C4CC Discussion Paper
System Levers and Person-Centred Care

Aligning System Levers to Enable Person-Centred Care for People with Long-Term Conditions

Disclaimer: this discussion paper does not represent the views of C4CC partner organisations

1. Introduction

C4CC aims, through the actions of a strong partnership and growing movement of people and organisations, to help make person-centred care the norm for people living with long-term conditions. To do this, we are taking action to influence and support local systems and practice, and to create the conditions for person centred care at a national level.

This briefing looks at the decisions made at a *national* level, which have an impact on the ability of people *locally* to work in a person-centred way. These national decisions are often referred to as "system levers". The purpose of this briefing is to:

- focus thinking on key levers
- promote consideration of opportunities for action and influence
- stimulate consideration of potential C4CC partner roles and activity

Discussion of system levers can quickly become technical and complex. The NHS alone is an enormous and complex system – and things get even more complex when we try to think about the NHS, social care and the community at the same time.

This briefing therefore attempts to simplify somewhat, to promote a focus on what is important, so that we can plan and take specific action. It will not go into detail, but rather give examples and attempt to set out the key issues. It asks:

- What do we mean by system levers?
- What does this mean for person-centred care for people living with long-term conditions?
- What needs to be done, and how might C4CC help?

One of the key things in this area that the C4CC hub team will be doing over the coming year is to work closely with the Realising the Value programme. One element of the RTV programme will be in-depth work to understand the impact of system levers on person-centred care. C4CC's role will be to support the work in this area, widely communicate the findings, and to work with the national system leadership bodies to effect change.

2. What do we mean by system levers?

To enable person-centred care for people with long-term conditions to become the norm, many changes are needed in the health and care system. Most of these

changes can only happen at a local level, and are the responsibility of local health and care services, and local communities.

> *Example of change at the local level*
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> For care and support planning to be routinely offered to people living with long-term conditions in a locality, many specific local changes will be needed.
>
> For example, within a single GP practice, a whole set of complex changes would be needed, for people (e.g. changing roles and relationships for staff and people with long-term conditions) and for organisational systems and processes (e.g. changing appointment lengths, how information is communicated, how appointment call and recall systems are set up). This kind of "whole system" change is hard – even within a single practice – and requires leadership and buy-in from within the practice itself. To scale this up across a whole locality – for example a CCG area – requires yet another level of local leadership, to build trust and buy-in across organisations with competing priorities. This kind of change cannot be nationally mandated.

However, the actions of national system leadership organisations also have an impact on local services, as well as on individual practitioners, people and communities. These actions are often referred to as national "system levers". At its simplest, this term means the decisions made at a national level which have an impact on how things happen throughout the health and care system. Examples would include legislation, targets and standards, measurement, the payment system, national financial incentives, rules about competition and regulation.

By the health and care system, we mean the NHS, statutory social care services, and the voluntary and community sector. The relevant system leadership organisations include the Department of Health, the Department for Communities and Local Government, NHS England, Monitor and the Trust Development Agency (now combined as NHS Improvement), the Care Quality Commission, Health Education England and Public Health England.[1]

Decisions made at a national level can either support or hinder the ability of people locally to work in a person-centred way.

> *Example of a national barrier to local change*
> The NHS payment system currently pays hospitals by activity. That is, they get paid according to how many people they treat. This system was designed to incentivise more activity at a time when this was important to reduce waiting lists for operations. However, this now acts as a disincentive for hospitals to work with people and communities to reduce admissions by supporting people to stay well. Many hospital teams work hard to support people to stay well *despite these rules*. But this element of the current payment system is a barrier that needs to be overcome, rather than an enabler which encourages person-centred, integrated care.

[1] A brief summary of each of these organisation's functions is included at Annex A.

With some issues, it can be a challenge to disentangle at what level barriers are caused. Legislation on information governance (IG) is a good example of this. IG means the rules about sharing data, particularly personal, confidential information. The legal framework governing the use of personal confidential data in health care is complex. It includes the 2006 NHS Act, the 2012 Health and Social Care Act, the Data Protection Act, and the Human Rights Act.

In order for people to only have to tell their story once, and for their interactions with different parts of the NHS and social care system to feel joined up, it is essential that information can be shared between different services (for example, sharing medical records between GP practices and hospitals). IG is often cited by people locally as a barrier to working in an integrated, person-centred way. However, it can be very difficult to understand how far the problem:

- is in fact one of legislation, which needs national attention to change;
- is not caused by the current legislation itself, but by a lack of clarity and understanding about what the legislation allows, requiring communication and engagement work (either nationally or locally);
- is not in fact caused by legislation at all – but is rather a cultural problem, for example resistance to sharing information in certain ways if this has not previously been common practice.

Finding solutions takes time. A particular issue on IG is the removal, in the 2012 Health and Social Care Act, of the normal ability of commissioners to share information where it is not for the purposes of the direct provision of care. The relevant national bodies (the Department of Health, NHS England, the Health and Social Care Information Centre (HSCIC) and Public Health England) have formed the Information Governance Alliance (IGA).[2] The IGA is leading work to understand how far these issues can be resolved within the current legislative framework. Solutions will be tested with national demonstrator sites to see if they meet their needs.

3. What does this mean for person-centred care?

3.1 National system levers

The table below lists examples of national system levers which have an impact on the ability of local areas to work in a person-centred way. Many have some elements which support person-centred working, together with other elements which can act as a barrier.

Examples of national financial and operational system levers

Financial	The overall payment system framework Tariff, best-practice tariffs NHS standard contract sanctions Quality and Outcomes Framework (QOF) Quality Premium (QP)

[2] http://systems.hscic.gov.uk/infogov/iga

	Enhanced Services (ES) Commissioning for Quality and Innovation (CQUIN) The Better Care Fund LTC Year of Care Commissioning Programme
Non-financial / operational / reputational	Legislation and national commitments (e.g. NHS England's Mandate) Regulation, audit and inspection Competition and choice NHS standard contract and service specifications, contract renewal or extension National measurement system: Operational standards (e.g. on waiting times) NHS Outcomes Framework and CCG outcomes indicator set NHS Levels of Ambition Work to develop person-centred outcome measures

This is a long list and it is likely that action will be needed in many of these areas, to create the optimum conditions to enable person centred care. C4CC will need to consider an appropriate approach to this, given capacity and context and the roles that partners may play.

For the purposes of this briefing, rather than exploring the list in detail, two significant issues for person-centred care - measurement and the payment system/financial incentives - are discussed briefly below as key examples of the kinds of issues that need to be worked through.

Measurement

Measurement is key to understanding how to design, deliver and improve health and care services. However, our national measurement system is not – yet – sufficiently person-centred. It tends to be dominated by indicators that are system-centric rather than person-centric. The national operational standards on referral to treatment, ambulance and A&E waiting times are good examples of system-centric measures. The current measurement system is not integrated (indicators are collated by different national agencies), and it is not being used systematically to improve local services – let alone to ensure that local services become more person-centred.

A number of recent publications have helped us understand what people living with long-term conditions want from public services; and to start to work out how to measure whether this is being delivered.

National Voices and Think Local Act Personal worked in partnership with NHS England to develop a narrative that describes what people living with long-term conditions want public services to offer.[3] The narrative is presented as a series of 'I statements' that are distilled into the core message:

[3] http://www.nationalvoices.org.uk/defining-integrated-care

'I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes that are important to me'

Developing a measurement system to understand whether this is being achieved is a difficult challenge, but one that is being responded to by a range of people and organisations. The Health Foundation's report *Measuring what really matters* considered which existing person-centred indicators would measure what matters to an individual living with long-term conditions. NHS England, the Health Foundation and others have built on this work. For example, NHS England and the Health Foundation are supporting a group of CCGs to test different ways of using the Patient Activation Measure to understand how interventions improve the knowledge, skills and confidence of people to manage their own health and care.[4] The team evaluating the Vanguard and Integrated Personal Commissioning (IPC) programmes are also working with local sites to include measures of person-centred, integrated care within the overall evaluation.

Over time, this could enable the overall national measurement system to become more person-centred. However, there are barriers to overcome in the current system itself. For example, the need to avoid increasing the reporting burden on the health and care system means that introducing a new nationally-collected measure can only be done if another measure is removed. Change will require political will and focus.

The payment system

While this is not the only way to influence the activities and priorities of the NHS, the allocation of almost £100bn does present a huge opportunity to incentivise providers to promote individual participation in health and care. In a mixed health economy, prices and financial rewards, national or local, can influence the behaviour and decision making of providers and commissioners.

NHS England and Monitor work together to create the framework of payment rules, prices and regulatory arrangements that make up the NHS payment system. This can be thought of as a set of tools – incentives, rewards and sanctions – which commissioners can choose from to manage relationships with providers.

Within the current payment system, there are a range of nationally set elements, for example tariff and best-practice tariffs and NHS Standard Contract sanctions. There are nationally-agreed performance-related incentives, including the Quality and Outcomes Framework (QOF), the Quality Premium for CCGs, Enhanced Service payments and Commissioning for Quality and Innovation (CQUIN) payments. The payment system also allows local flexibility in a range of circumstances, both for prices and for targeted incentives including local CQUINs.

It is widely acknowledged that the current payment system is not fit for purpose, given an aging population, the growth of long-term conditions and very constrained financial resources. Monitor and NHS England have already begun work on this, seeking to develop a payment system that will support integration (of health and

[4] http://www.england.nhs.uk/2014/05/16/patient-activation/

social care, primary and secondary care, mental and physical health), promote personalisation, and promote a shift of resources into primary and community care, where support for self-management and personalised care and support planning can be most effective.

Recent innovations such as the LTC Year of Care Commissioning Programme for long-term conditions have enabled the assessment and planning for a population's care across a range of services for a whole year – rather than paying for individual episodes of care. The new models of care Vanguards are also developing various payment system changes. New issues and lessons will emerge from these programmes over coming months and years, and responding to them will be an ongoing process.

Targeted incentives

It is sometimes suggested that if we could just design the right financial incentives for person-centred care, change would smoothly follow. Unfortunately, this is not the case. Monitor has found that while financial incentives have an important role to play, there are clear limitations. They are effective for incentivising specific, well-defined and measurable goals. But there is a high risk of unintended consequences. An incentive's impact will tend to reduce over time, but the behaviour it is rewarding will not necessarily continue after the incentive is removed.[5] Moreover, it is important to bear in mind that financial incentives can reduce professional motivation for a particular activity, by shifting motivation from professional duty or altruism to "compliance".

The implication is that targeted financial incentives should be treated with caution. The focus should be on "big ticket" changes that align system-wide goals. Incentives need to be based on clear and achievable metrics – and this is an area still being developed for person-centred care.

Box: Quality and Outcomes Framework

The Quality and Outcomes Framework (QOF) is a pay for performance scheme that was introduced in 2004 to improve quality of care in general practice. It currently constitutes roughly 13 per cent of practice income.

The QOF includes a range of national quality standards, based on the best available evidence. Practices score points according to their level of achievement against a range of clinical and public health indicators for these standards. Clinical indicators are across a wide range of individual conditions, for example coronary heart disease, dementia or depression. Public health indicators include health improvement areas such as offering support to stop smoking. At the end of the financial year the total number of points achieved by a practice is converted into a payment.

[5] See for example the Nuffield Trust's briefing on the NHS Payment System for more detail http://www.nuffieldtrust.org.uk/publications/nhs-payment-system-policy

Example indicators (out of a total of 77 indicators in 2015/16):[6]
CHD001: The contractor establishes and maintains a register of patients with coronary heart disease
CHD002: The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less
SMOK004: The percentage of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 24 months

Arguments for and against the QOF have been debated since its introduction. Reviewing this, a recent BMJ article concludes: "evidence for the overall success of the QOF is limited due to the lack of a control group and because any effect will be small and hidden among many other determinants of population health".[7]

This article concluded that the QOF is likely to have some specific effects on the capacity of general practice to work in a person-centred way, particularly in terms of embedding personalised care planning for people with long-term conditions:

- It incentivises process measures (e.g. concentrations of glycosylated haemoglobin or lipids in the blood) rather than the health outcomes that people want to achieve (e.g. symptom relief or quality of life). Process measures are useful, but need to be considered as part of good clinical care, rather than driven by financial incentives. The need to report against multiple QOF indicators is widely reported by GPs as a barrier to having a holistic conversation with patients about what matters to them.
- The focus of QOF on single-condition indicators is inappropriate for an aging population increasingly living with multiple long-term conditions. "*Following guidelines, a 70-year-old woman with three chronic long-term conditions and two risk factors would be prescribed 19 different doses of 12 different drugs at five different times of the day. Clearly we need to be increasingly judicious in the application of modern medicine, lest we replace the burden of chronic disease with the burden of diagnosis and treatment.*"

Making changes to QOF would require both further work to fully develop alternative proposals, and complex negotiations around the GP contract.

3.2 National demonstrator programmes

National policy is developed in a variety of ways. Over the coming years, the national demonstrator programmes announced in the Five Year Forward View (in particular the Integrated Personal Commissioning and Vanguard programmes) will be

[6] For the full current set of QOF indicators: http://www.nhsemployers.org/your-workforce/primary-care-contacts/general-medical-services/quality-and-outcomes-framework
[7] http://www.bmj.com/content/350/bmj.h2540.full?ijkey=kzQzecwKIZ8zvAL&keytype=ref
BMJ 2015;350:h2540 *Person centred coordinated care: where does the QOF point us?*

particularly influential. These programmes are important to consider as part of C4CC's overall work on system levers.

The aim of these programmes is to act as catalysts for change – not just improving services in the demonstrator sites, but developing models that can be replicated across the whole country. In July, NHS England published a support programme for the Vanguards, to tackle common problems and accelerate implementation. A published support package for IPC will follow.

These programmes will have a major impact on how national policy develops, and so have significant implications for enabling person-centred care for people living with long-term conditions.

C4CC is working with NHS England to develop the support offer to Vanguard and IPC sites, to ensure that person-centred approaches are at the heart of the models. A briefing on the Vanguards and IPC is included at Annex 2.

4. What action is needed?

We are currently at a national moment of opportunity for person-centred care. The vision of the Five Year Forward View has partnership working with empowered people and communities absolutely at its heart. The challenge is that making changes to national system levers is complex, often technical, work. Change is usually slow and iterative.

Much useful work is already happening. Work is underway across NHS England and other system leadership bodies to align financial and operational incentives with the vision of the Five Year Forward View. Other issues needing a national response will emerge from the IPC and Vanguard programmes.

There is a long way to go. We need to keep working together to really understand the barriers that people face locally, and to keep patiently chipping away at finding collaborative solutions. The Coalition for Collaborative Care's reach is unique in this regard, bringing together local and national expertise, and many different perspectives, to enable change.

What can the C4CC team do?

Given the evolving and complex nature of the situation, it is important to get really clear on what the problems actually are, rather than investing great effort on the wrong issues. Realising the Value's work on system levers will be important here. Realising the Value is looking in depth at the impact of system levers on person-centred care, and will make recommendations in spring 2016 for how to realign and refocus these levers.

The C4CC team has an agreement to work closely with the RTV team, taking their learning and ensuring that they are communicated and acted on.

C4CC will also work with NHS England and the other national system leadership bodies (some of whom are C4CC Partners) to ensure that they maintain a focus on

person-centred care for people living with long-term conditions. In doing this we will ensure, through our partners, members and coproduction group, that this work is connected to people's real lives and the reality of local systems and practice. In engaging with the national bodies it will be necessary to map concrete opportunities for positive influence, given the potential scope and complexity.

And we will continue to work with and influence the national demonstrator programmes. C4CC has already started work with the nine IPC sites, on scaling up care and support planning, coproduction and building community capacity. We are working closely with NHS England to develop an offer for the Vanguard sites.

What might C4CC Partners do?

C4CC's system leadership partners (NHS England, HEE, PHE and NICE) will continue work to align levers for person-centred care.

Our other partners and members have an important role in providing intelligence on what barriers people are facing locally, and what needs to change. Many partners will also be providing support to the IPC and Vanguard programmes on person-centred approaches including care and support planning and building community capacity.

5. Feedback

This discussion paper is being shared with C4CC partners and members, to promote consideration of opportunities for action and influence. The C4CC team would welcome any feedback, ideas and suggestions. In particular:

a) what do you/your organisation see as the key barriers and enablers to person centred care linked to national system levers?

b) what (practical and possible) roles might C4CC take to remove barriers and strengthen enablers?

c) what role can you/your organisation play?

Please send any comments to England.C4CC@nhs.net, by Friday 6 November 2015.

Annex 1: National System Leadership Functions

Department of Health	Responsible for government policy on health and adult social care in England
Department for Communities and Local Government	Responsible for government policy on local government, including community resilience and cohesion, housing and planning
NHS England	Strategic leadership of the NHS in England, overseeing the budget, planning, delivery and day-to-day operation of the commissioning side of the NHS
Monitor*	Financial regulator for health services in England
NHS Trust Development Authority*	Support and oversight to NHS provider trusts
The Care Quality Commission	Quality regulator for health and social care services in England
Health Education England	National leadership and coordination for education and training for the health workforce in England
Public Health England	Responsible for health protection, health improvement and addressing health inequalities

*Monitor and the TDA are merging to form NHS Improvement

Annex 2: National Demonstrator Programmes

The Vanguard and IPC programmes build on two previous programmes: the Better Care Fund and the Integration Pioneers. The table below sets out the basics on these four programmes. Some sites are involved in more than one programme (for example, Tower Hamlets is both an integration pioneer and an IPC site; Cheshire West is in all three programmes).

Main national programmes on integrated and person-centred care

Programme	Better Care Fund	Pioneers	IPC	Vanguards
Number of sites	All 151 health and wellbeing board areas in England	14 wave 1 11 wave 2	9 sites	15 MCPs 9 PACS 6 Care Homes 8 UEC sites 15 Acute Care Collaborations
Start date & duration	14/15: planning 15/16: implementation 15/16: tbc	13/14 for 5 years	15/16 for min 3 years	15/16 for min 3 years
Key focus	Creation of s.75 pooled budgets across health and social care to improve integration of care and support	Whole-system health and social care integration. No prescribed model	Individual-level costing, linked with person-centred care model with optional personal budgets	Five care models being tested – more detail below

The Better Care Fund supported every area in the country to make a start on integrating health and social care commissioning, through the creation of pooled budgets. The Integration Pioneers programme is supporting areas to test a wide range of innovative approaches to delivering integrated care. The Vanguard and IPC programmes build on these programmes, to focus on a small number of replicable approaches. The Box below gives brief details

Integrated Personal Commissioning

IPC is a voluntary approach to joining up health and social care for people with complex needs. Working in partnership between service users, the NHS, local authorities and the voluntary sector, the programme brings health and social care spending together at the level of the individual. It aims to consolidate a shift in power to people with complex needs, to help them shape care that is effective and meaningful to them. The model is based on person-centred care and support planning, combined with an optional integrated personal health and social care budget.

Vanguards (new care models)

Five new approaches to population health management are being tested, with the intention to identify replicable standards, tools and methods so that scale can be

reached.

- **Multi-specialty Community Providers (MCP):**
  - Blending primary care and specialist services in one organisation
  - Multidisciplinary teams providing services in the community
  - Identifying the patients who will benefit most, across a population of at least 30,000
  - Shift to capitated funding model

- **Primary and Acute Care Systems** (**PACS** – a significantly extended form of MCP):
  - Integrated primary, hospital and mental health services working as a single integrated network or organisation
  - Sharing the risk for the health of a defined population
  - Flexible use of workforce and wider community assets
  - Shift to capitated funding model

(PACS and MCPs will be required to offer personal health budgets as a core part of the model).

- **Enhanced health in Care Homes**
  - Multi-agency support for people in care homes and to help people stay at home
  - Using new technologies and telemedicine for specialist input
  - Support for patients to die in their place of choice

- **Urgent and Emergency Care**
  - New approaches to improve the coordination of services and reduce pressure on A&E departments

- **Acute Care Collaboration**
  - Enhancing the viability of local hospitals through new formal shared working arrangements between clinical specialists at different hospitals
  - Improving efficiency by sharing back office administration and management between different sites