Shifting the Balance of Power: rhetoric or reality in healthcare commissioning?

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Introduction

In healthcare the availability of resources – money, time, or human capacity – are often insufficient to meet all claims (wants and needs) on them. In this respect resources are considered scarce and must be managed. Given this, healthcare systems have to make decisions about what services to provide, where, and for whom. In England, health service reforms set out in 2001 sought to shift the balance of power for making such decisions toward the 'local' level (DoH, 2001). Resources were devolved to the newly created primary care trusts/organisations (PCT/Os) who became responsible, as the "lead organisation", for commissioning – assessing health needs; planning and securing health services; and improving health, within the framework of National Health Service standards and guidance.

In practice this meant consulting with healthcare providers; users; and the general population, cooperating with Strategic Health Authorities (SHAs) and the local authorities, managing and regulating all primary care services; and remaining accountable to the Secretary of State (through the SHA). (DoH, 2001) Above all PCTs were required "… in respect of each financial year, to perform its functions so as to secure that the expenditure of the trust which is attributable to the performance by which the trust of its functions in that year does not exceed [its income]" (the National Health Service Act, 1999).

However, there is evidence, at least anecdotally, that PCTs have been unable take control of commissioning (Ham, 2006; Harding, 2006; Maynard and Street, 2006). Mounting financial deficits in particular have been cited as evidence of a lack of successful commissioning – the 'blame' for which has been passed between the managers who are deemed to be ineffectual, and the government, who 'interfere' and whose policies 'hinder'. (Donnelly, 2006; Health Service Journal Panel, 2006; National Audit Office and the Audit Commission, 2006; White, 2006)

This paper attempts to examine whether there has been a shift in the balance of power within PCT commissioning. Using an empirical analysis of interview data, the paper focuses on trying to understand how commissioning is undertaken and organised at the local level. The paper provides a descriptive and critical thematic analysis of commissioning and discusses the challenges these themes raised for commissioning at

the local level. The paper concludes by suggesting that commissioning at the local level requires strengthening local commissioning structures and processes which account explicitly for the decision-making context.

Methods

In-depth interviews were conducted in six PCTs within one specific strategic health authority. The interview schedule used was based on work previously carried out in the UK and recent work conducted in Canada (Mitton and Patten, 2004). The interview schedule was revised throughout the course of conducting the interviews to incorporate new concepts as new themes emerged. The ordering of questions varied and they were never delivered verbatim. In this way, the schedule was used to guide the interview in an informal but purposeful way. (Mason, 2002) The last updated version of the interview schedule is reproduced in Appendix 1. The interviews used semi-structured and free-text questions to explore: definitions of commissioning, how commissioning was undertaken, the strengths and weaknesses in commissioning, and ways commissioning could be improved.

Sample

The interviews were conducted with key decision-makers from each PCO (n=6) within Northumberland Tyne and Wear Strategic Health Authority (SHA) as well as members of the SHA management team (22 individuals in total). These were all conducted at the interviewees' place of work and took approximately 1½ hours to complete. The interviews were audio-taped and transcribed verbatim with the participants consent.

Analysis

The transcripts formed the formal data for analysis. A constant comparative approach was used to identify broad themes and sub-themes. (Strauss and Corbin, 1990) This was facilitated using NVivo software (QSR NVivo, 2002) to manage the data set.

Analysis of the interviews sought to firstly, describe the ways that commissioning was understood and undertaken within the PCTs, and secondly, explore the challenges raised for the PCT in relation to commissioning. The broad themes that emerged from analysis of the interview accounts were used to provide both a descriptive and critical overview of local decision-making. These outline commissioning in terms of how interviewees

describe; relate to; and reflect on, commissioning concepts; context; structures; and methods.

Theme 1: concepts

The interviews explored concepts around commissioning by asking participants to define commissioning as well as priority setting and resource allocation. Analysis of the accounts revealed little consistency between definitions which was particularly noticeable by the interchangeable use of terminology both within and across interview accounts.

However, there was some consistency in the way interviewees referred to how these concepts related to one another. Essentially, two different views were identified. These have been interpreted as the discrete view and the holistic view. The discrete view refers to the concepts of commissioning, priority setting and resource allocation as distinct decision-making processes that can be delineated by the inputs and skills and organisations required in undertaking each process. For example, commissioning was sometimes reduced to simply refer to the contracting process, requiring negotiation skills, and undertaken by a commissioning manager within the PCT. The holistic view does not distinguish between these concepts in the same way – instead they are all part of one overarching decision-making process that cannot be assigned to any one role or level of the organisation. Furthermore, although these two views of commissioning seem to be very different, common to both was the notion that all the decisions made in commissioning (whether discrete or holistic) were constrained.

- **commissioning as constrained decision-making**

The constraint implied in 'constrained' decision making is that of resources. References to resources in the interview accounts tended to focus financial or monetary resources though some included human capacity and time. Resources were described as being constrained due to the fact that the initial budget allocation received by the PCT was finite. The extract below was typical:

> **"… the health budget is very clearly defined and comes as a cash limited sum with some elements of growth added on an annual basis." (PCO 9)**

Consequently, interviewees recognised there were not enough resources to fulfil all the competing demands, needs and wants (generically – claims) placed upon the PCT:

> **"The trouble is … there's not enough money to go around." (PCO 12)**

> **"… ultimately it comes back to the fact that there just isn't enough money around to do everything that we like to do. … we're almost in a situation where we can't square the circle and there isn't a balance between local need and the resource that's available." (PCO 25)**

All explicitly recognised that claims on resources were competing and not all claims could necessarily be met. Decisions therefore had to made about *what* or *who* to allocate resources to (and, implicit in this, is the decision about what to not to allocate resources to), *how* to allocate the resources, and *when*. This is reflected in the extract below.

> **"it is very much about taking responsibility for a defined population and taking an allocated amount of resources for their share in the NHS for that population and securing better health and better NHS services for that population using those resources." (PCO 29)**

These decisions were underpinned by three common principles identified throughout the interview accounts. These principles are summarised in bold and are reflected through the interview extracts that follow each in turn. First, ***claims had to be compared or judged against one another or against a set of common of objectives***.

> **"Priority setting is essentially I think about trying to… trying to assess the relative value of competing demands for resources for investment…" (PCO 17)**

> **"… we'd have to look at our framework and our objectives and look at what the PCT can afford, so we'd have to judge those priorities and how we do that in purist sense." (PCO 30)**

Second, ***claims had to be 'balanced' in order to meet a set of common objectives***. These included clinical objectives (i.e. the clinical benefits and risks associated with the choices), economic objectives (the need to achieve financial balance), political objectives (satisfying directives from central government or the demands of the local public and patients), and social objectives (addressing equity issues inherent in the NHS such as maintaining equal access for equal need).

> **"…it does feel like you're spinning a lot of plates in the air at the same time. You've got influences coming from all over the place, whether they are economic, whether they're social, whether, you know, they are to do with political influence…" (PCO 1)**

"… it's about balancing various bits of the jigsaw." (PCO 6)

Third, decisions had to be made in such a way as to maintain financial balance. Additionally, some interviewees recognised that maintaining financial balance alone was not desirable per se, but that it was also important to strive to get the most out of the money available. Therefore ***claims had to achieve value for money***. Indeed some positioned this in terms of suggesting that the PCT had a sense of duty both towards the tax payer (as the primary funder of health care) and the geographical population which the PCT served (as the end user of the health service) to do this.

"At the end of the say we have $350m of taxpayers money which I am charged, as accountable officer, for using wisely i.e. not only using properly … but also, for the decisions that we actually make, say 'are we making the biggest amount of impact for the money we get'?" (PCO 5)

"…we do take it very seriously that we are spending public money so we want to spend it to make the best possible use of it. We have a duty to do that to people." (PCO 8)

Theme 2: context

The context in which decisions are made was a prominent and recurrent theme within the interview accounts. Interviewees were keen to reiterate what can be described as the contextual constraints within which choices and decisions had to be made. These were: continual organisational and system change (and resulting instability); resource scarcity; and a restricted focus on new healthcare resources.

- **change as the only constant**

As one participant noted in the extract below, change is constant within the health service.

"…the only constant thing in all that we do is change." (PCO 6)

However this observation was not confined to one interviewee but was recognised by all as ongoing and integral to 'life' in the PCT – whether through reorganisation of structures and roles or changes in Government and, therefore policies. It was also pointed out by all that constant change results in a certain degree of instability for organisations and individuals who spend most of their time learning about forthcoming

changes, reacting to them, or recovering from them. Some referred to the impact that this had on both the organisation (in terms of performance) and the employees (in terms of job security). As can be seen in the following extract it was difficult to separate the two.

> **"...how firm is your position, whatever that happens to be from time to time – dying presently." (PCO 11)**

- **the battle for resources**

As well as indicating that resources were constrained, interviewees also implied that resources were scarce. Scarcity was described with reference to the level of resources that were available for making choices over. All respondents referred to the lack of resources which were frequently depicted as having to be 'fought over'. Some even suggested that monetary resources were so scarce that the PCT was in financial deficit. These points are illustrated in the following extracts.

> **"… by the time you've dealt with some of the main blocks of planning for the next year you're very often left with relatively small amounts of money to fight over …" (PCO 29)**

> **"… we are so far out in terms of whether we're going to hit the end of the financial year and thereby starting a deficit next year. That's the constraint within which we work." (PCO 10)**

Reasons for resource scarcity were attributed to inherent and historic deficits and funding pressures that were perceived to be unavoidable and that consequently 'absorbed' the majority of resources. Examples included: the increasing prescribing budget, changing population and demographics, increasing staff budgets, inflation and uplift, funding of capital plans, and funding the demands of the acute hospital sector.

- **fixation with the margin**

As noted above, the reasoning put forward by interviewees to explain resource scarcity imply that the majority of resources are already 'tied-up'. Analysis of the interview accounts suggests that the use of these resources is often not the focus of commissioning and the use of these resources is rarely questioned. Rather PCT commissioning has tended to focus solely on any additional (often referred to as marginal) new resources. The following extract highlights, what one interviewee refers to as, this fixation.

> **"there's a tendency to simply look at the marginal new money rather than the totality of the resource … recognising that at the moment we're dealing with a fixation of the marginal new monies." (PCO 24)**

Theme 3: structures

A number of structures were identified in the interview accounts. In the analysis, focus on structures was restricted to what have been described here as the formal structures and semi-formal structures that function within the boundaries of the PCT.

The formal structures were essentially those that are recognisable as being the accountable and responsible decision-making organisations or bodies. Within the interview accounts there were clearly two identifiable formal structures – the PCT board and the professional executive committee (PEC):

> **"… the decision-making process within the Trust … involves primarily working with my sort of fellow directors through the Executive Team, the Professional Executive Committee, and the Board." (PCO 7)**

The PCT board, (as suggested in the extract above) consisted of both executive and non-executive members. The PEC was primarily made up of key people driving the clinical agenda – largely primary care clinicians and primary care health professionals, as well as, in many cases, members of the PCT executive board.

Semi-formal structures were essentially multi-agency stakeholder groups. They were therefore not accountable structures but the work from these groups fed into the formal structures through the PEC and board. Their exact constituency and remit tended to vary between PCTs, and indeed over time, but they were generally labelled as health improvement groups (abbreviated to either HIGs or HIMPs); care streams; modernisation groups; or planning groups, that focused on specific disease areas; client groups; or policies. On the whole, the groups were managed and supported through the PCT but also included representatives from provider agencies (both managers and clinicians); primary care practitioners; the local authority (where relevant); voluntary groups; and service users. The existence of these different groups is illustrated in following extract:

> **"we've got, you know, joint meetings between different primary care organisations, we've got decision-making bodies between ourselves and**

our acute providers through what's called the modernisation board, care streams, a range of different mechanisms." (PCO 10)

Interviewees also referred to other semi-formal structures that were specific to particular PCTs. These were primary care practitioner forums and patient/public participation groups. GP forums were organised on a locality basis and contributions from these groups were fed through their local management committees into the PCT PEC. Public participation and public consultation groups tended to be formed by PCTs on a more ad-hoc basis.

Structures were often referred to in terms of their roles within commissioning. The roles of formal and semi-formal structures were distinct and could be split into three main functions – identifying and doing the 'legwork' or background work that feeds into commissioning decisions; validating or 'sounding out' commissioning decisions; and endorsing decisions.

- **structures as providing the legwork for commissioning**

An important role identified throughout the interviewees was that of supporting commissioning decisions, in particular from the 'bottom-up'. Interestingly, the structures that were primarily associated with fulfilling this role were the semi-formal structures referred to above. Specifically, the stakeholder groups were referred to as doing the "legwork" (as the extract below demonstrates) and working out the finer 'detail' for commissioning decisions.

"So we have a planning system underpinning the Board and the Professional Executive Group for all of the major clinical priority areas and other area involved in the NHS Plan. …and those planning groups do all the legwork …" (PCO 1)

Additionally, the other semi-formal structures such as GP forums met on a locality basis to identify as part of a broader agenda, local level decisions and service gaps that would form the basis for commissioning.

- **structures as providing a sounding board for commissioning**

An important role of structures identified through the interviews that was fulfilled by several structures was to provide a forum whereby commissioning decisions could be

considered and debated prior to making any recommendations. These structures were predominantly used to validate (i.e. 'sound out') decisions with clinical colleagues and also provide the opportunity for clinicians to voice their opinion and put forward their perspective. The extract below was a typical reference to the role of PECs:

> **"The role of the PEC quite clearly is to be a place where clinicians and health professionals voices can be heard and can take part in decision-making" (PCO 8)**

However, few structures seemed to exist that facilitated consultation with the general public in the same way.

- **structures as providing the veneer for commissioning**

The function of endorsing commissioning decisions was attributed solely to one structure – the board. The role of the board was often referred to as providing a 'final hoop' through which decisions would have to pass through before being 'signed-off'. This role was recognised by interviewees (both board member and non-board members) once removed from the 'day-to-day', 'nitty-gritty' commissioning work and therefore, was often described as simply providing the veneer for the commissioning decisions made elsewhere within the organisation. This is illustrated in the following extracts:

> **"… these things are very much part of the bread and butter of the executive team and effectively the staff. And that's not really the role of either me or other non executives to get involved in the day-to-day nitty gritty." (PCO 25)**

> **"… we'll report to the board about whether we think whats been agreed, what the financial impact is of that on financial balance, and all that. But the board isn't going to truly get into the details I think. I think that's a veneer I think." (PCO 11)**

In terms of fulfilling the roles described above, interviewees highlighted a number of problems that related to individuals' ability to do this. In particular interviewees made reference to the lack of expertise, capacity, and support for commissioning in PCTs. The focus of former of these was on the deficiency of analytic and critical appraisal skills specifically. Interestingly this was often countered by the view that this expertise could however be found in the secondary care (acute) trusts. These points are illustrated using the following extracts:

> **"… there's not enough people with information handling and analytical skills within the NHS – I think they are in short supply and we need to find ways of accessing that sort of expertise." (PCO 17)**

> **"if there is any expertise it's largely in provider organisations. So the people you're actually commissioning from hold all the aces if you're not careful" (PCO 5)**

In terms of capacity, reference was made not only to the limited number of individuals who posses the expertise, but also the time that those people could spend on commissioning (the first two extracts below are typical examples). Claims that the remit of PCT had expanded and continued to do so imply that the amount of time and level of detail devoted to commissioning was restricted (see final extract below).

> **"Capacity I think is an issue in terms of people's time and ability to engage in some of the processes." (PCO 7)**

> **"I do not think that we have yet got to the point where we can put enough managerial time and effort into pure commissioning to enable us to get right behind what those processes are. … to do it properly soaks up huge amounts of time." (PCO 22)**

> **"so you go back to the fact that as a new organisation PCTs have capacity problems in taking on all the workload, because we have, if you think about it, had quite a lot to cope with … and certainly from my perspective I haven't got anymore staff, you know they all wear several hats, and despite the best planning you could do, we are finding it difficult to deliver on some of the timescales…" (PCO 19)**

In relation to support, interviewees tended to discuss two aspects of support – material support and reassurance or back-up. With respect to the material, interviewees made reference to not having access to information tools and methods that they perceived necessary for commissioning. This is clearly demonstrated in this extract:

> **"…there is no information system in the PCTs [name] which allows them to suck in the activity and other information from provider organisations, or their performance indicators, and link them into the plans or work force stuff and be able to manipulate them. Now in this day and age again that is not rocket science." (PCO 5)**

As for reassurance or back-up, interviewees suggested that this was distinctly lacking both locally and nationally in commissioning. Examples given referred to a lack of

support in undertaking commissioning and a lack of support for the resulting decisions. These are illustrated respectively using the following extracts:

> **"Other SHAs in other parts of the country take a different view and are extremely supportive of primary care organisations developing their own roles and things of that sort. We've got no such support … they would probably dispute this, but from my perspective we've got not such support from this SHA at all." (PCO 12)**

> **"As a local population, as a local health economy, to make a decision that we're not actually going to invest in hospital services is not something probably I would suspect I would be able to get our local MPs to agree with." (PCO 18)**

Theme 4: methods

A substantial proportion of the interviews focussed trying to identify methods used for commissioning. The interview accounts revealed that there was no prescribed method for commissioning and consequently no single method was identified as being used. Rather, commissioning appeared to be driven by several methods, or more accurately, processes, of which elements of each were used within all of the PCTs. Those identified are used to describe commissioning as either evidence based, political, backroom, clinical or historical.

- **evidence based commissioning**

Evidence based is used here as a generic term to denote the use of data, and/or information (as described in the interview accounts) in commissioning. In terms of data, interviewees referred to epidemiological data - measures of disease incidence, prevalence, morbidity, and mortality; secondary care data - hospital activity data, length of stay (LoS), mortality rates etc; and primary care data - consultation rates, referral rates, prescribing behaviour etc. Data were collated and supplied by a local 'information service' which served more than one PCT. Evidence and information tended to be such things as the analysis of primary data (e.g. needs assessment; clinical effectiveness and cost-effectiveness analysis, impact analysis, analysis of trends – in mortality, activity, service delivery and demand); national health related documentation (e.g. the NHS plan, NSFs, and NICE guidance); local health documentation and reports (e.g. PCT public health annual report, public health observatory reports); and local authority documentation (e.g. social services, housing and education). Additionally, there was also reference to what can be described as tacit or experiential evidence such as professional expert, or user/carer

opinion. There was little mention of the use of 'research' or the outputs of research, academic or otherwise. The extract below summarises the above:

> **"obviously there's more detailed analysis within each of the care streams because you rely on them to do that detailed work, both on historical spend and trends; previous investments; needs assessments; NICE guidelines; national targets; what users and carers bring to the fore as their priorities; what the professionals and trusts themselves are bringing together, so it's a real mix. But we try and make it as evidence based as we can…" (PCO 9)**

Descriptions of evidence in the interview accounts revealed that evidence, as applied to commissioning, was essentially utilised in three different ways. First, evidence was used prospectively to predict or identify 'problem' areas mainly through highlighting needs and any gaps in the provision of resources to meet those needs. Second evidence was applied, again prospectively, to address problem areas by aiding choices such as deciding the appropriate care pathway, provision of services or drugs. Third, evidence was used retrospectively to support or defend a particular view point or way of currently doing things. The first two of these are illustrated using the following extracts:

> **"… in trying to identify needs and service gaps etc. They will be using a lot, you know, the core statutory collected information whether that is hospital activity data, morbidity and mortality data, or anything that the public health department normally provides…" (PCO 1)**

> **"… the PEC developed a series of statements around decision-making that would inform it decisions. …it's a list which has things on like: is this value for money, is it good clinical practice, does it fit with national priorities, has it been tested out with users and carers and such, so they have almost a check list." (PCO 20)**

However, it was evident within the interview accounts that rather than something that was regularly used, evidence based commissioning was something to strive for and was not necessarily practised to the extent that most would have liked or that was deemed, by them, to be appropriate. There was a lot of reference to the availability of (or access to) and quality of data and evidence. With respect to the availability of evidence, interviewees highlighted that PCTs tended to have greater access to secondary care data than to primary care data. In terms of the quality of evidence, local evidence in particular, was often criticised and described as being "pretty ropey". These views are reflected in the extracts below.

"The evidenced based information doesn't feel that accessible to me as a chief executive; it may be to our consultant in public health or the clinical people…" (PCO 1)

"in some instances it's quite surprising I think that, you know, the lack of data, you might imagine is just routine even down to, you know, 'how many people is a certain service treating?' You know, sometimes that basic information is not there. I mean the NHS has relatively good information about what is happening inside a hospital … But if you go into primary care there's much less." (PCO 7)

"[talking about the information used for commissioning] Erm, it's a sort of mix of national planning documents, with or without some pretty ropey local epidemiology." (PCO 18)

- **political commissioning**

Politics was viewed by many interviewees to dominate commissioning. The influence of both national and local politics was discussed – each of which is analysed respectively under separate headings of the BIG P and the little p.

the 'BIG P'

This refers to the national level; centrally determined; political drivers. Those discussed by interviewees are nicely summarised in the extracts below. These were national policy and planning guidance issued by the DoH (such as the NSFs and the NHS plan) and any associated timelines and targets set out in these and other documents or white papers (such as waiting time targets, Public Service Agreement targets and access targets), as well as similar guidance and targets issued through other 'qango-esk' organisations or 'special health authorities' (such as inspection/star ratings and key performance indicators monitored by the Commission for Health Improvement - the predecessor to the Health Care Commission, and mandatory NICE health technology recommendations). These are referred to collectively as national drivers herein.

"The key thing that drives us has to be what comes through from national and SHA policy and that's what tends to go into the LDP [local delivery plan], so that might be the public service agreement targets or other NHS planned targets, or NSF targets. It is the central imperatives, the central objectives which we tend to look at." (PCO 31)

The national drivers were referred to by interviewees both positively and negatively. In terms of the positives, most emphasised the laudable clinical and moral aims upon which the national drivers were perceived to be founded. Additionally, these drivers were

referred to as providing a clear direction for commissioning within the NHS that was based on the collective achievement of a common set of goals. The negative effects of national drivers were described by interviewees in terms of undesirable characteristics or features that were attributable to specific drivers as well as the process itself. In summary drivers were considered to be contradictory, not always relevant, narrow in focus, and highly prescriptive and inflexible.

Whether they were viewed positively or negatively, the national drivers were typically referred to as "the must-do's". As a "given", it was suggested throughout the interviews that the PCTs tended to focus on reacting to and directing/allocating resources towards these national drivers first. Also, by describing national drivers as the "hang em', flog em' issues"; the "hanging offences"; or "P45-ers", some interviewees even went as far as suggesting that the implications for not addressing the national drivers first and foremost were serious. In this way commissioning can be interpreted as being driven in a 'top-down' approach from the 'centre'. The following extracts illustrate these points:

> **"… there are obviously must-do's in relation to the NHS plan and meeting waiting time targets … by and large the local priorities have been the national priorities of access and waiting times, NSF's. The sort of hang em', flog em' issues." (PCO 6)**
>
> **"It's a given obviously that NSF's and targets need to met – fine." (PCO 30)**
>
> **"… it's then a question of judging within that modernisation board which are the highest, which are the hanging offences, if you like, and then working through that." (PCO 9)**

the 'little p'

The 'little p' refers to the influence of the local health bodies. Interestingly there was little discussion, by interviewees, of the role of the local government in healthcare commissioning and most focussed on the SHA.

Interviewees suggested that the SHA played a key part in the commissioning process – particularly in the decisions made by PCTs over the allocation of resources. The SHA's role was described as both guiding and interfering. In terms of providing guidance, the SHA was perceived, by interviewees, as 'holding the reins' for commissioning in line with its remit for setting the strategic direction across its 'patch' and making sure that this is

monitored and implemented. The interview analysis seemed to indicate that, for the most part, the commissioning plan and the resource commitments and priorities bound up in this were agreed locally across the SHA patch. However some of these plans served as an addendum to the national drivers described above, others were new. Either way, these were accompanied by additional targets and performance indicators which had to be met. In this way, the SHA was regarded as interfering. Additionally some interviewees discussed specific instances where PCTs were 'told' where to allocate resources. The extract below depicts, from one interviewee's perspective, the roles of the SHA in commissioning.

> **[talking about what goes into the LDP] "… what the SHA hints, suggests, arm twists, that we actually should be thinking about." (PCO 5)**

These two roles are also reflected in interview responses from the SHA. These indicate, on the one hand, that the SHA is simply one of many voices in the system and, rather than being controlling, is, as the extract below implies, pointing out the direction and sphere within which all commissioning decisions should be considered.

> **"In that sense we [the SHA] appear to be just another voice in the system, we're not controlling it but we are just pointing out that the relative priorities that they have appear to be inadequate compared to their mission id you like, and their statutory responsibilities." (PCO 29)**

Whereas, on the other hand, the following extract implies that the PCTs have little freedom in determining commissioning decisions and it is up to the SHA to "pull them up" if they want to allocate resources in a different way.

> **"If we fundamentally disagree with the way that they [the PCTs] want to allocate the resources then we would have to pull them in and say that we disagree and argue the case with them why. And we'd expect them to agree with us that they've got to balance their freedom against the priorities that are set both commonly by all the PCTs and Trusts in this area and ourselves, and their local initiatives." (PCO 27)**

- **backroom commissioning**

Backroom commissioning is possibly an extension of political (with a 'little p') commissioning – as highlighted below:

> **"… the priority setting process, resource allocation process is a largely backroom activity done … backroom political activity." (PCO 18)**

In contrast to political commissioning as described above which implies that political commissioning is explicit given that it is based on fulfilling either nationally or locally agreed policies; guidelines; or targets with which interviewees were all familiar, backroom commissioning can be interpreted as implicit *(local)* political commissioning.

Backroom commissioning was implicit in that many interviewees were not clear how the decisions had been made. It was described as a closed environment where 'big' deals about local priorities and the allocation of 'big chunks' of resource were brokered among the chief executives of the most 'important' organisations – the PCT, the acute hospital trust, and the SHA. This is reflected in the following extracts:

> **"… clearly there can be a smoke filled room, I guess with the NHS it wouldn't be, but instead a smoke free room in which a bunch of fairly influential people say 'so we'll do it like this then'." (PCO 11)**

> **"… my guess at the moment would be that a lot of the big decisions, the major investment decisions for the next year would be agreed between the Chief Execs and the Strategic Health Authority … but us, at the different level, won't really know how they came to that decisions." (PCO 10)**

- **clinical commissioning**

All interviewees made reference to the way commissioning can be influenced by clinicians (within both primary and secondary care) and the clinical setting. This was explained in four ways. First, clinicians were deemed to have a strong 'voice' that was dominant in commissioning. The notion of the clinician campaigning for or against service (organisational) and technological changes by 'shouting the loudest' was recurrent in many of the interview accounts (see extract below). Interviewees suggested that there was a powerful clinical consensus about the best way to manage healthcare which was rarely challenged by the PCT. This view was even more evident from interviewees' portrayal of the Royal Colleges who were depicted as being a powerful lobbying body that could influence commissioning by contesting decisions and shaping legislation.

> **"… if you look at investments … it has been where there have been committed clinicians and people who are willing to dig their heels in and kick and fight for their particular service area and it hasn't always been 'well this is actually best value for money, this makes best use of what tax payers are paying in, this achieves better quality of life outcomes overall'." (PCO 31)**

Second, clinicians influenced commissioning through their behaviour within a clinical setting. Reference was made to GPs in particular whose referral patterns, demand management strategies, and prescribing behaviour were considered by interviewees to drive resources allocation decisions. One example is given below:

> **"We have to take account of known trends in resource use in areas like prescribing, for example, which again we might not have explicitly chosen to spend our money on, nut is a reflection of individual, you know, it's been a clinical decision determined by GPs…" (PCO 17)**

Third, interviewees suggested that despite risk management strategies, unplanned events in the clinical setting had a significant impact upon commissioning decisions. These events were mainly described as administrative changes (for example changes in emergency admissions procedures), or legislative changes (for example changes in working times, or wage increases).

- **historical commissioning**

Perhaps the most consistently used commissioning method that interviewees referred to was, what has been termed, historical commissioning. As it implies, historical commissioning is based on history. In the interview accounts this process was described as simply allocating resources in line with some historical precedence. The examples used by interviewees described how resources were allocated in the same way year on year with slight adjustments for inflation and new service development monies. This is reflected in the following extracts which emphasise the notion that resources were just 'rolled over' or 'recycled' from one year to the next.

> **"… so much of the money and the healthcare is already, you know, just kind of gets rolled over." (PCO 6)**

> **"… the majority of resources that the PCT get are spent on, you know, the same basis that we spent [them] last year. … So the vast majority is just sort of recycled." (PCO 7)**

All interviewees recognised that historical commissioning was perhaps not an ideal process and many offered reasons to justify its prominent use. They indicated that the PCT did not start with a 'clean sheet of paper' and patterns of service use were determined by historical arrangements which were inherited by the PCT from its predecessor. This view is represented in the extract below.

> **"In fact a lot of what we do is based on historical reasons. We do a lot of stuff that the health authority did before us." (PCO 8)**

Interviewees highlighted that the historical pattern of provision was rarely examined to the same extent as new service developments that accounted for a smaller portion of resource. Some speculated therefore that some current patterns of service use were perhaps redundant but that making changes to these current patterns was a major challenge for commissioning – a point made in the following extract:

> **"I mean the biggest problem about resource allocation is that you can't necessarily achieve rapid shifts in the balance of resources between what you might like to do ideally in terms of resource allocation and reflecting priorities. Because essentially you've got an enormous burden is you like, or under-burden, of established activity which isn't necessarily overtly prioritised." (PCO 25)**

In summary, the analysis shows that in this specific set of interviews PCT commissioning was conceptualised as constrained decision-making. This was recognised as constraint in resources and this required having to make choices over the use of these resources. These choices had to be considered within the current context of continual organisational and system change, resource scarcity, and a focus on only new (as opposed to existing) resources. Formal and semi-formal structures served to provide the roles through which these choices could be identified, debated and validated, and endorsed. There was however some questioning of the capability of the PCT in fulfilling these roles. In particular there were issues around a lack of skills, capacity, and support. Finally, a number of methods or processes used for making these choices were identified. Of these, political; historic; and clinical processes seemed to dominate and aside from evidenced based commissioning which was limited in its use, all other methods were predominantly driven from out with the PCT.

Discussion and conclusion

With reference to shifting the balance of power, analysis of the themes outlined above implies that commissioning has not been happening in PCTs as envisaged in government policy. In particular the analysis reveals issues around control, choice, and empowerment in commissioning that, it can be argued, are inherent in the context, structures, and

methods outlined in the themes above. These issues are discussed below in relation how they challenge the PCTs ability to be able to commission at the local level.

Fundamentally, PCTs seem to lack control, choice and power in local level commissioning. In terms of control and choice, this is especially clear from the descriptions of commissioning methods/processes which show that a number of these fall out with the PCT structures that are responsible for commissioning. Instead, commissioning decisions appear to be controlled elsewhere, by other organisations, or individuals in the system. In particular central Government (through national drivers) is perceived to be essentially controlling the allocation of resources at the local level with resources being directed first and foremost to meet these. Looking back at the analysis, on the one hand PCTs are accepting of this – primarily because the national drivers have some positive features. Whereas on the other, it is clear that PCTs also have little choice in the matter and control is maintained through performance management arrangements that ensure the compliance of PCTs in meeting these national drivers. Additionally, commissioning is also controlled locally, by the acute trusts (through the predominance of historical arrangements) the clinicians (through their actions in clinical setting) and SHA (through the setting of additional local strategic priorities). Moreover, PCTs do not have the power to be able to make commissioning decisions (even if they were given the control and choice to). Reference was made in the analysis to the notion of PCTs as being immature – both in terms of their existence and function. In this respect PCTs are perceived to be incapable or not developed enough to take on the challenges of commissioning. They often lacked knowledge and information, the capacity (time and analytical), and the support (nationally and locally) for making commissioning decisions and implementing them. However, using a 'chicken and egg scenario', there also seems to be little point in investing (both resources and time) into bolstering local PCT commissioning given that the majority of decisions are in fact made elsewhere (nationally and locally).

Given the latest policy developments such as the reorganisation of PCTs and SHAs, the establishment of foundation trusts, and the resurgence of practice based commissioning, it is important to take heed of these issues in order to develop and sustain local level commissioning. This partly involves empowering organisations, but it also involves

strengthening structures and strengthening processes – all of which require challenging the culture and structures that are ingrained in the NHS.

This is certainly beginning to be recognised by some in the health service who are calling for better ways to manage the delivery and organisation of healthcare services and resources whilst explicitly accounting for the political and structural context. (Goodwin N, 2006(a); Goodwin N, 2006 (b); Edwards N, 2006) As academics and researchers in health services research and health economics we should increasingly be working with those in the service to achieve this common goal.

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Appendix 1: PCT Interview Schedule

Words in bold are topic headers. Questions are shaded and represented by Q and should be read out to the participant. *Words in italics are instructions for the interviewer.* Bulleted points are suggested responses that may require further probing to elicit.

Introductions. Present participants with information sheet (read out loud) and consent form. Reiterate issues of: confidentiality and anonymity, the purpose of the study, study funding, what is going to happen with data. Ask them to read and sign the consent form.

[ ] tape on
[ ] volume level

Information on role

Q1. Can we begin by you telling me a bit about what you understand of the terms priority setting and resource allocation?

Thank you. What I would like to focus on in this series of questions is the actual process of priority setting and resource allocation rather than the outcomes or results of the process – though examples of these are sometimes useful for illustrating a point,

Q2. I'd now like to know more about what your role is in terms of <u>setting priorities</u> and <u>allocating resources</u> in the PCT?

- Focus on process of commissioning
- Encourage them to be as specific as possible
- Probe for role in relation to priority setting

Description of current priority setting process

Q3. Can you describe for me the process that is currently used to identify local priorities for the PCT?

Probe for:

- Sources of information currently used in determining / identifying short and long term priorities in the PCT
- Types of information used to support priority setting decisions

Refer to the completed pre-interview sheet.

Q4. How are resource allocation/re-allocation decisions made within the PCT? (i.e. how much money goes where? / to different service areas? / or to whom?)

Probe for:

- Methods used to determine how resources are allocated between competing priorities
- How are decisions made to divide up the resources across the communities within your PCT (or various services within your community)?

Q5. In practice, is the identification of priorities in the PCT a completely separate function from the production of the local development plan?

Clarify whether the LDP covers just their PCT or others within the SHA (which ones?)

- SHA wide / SHA priorities
- What are the implications of this either way?

Feedback on current process

Q6. Do you think that the current process of setting priorities and allocating resources works well? Can you give examples of when the process has worked well/poorly or any strengths and weaknesses of the current process?

Probe for:

- Strengths and weaknesses of the current process

Q7. Can you describe for me, in your own experience, how national work programmes impacted (positively or negatively) upon the local priority setting process?

These are: national services frameworks, NHS plan, NICE guidelines, NICE technology appraisals, waiting list and other initiatives, inequality targets, health strategies (e.g. HIV and sexual health strategy).

As much as is possible try to get them to identify specific national work programmes that either hinder or help the local process and also specific local priorities/initiatives forgone.

Probe for:

- How the PCT decides between local/national priorities
- Which takes precedence
- Extent to which national policy dictates the local priority setting process.
- To what extent national programmes render impossible the ability to plan locally and address local priorities.
- Whether funding and implementation of local priorities/ initiatives have been forgone ***/*** displaced specifically in order to implement nationally identified / dictated priorities.
- Whether local priorities forgone may have been more or less beneficial / worthwhile to the communities within their PCT.

Improving the priority setting process

Q8. How can the current process of setting priorities and allocating resources be improved?

Refer to the completed pre-interview sheet.

Probe for:

- Specific examples.
- How they would result in improving the process.

Q9. Which types of information (or data or evidence) would you most want to use that you feel could improve decision making in setting priorities and allocating resources?

Probe for:

- The value they see in these pieces of information.
- How they would use these pieces of information? (i.e. how would these be used/in what ways would they improve the decision-making process?)
- Capacity to deal with/critically assess information and information systems capacity.

Barriers/incentives to improving/changing the process

Q10. What barriers are faced/encountered in undertaking the priority setting process within the PCT?

Probe for:

- What barriers they face.
- What barriers the organisation faces.

Q11. More specifically, what barriers are faced/encountered when re-allocating resources from one service area to another?

Probe for:

- What barriers they face.
- What barriers the organisation faces.

In both cases focus on:

- Organization and professional boundaries / and / or barriers
- Time to make decisions
- Recording and presenting of financial information

Q12. You are probably aware that recent discussions in the literature have centered around the importance of incentives in engaging decision makers in an explicit priority setting process. What specific types of incentives could be put in place that might improve participation in an explicit priority setting process [which has at its core the notion of re-allocation of resources]?

Probe for:

- Organisational level incentives at a general level and specific to their organisation.
- Personal level incentives.
- Engaging at the across the primary / secondary care interface

Engaging the public/incorporating community values

Q13. How has the public been used in priority setting/ resource allocation processes in the past?

Refer to the completed pre-interview sheet

Q14. What information is important to get from the public?

- How do you deal with / handle this information
- What about patient forums – where do they fit into the process?

Q15. Ideally, how would you want the public to be involved in the priority setting/ resource allocation process?

Reflection on overall process

Q16. Overall, is the current process of setting priorities and allocating resources fair and transparent?

Q17. Academics working in the area of priority setting in Canada have developed a framework for evaluating priority setting decisions called accountability for reasonableness. The premise of this framework is that an institution's priority setting decisions may be considered fair if they satisfy four conditions: publicity, relevance, appeals and enforcement.

Hand the participant card 1.

How do you think these concepts relate to the current priority setting process undertaken within the PCT?

Final remarks

Q18. Is there anything else you want to add that we haven't covered?

- Role of the SHA
- Role of the PEC
- Impact of new initiatives (foundation hospitals bill, patient choice agenda, financial flows) on local process

Close interview. Thank respondent. Offer reassurance that all responses will be held in confidence and neither the role of the participant nor the name of the PCT will be identified in dissemination of results.