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Potential research priorities arising from proposals for NHS reforms in England

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Potential research priorities arising from proposals for NHS reforms in England

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Introduction

This report, undertaken as part of the 2011 work programme of the Department of Health-funded Policy Research Unit in Policy Innovation Research (PIRU), outlines emerging trends and issues within the current health care policy landscape in England. It is designed to help PIRU anticipate potential priority areas where new research to support policy development might be required. We have assessed the overall landscape, as well as debate around that landscape, reviewed existing and emergent policy issues, and synthesized available evidence around these issues, to identify gaps in knowledge which may merit new research.

The report was prepared by James Barlow and Jane Hendy, with support from Adele Casamassima.

About this report

A horizon scanning exercise of this nature can only provide a snapshot of what is inevitably a fast-moving environment. The backdrop to the health policy landscape in England is shaped by broad social and demographic trends that are influencing the demand for and provision of health care – for example, the rise in the proportion of older people or people with long-term chronic conditions – as much as the potential policy and other interventions that have been suggested to cope with them.

While these are clearly very important in influencing overall health care policy, we focus in this report on the specific health care issues and possible policy interventions that are expressed in the Health and Social Care Bill and the subsequent responses to it during 2011. To some extent, the longer term and broader trends are being addressed in the parallel PIRU Health and Social Care Futures project which is developing future scenarios for the NHS in England with a view to understanding more fully their resource, workforce and other implications (the ‘NHSx project’).

This report presents the findings from horizon scanning activities undertaken between January and August 2011. This period captures insights from debate in England regarding the proposed health care reforms and subsequent ‘listening exercise’¹. Our analysis identifies existing and developing evidence underlying the various policy issues outlined in the Bill and any areas where current evidence is weak or absent. These evidence gaps suggest priority areas for new research to support effective policy implementation and evidence-based policy innovation. The methodological approach is described below.

Methods

The horizon scanning involved both formal and informal search strategies. The formal strategy relied on a keyword-based reviewing process. Our goal was to identify documents making a core contribution, either conceptually or empirically, to current policy. Our starting point was to identify a heuristic list of potential policy areas and literature considered to have shaped the 2010 NHS White Paper, *Equity and excellence – liberating the NHS* and recent policy thinking. We searched for these sources using websites such as Web of Science to identify recently cited work.

¹ <http://healthandcare.dh.gov.uk/working-together-for-a-stronger-nhs-how-to-get-involved>



Informal approaches involved browsing the website information of different health care organizations and being alert to ongoing political debates on UK health care reform. This allowed us to prioritise topics which could result in potential policy interventions, pilots and field trials. Informally scanned sources include:

- Public consultations and press releases by DH, professional associations (e.g. BMA); and patients' groups
- Outcomes from conferences and meetings of UK health care think-tanks and other bodies, including King's Fund, IPPR, Policy Exchange, Civitas, NHS Confederation, and the Nuffield Trust
- News and reader comments and blogs in the media (e.g. HSJ, BBC, *The Guardian*).

Our reporting and analytical strategy for the emerging policy issues is tabulated below.

Findings of the horizon scanning exercise

Health care reform in England embraces a number of broad themes. As well as the longer term, demographic, social, economic and technological trends, the current policy debate is underpinned by a need to increase the efficiency and integration of health and social care services. New approaches to the organisation and funding of health care are shaped by these broad trends and also by the ideological nuances of the government of the day. Some of these approaches are innovative, in the sense that they have not been previously used within the English health care system (but may have been used elsewhere). Others are innovative in the sense that they are wholly new ideas.

Under an evidence-informed policy model, the extent to which there is existing evidence for the benefits or costs of a potential new intervention will influence the need for new research to provide backing for its introduction. Our initial scanning activity yielded a number of major areas where future policy intervention is being (or might be) proposed. These formed the basis for five tables (see below), which describe in detail different potential interventions and provide a snapshot of the strength of evidence supporting each intervention:

Table 1: Improving health outcomes and quality of care in a context of cost constraints

Table 2: Changes in patient expectations and attitudes

Table 3: Self-management approaches – increased personal responsibility for health

Table 4: Placing patients at the centre of services and increasing accountability to patients

Table 5: Market-based approaches for generating competition, reducing costs and improving performance



Each table has five columns describing:

- **Current policy proposals** – this refers to core policy propositions and suggested implementation rationales
- **Key drivers for that proposal** – the main health care reform drivers as they apply to specific policy proposals
- **Available supporting evidence** – from both established research and ongoing studies regarding the potential policy interventions
- **Identified need/type of research for new evidence generation** – describes potential future research that might be needed to provide evidence for supporting implementation of the potential policy intervention.

Conclusions

The exercise identified a large number of areas where there is emerging policy interest, but where the current evidence base suggests that new research may be merited. For example, the general move is towards increased integration of health and social care services, and integration around specific care pathways. While there has already been much research on the integration of care services, understanding how to design integrated models to deliver particular desirable outcomes and incentivise partners to do this appears to be less well developed.

The column ‘Potential Future Research’ in the tables lists a number of areas where more detailed consideration of the scope of any research effort will be required. We have not attempted to prioritise the listed topics in any way. In summary, the key areas we believe merit attention relate to the following:

1. Improving health outcomes and quality of care in a context of cost constraints

This will be a major objective for government into the foreseeable future:

- While there is a desire to develop new, possibly more integrated, care pathways and associated commissioning and payment models, more work needs to be carried out on the design of care pathways which incentivize innovation in service delivery, including ways of rewarding outcome rather than activity, and methods by which commissioning and provider bodies can be incentivized to adopt good practices for moving care closer to patients’ homes.
- There is considerable research on the impact of different approaches to remote care (telehealth and telecare), but work is also needed to develop regulatory and technical frameworks that support remote monitoring and care provision.
- There may be value in identifying areas of care delivery where the demand for high-tech, high-cost interventions can be reduced or substituted by more efficient service/care delivery models, e.g. ‘disruptive innovations’ involving simpler, cheaper technologies that provide sufficiently high quality outcomes.ⁱⁱ
- There is a need to develop quality standards and associated measures for all the main pathways of care covering both health and social care, aligned to the key domains of quality – effectiveness of treatment and care provided, safety of care provided, and patient experience. Work is needed to establish more

ⁱⁱ Christensen C, Bohmer R, and Kenagy J. 2000. *Will disruptive innovations cure health care?* Harvard Business Review 78(5):102.



consistent health and well-being outcome metrics for NHS, public health and social care interventions and services.

2. Changes in patient expectations and attitudes

This addresses the rise in health care ‘consumerism’ and how this can be harnessed to support beneficial changes in health care demand. Empowering patients by improving their ability to exercise choices over their own health has been on the NHS policy agenda for several years. Areas for possible research include:

- The extent to which models of patient choice can be introduced in cases of complex or long-term care pathways, where it is not clear how or when different care providers are chosen along the care pathway.
- How to make better use of information/feedback from patients in the design and improvement of care services. Patients are a free source of information on the quality of care services and they should be incentivized to participate and contribute where possible to service design. Work is needed to explore how best to achieve this and ensure that more weight is given to patient/customer experience surveys, patient satisfaction and real time feedback.

3. Self-management approaches – increased personal responsibility for health

Ensuring people are more involved and proactive in the management of their own care has been a key policy goal for a number of years. However, the evidence for how to achieve this is limited, particularly in relation to:

- Different diseases or conditions
- Changing the relationship between health care organizations and patients towards one that is more interactive
- The best platforms for providing information to patients in a convenient, efficient and effective way
- Measurement of the benefits in relation to health outcomes and cost savings.

Mental health provision also appears to be under-researched, particularly how to increase understanding among key stakeholders of preventative issues, the impact of mental health on service commissioning, and admissions to primary and secondary care services.

4. Placing patients at the centre of services and increasing accountability to patients

This particularly addresses how to achieve transparency in commissioning care services and pathways. Areas for possible research include:

- Commissioning models which provide transparency and accountability, and balance clinically-led commissioning with retaining overall control and accountability over the system.



-
- How to make information accessible, and easy to understand and use by patients and public.

5. Market-based approaches for generating competition, reducing costs and improving performance

Increased use of competition is highly controversial within the current policy reforms. While there has already been some recent research on supply-side competition in the NHS, areas for further work include:

- The impact of price competition on care pathways that are not covered by tariff prices under the PbR policy (e.g. mental health and community services, specialist acute care and non-elective care), all of which may suffer reduced quality through price competition.
- Payment systems that can facilitate the integration of services (e.g. bundled payments, pooled budgets) and that can link financial rewards to the quality and outcomes of care.
- The impact of ‘any qualified provider’ models, including on feasibility of commissioning whole pathways of care through such providers.



Table 1 Improving health outcomes and quality of care in a context of cost constraints

Policy proposition and rationale	Key drivers	EVIDENCE		Potential future research
		Established	Developing	
Health outcomes based on clinically relevant targets ^{1(para 3.1,3.2)}	Trade-off between volume/efficiency targets and safety/quality of care ^{1(para 3.3)}	Apparently poorer clinical outcomes in UK when compared with some other EU countries ^{1(para 1.8)}	<ul style="list-style-type: none"> Delivering health and social care in community settings to prevent unplanned admissions to hospital (Partnership for Older People Projects)² Redesign clinical pathways to achieve clinical consensus while agreeing accountabilities³ 	<p>New care pathways and associated commissioning and payment models:</p> <ul style="list-style-type: none"> Design care pathways which incentivize innovation in care/services delivery⁴ Simplifying commissioning through disease and tariff pathways paid for by rewarding outcome not activity⁴
Integration of health and social care services to deliver the best patient outcomes ^{1(para 3.11)}	<p>Release synergies and efficiencies by developing joint and coherent arrangements between health and social/community care:</p> <ul style="list-style-type: none"> Cut overlapping functions/resources use Cut bureaucracy and increase efficiency 	<ul style="list-style-type: none"> Integration of health (NHS) and social care models can improve care delivery to patients with long-term conditions^{5,6} Evidence from Kaiser Permanente, the Veterans Health Administration and the Alaska Medical Service about the benefits of integration³ 	<ul style="list-style-type: none"> A pilot programme including 16 Integrated Care Pilot studies (ICP)⁷ to evaluate a range of integrated models for service delivery. Study included different scale and scope of integration among different stakeholders^{8,9,10,11} Development of GP commissioning consortia which include hospital doctors provides an opportunity to encourage increased integration via the involvement of secondary care clinicians alongside primary care teams¹² 	<p>Integration of care services:</p> <ul style="list-style-type: none"> Redesign service delivery models to benefit from horizontal and vertical integration with other NHS bodies (primary, community and secondary care services)^{13,14,15} Integrate services around individuals and outcomes not around systems and processes¹⁶ Provide incentives to make integration sustainable, e.g. by allowing bundled payments across pathways of care, and allowing provider networks to be at financial risk of capitated budget⁴



Table 1 Improving health outcomes and quality of care in a context of cost constraints

Policy proposition and rationale	Key drivers	EVIDENCE		Potential future research
		Established	Developing	
<p>Make better use of available resources by:</p> <ul style="list-style-type: none"> Rationalizing and simplifying the health care system to increase productivity^{1(para 5.3,5.12)} Focusing on care integration and community engagement (social enterprise)^{1(para 1.17,3.11,4.21)} 	<p>To deliver efficiencies and control costs</p>	<ul style="list-style-type: none"> Benefits of care integration include improving access to care, managing demand and reducing delayed transfers¹⁷ Limited evidence that service integration improves clinical outcomes and its impact on costs is mixed^{17,18} Unplanned hospital (re)admissions occur through emergencies and are often linked with psychiatric issues and chronic conditions¹⁹ 	<ul style="list-style-type: none"> Pilot study “Principia” modelled a service provision framework to achieve shifts in care from hospital to the community³ Financial penalties to reduce readmissions¹⁹ (e.g. 30 days hospital readmission policy, 30% marginal tariff, a local “tariff flexibility”)²¹ 	<p>Other approaches to performance improvement and simplification of service delivery:</p> <ul style="list-style-type: none"> Service delivery models focused on hospital upstream intervention,¹⁹ home based care to deliver low-cost/higher quality care, prevention, knowledge, wellness, communications³ Improve co-ordination and efficiency of care by developing strong community services and engagement³ Identify areas of care delivery where demand for high-tech, high-cost interventions can be reduced or substituted by more efficient service/ care delivery models²⁰
		<p>Long-term condition care at home through multiple approaches: monitoring, community services, medications and medical communication³</p>	<ul style="list-style-type: none"> Diagnostic equipment outside hospitals to reduce hospital use and increase patient convenience²² Shift routine monitoring of patients to ambulatory care to avoid hospital use and improve patient satisfaction²² Increase access to services, reduce waiting time, avoid admissions and provide care closer to home by introducing advanced paramedics/ practitioners in community health and acute care services²³ 	



Table 1 Improving health outcomes and quality of care in a context of cost constraints

Policy proposition and rationale	Key drivers	EVIDENCE		Potential future research
		Established	Developing	
Invest in prevention and early intervention ²⁴ (para 2.9,3.23,4.53)	<ul style="list-style-type: none"> • Cost-effective management of chronic and long-term conditions • Shift of policy towards focusing on lifestyle 	<ul style="list-style-type: none"> • Rationale for specialist and disease focus during diseases' onset²⁵ • Cost-effectiveness of early diagnosis and intervention (e.g. in <i>Early Intervention in Psychosis</i> (EIP) services)²⁵ 	<p>Changing location for the provision of care to home settings by employing remote diagnoses and patient monitoring:</p> <ul style="list-style-type: none"> • The use of Motiva for patients coping with severe heart failure led to a 67.8% reduction in hospitalizations²⁴ • Telecare studies including the Whole System Demonstrator (WSD), Scottish Assisted living demonstrator programme,²⁴ telehealth trial in Cumbria and Lancashire focusing on telestroke intervention,²⁴ telehealth solutions for heart patients in Wakefield²⁴ • Leverage on public health programmes and initiatives²² • Roll-out of "Public Health Responsibility Deal" to support society-based approaches to prevention and early intervention²⁴(para 11-f) 	<p>Focus on reducing costs of long-term chronic conditions:</p> <ul style="list-style-type: none"> • Identify and prevent risk factors • Costing and evaluation of care pathways for chronic diseases, based on clear metrics, to facilitate commissioning, comparison and managing improvements in care service delivery²⁶ • Include "early disease intervention" in commissioning and care services design
Identify technologies supporting new ways to deliver care in a timely and effective way (improving diagnosing, prevention, treatment and monitoring of disease) ¹ (para 3.16)	<ul style="list-style-type: none"> • Reduce costs while improving efficiencies • Increase quality and productivity using fewer resources • Maximize use of skilled staff 	<p>Innovations to deliver improvements in quality of care and productivity:</p> <ul style="list-style-type: none"> • Innovation influences the cost and the practice of health care by enabling different ways of monitoring patients, running medical communication, smart medications (pharmaceuticals)³ 	<ul style="list-style-type: none"> • Whole System Demonstrator programme on the impact of telehealth and telecare on patients' independence, use of care home and hospital need²⁹ • Development of digital health care services generating financial value for NHS and improving efficiency (NHS Direct)^{67,68} 	<p>Range of studies to demonstrate impact of different approaches to remote care:</p> <ul style="list-style-type: none"> • Develop regulatory and technical (ICT) frameworks supporting innovation for remote monitoring and care provision • ICT support for behaviour change, to improve patient compliance with



Table 1 Improving health outcomes and quality of care in a context of cost constraints

Policy proposition and rationale	Key drivers	EVIDENCE		Potential future research
		Established	Developing	
<p>Support on-line patient/clinician communication and exchange of patients' data as a new way of delivering care/services efficiently</p> <p>¹(para 2.5,2.6)</p>		<ul style="list-style-type: none"> • Telehealth to keep patients out of hospital²⁷ • Benefits of telehealth in various areas, including patient and carer satisfaction and reduction of secondary care admission²⁸ • Positive experience in Cornwall about adopting telehealth for patients with COPD, heart failure and diabetes²⁸ • Lack of GP engagement with telehealth initiatives²⁸ 		<p>medication, diet and exercise</p> <ul style="list-style-type: none"> • Provide educational information through user-friendly technology to help patients gain a better understanding of their illness and take greater control of their lifestyle • Breakdown telehealth services providing a “menu of services at different levels”. This may help to customize services to the needs of patients and the available budget, drive down prices and deliver short-term visible benefits²⁸ • Incentivize adoption by exploiting current policies for moving care closer to patient home • Develop strategies to overcome low confidence in remote care delivery (telehealth):²⁸ <ol style="list-style-type: none"> 1) new information strategy to feed back patients' positive experiences to clinicians; 2) introduce incentives to clinicians (quality and outcomes rewarding system) to adopt telehealth; 3) mainstream telehealth into the education and training of all health care professionals to increase awareness



Table 1 Improving health outcomes and quality of care in a context of cost constraints

Policy proposition and rationale	Key drivers	EVIDENCE		Potential future research
		Established	Developing	
<p>Maximize use/sharing of patient-held information/records by developing electronic networks and expand them to third parties (social, community and health care)^{1(para 2.12)}</p>	<ul style="list-style-type: none"> • Increase productivity and performance • Help patients to better manage their records and their conditions • Enable successful integration 	<p>Widespread/shared information enables better care, better outcomes and reduced costs^{1(para 2.5-2.9)}</p>	<ul style="list-style-type: none"> • Patient information sharing across and between organisations to identify barriers/facilitators in the development of e-health systems and their impact on different parts of the health care system⁶⁶ • Evaluation of implementation and cost-effectiveness of electronic networks as a tool for achieving integrated service delivery⁶⁹ 	<p>Information management protocols and approaches: Including common guidelines, data protection, data definitions and technology standards for effective sharing of information and as enabler of integrated care⁷⁰</p>
<p>Types of quality standards:</p> <ul style="list-style-type: none"> • NICE to create quality standards and associated measures for all the main pathways of care covering areas from both health and social care^{1(para 3.12-3.14)} • Outcomes framework and NICE quality standards included in commissioning contracts and financial incentives^{1(para 3.1)} 	<p>Enable international comparison of quality indicators in relation to key groups and services (for children, older people and mental health)^{1(para 3.8)}</p> <p>Account for patient needs and patient satisfaction</p>	<ul style="list-style-type: none"> • High mortality rates from respiratory diseases, cancer and stroke outcome measures¹⁶ • Poor care management as proved from high levels of acute complications and avoidable hospital (re)admissions^{1(para 1.8)} 	<p>Define care standards and guidelines helping to avoid admissions for sub-acute and post-acute conditions³</p>	<p>New outcome metrics: Establishing more consistent health outcome measures for NHS, public health and social care^{1(para 3.11),3}</p>
<p>Measure care outcomes on the basis of three aligned domains of quality including:^{1(para 3.8)}</p> <ul style="list-style-type: none"> • Effectiveness of treatment and care provided • Safety of care provided • Patient experience 				



Table 2 Changes in patient expectations and attitudes

Policy proposition and rationale	Key drivers	EVIDENCE		Potential future research
		Established	Developing	
Empower patients by increasing their choices ^{1(para 2.20)}	<p>Consumer focused care is a driver for:</p> <ul style="list-style-type: none"> • Pushing market mechanisms to change provider behaviour and improve quality^{31,1(para 2.18)} • Increasing responsiveness to patients' needs • Improving outcomes • Driving changes in NHS culture and enabling integration of health and social care^{1(para 2.21,2.22)} • Improving compliance with chosen treatments • Support patient self care responsibilities • Strength personal health budgets policy 	<ul style="list-style-type: none"> • Patients' involvement in care decisions improves their health outcomes,³² induces compliance³³ and reduces costs as in the case of management for long-term conditions^{34,35} • Introducing patient choice (i.e. choice of GPs and health authorities during the quasi-market reform) led to a decrease in waiting times but also resulted in poorer quality of care^{39,59} • Less than 50% of GPs proposed patients should choose their providers⁴⁰ • Demand for care is rising following an increased ageing population and people with disabilities living for longer • Patients have increased their expectations about care, their demands for convenience and choice⁴² • People's expectations of health care services outstrips current NHS delivery capacity⁴³ 	<ul style="list-style-type: none"> • Research on the impact of choice on equity, the mechanisms driving choices – inequality in access to care with respect to disadvantaged patients and choice of hospital services³⁶ 	<p>Evidence linking patient choices with behaviour changes:</p> <ul style="list-style-type: none"> • Models of patient choice in the case of complex or long-term care pathways where it is not clear how/when care providers are chosen along the care pathway²⁰



Table 2 Changes in patient expectations and attitudes

Policy proposition and rationale	Key drivers	EVIDENCE		Potential future research
		Established	Developing	
<p>Enable choice for patients through increasing freedom to choose over treatment options, hospitals and consultant-led team, GP-practice^{1(para 2.11,2.20)}</p>	<ul style="list-style-type: none"> • Improve quality • Delivering choice • Performance driven by patient choices 	<ul style="list-style-type: none"> • Previous reform only promoted provider choice for first appointment of elective care^{1(para 2.19)} • Evidence suggests that patients choose appointments on the basis of waiting time, convenience and continuity of care (seeing the same nurse or GP) • Speed of access at the expense of patient choice is not desirable • Quality improvement under non-urgent primary care settings is based on patients' broader choice opportunities⁷¹ • Doctors focusing on achieving waiting time (quality) targets (backed by incentive payments) did not respond to patient choice needs⁷¹ • No real progress so far to make NHS patient-led³⁸ 	<p>Current use of <i>Choose and Book</i> is limited:</p> <ul style="list-style-type: none"> • Uptake of choice is not widespread and many patients do not practise choice³⁷ • <i>Choose and Book</i> system on which patient choice relies is restrictive and the quality of information on providers available to patients is weak³⁰ 	<p>Approaches to increasing patient choice:</p> <ul style="list-style-type: none"> • Increased control and choice through easing access to information about care options, clinical outcomes and performance information • Provide timely information about the availability of treatment options to support patient choice (e.g. new research studies and treatment and care delivery service options) • Maximize use of <i>Choose and Book</i> for standard acute care by making providers list consultants' names on <i>Choose and Book</i> lists^{1(para 2.21)} • Any booking system in primary care should be flexible enough to reflect different types of patients and their need to see their doctor of choice at a convenient time⁷¹
<p>Increase and support access (to enable choice): 24/7 access to urgent care services (e.g. GP out-of-hours services) and use of ICT to facilitate communications with doctors^{1(para 2.20)}</p>	<ul style="list-style-type: none"> • Improve efficiencies and patient satisfaction • Shift the location of service provision • Cutting costs from unnecessary hospital visits and unscheduled admissions 	<ul style="list-style-type: none"> • "Poor" level of care due to spending cuts for out-of-hours GP services^{72,73} • Increasing use of ICT to support online health applications for health professionals⁷⁴ and consumer health applications^{75,76,77} • Patients look for health information, accessing NHS Direct and NHS Choices, blogs and disease patient networks⁷⁸ 	<ul style="list-style-type: none"> • NHS Direct is trialling pilots on the use of web services, patient management, and non-emergency phone services • NHS Bristol is due to roll out a trial for using mobile phones for telehealth 	<p>Potential benefits and regulatory aspects:</p> <ul style="list-style-type: none"> • Lack of regulation and clear guidelines • No evidence available about the effectiveness and their impact on health behaviour⁷⁷



Table 2 Changes in patient expectations and attitudes

Policy proposition and rationale	Key drivers	EVIDENCE		Potential future research
		Established	Developing	
Implementation of personal health budgets ^{1(para 2.22)}	Personal budgets give people real control over choices which, in turn, can drive clinical and services performance	<ul style="list-style-type: none"> No real progress so far to make NHS patient-led³⁸ Positive evidence in UK from ongoing programmes of personal health budget pilots plus international and social care experiences²⁶ 	Positive evidence from the current Personal Health Budget pilot programme ^{70,71}	Payment/reimbursement models: <ul style="list-style-type: none"> Reform payment system to make money follow the patient (personal health budgets)^{1(para 2.21)} Expand pilots around personal budgets in NHS continuing care before a more general roll-out of this policy^{1(para 2.22)}
GP consortia and commissioners have to work in partnership with local communities and patients ^{1(para 4.6)}	Empower communities to drive improvement of services, local partnerships and care integration	The cost-effectiveness of empowering communities based on improvements in the mental and physical health of communities ⁴¹	A pilot study on active and engaged commissioning for people with long-term conditions ⁷⁹	How to best involve patients/public in: <ul style="list-style-type: none"> commissioning strategy accountability consortia decision-making
More weight to patient/customer experience surveys, patient satisfaction and real time feedback ^{1(para 2.8,2.9)}	To improve patient compliance and satisfaction	Patient satisfaction and customer care improve through health care supply: <ul style="list-style-type: none"> Community care/services have delivered financial and patient benefits due to diffusion of new technologies in primary care⁴⁴ Provision of rehabilitation and palliative care nearer to the patients^{45,46} Establishment of nurse-led primary care clinics reducing the need for hospital outpatient facilities 	<ul style="list-style-type: none"> A number of hospitals have reduced their readmissions by including patient interviews at the time of readmission to help find underlying causes that were not picked up by clinicians¹⁹ A pilot study on designing patient-centered service improvement by using patient experience⁸⁰ 	Better use of information/feedback from patients: Patients are a free source of good information and they should be incentivized to participate/contribute where possible to care services' design ¹⁹



Table 3 Self-management approaches – increased personal responsibility for health

Policy proposition and rationale	Key drivers	EVIDENCE		Potential future research
		Established	Developing	
Patients to be more responsible for their own care and health status ^{1(para 2.18)}	Patient self-care increases patient compliance and reduces the demand for health care	Evidence supporting the impact and cost-effectiveness of an approach empowering communities ⁴⁷		<p>Making patients involved and proactive in the management of their own care:</p> <ul style="list-style-type: none"> • How to do this within different disease frameworks • How to change the relationship between health care organizations and patients from passive to active /interactive • What are the best platforms (multi-channel) to drive convenience, efficiency and effectiveness⁶³ and cope with access to health information for people who are digitally excluded? • How to measure outcomes and cost savings/reduced resources wastage
Information to support health care self-management by covering different conditions, treatment options and lifestyle choices ^{1(para 2.5,2.6)}	The use of the internet to impact on patient self-management, expectations and behaviours ⁸¹			<ul style="list-style-type: none"> • Develop analytic and strategic/ operational frameworks for health care organizations and health professionals for embracing internet-driven patient information and its use⁸¹ • Need to integrate the self-care agenda (for chronic diseases) with internet-facilitated and self-initiated patient activities into the delivery of care⁸¹



Table 3 Self-management approaches – increased personal responsibility for health

Policy proposition and rationale	Key drivers	EVIDENCE		Potential future research
		Established	Developing	
<p>Long-term chronic conditions including cardiovascular disease (coronary heart disease and stroke), cancer, diabetes, dementia, mental ill health and obesity are priority targets for preventive care and patients' behavioural changes⁴⁸</p>	<ul style="list-style-type: none"> To reduce the burden of chronic diseases through effective prevention and individual behaviour change Drive cost savings and improve health outcomes by patient participation 	<ul style="list-style-type: none"> Well-being, resilience and attitudes to behaviour change affect the success of public health intervention⁴⁹ Preventive care is enabled by Self-responsibility and behavior change⁴⁸ 	<p>Leverage on patient responsibility to improve outcomes, burden of long-term disease and associated social care dependency levels²²</p>	<p>Tools that can induce public behaviour change:^{50,22}</p> <ul style="list-style-type: none"> Personal budgets Benefits provision Incentives for patients to comply with health care goals
<p>'No health without mental health': improve public mental health and well-being across whole population to achieve social, health and economic goals^{49,51,52}</p>	<p>Promote well-being to drive changes in behaviour and improve attitudes towards own health management</p>	<ul style="list-style-type: none"> Evidence shows that mental well-being has positive impact on health, social and economic outcomes⁴⁹ and ref therein Evidence about the cost-effectiveness of mental health prevention and promotion⁵³ Evidence and rationale for well-being⁵⁴ Communities do not engage with services and public health initiatives unless public mental well-being is improved⁴⁹ 	<p>Change 4Life project⁵⁵</p>	<p>More attention to mental health provision:</p> <ul style="list-style-type: none"> Increase understanding among key stakeholders of prevention and promotion of public mental health, its impact on commissioning consortia and in reducing admissions to primary and secondary care services⁴⁹ Metrics to evaluate mental well-being (local outcomes, proxy indicators, broad/cross government outcome measures) as part of GP performance assessment⁴⁹



Table 4 Placing patients at the centre of services and increasing accountability to patients

Policy proposition and rationale	Key drivers	EVIDENCE		Potential future research
		Established	Developing	
<p>Transparency and accountability of information to patients by timely action on patient experience and feedback^{1(para 2.8)}</p> <p>A revolution in how information flows and is used within NHS^{1(para 2.5,2.6)}</p> <p>Increase transparency and accountability of providers for the accuracy of patient data^{1(para 2.16)} and public comparable information (e.g. safety, effectiveness, patient experience)^{1(para 2.10)}</p>	<ul style="list-style-type: none"> Support patient choice⁶³ Give more control to patients Enable behaviour changes and efficiencies by diffusing information Promote quality Increase public accountability 	<ul style="list-style-type: none"> User experience and feedback can drive health care providers' responsiveness⁵⁶ Open publication of information improves clinical practice⁶⁵ Little evidence that patients use the available information²² 	<p>How to achieve transparency in commissioning:</p> <ul style="list-style-type: none"> Commissioning models which provide transparency and accountability, and balance clinically-led commissioning and retain system control/ accountability²⁰ Make information accessible, easy to understand and to use 	
<p>Key public information supporting accountability and choice to be focused on safety, effectiveness and patient/carer experience^{1(para 2.10)}</p>	<p>Enable comparison of peers to trigger competition and assess performance^{1(para 2.8,2.9)}</p>		<p>Need to set out and trial how accountability arrangements will work in practice²⁰ within pathways of care for clinical and community service delivery</p>	
<p>Widespread use of patient experience data and Patient Report Outcome Measures^{1(para 2.7)}</p>		<ul style="list-style-type: none"> Mid-Staffordshire case – relevance of patient and staff feedback for quality control^{1(para 2.26)} Hospitals reducing readmissions through patient interviews at time of readmission to find underlying causes that were not picked up by clinicians¹⁹ 	<p>How best to capture patient feedback/ experience when measuring health outcomes^{1(para 2.7)}</p>	



Table 4 Placing patients at the centre of services and increasing accountability to patients

Policy proposition and rationale	Key drivers	EVIDENCE		Potential future research
		Established	Developing	
GPs-led consortia to take commissioning decisions according to patients’ best interests ¹ (para 4.11)	Drive up quality	Poor commissioning can be damaging to the integration of services ⁵⁶	Evidence from pathfinder commissioning consortia uptake and GPs’ willingness to engage with commissioning policy ²⁰	<p>Clarify commissioning outcomes framework and GPs’ financial incentives for effective management of.²⁰</p> <ul style="list-style-type: none"> • GPs’ conflict of interest • Patients’ confidence in GPs’ commissioning decisions • Effective commissioning
Include public and first line health professionals (e.g. hospital doctors) within local commissioning decisions/ boards ¹ (para 4.6)	<ul style="list-style-type: none"> • Increase accountability • Support integration of care 			<p>Optimum configuration of commissioning boards to account for:</p> <ul style="list-style-type: none"> • Primary and secondary care performance • Overall patient satisfaction • Coordination of service provision²⁰
Transparency in local achievements following commissioning and expenditure decisions ¹ (para 4.11)	<ul style="list-style-type: none"> • Drive local overview scrutiny • Increase accountability • Reduce spending • Reduce variations in the quality of services 	Successful pilot in reducing acute spending by monitoring unscheduled care activity, emergency admissions and GP out-of-hours activities ^{82,83}	<ul style="list-style-type: none"> • Clinical commissioning groups to roll-out “Urgent Clinical Dashboard” to make GPs accountable for expenditure linked with their patients • Clinical commissioning groups to decide levels of service provision to improve efficiencies (pilots about non-emergency phone services, practice local-level reporting systems, web-services, out-of hours appointments, 24/7 care services)^{84,85} 	<p>How to enable direct engagement/ responsibility to clinicians for:</p> <ul style="list-style-type: none"> • How services are delivered and resources committed • Commissioning expenditures • Linking clinical decisions with their financial consequences



Table 5 Market-based approaches for generating competition, reducing costs and improving performance

Policy proposition and rationale	Key drivers	EVIDENCE		Potential future research
		Established	Developing	
Promote supply side competition for health care services provision by a variety of providers including private sector, the NHS and the third sector (social enterprises) ^{1(para 4.21)}	<ul style="list-style-type: none"> Promote cost effectiveness Increase choice of services Improve quality 	<p>On the supply side:</p> <ul style="list-style-type: none"> Specialized services require limited competition to ensure quality, while in cases of less specialized services competition is more effective for improving quality and efficiency⁸⁶ Competition helps to provide services which are value for money¹⁷ Mixed results from the use of competition in the NHS as a means to improve performance⁷⁰ Limited evidence on impact of direct competition for individual patients' custom between services (hospital and community based) and GPs⁵⁷ Competition for the market as used by US Medicare enables cost reductions and quality improvements Evidence about cost containment strategies and competition from the German health care system⁹² 	<p>On the supply side:</p> <ul style="list-style-type: none"> Competition for the market encourages co-operation among providers: 16 PCT organizations piloting integrated service delivery^{70,87} International experience about competition within the market enabling pathway-based disease management and being piloted in US and UK^{70,87,88,89} 	<p>Supply side competition models and issues:</p> <ul style="list-style-type: none"> Need to reconcile and balance conflict between competition, collaboration and integration of care services Competition has to align with choice of providers without leading to fragmentation of services or reduction in quality⁹⁰ Promote market principles where appropriate to avoid challenges when "the wrong type of competition" is used in health care^{70,91} Tailor competition to local circumstances (e.g. rural vs urban areas) and to the spectrum of services in the NHS (A&E and specialist services vs long term and chronic disease services management)⁸⁶ Pilot how integrated services and competition rules can be delivered in practice²⁰



Table 5 Market-based approaches for generating competition, reducing costs and improving performance

Policy proposition and rationale	Key drivers	EVIDENCE		Potential future research
		Established	Developing	
Pricing mechanisms based on tariffs of nationally regulated prices driving productivity and accounting for defined quality of services on the basis of clinical evidence and outcomes ^(para 5.12)	To achieve long term financial benefits	<ul style="list-style-type: none"> • Price competition per se leads to reduction in quality and increase in transaction costs⁵⁹ • In UK and US, competition for health services at fixed prices led to improvements in quality and efficiency (improved access, reduced waiting times, increased efficiency, improved financial management)^{60,61} • Pricing regulated by a tariff system based on health outcomes, and not on volume/activity, prevents providers competing on quality and safety of care^{93,94} 		<ul style="list-style-type: none"> • Trial the impact of price competition on care pathways that are not covered by tariffs under the PbR policy²⁰ (e.g. mental health and community care, non-elective, long-term, complex care and large proportion of specialist acute care). These may suffer reduced quality through competition • Also need to trial payment systems that can facilitate integration of services (e.g. bundled payments, pooled budgets) and link financial rewards to the quality and outcomes of care^{20,70} • Develop payment systems rewarding health outcomes not activities (current PbR system)⁴ • Current PbR can “ossify innovation” and a new pricing system should work across care pathways and provide scope and financial incentive for innovation⁴ • Develop a tariff system that comprises more than one service to facilitate commissioning of integrated pathways of care⁹⁰



Table 5 Market-based approaches for generating competition, reducing costs and improving performance

Policy proposition and rationale	Key drivers	EVIDENCE		Potential future research
		Established	Developing	
<p>'Any qualified provider' to deliver services^{1(para 4.21)}</p>	<ul style="list-style-type: none"> To drive innovation Support competition Provide options for patients to choose from 	<p>Private providers are risk minimizers and profit maximizers, leading to the risk of "cherry-picking"⁶²</p>		<p>Impact of 'any qualified provider' models:</p> <ul style="list-style-type: none"> 'Any qualified provider' policy is not supported by evidence of real patient and cost benefits and studies in this area need to focus on feasibility of provision and commissioning of whole pathways of care⁹⁵ Policy roll-out by a multi-staged implementation strategy in areas of care most likely to benefit from any qualified provider policy. These should include elective and episodic care where outcomes are defined and easy to measure²⁰ Promote provision of integrated packages of care by creating networks of regulated providers competing according to specified products, quality and tariffs⁹⁰ Trials to test best models for the point at which patients exercise choice between providers (this is difficult to predict in the case of complex or long-term care pathways)²⁰ Create a market/opportunities for providers/competitors (new market entrants) able to focus on



Table 5 Market-based approaches for generating competition, reducing costs and improving performance

Policy proposition and rationale	Key drivers	EVIDENCE		Potential future research
		Established	Developing	
On the demand side: Implement effective commissioning and patient choice policies ^{1(para 4.11)}	To drive up quality and efficiencies	<ul style="list-style-type: none"> Effectiveness of choice and competition framework is dependent on clear regulatory framework and good information⁹⁷ Evidence about the indirect impact of choice-generated competition on quality^{98,99} 	Limited evidence on choice and competition operating within the same framework ⁹⁶	<p>consumers/patient-centric health care solutions, as in the case of voluntary sector^{3,96}</p> <ul style="list-style-type: none"> How to address problem of clinical commissioning groups facing financial incentives to refer patients to services owned and run by their member GPs⁵⁷ Facilitating both commissioning and patient choices by enabling patients to choose from pre-approved provider lists that have met defined service specifications²⁰ Ambiguity about who the main purchaser is within NHS: patients or commissioners. Different relevance of patients' choices versus GPs' referring/contractual decisions to the impact of hospital competition⁵⁷



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