ongoing influence of competition; the importance of context; clarity of governance arrangements; limits of the consensual model of decision making; the development of accountability; and management of conflicts of interest.

Following publication of the report, we are now embarking on further research to investigate how the developing forms of statutory and non-statutory collaboration in ICSs, together with the existing landscape of statutory organisations and forums, interact to support the achievement of system goals.

Reports & Publications

(1) Bramwell D, Hotham S, Peckham S, et al. **Evaluation of the introduction of QOF quality improvement modules in English general practice: early findings from a rapid, qualitative exploration of implementation**. BMJ Open Quality 2022.

(2) Checkland, K., Hammond, J., Warwick-Giles, L., Bailey, S., **Exploring the multiple policy objectives for primary care networks: a qualitative interview study with national policy stakeholders.** BMJ Open 10, 2020.

(3) Checkland, K., Hammond, J., Morciano, M., Warwick-Giles, L., Lau, Y.-S., Bailey, S., Sutton, M., **Primary Care Networks: exploring primary care commissioning, contracting, and provision - Interim report.** PRUComm, 2022.

(4) Warwick-Giles, L., Hammond, J., Bailey, S., Checkland, K., **Exploring commissioners' understandings of early Primary Care Network development: qualitative interview study**. British Journal of General Practice, 2021.

(5) Morciano, M., Checkland, K., Hammond, J., Lau, Y.-S., Sutton, M., 2020. **Variability in size and characteristics of primary care networks in England: observational study.** British Journal of General Practice, 2020.

(6) Hutchinson, J., Hammond, J., Sutton, M., Checkland, K., **Equity and the funding of Primary Care Networks**. British Journal of General Practice, 2021.

(7) Warwick-Giles L, Hammond J, Checkland K **Telephone survey two - short report: PCNs and COVID-19** PRUComm 2021.

(8) Odebiyi B., Walker B., Gibson J., Sutton M., Sharon Spooner S., Checkland K. **Eleventh National GP Worklife Survey.** PRUComm 2021.

(9) Malisauskaite G, Yiu-Shing Lau, Brookes N, Hussein S, Sutton M **Measuring unmet health and care needs among older people using existing data** PRUComm 2021.

(10) Sanderson M, Allen P, Osipovic D, Petsoulas C, Lau Y, Boiko O, Lorne C, Sutton M. **The Developing Architecture of System Management: Integrated Care Systems and Sustainability and Transformation Partnerships.** PRUComm, 2022.

(11) Hammond J, Checkland K November 2021: **Health and Care Bill 2021 briefing - General Practice commissioning** PRUComm 2021

(12) Sanderson M, Osipovic D, Checkland K, Petsoulas C, Allen P. **Research note exploring the potential role of provider collaboratives** PRUComm 2021.

(13) Allen P, Sanderson M, Osipovic D, Petsoulas C. **Health and Care Bill commentaries** PRUComm 2021.

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