Realising
the Value
Empowering people,
engaging communities

What the system can do

The role of national bodies in
realising the value of people and
communities in health and care

Report

November 2016

About the Realising the Value programme

Over the last 18 months, the Realising the Value consortium has brought together the perspectives of people with lived experience, the voluntary, community and social enterprise (VCSE) sector, practitioners, academics, commissioners, providers and policymakers to consolidate what is known about person- and community-centred approaches for health and wellbeing and make recommendations on how they can have maximum impact. The Realising the Value programme has also developed practical resources to support implementation of these approaches at the frontline.

About this report

This report – produced as part of the Realising the Value programme – reviews the wide range of mechanisms that national bodies use to achieve their policy objectives for health and care services. In particular, the report assesses the impact these mechanisms have on person- and community-centred approaches and suggests how national bodies can remove barriers and support the implementation and spread of these approaches.

It is aimed at policymakers in government departments and arm's-length-bodies but we hope it will also be of interest to anyone interested in how national policies and context can better support the implementation and spread of person- and community-centred approaches for health and wellbeing.

Acknowledgements

Contents

Executive summary

"What switched me on to more person- and community-centred approaches? Seventeen years as a GP. When you follow the medical line alone, you lose people. For example, after many years of talking with people about losing weight I found that if you ask different questions you get different answers – money or housing problems or how they're feeling in themselves may be at the root of it… People need to have different, much more holistic conversations about what matters to them, not what we think matters for them."

Dr Karen Eastman, Clinical Director, Horsham and Mid Sussex CCG

"The Living Well course helped me to take back some control. I started to understand the importance of diet and exercise, making lasting changes that make me feel physically and emotionally stronger."

Participant on a Penny Brohn UK Living Well course

A note on language

The Realising the Value programme uses the term 'person- and community-centred approaches for health and wellbeing' to describe a wide range of approaches and interventions united by a common purpose: to genuinely put people and communities at the heart of health and wellbeing. And to do this by focusing on what is important to people, what skills and attributes they have, and on the role of their family, friends and communities. The levers that national bodies can use will often – but not always – be the same for approaches focused on increasing person-centred care for individuals and those seeking to encourage more community-centred approaches for health and wellbeing. For example, changes to the undergraduate curricula for health care professionals are more likely to be an effective mechanism for person-centred care whereas workforce-focused interventions such as giving district nurses more flexibility over their working patterns and more autonomy may be more beneficial for increasing community engagement. The report makes this distinction where relevant but otherwise we refer to person- and community-centred approaches for health and wellbeing.

It is welcome that national policies, including the NHS Five Year Forward View, increasingly recognise that to improve health and the quality of care, people and communities should be active in co-creating health and wellbeing with the formal services and the staff who support them, not passive recipients of care or services. Evidence is growing that more person- and community-centred approaches to promoting health and providing care will lead to improved health and wellbeing for individuals, as well as stronger and more resilient communities and social networks. In time the hope is that these approaches may also contribute to reducing demand on formal services.

In England, a wide range of person- and community-centred approaches for health and wellbeing are already in full operation or being tested, spanning health, social care, wider public services and communities. NHS England has also been developing a self-care programme ensuring that person- and community-centred approaches are embedded in key national programmes. If the policy direction is clear, the key question addressed in this report is how can we achieve faster progress?

Learning from Realising the Value (RtV) and other programmes, such as Integrated Care and Support Pioneers, highlights that most of the factors associated with successful implementation of person- and community-centred approaches for health and wellbeing are to do with local context. This could involve passionate individuals leading change, local partnerships growing strong on the back of successful pilots, supportive local leadership, or time spent building and sustaining relationships across organisations and with communities. Clearly, the local context is the primary responsibility of local organisations and communities.

However, local context is influenced by the policies designed by national bodies, such as NHS England, Health Education England (HEE), NHS Improvement, the Care Quality Commission (CQC) and the National Institute for Health and Care Excellence (NICE). And while national policies can help progress, they can also unintentionally hinder. Commonly cited obstacles include: contracting arrangements, commissioning structures, competition, information governance, and competing national directives. National bodies have a crucially important role in identifying and reducing or removing these avoidable barriers.

Some of these barriers have arisen because they may serve other policy goals, rather than encouraging person- or community-centred approaches. And there are a great number of policy priorities and initiatives at present. The most obvious is work to ensure that the NHS in England lives within its growth-constrained budget, while still achieving the goals set out in the NHS Constitution and the changes set out in the NHS Five Year Forward View. In the 18 months since the RtV programme was commissioned, the New Care Models and Integrated Personal Commissioning programmes have started; the second wave of Integrated Care and Support Pioneers was announced (and the early evaluation of the first wave was published); there have been several 'devolution deals' in health care;[1] and Sustainability and Transformation Plans (STPs) were announced.

This report – produced as part of the RtV programme – focuses on how national bodies can best remove barriers to progressing person- and community-centred approaches for health and wellbeing. It reviews the range of mechanisms (often called system levers) national bodies use to influence health and care services to achieve policy objectives, and the impact these have on person- and community-centred approaches for health and wellbeing. It suggests what national bodies might best do to help implement and spread these approaches, including the five approaches that the RtV programme focused on: self-management education; peer support; health coaching; group activities; and community asset-based approaches.

Local action will continue to be the main driver of change towards more person- and community-centred approaches, particularly in the current complex, pressurised and dynamic context. However, this report identifies six key findings relevant for policymakers and national system leaders, and a range of specific actions that could be taken in areas such as education and training, regulation and commissioning to help create an environment conducive to these approaches flourishing.

Key findings for policymakers and national system leaders

National bodies should focus on people as well as systems

Many national initiatives seek to empower people and communities to stay healthy or be more engaged in their care. Traditional mechanisms such as payment incentives or regulation can be helpful, for example by providing a focus on person-centred care through regulation or financially rewarding certain activities. But they can only go so far in encouraging new relationships between health and care services, individuals and communities to develop locally.

'People-focused' approaches offer significant potential to change the relationships between individual patients and the health and care staff they interact with, and between services and the communities they are set up to serve.[2] If staff morale is low with high numbers of staff reporting they are working under stress or without sufficient support to provide high quality care, this is likely to have a detrimental impact on people's motivation and ability to provide compassionate, person-centred care. Conversely, when staff are supported to work in new ways and develop new relationships with the people they support – eg through supported self-management, health coaching or shared decision making – they have increased job satisfaction and report more meaningful relationships with patients and communities.

Much of what impacts on the workforce is determined at a local level. National policy could, however, go much further to encourage local bodies to focus on: staff engagement and morale; supporting the informal workforce – patients, service users, carers and volunteers; building capability in commissioners and the voluntary and community sector workforce; and focusing on the values that should underpin selection and recruitment of staff at all levels.

National policies must be coordinated

National bodies need to align levers to achieve desired goals. The existing national initiatives to empower and engage people and communities in improving health and care sit alongside a raft of policy 'must dos' with other objectives, such as achieving financial stability, managing performance and improving safety. All of these impact on one another, and can do so in ways that impede progress. Greater visibility at national level about the various levers being used, what they are trying to achieve and how they impact on each other would help.

There are a many good examples of national bodies coming together to make joint commitments on transforming health and care. These include the Shared Commitment on Integrated Care and Support[3] and, most recently, the shared commitment and call to action on engaging and empowering communities.[4] These can be helpful statements of intent and provide focus for the work of national bodies but, as noted in the early evaluation of the Integrated Care and Support Pioneer programme, they do not always reduce barriers to implementation on the ground. Too often these statements are developed for particular programmes or work streams by different organisations – or sometimes by different teams in the same organisation – without taking account of what else is going on. Sometimes there isn't enough consideration about how the commitments will be delivered in the face of other objectives or demands on the health or care system.

National initiatives have potential but how they are implemented is central to their success

National initiatives that support local partnerships to develop and trial new approaches and models of care offer significant potential to support greater take up of person- and community-centred approaches for health and wellbeing. These are often place-based and when done well are partnerships between a range of services and sectors – for example health, social care, wider public services, the voluntary and community sector – and people and communities. However, there is a real risk, particularly when faced with the day-to-day pressures on health and care services, that these types of initiatives will not be supported in the ways that will allow them to be most effective.

The partner sites that we have worked with throughout the RtV programme have shown that much of their success depends on the relationships they developed – with commissioners, other providers in both statutory and voluntary services, and with their communities. These take time to develop but the benefits can be enormous, including the freedom to take risks and try new things. In our climate of increasing performance and financial pressures it can be challenging to prioritise person- and community-centred approaches over other, pressing, demands. But for progress to be made and identified, national programmes such as the New Care Models must give teams the space and flexibility to implement, test and develop their approaches. They must avoid putting pressure on them to show outcomes too early. National bodies must also be alert to the detrimental impact that top-down directives or targets can have on local attempts to implement these approaches and the willingness or ability of commissioners to invest in these approaches.

To give these types of improvement initiatives the best chance of success, national bodies should pay particular attention to:

- capturing and sharing learning to support the spread of approaches beyond mature and high performing areas

- giving sites practical support – particularly to tackle the barriers that are outside of their direct control – as well as guidance and tools

- understanding why progress is being made (or not) in current initiatives to inform future programmes

- providing time and flexibility for local sites to develop, and resisting the temptation to overload programmes with objectives or specific activities.

A thriving and sustainable voluntary and community sector is crucial

A strong and sustainable voluntary and community sector is needed for person- and community-centred approaches to thrive. This should ensure that there is a wide range of services available to provide the support that people and communities want and need. It can also provide a route for statutory services to engage with, and co-design services with people and communities they often don't reach. However, the current system of procurement can act as a barrier through fragmented commissioning between health services, short-term contracts and gaps in health commissioners' understanding of commissioning for social value.

National bodies can better support the voluntary and community sector by ensuring that:

- there are a range of contract and grant mechanisms available for commissioners to use with voluntary sector partners.

- outcomes-based commissioning models are developed considering their impact on the voluntary sector
- commissioners are supported to develop the knowledge, skills and capability to work with the voluntary sector and to understand how to commission for wider social value.

The voluntary and community sector can also do more to help commissioners by improving how it captures and communicates its impact. Large national charities and coalitions can take a lead in supporting capability building in the sector.

A coherent measurement framework can help unlock barriers to person- and community-centred approaches for health and wellbeing

While action is needed in lots of areas to progress person- and community-centred approaches, focusing on measurement – and in particular developing a simplified outcomes framework and a core set of national outcomes focused on what matters to people and communities – could help to unlock other barriers such as how to design effective payment mechanisms for person- and community-centred approaches for health and wellbeing. In the short term, national bodies should provide practical support to local areas around measuring personal outcomes. They should also support the understanding of how existing data can provide a richer picture of services and how they are supporting people to achieve the outcomes that matter to them.

Alongside this, work is needed to develop and test mechanisms for aggregating personal outcomes data to be useful at an individual, organisation and population level. Finally, a key priority is for national bodies to come together and agree the purpose and content of a single, simplified, cross-system outcomes framework based on outcomes that matter to people and communities to replace the existing national outcomes frameworks for the NHS, social care and public health.

National bodies could do more to ensure co-production is embedded at all levels of the system

Many of the most impactful and resilient improvement programmes, best policy initiatives and most successful training courses in health care are ones where:

- patients, service users and carers have been involved in identifying the need for change
- the solutions have been co-designed and co-produced by people and the providers, policymakers and practitioners they work with.

While many organisations at both a national and local level do involve patients, service users, carers and wider communities in different ways, relatively few are genuinely co-produced. Support and training is needed for both people and the practitioners and policymakers they work with to support co-production. National bodies can help by:

- ensuring that co-production is prioritised in all of their work streams
- signalling the critical importance of co-production in key national strategies, such as the National Improvement and Leadership Development Strategy being developed by NHS Improvement
- promoting tested models of co-production to local organisations
- supporting the development of patient leaders and developing a consistent package of training and support for patient leaders and other lay representatives involved in improving national or local health and care services.

1: Introduction

This report – produced as part of the Realising the Value (RtV) programme – reviews the wide range of mechanisms that national bodies use to achieve their policy objectives for health and care services. In particular, the report assesses the impact these mechanisms have on person- and community-centred approaches and suggests how national bodies can remove barriers and support the implementation and spread of these approaches.

Conversations with our partner sites[5] have suggested that **local factors** have driven the implementation of successful person- and community-centred care – be they passionate individuals leading change or local partnerships that have grown strong on the back of successful pilots. Our partner sites primarily described their 'enablers' as local (partnerships, community involvement, organisational leadership, and relationships with commissioners who were willing to take risks), and the barriers they faced as national (contracting arrangements, commissioning structures, and the status quo of a medicalised model of care, for example). This also reflects findings in the recent evaluation of the Integrated Care and Support Pioneers programme.[6]

While local action is clearly important, **supportive national policy** is too. The NHS Five Year Forward View places strong emphasis on developing people and communities as a way to improve health and wellbeing for individuals, deliver wider social benefits and, over time, help to reduce demand on formal health and care services. The most successful local organisations are well placed to use this opportunity to build momentum – but this requires a sophisticated understanding of the national landscape and how it can be used to best advantage. Penny Brohn UK, one of the RtV partner sites, reported that the work of Macmillan and the NHS on the National Cancer Survivorship Initiative in 2009–13 allowed them to have a voice and to help shape this policy. As a result Penny Brohn UK developed its flagship Living Well course based around the key themes and policy direction of the Initiative's report. More recently, Unlimited Potential, another of the RtV partner sites, said that the devolution deal in Greater Manchester has helped galvanise new conversations between statutory agencies and the voluntary sector. This has enabled them to explore issues with local leaders in a way that is more relevant to their local situation than was possible when these matters were dealt with at national level.

Throughout this report, we consider the balance between national policy and local action – finding the right balance is hard. RtV partner sites suggested that national and regional administrative tiers of the NHS should concentrate on creating an enabling environment which supports local teams to drive the agenda. In their view, these bodies should signal the importance of person- and community-centred care approaches through their decisions, plans and actions, allowing local systems and organisations to test how approaches can best be implemented locally.

The recommendations in this report focus on what national bodies like NHS England, HEE, the Care Quality Commission (CQC) and NHS Improvement can do to help create the conditions that allow person- and community-centred approaches to be embedded and to spread more widely in health and care services and in communities themselves.

Methodology

This report is informed by the following:

- A rapid evidence scan[*] of empirical literature about the impact of national mechanisms on developing and spreading person- and community-centred care approaches. The scan found that few relevant studies have attempted to understand what system levers are effective in supporting person- and community-centred approaches for health and wellbeing.

- A review of recent policy reports and other publications that have recommended changes to national system levers to support person- or community-centred approaches for health and wellbeing.

- The experiences of the five RtV partner sites.

- Insights from interviews and ongoing conversations with people with expertise in person- and community-centred approaches or who are working in national bodies.

What are national system mechanisms or levers?

Often when people talk about system levers, they are referring to 'hard levers' such as contracts, payment systems and regulation. These sit within a much broader suite of methods used to influence the health and care system.

The recent Health Foundation report, *A clear road ahead: Creating a coherent quality strategy for the English NHS,*[7] describes this wide range of available levers. They are grouped according to their focus and the intended target of their activity (see Table 1 on the next page).

Many of the patient- and public-focused interventions identified in *A clear road ahead* are exactly the type of approaches that the RtV programme seeks to promote. Our analysis focuses on how the other levers or mechanisms outlined in the taxonomy can best support these approaches. We have focused on specific interventions from the taxonomy and elsewhere that have most relevance and potential impact on person- and community-centred approaches for health and wellbeing. This report, therefore, uses an adapted version of the taxonomy described in *A clear road ahead* to discuss system levers as they relate to person- and community-centred approaches for health and wellbeing.

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[*]   The scan is available as an annex to this report. Available via the Realising the value website.

Table 1: Classification of quality-focused interventions

	Focus of intervention	Definition
People-focused interventions	**Patient and public**	Interventions that recognise the importance of patients as active participants in health care at individual and collective levels
	Workforce	Interventions that focus on workforce planning and engagement
System-focused interventions	**Improvement**	Interventions that are concerned with quality aspirations and lead to innovation and learning for improved performance and organisational culture change
	Regulatory	Interventions with a regulatory focus that aim to improve health care, guarantee minimum acceptable standards, reassure the public about quality of care, and protect patients' rights
	System management	Interventions that are concerned with the functions and interactions of the different components of the NHS as a system and focus on defining, driving, measuring or reporting quality
	Health care delivery	Interventions that address the organisation and delivery of health care services

2: People-focused interventions

Recommendations

Alignment of effort

- HEE's strategy, Framework 15 is a clear document with big ambitions; all stakeholders should be encouraged to translate this into action and create a delivery mechanism to achieve this.

Investment in workforce development

- While it will be difficult, it is essential that HEE delivers on its commitment to shift the balance of funding to provide more support for existing workforce development.

Values-based recruitment

- National bodies should continue to champion the use of values-based recruitment by universities and local employers, building on the work already undertaken by HEE and Skills for Care.

Education and training

- Curriculum reform needs to happen at much greater scale, with action at all levels of the system including universities, royal colleges, professional regulators such as the General Medical Council (GMC) and the Nursing & Midwifery Council (NMC) as well as HEE.

- The work to develop a common skills framework for person-centred care led by HEE should be encouraged and supported.

- There should be a focus on embedding person- and community-centred approaches into the supervision and ongoing training of health care professionals, increased patient and service user involvement in education and training, and more opportunity for trainees to undertake placements in community settings.

New roles

- Work on developing new roles to support person- and community-centred approaches needs to start now. This should focus on:

  – Building the evidence base for new roles, including the evidence of cost effectiveness and understanding which roles are most effective in which circumstances

  – Commissioning and developing roles where there is the most evidence such as peer support and the effective lay interventions identified in NICE's guidance on community engagement

  – Providing advice and support to local employers on implementing new roles, including overcoming barriers to employment and addressing issues around professional responsibility.

Staff engagement

- National bodies with remit over workforce policy and development should prioritise staff engagement. Leaders at all levels of the system, especially locally, should harness, celebrate and support creative ways to reconnect staff with their intrinsic motivations, in line with examples such as '#Hellomynameis'.

- Initiatives that focus on service improvement and co-production should be encouraged – building capability throughout staff groups. These have the potential to be particularly effective where funding for investment in workforce development is limited.

The informal workforce and supporting social movements

- National and local bodies should explicitly recognise patients, carers and volunteers as an essential part of the wider health and care workforce and ensure they are provided with appropriate support and training to work in partnership with health and care services, commissioners and policymakers.

The formal health and social care workforce in England is made up of almost 3 million people (1.4 million NHS staff[8] and 1.45 million social care staff[9]). It is estimated that there are 1.7 million active health and care volunteers across England, Scotland and Wales[10] and over 6 million people in the UK (5.4 million in England alone) who are carers for a family member or someone close to them.[11]

Staff morale is currently low with high numbers of staff reporting that they are working under stress or without sufficient support to provide high quality care or manage difficult situations.[12] This is likely to have a detrimental impact on people's motivation and ability to provide compassionate person-centred care. Conversely, when staff are supported to work in new ways and develop new relationships with the people they support – eg through supported self-management, health coaching or shared decision making – they have increased job satisfaction and report more meaningful relationships with patients and communities.[13]
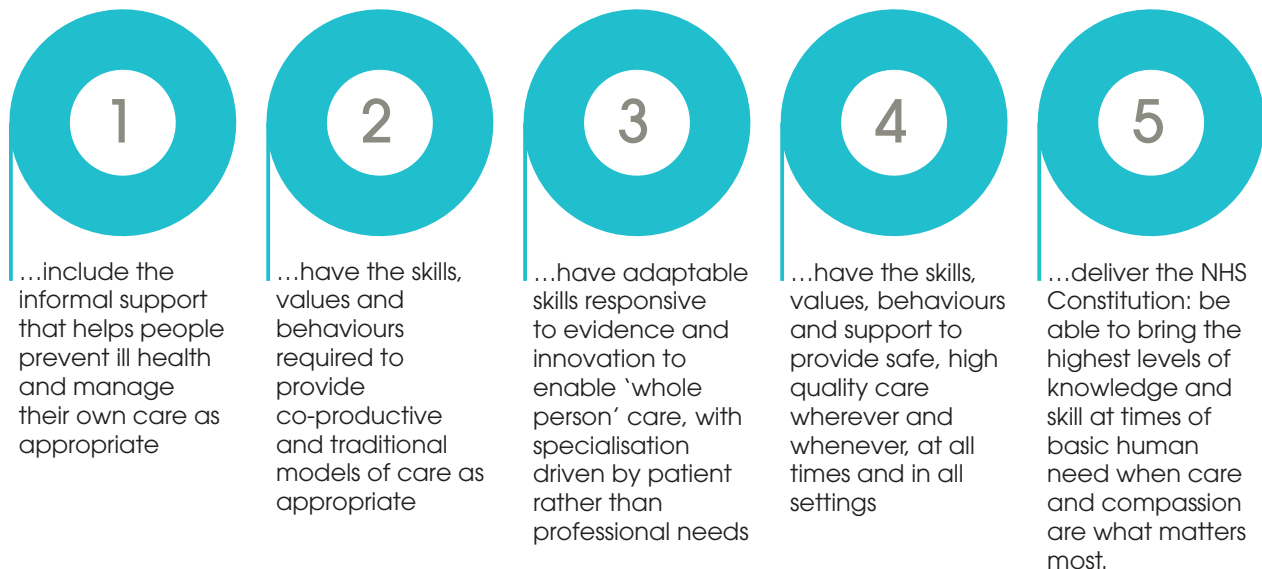
Person-centred care is widely recognised in policy, guidance and curricula in health and social care[14] and there are many examples of good practice in supporting staff to work in a person-centred way but it is not fully embedded in the care provided in the NHS or in social care. We are still a long way from the place where every encounter with health and care professionals is person-centred and people are active partners in their own health and care, supported through approaches such as personalised care and support planning. Further, while there is growing recognition of the wider role of health and care staff in supporting healthy communities,[15] this is not yet widely reflected in policy documents or in training and curricula. Nor are patients, carers and volunteers fully recognised and supported as part of the wider workforce.

Addressing workforce issues is a critical lever for person- and community-centred approaches. Yet 'hard' levers in workforce policy are limited and the system is complex. A large number of organisations have responsibility for some aspect of workforce management – planning, education and training, professional regulation or setting pay and conditions – and strategic coordination appears weak.[16]

HEE's 15-year strategic framework clearly sets out the challenges facing health and care services and a compelling vision of what the workforce of the future needs to look like.[17] The strategy sets out five characteristics (Figure 1) that strongly support the need for a much greater focus on person-centred care and explicitly recognise patients, carers and volunteers as part of the wider workforce. In particular it recognises the need to 'start thinking about patients as "members of a community of health", where qualified/paid staff may be one of, rather than the sole source of, advice and support to a person.'[17]

Figure 1: The characteristics of the future workforce

The workforce will...

1	2	3	4	5
...include the informal support that helps people prevent ill health and manage their own care as appropriate	...have the skills, values and behaviours required to provide co-productive and traditional models of care as appropriate	...have adaptable skills responsive to evidence and innovation to enable 'whole person' care, with specialisation driven by patient rather than professional needs	...have the skills, values, behaviours and support to provide safe, high quality care wherever and whenever, at all times and in all settings	...deliver the NHS Constitution: be able to bring the highest levels of knowledge and skill at times of basic human need when care and compassion are what matters most.

However, there are lots of barriers to achieving this vision. A key challenge is how to shift the balance of investment and the focus of workforce planning from training future health and care professionals to focusing more on current workforce development and embracing patients, carers and volunteers as a key part of the workforce. This shift is necessary to encourage more person-centred health care and better use the power of people and communities to improve health and wellbeing. This chapter explores how national bodies can better support the development of the formal and informal workforce through improvements in:

- the initial training of the clinical workforce

- the development of new roles

- support for the existing workforce

- staff engagement

- training and support for the informal workforce

- support for social movements in health.

Education and training (future clinical workforce)

Person-centred care is included in many of the outcomes frameworks for education and training set by professional regulators and bodies such as Skills for Care. It is also included in the curricula for many courses for health and care professions. Positive progress is being made by a number of royal colleges and universities to introduce a greater focus on person-centred care into the undergraduate and postgraduate training curricula. This progress may at times seem slow but the difficulty of getting new content into already-crowded curricula should not be underestimated.

Despite these successes, there is a continued belief that the way in which health and care professionals – particularly doctors – are trained does not prioritise person-centred care, and in fact reinforces the idea that doctors are the sole source of expertise and that medical knowledge is paramount. Even where person-centred care is included in curricula it is not always assessed in the same way as clinical knowledge.

There is a growing body of evidence and learning from practice about how education and training can support health and care professionals to work in more person- and community-centred ways. Core components[18] of this are:

- asset-based – seeing people as people, with strengths and abilities and as part of wider social networks, not as a set of conditions or problems

- a mindset and approach that values partnerships with patients, service users and communities

- equipping people with the core knowledge, skills and techniques but also the confidence to support people to be more active partners in their own health and care

- giving people a grounding in, and understanding of, behaviour change approaches and techniques.

How education and training is delivered can also impact on how far it supports people to deliver person-centred care and to engage with wider communities. Core elements[19,20] include:

- greater opportunities to train alongside people from different professional groups

- involving patients, carers and service users in education and training. As with improvement (see Chapter 3), these attempts are most likely to be successful when all stages are co-designed with patients and carers, from the design of curricula through to teaching and assessment.

- ensuring health and social care trainees have more, and earlier, exposure to working in communities and community settings.

There is encouraging work underway, led by HEE, to develop a clear and consistent framework of the knowledge, skills and competencies that should underpin all education, training and development for staff in both clinical and non-clinical roles across health, social care and wider public services.[21] This will be helpful in creating a shared understanding across the workforce and to better understand how training can support people to take on the new roles and responsibilities needed to work in partnership with people and communities.

To be successful, this framework will need to consider and address not only the core competencies but also how workforce education, training and development can support wider behavioural and mindset changes. The key challenge will be how quickly the outcomes from this work can be scaled up. This requires action by a wide range of organisations from HEE, NHS England and professional regulators like the GMC and NMC at a national level, to deans, universities, trusts and GP training practices at a local level.

> *'How do we identify core attributes of people entering the professions? Are we clear what we are looking for? And it comes down to: are we looking for biomedical scientists or are we looking for doctors? We are probably looking for both, but for me it is about how we identify people who at this really early stage have the right attributes.'*
>
> Interviewee

More focus is also needed on how we select people to become future health and care professionals. Changing the curriculum and how health and care professionals are trained is important but, on its own, will not be enough. Since 2015, all higher education institutions contracted by HEE to deliver NHS-funded training programmes must assess prospective students against HEE's values-based recruitment framework – which is based on the NHS Constitution – while also continuing to select based on aptitude and skills. Employers are also encouraged to use the HEE framework and associated tools to improve their recruitment processes.[22] The Department of Health has commissioned a three-year study to consider how universities and NHS organisations are implementing the framework, and how this affects students, staff and patients. This is positive, but even longer-term evaluation and monitoring is likely to be needed to show the ongoing impact of values-based recruitment.

There are also leading examples in practice, such as the Doubleday Centre for Patient Experience, established to involve patients and the public in training doctors. Medical Education Partners (patients, carers and other lay people) are involved at all stages, including on interview panels for prospective medical students.[23]

Much has been written about the 'hidden' or 'informal' curriculum, particularly in medicine. The behaviour and attitudes that students, trainees and junior health care professionals see modelled by teachers, supervisors and other role models like senior colleagues and consultants are a powerful influence on how they behave.[24] One of our interviewees identified the challenges of ensuring that staff in GP practices model the right behaviours and attitudes with their trainees and outlined the importance of clinical supervisors and training organisations being 'signed up' to the agenda.

> *'It is a bit of a chicken and egg situation, again, where in order to get people coming through they have got to be trained in the right way. But in order to train them in the right way you need to make sure people doing the training have been trained first.'*
>
> Interviewee

Developing new roles

> *'Introducing peer case-workers has provided a level of support for our patients, which we have never been able to achieve using healthcare professionals alone.'*
>
> Quote from an NHS trust about
> Positively UK peer support services

In a review of community-centred approaches, Public Health England and NHS England identified a range of new roles including health champions and community navigators who can act as bridges between communities and formal health and care services.[25]

There are many examples of new roles that focus on supporting individuals, including peer supporters and health coaches. Other roles, such as community connectors, are primarily focused on engaging and supporting communities. Often these roles are in community organisations but there is an increasing interest in how they can be developed in formal health services.

Peer support is one area where there is good evidence from research and practice[26] of benefits, including significant improvements in health and wellbeing for people with long-term physical or mental health conditions.[27] Peer support is also clearly valued by patients, carers and service users[28] but is largely absent

from policy documents on education and training and health service delivery.[14] An exception is NICE's recent guidance on community engagement,[30] which recommends peer approaches as effective in helping represent local needs and priorities for health and wellbeing.

Social prescribing offers another mechanism to support the rapid spread of new roles. There is renewed national focus on developing social prescribing through the General Practice Forward View and the New Care Models programme.[31] While GPs and nurses can directly connect people with community and peer support services through social prescribing, it can be difficult for them to keep up with the full range of options in their local community. Similarly short consultation times can make it hard for staff to work with people to set their goals and match them with the right support services. There are a number of emerging social prescribing models[32] that can equip a range of people – both lay and professional – to work alongside GPs. These models can connect people to a range of support in the community and free up GPs' time to spend with people who need more intensive clinical support.

Traditionally, the NHS has been slow to adopt new roles,[33] but national focus and coordinated support for new roles is required if they are to spread. They also need to be developed as genuine substitutes for existing roles rather than creating more demand for services.[34] Work on new roles by local HEE teams is mostly focused on extending the roles of existing staff, including physician and nurse associates.[35] Conversely developing broader community-focused roles has not been prioritised partly because of pressure on HEE to meet shortages in traditional roles alongside its increasingly restricted budget for wider workforce development.

There are barriers to implementing roles such as peer support workers into the NHS. Locally, these might include employment issues such as criminal records checks and overcoming professional resistance to new roles, which staff may feel challenge their professional identities. At a national level, there may be an issue about how regulators recognise new roles when assessing the safety or quality of services. These are not insurmountable, but they need close attention at local and national level.[34]

Of course, many of these new roles will develop locally to meet specific needs. Being Well Salford and Positively UK, the RtV partner sites for health coaching and peer support, identified some of the most important enablers to developing health coaching and peer support roles.

For practical tips from the Realising the Value programme on implementing health coaching and peer support, see *Making it happen: Practical learning and tips from the five Realising the Value local partner sites*.

Support for the existing workforce

More support for workforce development

Most education and training focuses on the initial formal training of health care professionals. National bodies pay less attention to the recruitment and ongoing development and support needs of the current workforce, particularly those in patient-facing non-clinical roles such as GP receptionists.

Of HEE's £5 billion budget, over 95% is currently spent on training future clinical staff. In 2014/15 only 4% was spent on general workforce development; a figure due to be further reduced following the 2015 spending review.[36] This funding covers the entire workforce which, by HEE's own figures, includes almost 40% of staff in non-clinically qualified supporting roles who provide an estimated 60% of all patient contact.[37] This is not the only source of funding for workforce development, much of which is delivered and paid for by NHS organisations locally but it does highlight the lack of priority for wider workforce development at a national level.

Ensuring that we have the correct number of health and care professionals with the right knowledge, skills and attributes is essential but it needs to be alongside a much greater focus on how we train and support the existing workforce, many of whom will still be working in 2040 and beyond.

> *'Our current approach to planning (driven largely by supply-side issues) will not produce a workforce fit for the future needs of patients. The annual workforce planning process drives us to ask how many of which type of profession do we need, constrained by existing professional groupings and largely focussed on numbers.'*
>
> HEE Framework 15[17]

HEE's strategy commits to shifting the balance of funding to provide more support for workforce development, which is welcome. But, given well-documented staff shortages in existing professional groups and ongoing budgetary pressures, it is difficult to see how this will be possible in the short term. The set of actions included at the end of the strategy are not sufficient for this change to happen incrementally over the next 5, 10 or 15 years without more concerted planning starting now.

Recruiting for values

As with selection to training courses, values-based recruitment offers significant potential to help ensure that people recruited to positions in health and social care share the values of the organisation and the wider system (for example the NHS Constitution). As already noted, HEE provides resources and encourages employers to use its values-based recruitment framework but has no power to compel organisations to do this. Similarly, Skills for Care has developed a values-based recruitment toolkit for recruitment in social care. Evidence shows that staff recruited and supported using such an approach have stronger caring values, including compassion, respect and empathy.[38] Being able to empathise and see patients as people first and foremost can be a key step towards health and care staff seeing people as equal partners in their care and embracing partnership working.

Focusing on improvement can support staff development

In the absence of more money from HEE's budget (see above), it is important for both local and national bodies to consider how they can boost support for workforce development through other activities. Education, training and support for staff are core elements of many successful projects at a team or organisational level to embed person- and community-centred approaches. Lack of engagement by health care professionals, concerns about risk and loss of professional identity are commonly cited as barriers to more person-centred working. However, training and support for staff can help overcome these obstacles,[39] as can greater use of behavioural approaches such as those explored through the RtV programme. The benefits that can be gained by supporting and training staff to work in new ways, including increased job satisfaction, are significant. Without diminishing the need to continue to hold HEE to account for delivering its strategy, this should be alongside efforts to increase the use of improvement approaches to support workforce development (see Chapter 3) and through greater staff engagement.

Staff engagement

'Conventional workforce policy instruments focused on regulation, financial incentives and contracts are not currently securing the rapid changes in the shape, motivation and behaviour of the workforce needed to support affordable new models of care in the NHS. If the current pace of change continues, it seems likely that the workforce the NHS depends on in 2020 and 2030 will be broadly similar in character and composition to the one it has today, just as today's staffing picture is similar to that of five and 15 years ago. Policies based on a more sophisticated understanding of the intrinsic motivation of health professionals, and focused on professional culture and values, staff morale, staff wellbeing and staff engagement will be needed if the NHS is to retain and motivate people to provide good care in a busier NHS and in the context of continued pay restraint.'

Fit for purpose?, the Health Foundation 2016.[16]

A strong impetus for people who work in the NHS and across care services is the intrinsic motivation to help and support people. The NHS and the wider public service has the potential to foster a skilled workforce with shared purpose and values who are motivated in a way that connects with the reasons they decided to work in health or social care.

There are clear links between staff engagement and wellbeing and improved patient experience and outcomes.[40] The Behavioural Insights Team's work for the RtV programme highlighted that the system and processes in organisations often meant that extrinsic motivations – such as financial incentives or the pressure to meet targets to avoid punishment – often overshadowed intrinsic motivation.[41] This is backed up by a Health Foundation report noting that the inherent psychological burdens of care can combine with poor organisational culture and stressful working conditions to create emotional burnout and compassion fatigue,[16] neither of which are conducive to person-centred care.

The Behavioural Insights Team (BIT) has developed two practical guides on how behavioural approaches can support self-management and help to spread person- and community-centred approaches. The guides, *Supporting self-management* and *Spreading change* include ideas and tools for practitioners, commissioners and others seeking to impact change in practice. Available from the Realising the Value website.

These systemic issues are unlikely to be addressed by training alone. We need to think more creatively about how to help people working in health and social care to stay connected to their intrinsic motivations. An important element in achieving this is creating the conditions for staff to feel supported and to have time to reflect on their practice. The Schwartz Rounds[42] have shown strong early promise in this respect and national bodies should consider how more opportunities for reflective practice and sharing the challenges of work can be fostered. Increased opportunities for staff to lead and be involved in improvement – and to use techniques like Plan Do Study Act, rapid cycle evaluation or models such as the 100 day challenge work led by Nesta and the Rapid Results Institute – are also good ways to engage people in thinking about the need for change, reflecting on what works and being motivated to continue to improve.

Supporting networks of health and care staff and others is integral to achieving transformational change.[43] They can create opportunities for staff and others to come together – virtually or in person – around common challenges, share learning and provide peer support. They are particularly critical in helping people to understand **how** to achieve change not just **what** to change. There are many good examples of networks championing person- and community-centred approaches. These include:

- the network led by the Royal College of General Practitioners to spread personalised care and support planning[44]

- the communities of practice developed as part of National Voices' Wellbeing our Way programme, which support voluntary and community organisations to develop capability in person-centred care[45]

- the communities of interest led by the RtV programme partner sites in each of the five RtV focus areas.

For recommendations on how communities of interests and networks should be supported see the final programme report, *Realising the Value: Ten key actions to put people and communities at the heart of health and wellbeing.*

For more information on the communities of interest developed by the five Realising the Value programme sites, see *Making it happen: Practical learning and tips from the five Realising the Value local partner sites.*

Engaging and supporting staff to work in community-centred ways may require different mechanisms or levers to those already discussed. In particular, giving staff more flexibility in how they work and the scope of their roles and greater autonomy could be a powerful driver of change. However, making these changes is not always easy. A team in Fife, supported by the Health Foundation, sought to reduce reliance on formal health care through stimulating a greater range of community asset-based care and support. They found that they had underestimated the impact of the change they were seeking on how staff saw their role and their professional identity. Staff, including nurses, physiotherapists and occupational therapists, needed ongoing support to feel comfortable focusing on people's lives, the community and providing social support rather than simply delivering traditional health and social care such as wound dressings or practical aids such as spill-proof cups.[46] The Buurtzorg model of home care in the Netherlands is a well-known example of a successful international initiative, where home care teams are given greater autonomy and flexibility in their roles and how they manage their time. This has led to staff spending more time with their clients while still meeting service standards. There are teams in the UK exploring whether this model could be developed for our context. More work to understand and test this type of model is welcome.[47]

Harnessing staff motivation

There is a growing interest in how national bodies can support social movements for health amongst patients, carers and the wider population (see 'informal workforce' section).[48] There is also the potential for such movements to develop within the health and care workforce. The '#Hellomynameis' campaign started by Dr Kate Granger was incredibly simple but resonated with frontline staff in a powerful and personal way. NHS Change Day (now 'Fab Change Day') was started in 2013 by a small group of clinicians and improvement leaders and has been described both as the largest day of collective action for improvement in the history of the NHS[49] and as a social movement.[50] Nationally led campaigns – no matter how well organised – are unlikely to recreate something like '#Hellomynameis'. But they

can support staff to find their own ways to reconnect with their intrinsic motivations and, through this potentially support social movements to emerge, grow and evolve. NHS England and other national bodies should explore creative ways to harness, support and celebrate these 'movements'. A good example is the increasing focus on changing the question in consultations with patients from 'What is the matter with you?' to 'What matters to you?' First used in the context of implementing shared decision making[51] and later adopted by the US Institute for Healthcare Improvement,[52] it is gaining momentum in the UK. In 2015, the Scottish Government Health Directorate hosted a national 'What matters to you?' day, which encouraged organisations and people to sign up to commit to changing the question for one day and sharing the results.

The informal workforce

HEE's 15 year strategy, Framework 15, includes patients, carers and volunteers as part of the informal health care workforce.[17] The strategy recognises that people can contribute significantly to their own health and wellbeing and that of their family, friends and wider communities.

More than 15 million people in England live with one or more long-term condition. On average, they spend around three hours a year in contact with formal health and care services; the rest of the time they manage their condition and their life on their own or with support from family, friends, carers or wider social networks.[53] More than six million people in the UK say that they are caring for someone else on a regular basis. Over 1.7 million people already volunteer in a health and care setting and many more say that they would be prepared to volunteer.[54] It is little wonder that patients and communities have been described as 'the renewable energy'[55] of the NHS and an 'untapped resource'.[56]

While these statistics are often quoted, national bodies struggle to know how to practically harness the energy, and draw on the assets, of patients, service users, carers and communities to support better health and wellbeing. The approaches explored in the RtV programme can help people develop the knowledge, skills and confidence to address other areas of their life and return to work, education or volunteer themselves. Three promising ways in which national bodies can help to achieve this are through:

- increased support for volunteering

- developing and building patient leaders

- supporting social movements.

Volunteering

Volunteers are an increasingly important part of the health and care workforce. There is evidence that high quality well-supported volunteering not only benefits people receiving care but also organisations. In addition, it has reciprocal benefits for people who volunteer.[25] Age UK's successful personalised integrated care programme includes volunteers and staff as core members of the multidisciplinary team supporting older people to stay independent.[57]

Despite these great examples, overall there is little support or training for people who volunteer in health and care organisations. A recent review of the role of the voluntary, community and social enterprise sector in improving health, wellbeing and care outcomes (VCSE Review)[58] highlights that volunteering needs to be valued, improved and promoted. In particular, it recommends that all settings, with strategic leadership from NHS England, should develop more high quality, inclusive volunteering opportunities, focusing

on young people and people from disadvantaged communities. It identified the Active Communities[59] and Health as a Social Movement[60] programmes as levers for achieving this change. The review also recommended focusing on how volunteers are recruited, trained and supported. The evidence for peer support (which is often delivered by volunteers) backs the need for proper attention to help overcome barriers to people taking part.[61] Paid staff also need support and training to work well with volunteers.

Support and investment from HEE, NHS England and other national bodies to create more opportunities for volunteering in health and care services and in the wider community could support improved health and wellbeing for people but also forge stronger relationships of trust and cooperation between people and communities and formal health and care services.

Patient leaders

'If we can take the risk of emerging from our boxes of "patient" or "professional" and venture into the territory where boundaries are blurred, and both "sides" are prepared to walk in the shoes of the other, then we have the potential to create something radically new. This is not about professionals having to relinquish power in an already chaotic and uncertain climate, but about strengthening the power base so there is more of it to go around'

Alison Cameron, patient leader[62]

To make the NHS Five Year Forward View vision of empowered and engaged patients and communities a reality, patient leaders should be supported and developed to work as equal partners in strategic decision making in national bodies. It is encouraging that this appears to be recognised by NHS England with, among other work, support for the King's Fund collaborative leaders programme; and by the CQC[63] through its widespread use of experts by experience in developing policy and taking part in inspections. There are also examples of health care organisations appointing patient leaders as Directors of Patient Experience.

There are over 700 patients, carers and service users formally appointed as representatives on NHS England and NHS trust boards, clinical reference groups and clinical commissioning groups (CCGs). Until recently there has been little coordination of, or support for, people in these roles. Recognising this, NHS England has developed a blended (online and face-to-face) training programme for 'Patient and Public Voice' representatives, which, at the time of writing, is about to be piloted with a small number of board-level and clinical reference group representatives. The training includes modules on roles, using data, influencing skills and practical leadership. The training aims to equip people with the information, knowledge and skills they need to engage effectively with decision making in NHS organisations.

This is a welcome development and one that could – depending on the outcomes of the pilot – be rolled out more widely across the NHS. It may also be helpful if other bodies such as NHS Improvement and HEE adopted the programme to support patient leaders across all national system bodies to ensure a consistent package of support.

Supporting social movements

Patient and professional-led campaigns to make health care services more person-centred are often described as social movements and there is growing interest in understanding how national bodies can support them. Some people argue that health and care services will only become more person-centred and embrace person- and community-centred approaches fully when there is greater 'pull' or demand from patients or service users for change.

National bodies are not able to control social movements but they can support and nurture them to improve services or empower people and communities to draw on their own assets to improve their health and wellbeing. NHS England is currently funding a three-year Health as a Social Movement programme. This is drawing on the history of social movements both in and outside the health context, as well as working with six New Care Model sites ('vanguards'),[64] to support the development of their own social movements.

There are many great examples of people being empowered and inspired through their connection with person- and community-centred approaches and there is no doubt that it can transform individual lives.

> *'Without Positively UK I wouldn't have been the person I am today. Through the support groups I was able to make friends. I now have a social life. Through the motivation I received I went back to school, have gained a BA and look forward to getting back to work.'*
>
> Positively UK service user

Finding ways to harness and bring people together around their positive experiences of these approaches can be very powerful. Communities are also mobilising and connecting both virtually and in the real world around an ambition of healthy and thriving communities, often in partnership with statutory bodies and the voluntary and community sector. One example is Sheffield Flourish.[65] which describes itself as a digital wellbeing community hub and connects people through online networks and communities and face-to-face events. While these initiatives are not always social movements in their own right, they may be the nascent beginnings of a social movement for change that can be nurtured and supported.

3: System-focused interventions: Improvement

Recommendations

Co-production, embedding learning and capacity building

- In developing and implementing its national improvement strategy, NHS Improvement should consider how existing programmes aimed at identifying service user leaders and supporting them to engage in the change process could be scaled up. It should also promote existing tested models of co-production.

- National bodies should work collaboratively to consider how to best develop patient representatives and leaders.

- National bodies should continue to support staff working on and leading improvement programmes to connect, share learning and overcome common challenges including through the use of networks and communities of practice.

Data and measurement

- To move towards a simplified, cross-system outcomes framework focused on what matters to people and communities, national bodies including the Department of Health, Public Health England and the Local Government Association should work with local areas already trialling and testing new outcome frameworks and value metrics and with people and communities to build a consensus on this new framework.

- Alongside work to develop a simplified cross-system outcomes framework and core national metrics that reflect what matters most to people and communities, national bodies should continue to support work to:

  - explore mechanisms for aggregating personal outcomes data to be useful at an individual, organisation and population level

  - understand how available data, using both reliable process measures of approaches such as shared decision making and care planning, as well as available outcomes, can best be used to help build a richer picture of how far health and care services are responding to what matters to people.

- Emerging plans to allow people to link personal data about their health and wellbeing into NHS medical records must be co-produced with patients and clinicians to make sure they are useful for people in their individual encounters with health and care staff as well as for the wider system.

Improvement-focused interventions offer huge potential to embed person- and community-centred approaches for health and wellbeing. They are usually locally driven with a clear objective to improve quality through reducing variation and improving outcomes or experience. Effective co-production of improvement initiatives will ensure patients, service users and communities are at the centre of service change. Alongside a focus on leadership capacity building, it can help to embed learning and the sharing of best practice.

Data collection, measurement and analysis can aid prioritisation and provide rapid feedback about the effectiveness of interventions and the impact on people accessing services. Measures that focus on what matters to individuals that can also be used at a population or system level will enable incentive systems to develop that support the spread of person- and community-centred approaches.

This chapter discusses ways in which an increased focus on co-production, embedding learning and capacity building within improvement-focused interventions, alongside different uses of data, technology and measurement, can help support the implementation of person- and community-centred approaches for health and wellbeing.

Co-production, embedding learning and capacity building

In seeking to embed person- and community-centred approaches into health and social care and wider health and wellbeing services, it is important to pay attention to the way in which services are improved, changed, transformed or redesigned over time.

Many of the most impactful and resilient improvement programmes have been co-identified, co-designed and co-produced between service users and providers working together as equal partners. Here the teams are developing interventions with and for local people that are then jointly owned by providers and users. This gives them relevance and legitimacy that is hard to achieve through any other means.

Box 1 describes the lasting benefits an improvement team derived from using a co-production approach in one project.

Box 1 – NOHARM: A co-produced quality improvement project in Stockport

As part of the Health Foundation's Shine 2012 programme, a team at Stockport NHS Foundation Trust undertook a quality improvement project[66] to design a pathway to help identify orthostatic hypotension – a drop in blood pressure while standing – in older patients to reduce falls and unnecessary medication.

The project used a co-production method to allow patients and staff from across the whole health and social care economy to work together to share experiences and identify important 'touchpoints' where the pathway could improve.

As well as developing a pathway that could be rolled out across the trust, the co-production approach has had a major impact on how the trust approaches quality improvement. According to the project manager, Iain Rogers, the project has 'broken down barriers and built some bridges' between different services and organisations and given people 'a new respect for each other that goes beyond everyday professional courtesy'. It has succeeded, he argues, in getting patients and staff with 'different sets of expertise and levels of seniority not just listening, but hearing one another.'[67]

The problem is that although many improvement projects are shaped by service user views in some way, relatively few are genuinely co-produced.[68]

In recent years the time and resources given to capturing the opinions and experiences of service users about their care has grown appreciably: surveys, online feedback and focus groups are now commonplace in health and social care. Patient shadowing techniques and observation of patient and professional engagement are also on the rise. Service user stories, meanwhile, can be a valuable means of building the necessary will and momentum among staff to change the way a service is delivered.[69]

But it is more difficult to find organisations where service users are routinely involved as equal partners at every step of the change process – from identifying the problem; to establishing a shared vision or goal for change; to designing, delivering and evaluating potential solutions. Organisations often lack the skills, time and infrastructure to make it happen; they also need to make significant changes to their ways of working, which cannot be done quickly.

Even organisations with a strong track record in service user involvement can find it difficult to make co-production a consistent feature of their quality improvement work. Box 2 considers the challenges that East London NHS Foundation Trust, rated as 'outstanding' by the CQC in 2016, has experienced in trying to ensure that service users can drive change.

Box 2 – East London NHS Foundation Trust: Putting service users at the heart of quality improvement

East London NHS Foundation Trust launched an organisation-wide quality improvement programme in February 2014.

This aims to change the culture of the organisation by shifting power and decision making to the frontline and enabling teams and service users to work together to tackle complex quality issues. To support this work, the trust has set up a central QI team and a QI skills capability building programme.

By August 2015, over 160 improvement projects were running throughout the trust. Service users and carers were involved in a number of these, either as members of the project team or as occasional advisers. But two-thirds of projects had no service users or carers involved at all. An evaluation by the trust suggested that this may have been due in part to anxiety among staff about service user or carer involvement or a lack of knowledge or confidence about how best to include it. Some staff also distinguished between their day-to-day activities, where collaborative working was the norm, and 'formal QI projects', where it was rarer.[70]

The trust responded by stepping up the involvement of its Patient Participation Team in the QI programme. It developed tailored guidance and process maps for staff and created opportunities for staff to talk through the challenges of involving service users and carers. It also created a bespoke QI training package for service users and carers. The trust has committed in its Quality Strategy for 2016–18[71] to examine new ways to deepen the involvement of service users and patients in its QI work.

The example of East London (Box 2) highlights the importance of aligning organisations' improvement and capability building strategies and other work streams and programmes connected with patient and service user participation.

Similar alignment is needed at regional and national level. The development of the National Improvement and Leadership Development Strategy, in response to recommendations in the review of centrally funded improvement and leadership development functions,[72] offers a significant opportunity to do this. The strategy, along with other nationally led work focusing on developing improvement capacity and capability, needs to reflect the critical importance of co-production and unlock any barriers preventing service users from playing a full role in this process.

In implementing the strategy, NHS Improvement needs to consider how existing programmes aimed at identifying service user leaders and supporting them to engage in the change process – such as the Leading Collaboratively with Patients and Communities programme[73] led by The King's Fund – could be scaled up. It should also promote existing tested models of co-production,[74] which provide useful frameworks for trusts and others to use when establishing or developing the ways they engage with patients, service users, carers and the wider public. Common features of all of these models include:

- establishing shared values and principles
- providing training and support for all parties including staff and people with lived experience
- being clear about the purpose for engaging and people's roles
- regularly reviewing progress and impact.

Equally important is promoting a culture of distributed leadership in organisations to ensure that people at all levels have the confidence, capacity and opportunity to identify and pursue change.[75] A traditional top-down leadership model, which is still prevalent in many parts of the health and social care system, will stymie any efforts to promote and embed co-production.[75] We need to recognise – at every level of the system – that no single person, however well qualified, has the knowledge, insight or resources to provide solutions to quality challenges that affect multiple staff and service users. For example, the mental health charity, Mind, changed its approach to service user engagement. They replaced occasional consultation meetings with large panels of service users, instead giving much more control and support to individual teams to engage people in their day-to-day work. While people tended to start small, over time they found they enjoyed and benefitted from this way of working and became more ambitious in how they engaged service users in their work.[76]

The lessons outlined above are relevant not just to local improvement projects in individual organisations but also to nationally led improvement initiatives; current examples being the New Care Models and Integrated Care and Support Pioneer programmes. NHS England and other national bodies also need to pay careful attention to the time and support given to local organisations involved in nationally led improvement programmes, particularly during the problem diagnosis and project design phase. As already described, it takes a great deal of time and effort to co-identify, co-design and co-produce change. Giving improvement teams that include staff and service users the chance to get to know each other and build trust at the very start of the process is vital for meaningful, sustainable change. Yet in many cases the onus on local sites to develop and design interventions quickly, often in only a few months, makes it difficult to foster such relationships.

Similarly, a degree of caution is needed at national level about how quickly interventions can be spread once they have been shown to be successful in one place. Most solutions, because they are shaped by relationships and priorities unique to that area, are context-specific and cannot be easily replicated in other areas. The originator site may identify some high-level principles, or simple rules, from their work that can guide adopter sites. But the same effort made to build the will for change and develop relationships in the team needs to be replicated at each and every adopter site.

As discussed elsewhere in this report (Chapters 2 and 6), national bodies can do more to capture and share learning, provide practical support and foster networks and communities of interest. All of this can help people to identify ways of overcoming barriers to successful implementation and spread.

Data and measurement

When used appropriately, data have the potential to help incorporate person- and community-centred approaches into the NHS. Data collection, analysis and feedback can: identify priorities for intervention; support shared decision making between patients and health care professionals; monitor the impact of ongoing improvement; and provide appropriate metrics to guide action at each level of the health care system.[77] Given these many potential uses of data, it can be difficult to know what to measure, let alone how to do it. This becomes even more challenging as we move outside the 'traditional' medical model of delivering and receiving care. To incorporate the full experience of patients and communities, our technology to collect and share data must reach outside the traditional actors (doctors, managers, analysts) and into the hands of patients, carers and their community support systems.

How data is collected

While technology does exist that allows patients to easily record their symptoms, outcomes and wellbeing using a variety of digital methods, there has been little success in integrating such collection systems into the standard patient record and interpreting them in the context of the whole patient experience. Where this **has** been achieved it allows clinicians and those providing care to see the interaction between the care provided and the patient's experience of care and the impact on their goals.

Case study: Measuring quality of life for children and young people using palliative care[78]

Palliative care is all about improving quality of life, but it is hard for services to know whether they are doing this successfully. 'All our patients have underlying conditions which are deteriorating, often with complicating comorbidities,' explains Nicky Harris, Palliative Care Paediatrician and Visiting Fellow at the University of the West of England.

In 2011, Nicky's team developed the web-based tool MyQuality (my-quality.net) to address this problem. Individuals identify and describe their health, emotional or social priorities, and then rate any change in each measure over time, using a smartphone or computer, with responses added to a graph in real time. People can choose to keep their data private or share it.

A preliminary evaluation of MyQuality confirmed that it is quick and easy to use. Almost a third of users have personalised their options using free text, so they are meaningful for their own circumstances. 'Families love the fact it's empowering,' explains Nicky. 'And providers like it too, as it helps with collaborative decision making.'

However, there have been challenges in moving to the new system. 'It's a different process, so you need to develop new ways to work together', explains Nicky. 'But where people have the drive to do that, it can change the way we provide care.'

In late 2016, the Secretary of State for Health committed to the NHS making much greater progress in enabling people to link apps and wearable health technology into their medical records in 2017. It's not yet clear how this will differ from previous initiatives that have not always delivered the anticipated benefits.[79] To have the best chance of success, these initiatives need to be co-produced with patients, service users, carers and health professionals. This will make sure they are useful for people in their individual interactions with health and care staff; support them to monitor their own health and track progress towards achieving their goals; and benefit the wider system. They also need to accommodate patient preference in recording and sharing data. Some patients might prefer to submit data electronically and others to use more traditional methods.

Uses of data and measurement

There are a range of outcomes that it may be important to measure and understand to support services to provide more person-centred care. There are also a range of reliable process measures of things like shared decision making and care and support planning which can be helpful in monitoring whether individual practitioners or organisations are working in person-centred ways. The system is currently too heavily weighted towards collecting data that organisations value which are often based on clinical outcomes or system processes. While clinical or service outcomes – like reductions in blood pressure or how long people wait for treatment – are important, what people often value more is how services support them to achieve life goals, such as being able to walk to their local social club or dance at their daughter's wedding.

Measurement is complex at the best of times and can only ever provide a partial picture. However, being able to measure these personal outcomes combined with reliable measures of person-centred processes – however incompletely – and making the data available to individuals and to the health and care staff who support them can be incredibly valuable in its own right. It can support shared decision making, as well as enabling people to more effectively manage their own health and care. Making data available in a timely manner to frontline staff can also encourage them to make improvements in their practice or teams and, therefore, be a powerful driver for change. A key criticism of some national data collections such as patient reported outcome measures is that they do not include timely feedback loops to frontline staff or patients.

> *'The patient fills in the form, it goes to a market researcher, then six months later it goes to the Health and Social Care Information Centre. So the doctor and the patient are the only two who don't get it. The doctor asks the same questions that were in the PROM but can't use it to inform the consultation.'*
>
> Participant at the Health Foundation's 'Measuring personal outcomes' meeting, December 2015

A key challenge for health and care services is being able to understand and use personal outcomes data to inform decisions at an organisation, population or national level. While some may argue that monitoring patient outcomes and personalised experiences of care has no role or validity outside the relationship between those providing care and those receiving it, we believe it is important to understand how 'personalised outcomes' vary among the population and for this to be able to be presented in a way that is useful for clinicians, commissioners and policymakers. This brings transparency around the quality of care received and information on the success or otherwise of improvement initiatives.

The Right Care programme is an example of a national initiative using data to understand variation of care through analysis and local collaboration. The programme aims to maximise the value the patient derives from their own care and treatment and the whole population does from the investment in their health care.[80]

Right Care's philosophy centres on personalising difficult decisions about care and making sure these are optimised by patient decision aids and shared decision making. It began as a locally-led improvement initiative and is now an official NHS England programme. The Right Care programme has developed tools, resources and decision aids to support wider roll out of the programme. Despite focusing on increased personalisation, the programme relies on existing data, which is often system orientated and focused on process measures. Still, its support for shared decision making is encouraging.

A range of validated tools seek to measure holistic concepts, or components, of person-centred care.[81] Yet these have primarily been used in academic studies focused on hospital care. Little research has assessed the impact of person-centred care at a national or population level. Table 2 outlines the main nationally led initiatives being used to measure aspects of person-centred care or personal outcomes.

Table 2: Ways of measuring person-centred care

National surveys are the main means of collecting data about person-centred care in the NHS; these include the GP Patient Survey, Inpatient Survey and national surveys of mental health and cancer patients. These have the advantage of large sample sizes but are not intended to capture personalised outcomes. They focus on process measures and patient experience rather than whether services support people to achieve the outcomes that matter to them. They also provide limited comparable data that can be used in monitoring or driving improvements at a local level.[82]

Patient reported outcome measures (PROMs) are also often cited as an example of a nationally led initiative that aims to capture personal outcomes data and use it to monitor quality at a local level. NHS providers submit PROMs data in four areas of surgery: hernia, hip replacement, knee replacement and varicose vein. There are also more generic PROMs (such as the EQ-5D) that assess the impact of specific interventions on quality of life. While PROMs are useful in rating the impact of standardised interventions across populations of people with similar conditions, they are not able to capture overall patient outcomes or help to understand the impact of different service interventions across care settings. A key criticism of PROMs is that they are often developed without involving patients and focus on clinical or service-determined outcomes. There are limited examples of PROMs being based on the outcomes that patients state are important to them. A lack of timely feedback of PROMs data to clinicians also limits their usefulness in the clinical encounter.

Person-centred outcome measures (PCOMs) are designed to measure outcomes against goals set by the individual and their carers/family. PCOMs are often seen to offer more potential to support person- and community-centred approaches as they are not based on system-orientated outcomes. NHS Improving Quality had a stream of work on PCOMs[83] and NHS England subsequently supported eight pathfinder sites in 2015 to test different approaches to developing PCOMs for children and young people. Although the pilot programme has finished, an evaluation of this work has not been published and next steps are not clear. Given the focus on personal outcomes that matter to individuals, PCOMs cannot be easily generalised or aggregated up to population level. However, there are examples of questionnaires being developed that include pre-set outcomes that are co-designed by people with similar characteristics or conditions, as well as the opportunity for people to add free-text comments about what matters to them.

The **Patient Activation Measure (PAM)** is a commonly used measure of a person's knowledge, skills and confidence to manage their health and care. There is a growing evidence base, mainly in the US, suggesting that people with higher activation scores make less use of health care services, particularly emergency services. NHS England is supporting six organisations to pilot the use of PAM – as a tool for targeting interventions and as an outcome measure – which is being evaluated using qualitative methods.[84] It has also acquired two million licences to use the PAM questionnaire which New Care Model vanguard sites and other teams have been selected to receive. Meanwhile in one clinical commissioning group (CCG) area, a quantitative evaluation is using available data to examine the characteristics of patients with long-term conditions with different levels of activation who do not complete the PAM questionnaire, including how they use the health care system.

While there are positive elements in all of these approaches, there is no coherent framework[85] to help national bodies, commissioners and other system leaders understand how to use existing data to support more person-centred approaches, or identify what gaps need to be filled. This framework needs to be informed by an understanding of the value that people and communities create for their own health and wellbeing. Without developing measures that better incorporate personal and social outcomes that can be understood at the population level, policymakers will continue to rely on the available ones. Too often this leads to a focus on emergency hospital admissions without considering the wider patient experience or the outcomes that matter to people and communities.

In *New approaches to value in health and care*, the RtV consortium calls for a consensus to be built on replacing the existing National Outcomes Frameworks and highlights the need for a simplified, cross-system outcomes framework to be created. The devlopment of this framework should be equally led by those local frontline areas (including pioneers and vanguards) that are already trialling different value and outcomes frameworks.[86]

For more details about the arguments for a new outcomes framework, see the Realising the Value paper *New approaches to value in health and care.*

Building consensus and developing a new framework and measures to support it will take time and work needs to start now. Alongside this, there is a need to consider how the available data and measures – including both reliable process and outcome measures – can be better used and combined to help build a richer picture of how far health and care services are responding to what matters to people and communities.

'For me, the individual's outcome is the first priority. We haven't really sorted out how to aggregate that up for populations. But showing clinical outcomes, PROMs and PCOMs can give us some very rich data'.

Participant at a two-day summit on measuring personal outcomes
hosted by the Health Foundation in December 2014

4: System-focused interventions: Regulatory

Recommendations

Legislation

- The Department of Health, the Cabinet Office and NHS England should work to ensure much more widespread use of the Social Value Act by health commissioners. This could be achieved through:

  – training and support packages for health care commissioners

  – ensuring that social value principles are embedded in performance and accountability frameworks for CCGs.

Regulation

- The CQC should review 'key lines of enquiry' across all sectors in relation to person-centred care and introduce questions covering personalisation, social action and the use of volunteers as recommended by the VCSE Review.

- In defining its role and developing and implementing its strategy, NHS Improvement should be mindful of the need to strike the right balance between its regulatory and supporting functions. In the short term, NHS Improvement should ensure that the Single Oversight Framework and accompanying support packages include support for organisations on implementing person- and community-centred approaches for health and wellbeing.

- Both the CQC and NHS Improvement should ensure that staff on their inspection teams and those who work directly with provider organisations are trained and supported to understand what good person- and community-centred practice looks like and how it can be assessed.

This chapter considers the role of legislation and regulation in supporting person- and community-centred approaches to wellbeing. Legislation is perhaps the most direct way that the government can set out the high-level requirements it expects health and care services to meet, which then influence policy and provide the levers for national bodies to achieve change. Regulation, on the whole, provides a mechanism for national bodies to assure the quality of care provided and how organisations are run while providing mechanisms to take action when organisations fail to meet the necessary standard.

Legislation

A range of legislative duties seek to direct how health and social care providers and commissioners involve people and communities in decision making. This includes shaping services and commissioning responsibilities to respond to what matters to people and communities about their health and wellbeing.

The Health and Social Care Act 2012[87] – supported by the Transforming Participation guidance[88] – requires NHS England and CCGs to:

- promote involving patients and carers in decisions that relate to their care or treatment

- ensure public involvement and consultation in commissioning processes and decisions

- enable patients to make choices about aspects of health services available to them (NHS England only).

The Care Act 2014 is seen as a seminal piece of legislation for social care. It includes a duty on local authorities to promote an individual's wellbeing and emphasises the role of local authority commissioners in shaping the market, rather than simply procuring services that others make available. The statutory guidance for the Act also refers to the importance of co-production with service users, carers, user groups and voluntary and community organisations in many aspects of local authority commissioning, including in developing local strategies and plans and in market shaping.[89]

The Public Services (Social Value) Act 2012 (Social Value Act) requires people who commission public services (including NHS services) to think about how they can also secure wider social, economic and environmental benefits. Local authorities have been at the forefront of using the Act to inform their commissioning and there are some positive examples of how it can support better value for local areas and lead to more innovative thinking by local commissioners (see Box 3).

Commissioning for social value

A recurring message from the RtV programme consortium members and partner sites is that the Social Value Act, in particular, offers the potential to support increased uptake of approaches that empower people and communities, but it is not well known about or used in health care commissioning. A review of the Act by Lord Young in 2015 found that, despite promising examples of how the Act was supporting commissioning for value in social care and other public services, there was limited evidence of its take up by health commissioners.[90] There is also anecdotal evidence that supports this, including discussions with our partner sites and wider consortium, and a survey of National Association for Voluntary and Community Action chief executives to which only four respondents said that their local CCG had a social value strategy in place.[91]

The review of the Social Value Act recommended that the Cabinet Office should work with NHS England and Public Health England's Sustainable Development Unit to set up a social value steering group to embed social value more widely in strategic health commissioning. This was reinforced by the findings of the VCSE Review.[58] This review included an additional recommendation for NHS England and the Cabinet Office to 'work in partnership to ensure that training and resources provided to NHS and local authority commissioner and procurement teams support and encourage them to commission for social value.' The findings from the RtV programme reinforce the need for steps to increase the understanding and use of the Social Value Act in health care commissioning.

Box 3 – How the Social Value Act supports commissioning for value

The social enterprise Unlimited Potential (a RtV partner site) was awarded a contract by Salford City Council, which found that some people were not likely to use traditional stop smoking services. Its Smoke-Free Spaces programme aims to reduce the harm caused by second-hand smoke by promoting smoke-free environments. It employs local people to speak to other local people about making their homes smoke free: this reduces the health impact of second-hand smoke; makes it less likely that other younger relatives in their household will start smoking; and for some is a step towards quitting altogether. In 2013/14, 5,886 households in Salford pledged to become smoke free, while 3,684 pledged to make their cars smoke free. A survey of 20% of these people found that nearly half of them had reduced their smoking six months after signing the pledge, while more than a quarter had quit altogether.[90]

Duties to involve people in the Care Act and the Health and Social Care Act

The Care Act 2014 has played an important role in helping local authorities to see their role as commissioning bodies differently. Throughout the RtV programme, interviewees stated that there is a real need for capability building among health commissioners, in particular in increasing their understanding of asset-based approaches and the role of communities and the voluntary and community sectors. We often heard that local health commissioners act more as procurers of services than shapers of markets (see 'Commissioning and contracting' on page 37). Support – whether through legislative or other means – for health commissioners to embrace this broader role could be an important step towards increasing the awareness and commissioning of person- and community-centred approaches.

The VCSE Review recommended that NHS England should issue revised statutory Transforming Participation in Health and Care guidance in 2016 on working with the voluntary sector as a key way for health care commissioners to fulfil their duty to involve people in decisions about their care and in the design and delivery of services. At the time of writing, NHS England were undertaking a review of the guidance. This provides a good opportunity for NHS England to provide more comprehensive guidance to commissioners including about how to engage individuals, communities and the voluntary and community sector to ensure wider social value.

The NHS Constitution

While not a legislative requirement, the NHS Constitution sets out the rights of patients, the public and NHS staff, a series of pledges, and the responsibilities of people using and providing NHS services and the wider public. The Constitution is clear on the importance of person-centred care and the rights of people to be involved in decisions about their own care. It is often cited in policy documents and has influenced the development of many policy initiatives, including values-based recruitment (see Chapter 2). However, there is very low awareness of the NHS Constitution among patients and the public while awareness among staff groups varies.

Regulation

Institutional regulation

Institutional regulation describes the role of those national bodies that oversee, monitor and assess health and social care organisations. The two main regulators are the CQC and NHS Improvement (created by the merger of Monitor and the Trust Development Agency). In workshops with the RtV programme partner sites and their wider stakeholders, including GPs and commissioners, the complexity and bureaucracy of inspections by regulators was cited as a barrier to implementing the sites' approaches. A key issue identified in the Health Foundation's recent report on a coherent quality strategy for the NHS, *A clear road ahead*, is the need for greater coherence and alignment across these regulatory bodies.[7]

Regulation is an important lever for governments and policymakers as it provides a mechanism for safeguarding quality and identifying where there are concerns about individual organisations on patient care, safety or financial performance. It can be used to reward performance – an outstanding rating from the CQC for example – but on the whole is seen as a risk or performance management lever. Not surprisingly given the potential consequences, meeting regulatory requirements is taken extremely seriously by organisations and often a lot of time and effort is spent on preparing for a CQC inspection giving priority to the areas it is expected the inspection team will focus on.

Regulation alone is unlikely to be a driver towards the wider adoption and spread of person- and community-centred approaches for health and wellbeing, but it is important that the approaches are included in regulatory frameworks. If they are a component of inspections it may help them to become a priority for boards, chief executives and senior leadership teams – and in turn their staff's efforts – across health and social care.

How person-centred care is reflected in regulation and inspection

In recent years, there have been many changes to the way in which health and social care services are inspected and regulated, and also to the roles of the main regulatory bodies. Many of these have been in response to findings from inquiries into events at Mid Staffordshire NHS Foundation Trust, Morecambe Bay, Winterbourne View and other places that found significant failings in patient care. Understandably, this has meant that the reforms have mainly focused on patient safety, risk assessment and how inspections are carried out.

Some of the reforms have focused on person-centred care. For example, the CQC's new framework for regulation and inspection includes person-centred care as a Fundamental Standard. Person-centred care is also reflected in the 'key lines of enquiry' that CQC inspectors use when inspecting services. In particular, there are questions for all services (hospitals, primary care and social care) that explore how far people are involved in decisions about their care, how they are supported to make decisions, and how patient feedback is used to improve services. While on paper, many of these developments are positive, our interviewees noted that inspections still felt very process oriented and lacked a strong emphasis on how services are supporting person-centred care.

Person-centred care is a multi-faceted concept and it can be difficult for teams to judge how far services are providing it. A key priority for national regulators should be improving how inspection team members, including lay representatives, are supported and trained – for example through the CQC Academy – to understand and assess for person-centred care.

There is also scope for the questions asked in inspections (the Key Lines of Enquiry) to be improved. In the health care sector, the focus of the CQC key lines of enquiry is heavily weighted to clinical factors and questions about how services or professionals are 'managing' people with long-term conditions. There are no questions on whether services support people to manage their own health and care, for example through self-management education or peer support services. More could also be done to ensure consistency of approaches across different sectors. This could help with assessing how services ensure consistent person- and community-centred care in organisations and when working across boundaries, for example between acute settings and primary care or health and social care. The VCSE Review specifically recommended that the CQC should review its key lines of enquiry and ratings' characteristics across all sectors to include the value of personalisation, social action and use of volunteers, who are proven to achieve improved quality of care: a recommendation that we would endorse.

Regulating new models of care

People's health and care needs – particularly people living with long-term conditions – are often complex and require interaction with and support from multiple teams and services. Inspecting and rating a single provider will not be able to reveal the extent to which health and care services are supporting people's health and wellbeing holistically. However, a potential limitation on regulatory bodies' ability to focus on person-centred care is that their remit only extends to individual organisations.

The CQC is aware of this issue and is taking steps to address it. The increase in the number of thematic reviews they undertake is encouraging – they have completed reviews on end-of-life care (based on the National Voices narrative for person-centred coordinated care), patient involvement in care and integrated care for older people. The focus on pathways or specific topics that thematic reviews allow rather than individual services should help to ensure that assessments of quality are more holistic.

The CQC has also piloted a number of place-based reviews. A potential limitation of these is that the CQC can still only rate and assess individual organisations, and the data available are still specific to organisations. The early reviews did attempt to look at how organisations work together and used focus groups with the voluntary sector but this felt limited. Perhaps more promising for assessing holistic person-centred care is the work the CQC is doing to develop its approach to assess the quality of integrated and place-based care, including, for example, how it regulates new care models.[92]

Balancing regulation and support functions

The performance monitoring and assurance aspects of the regulator's role need to be balanced with its role in supporting and encouraging improvement. In *A clear road ahead,* the Health Foundation found that the balance of approaches used by national bodies was too skewed towards control rather than improvement through support.[2] Person- and community-centred approaches are likely to progress faster through support. While establishing NHS Improvement is a promising development in this respect, there are still questions about how it will achieve this. In late 2016, NHS Improvement consulted on a Single Oversight Framework for its regulatory role (to replace the separate frameworks for Monitor and the NHS Trust Development Authority). In the consultation document, NHS Improvement set out an approach that included both oversight and intervention when concerns are raised but also a package of support for organisations that varied according to their (assessed) status and any identified or potential concerns. There is potential for this support – albeit much of which would be voluntary – to include practical resources and guidance for trusts on how they can develop and implement approaches to support and empower people and communities and to improve health and wellbeing.

5: System-focused interventions: System management

Recommendations

Commissioning and contracting

- National bodies need to be aware of the impact of commissioning decisions and contractual models on the voluntary and community sector. They should ensure commissioners and providers are able to use a diverse range of available mechanisms for working with voluntary and community sector organisations and that they are supported to understand how best to use these to meet the needs of local people and communities.

- National bodies, including large national charities, should support capability building in the voluntary sector. Priorities should include building capability in the use of data, measurement and evaluation.

Payment and incentives

- Payment system reform needs to be comprehensive and joined up (across all of health and ultimately across health and social care) with a focus on the whole patient journey.

- New care model vanguards and other pilot areas should continue to be encouraged to trial new payment mechanisms and incentives and NHS England and NHS Improvement should ensure that learning from what works – and what doesn't – is shared widely and used to inform wider national payment reform.

- Consistent methods of extracting learning should be built into local and national evaluation frameworks for national improvement programmes. Local areas are unlikely to have the necessary resource and expertise to do this alone, so continued national support for evaluation will be critical.

Commissioning and contracting

Effective commissioning can play a central role in attempts to improve quality of care by ensuring that services provided in a local area are centred on what really matters to people and communities. It can help people to control and manage their own health and care, and lead to greater integration of services, while helping to make the best use of the resources available.[93] In short, it should be an effective lever to help embed exactly the type of approaches that the RtV programme is concerned with. The RtV programme partner sites provided many examples of successful relationships with commissioners built on trust. They also described ways they had helped make it easier for them to commission their services.

However, in reality much commissioning does not work in this way. Even where helpful duties exist – such as those set out in the Care Act 2014 and the Social Value Act – many factors can act as barriers. Many of these were raised in workshops with the RtV partner sites or mentioned by interviewees. From this, we identified two key actions to improve the commissioning of person- and community-centred approaches. These are:

- focusing on developing a thriving and sustainable voluntary and community sector

- building capability among commissioners and voluntary organisations.

Because of the current national focus on personalised commissioning, through the Integrated Personal Commissioning (IPC) programme and national targets to increase the number of people with a personal health or combined health and social care budget, these initiatives are also considered in this chapter.

This chapter focuses on commissioning in health and social care as a key mechanism for designing and procuring new services as well as reshaping existing ones. However, how services are designed and procured is evolving through routes such as the Sustainability and Transformation Plans (STPs), the focus in the NHS Five Year Forward View on new care models, and devolution initiatives. Many of these routes include testing new ways of integrated working across health and social care with other public bodies and with voluntary and community organisations. Therefore, the recommendations included in this report are intended to be relevant not just for CCGs and local authority commissioners but also for any emerging structures and mechanisms that impact on how services are designed, commissioned and procured.

A sustainable voluntary and community sector

'The VCSE sector is one vital route towards people power. It's not the only route, and sometimes the VCSE sector doesn't actually achieve that. It's not perfect in that respect. But when it works well, it is a route to people power and, particularly, it's a route to co-production and co-design, and engagement with groups and communities that statutory services don't have a strong track record of reaching.'

Alex Fox, CEO Shared Lives and Chair of the
Joint Review of the Voluntary and Community Sector

A clear theme from the RtV programme's work with partner sites is that a strong and sustainable voluntary and community sector is needed for person- and community-centred approaches to be routinely commissioned. This was an equally clear message of the recent VCSE Review but is still not the reality for many voluntary and community organisations. We believe that there are four areas where action is needed to make the goal of a sustainable voluntary and community sector a reality. These are:

- addressing the challenges of fragmented commissioning

- creating a better balance between collaboration and competition

- commissioning for outcomes in a way that best supports local collaboration and relationships between statutory services and the voluntary and community sector

- developing capability and capacity among commissioners and staff in voluntary and community sector organisations.

Fragmented commissioning

All of the RtV partner sites cited the fragmented nature of commissioning as a key barrier. Several interviewees noted that local authority commissioners tend to take a more holistic approach to commissioning and are more used to partnering with the voluntary sector. However, the experience of our sites suggests that fragmentation is an issue across health and social care. Positively UK, who provide peer support for people living with HIV, also reported that this fragmentation existed not just between health and social care but also between health and public health because of the division created by the Health and Social Care Act reforms; an issue recently highlighted by the Health Select Committee.[94]

A number of the sites also felt that not only were commissioners fragmented in health and social care, but the commissioning process – which often put voluntary and community organisations in competition with one another – further fragmented provision, meaning the end service user faced a confused and disjointed picture. This is explored in the next section.

The issue of fragmentation is not just related to how services are commissioned. Commissioners who want to commission person- and community-centred approaches can find it difficult to know how to engage with the myriad local community organisations in their area. The voluntary sector members of the RtV consortium advised that a number of voluntary and community sector organisations are working with NHS England and others to explore the potential to develop a single point of contact model to facilitate relationships and support commissioning of the voluntary and community sector in a particular area, which may help to address these issues. A similar recommendation was made in the VCSE Review.[58] A number of the RtV partner sites already work in similar ways with their local commissioners. Key benefits are that this can reduce the 'hassle factor'[41] for commissioners and alleviate some of the burden on very small local voluntary and community sector organisations.

> For more information on how the Realising the Value partner sites have worked with commissioners and other partners to deliver better outcomes for people, see *Making it happen: Practical learning and tips from the five Realising the Value local partner sites.*

Encouraging collaboration rather than competition

All the RtV partner sites were united in placing importance on relationships with the wider health community. None of them are able to operate in isolation and they all attributed a large part of their success to the links they had made with commissioners, other providers and service users.

A collaborative and community focus was thought by the sites to build knowledge, experience and enthusiasm for their work, adapt them to better meet the community's needs, improve communication, and enable peer support structures. These take time to develop and need to be nurtured and supported. In the case of one of our partners, Being Well, they took what might be considered a 'risky' approach by being very open and transparent with their commissioners. This includes, for example, involving them in regular meetings where both the successes and challenges of the health coaching service operations are discussed. The team credit this with helping build high levels of trust and credibility with their commissioners.

All of the RtV partner sites felt that their ability to work in a collaborative and community-focused way was undermined by the competitive nature of commissioning in their area. For some this was a greater problem than others, but all felt the drive for competition in services could undermine the collaborations and communities they were seeking to build.

Recent research on NHS commissioning suggests that NHS managers still prefer to collaborate than compete. However, there has been a shift towards competition, influenced by an increased focus in government policy over the past 15 years.[95] Some see competitive procurement as a lever to encourage more person- and community-centred approaches, although the RtV partner sites have all found competition to be a barrier.

Collaborative commissioning is clearly possible, despite these barriers, but it requires all parties to invest the time and resources in building and sustaining relationships and developing a shared vision for success and priorities to action (see example in Box 4).

Box 4 – Collaborative commissioning

Stockport Together is a New Models of Care vanguard site of integrated health and care services that was previously supported by Nesta's People Powered Health programme. It is developing a model designed to wrap provision around the person and to empower greater self-management of care. Partners include two foundation trusts, the council, a CCG, the local GP federation and the third sector. At its core, alongside developing the new care model, it seeks to grow peer support and social action, encouraging activated citizens to come together to help make communities 'kinder' and more connected. The approach involves a new way of commissioning services from the voluntary sector, using alliance contracting and outcomes-based commissioning around three main aims, to:

- reduce the need for formal care and health provision by strategically targeting those most in need of support

- build greater capacity in the community and the voluntary sector

- create a more joined-up and collaborative system of preventative support in communities with providers working closely with them.

There is a focus on growing social action that is locality-based, for example through developing neighbourhood community hubs in spaces that are already used and trusted such as cafes, to start new conversations about wellbeing.[96]

Outcomes-based commissioning

'One of the things that we're trying to work with commissioners to do is to commission… rather than commission by hours, it's commission by outcomes, so not this person needs X number of hours, that's what you have to deliver, but what outcomes do you want for this person, and then how can you go away and deliver that as an organisation?… they want to be able to live on their own, they want to be able to not have sleep-in services, that sort of thing, it will enable us to measure outcomes for people [to be] able to see a direct impact on their outcomes in terms of health and wellbeing and how they feel.'
Interviewee from organisation delivering services for people with learning disabilities

Interest is growing at national and local levels in exploring different models of outcomes-based commissioning. There are different definitions of outcomes-based commissioning, but a Health Foundation report identified five core components that are commonly included in such an approach.[97] One is a focus on populations and outcomes that matter to those populations, usually developed through partnership working with people and communities.

Outcomes-based commissioning approaches are still in the development phase and need long-term support from NHS England to support commissioners and providers, and share learning between those experimenting with different approaches.[97]

Learning from the RtV programme highlights the need to better understand the consequences of different approaches to outcomes-based commissioning on relationships with the voluntary and community sector.

Alliance contracting was seen as potentially more conducive to collaborative relationships with and between the voluntary sector than, for example, a prime provider model. A key difference between alliance and prime provider models is the nature of the relationships between the parties and how risk and reward is shared. An alliance model is generally more collaborative and depends on mutual trust, although is not yet well tested in health care. It also often does not involve structural change and is led by commissioners who are part of the alliance and share the risk.[98]

A key barrier to commissioning for outcomes that matter to people and communities is being able to capture and measure these so they can be used to support more effective commissioning. As noted elsewhere in this report (see 'Data and measurement' on page 28 and 'Payment and incentives' on page 44), more work is needed to develop a framework that prioritises values for people and communities and to develop effective ways of measuring these.

For more information on the RtV programme's work on developing new approaches to value in health and care see the paper *New approaches to value in health and care.*

The need for a wide range of funding and investment approaches

The RtV programme partner sites and voluntary sector partners in the RtV consortium reported an increasing tendency for commissioners to use contracts rather than grants with voluntary and community sector organisations. Partner sites saw this as unhelpful, particularly when combined with the short-term nature of many contracts, which fail to provide sufficient security, particularly for small local organisations.

The VCSE Review also noted the drift from grants to contracts by local authority and health commissioners. It proposed recommendations on how national bodies and commissioners at all levels can use the funding and investment levers available to them to support a sustainable voluntary and community sector, which in turn can contribute significantly to supporting better health and wellbeing in communities. This needs a strategic approach to using different kinds of funding – grants, contracts, social prescribing models, social investment, increased use of personal budgets – to create a more diverse range of interventions and providers.[58]

Capacity and capability building

Commissioning for person- and community-centred approaches for health and wellbeing requires commissioners to work differently. Commissioning in this way means starting with the assets and capabilities of individuals, communities, and the voluntary and community sector; providing statutory services is a secondary concern.[99]

Throughout the RtV programme, the role of commissioners in shaping the market – rather than simply commissioning or procuring services that were already available – was mentioned by partner sites, consortium partners and others. This was seen as better understood in social care, largely thanks to the Care Act 2014 and associated guidance that makes this duty explicit. Similarly, the greater awareness among local authority commissioners of the Social Value Act was seen as important in supporting more person- and community-centred approaches to be commissioned.[*]

Much can be done in health to support commissioners to better understand their duties under the Social Value Act. Guidance and toolkits will be helpful, but to be most effective and reach beyond those who are already committed to this approach, it will need to be aligned with and embedded in the everyday priorities for commissioners.

Voluntary and community sector organisations also need to be supported to develop capability to work in different ways with commissioners across health, social care and, increasingly, wider public services. The focus of voluntary and community organisations is often on providing support to individuals but they lack the capability and capacity to bid for and manage programmes. They also may not place the required focus on building evidence and capturing outcomes. This can lead to frustration on the part of commissioners who do not see them as commissionable. Voluntary and community organisations should not completely change to meet commissioners' requirements but may need to change some of the ways they work both with commissioners and other voluntary organisations. In particular, more needs to be done to support them to develop their capability to capture and communicate their outcomes and impact, as well as support them in understanding relational aspects of commissioning, including how to build and sustain relationships with commissioners.

Commissioners are under increasing pressure to show that the services they commission are evidence based and, in particular, that they represent value for money. This makes it even more important for local voluntary and community sector organisations to capture the evidence for and impact of the services they provide. Yet many, especially smaller ones, lack the resources and skills to collect and analyse data and to use this to build a case about the potential benefits and impacts of their services. When done well, however, it can be very effective. Penny Brohn UK reported that its focus on evaluation allowed it to demonstrate the value of its services in a robust way. Its work using the patient activation measure (PAM) has led to being involved with a local CCG and represented on the groups developing the Sustainability and Transformation Plans[100] in the Bristol area. Supporting other voluntary organisations to build capability in measurement and evaluation should be a priority of national organisations and can be supported through better knowledge sharing and exchange among voluntary sector organisations.

Personalised commissioning

One of the main ways policymakers have sought to make commissioning more person-centred is through a focus on personalised commissioning, including using personal budgets in both health and social care. There is growing evidence about the benefits of people being in more control of the care and support they

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[*]   For more information on the Social Value Act, see Chapter 4.

receive.[101] The evaluation of the personal health budgets pilot also provided important insights into when personal health budgets are most effective, such as when people are given greater flexibility about what they are used for.[102]

Personal budgets are more established in social care. For example over 120,000 people receive a direct payment for their social care needs as well as over 92,000 carers.[103]

The latest NHS England mandate includes the commitment that 50–100,000 people will have a personal health budget or personal budget that combines NHS funding with social care by 2020.[104] It is also expected that personal health and integrated budgets will form a part of all Sustainability and Transformation Plans.[105] This is a welcome focus but attention also needs to be paid to how these targets are met to ensure that they lead to people being generally in control of their health and care and supported to access the care and support they want and need, rather than simply being a number that needs to be met. NHS England has set up a network for NHS and local authority staff to share learning and is providing a package of support to CCGs to expand personal health budgets beyond people who receive continuing health care funding, which should help.

The IPC programme is focusing on joining up health and care for people with complex needs. It is working initially with nine demonstrator sites but has published a framework and a range of resources that others can use. Notably, the programme sees building community capacity and peer support alongside personalised care and support planning as key factors in supporting a shift to more personalised commissioning. This recognises that while different payment mechanisms and the use of personal budgets are important, they will not on their own be enough.

Figure 2: Five key shifts needed for integrated personal commissioning

1: Proactive coordination of care
A proactive approach to integrating care at individual level around adults, children and young people with complex needs

2: Community capacity and peer support
A community and peer focus to build knowledge, skills and confidence for self-management

3: Personalised care and support planning
A different conversation about health and care focused on what is important to each person, through personalised care and support planning

4: Choice and control
A shift in control over the resources available to people, carers and families, through personal budgets

5: Personalised commissioning and payment
A wider range of care and support options tailored to individual needs and preferences, through personalised commissioning, contracting and payment

Early learning from the IPC programme echoes many of the messages from the RtV programme, including the importance of allowing time for people to develop relationships of trust. One of the people interviewed for this report and who is involved in the IPC programme noted that when sites have developed good relationships across the board – with health and social care commissioners, finance teams and senior leaders – they are often able to make more progress as they are trusted to try new things.

Payment and incentives

The NHS payment system defines both the mechanisms through which NHS-funded care is paid for, and how much is paid. Commissioners use elements of the system to incentivise providers to achieve desired objectives of care, such as better health outcomes, activity levels, improved efficiency, and reduced waiting times. It is a highly complex mix of methods, prices, incentives and penalties, which has evolved out of a decade of reforms to its separate components, in isolation from one another, rather than system-wide planning in line with the ambitions for the care system set out in the NHS Five Year Forward View.[106] It is expected to drive change but evidence suggests this aim is overstated and that even where it can impact, alone, it is a blunt and limited instrument.[107] Instead, it must be aligned with the other levers and incentives available to commissioners.

Recommendations about how to embed person- and community-centred approaches often include changes to the payment system but, as a GP interviewed for the RtV programme noted, payment mechanisms can help but will not unlock change on their own; cultural and other system-wide barriers are more important.

As a result of the many objectives of the current payment system, a wide range of approaches are employed across sectors and areas. These are not always aligned in the signals they provide, either with one another, or with stated system objectives. For example, paying for activity in the hospital sector incentivises higher activity levels, while paying for much of community care irrespective of the activity has the opposite effect. Together, these signals are contrary to the objective to shift care out of hospitals into the community.

That separate payment systems focus on single areas (such as emergency care) or episodes of care is also not consistent with how patients use and move through the care system. For example, it has been suggested that while the Quality and Outcomes Framework (QOF) has been successful in driving improvements in primary care generally, it can work counter to person-centred care by rewarding processes for individual diseases rather than supporting improvements in a person's overall health and wellbeing.[108] A joined-up system that focuses on patient pathways across health and social care should be more conducive to person- and community-centred approaches. Payment approaches are also often short term (for example, the annual cycle for activities under the Commissioning for Quality and Innovation (CQUIN) payments framework) and do not strike the right balance between being nationally directed and locally determined to meet the needs of individual areas and populations. Both of these factors can weigh against attempts to make services more person- and community-centred.

The NHS payment system is frequently overloaded with objectives – increasing efficiency, moderating activity, improving quality, improving patient outcomes. While there is evidence that payment approaches can promote productivity and quality of care, the evidence review undertaken to inform this report on national system levers (Annex 1) found no evidence of the impact of the payment and incentives system on attempts to implement person- and community-centred approaches for health and wellbeing.

Incentivising such approaches is just one of many possible objectives. We do not yet have the evidence to support a role for the payment system in moving us towards a system that supports and empowers individuals and communities in their health and care.

It is widely agreed that the NHS payment system needs reform if it is to support new models of care, integration and joint working, and person-centred care – and early reforms in this direction are underway. Joint discussion papers from NHS England and Monitor in 2013[109] and 2014[110] acknowledged the need for a blended approach to payment reform including more certainty about tariffs, a clear national framework, and much more flexibility for local areas to set tariffs and develop incentives to reflect their populations.

Since the NHS Five Year Forward View was published and Monitor and TDA merged to become NHS Improvement, among other events, there appears to have been a greater focus on local vanguard areas testing new payment and contracting models. However, wider reforms are beginning to happen. A recent example is the move to fix the national tariff for two years rather than one, with NHS England signalling that this may lead to an even longer fix for greater stability.[111] And to allow more local flexibility, it was announced in late 2016 that NHS England and NHS Improvement will be open to proposals from local areas to drop the payment by results system and instead allocate funding on a population basis.[112] Given the shortfalls of the current system in supporting person- and community-centred care, this may provide opportunities to develop local systems to support these ambitions. It will be vital to evaluate and learn from emerging local payment systems.

Many reports have recommended changes to the way the payment system is structured towards rewarding and incentivising providers based on the (broader wellbeing) outcomes that they deliver for individuals.[113] There are many positive elements of these but they are usually not framed in the context of wider payment system reform or the implications for other objectives if the system is reformed in this way.

A 2014 Nuffield Trust report highlighted a number of areas where the analysis suggested more rapid progress could be made (alongside longer-term redesign of the payment system). Two of these are particularly relevant to thinking about the potential for the payment system to support moves towards more person- and community-centred care. These are:

- refocusing the 'pay-for-performance' elements of the system towards improving integration and coordination of care

- proactively engaging with the design and evaluation plans for payment pilots that support integrated care and improved outcomes to maximise the lessons that could be learnt for the wider NHS.[107]

These recommendations are still relevant. Permitting a range of areas to trial new payment and contracting mechanisms – through programmes such as New Care Models, IPC and Integrated Care and Support Pioneers – is a positive development. It is important, however, that these areas are given the time they need to trial new approaches. These also need to be properly evaluated. The financial and other pressures on the system make it difficult for this to happen, with increasing expectations and demands that such approaches show positive results quickly or risk being stopped. There is a real danger that the system will prematurely pick up and run with a model or approach that has not been tested properly or is implemented without a good enough understanding of what makes it effective, and in what circumstances.

A key question is how we move to a new approach that is fundamentally different from the current one without destabilising the existing system. Sufficient funding must be ensured for providers that need to change how they work, as well as supporting existing services that must be maintained for the time being at least. In a 2015 report, *Making change possible: a transformation fund for the NHS,* the Health

Foundation and The King's Fund made the case that there need to be specifically earmarked resources for transformation to new ways of delivering care.[114] They acknowledge that finding additional funding is exceptionally difficult in the current financial climate, but warn that without dedicated financial and practical support for transformation, we risk that services will not be able to become more productive, resulting in higher running costs over the long term.

Although the 2015 Spending Review announced a £2bn real-terms increase in the Department of Health budget for 2016/17, most of this will be used to cover rising provider deficits, pension costs, and increasing demand for services, leaving only a limited amount for investing in transformation to achieve the changes set out in the NHS Five Year Forward View.[115] Given the risks of not making these essential changes to the way services are organised and delivered, funding to support this should be viewed as an investment. Funding transformation should therefore be considered as a capital investment, rather than coming out of resource budgets and diverting funds away from the day-to-day running of existing services.

6: System-focused interventions: Health care delivery

Recommendations

Nationally led health and care improvement and place-based initiatives

• National initiatives that support local partnerships to develop and trial new approaches and models of care, or seek to achieve place-based whole system change, offer significant potential but how they are implemented is important. To help ensure that these initiatives support person- and community-centred approaches, national bodies should pay particular attention to:

  – capturing and sharing learning to support the spread of approaches beyond mature and high performing areas

  – giving areas practical support – particularly to tackle the barriers that are outside of their direct control – as well as guidance and tools

  – providing support to areas to maximise community engagement in developing and implementing programmes

  – understanding why progress is being made (or not) in current initiatives to inform future programmes

  – ensuring alignment of key messages across programmes to avoid teams involved in multiple programmes facing conflicting priorities or requirements.

National clinical programmes

• NHS England should ensure that, in implementing the recommendations from national clinical reviews on maternity services, mental health and general practice that recommendations on person- and community-centred approaches are given the same weight as those that apply to other areas such as access to treatment or clinical outcomes.

As a policy lever, national initiatives and programmes that seek to transform care through supporting local organisations and areas should generally be welcomed. Focusing on proactive support and flexibility for local areas rather than on targets or directives has great potential to improve health and care.[116] To maximise this, national regulatory, financial and performance management levers must be closely aligned with nationally driven programmes aimed at promoting greater integration across health and care.

These initiatives range in scale from pilot programmes supporting a small number of leading organisations or partnerships, through place-based initiatives that apply to certain areas or populations to nationally mandated initiatives that apply to all areas in England. How they are implemented and how they align with one another and with other national policy levers is crucial.

Another key mechanism national bodies use to transform services is through a focus on core clinical areas. Ensuring that person- and community-centred approaches are embedded in current national focus on areas such as maternity, mental health, learning disabilities and cancer is important although the extent to which areas are ready to adopt them may vary.

Nationally led health and care improvement initiatives

Various governments over the years have used national initiatives that seek to pilot or test new approaches to transform or improve care, with a noted increase in the mid-2000s.[117] Using national pilots to develop or implement policy can have a number of objectives, such as experimentation, early implementation, demonstration and sharing learning. They often have more than one purpose or the purpose may change over time.[117]

In recent years, a range of national initiatives have been designed to support a move to more place-based health care or to bring together organisations and leaders across health and social care and sometimes other public services (see Table 3 overleaf). A focus on place-based health care delivery is generally accepted to be helpful to attempts to embed and spread person- and community-centred approaches for health and wellbeing as, if implemented well, it can ensure that leaders focus on what matters to people and communities and take a more holistic view of the health and care needs of a local population.

In this chapter, we draw on examples from three ongoing national programmes that are seeking in different ways to embed person- and community-centred approaches in the development of new models of care and new ways of working across health and social care boundaries. The programmes are:

- **The Integrated Care and Support Pioneers programme** – 25 'pioneers' in two waves, 5–7 year duration, shared definition of integration as coordinated person-centred care, developed by National Voices with patients and service users.

- **New Care Models programme** – five new models, 50 'vanguard' sites, six principles of engaging people and communities developed to underpin the development of new care models, particular focus on person- and community-centred approaches in: multispecialty community provider (MCP) sites (14 sites); integrated primary and acute care systems (PACS) (nine sites); Enhanced care in care homes (six sites) vanguards.

- **Integrated Personal Commissioning (IPC) programme** – nine demonstrator sites, focusing on joining up health and care services for people with complex needs including through using combined health and care personal budgets where appropriate.

Table 3: National policy initiatives designed to support place-based leadership of health care

Initiative	Lead body	Stated purpose
Devolution Deals, and the Cities and Local Government Act	HM Treasury; NHS England	The government... is ready to have conversations with any area about the powers that area wishes to be devolved to it and about their proposals for the governance to support these powers if devolved.
New care models programme, including Vanguards	NHS England	Through the new care models programme, complete redesigns of whole health and care systems are being considered.
Quality in a Place programme	Care Quality Commission	To understand the extent to which we can provide evidence to support whether reporting on the quality of care in a place can be a lever for improvement.
Integrated Care Pioneers programme	NHS England	Developing and testing new and different ways of joining up health and social care services across England.
Sustainability and Transformation Plans	NHS England, NHS Improvement	Every health and care system will be required, for the first time, to work together to produce a Sustainability and Transformation Plan, a separate but connected strategic plan covering the period October 2016 to March 2021.
Better Care Fund plans	NHS England, Department of Health	A local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their wellbeing as the focus of health and care services.
Success Regime	NHS England, NHS Improvement	A new regime to address [longstanding] issues, and create the conditions for success in the most challenged health and care economies.

Source: Catalyst or distraction? Health Foundation, 2016

In each of the three programmes, local providers or areas were invited to apply. Their names – vanguards, pioneers and demonstrator sites – imply that the focus is less on piloting the effectiveness of the proposed change and more on acting as early adopters or demonstrating that these approaches work. They are expected to spread further and could have a profound effect on how health and care services are designed and delivered for many years to come as the contracts for new models are expected to be issued for ten or more years.

The focus on person- and community-centred approaches in the New Care Models, Integrated Care and Support Pioneers and IPC programmes provides a welcome focus and profile to these approaches, a point reinforced by interviews with the Integrated Care and Support Pioneers as part of the early evaluation[118] and with the RtV partner sites.

The new care models are underpinned by six principles for engaging people and communities. These include: that care and support is person-centred, personalised, coordinated and empowering; that services are created in partnership with citizens and communities; and volunteering and social action are key enablers.[119]

The draft framework for the MCP model also states that a 'defining feature of a multispecialty provider is that it nurtures social capital and community resilience' and there are examples of how vanguards are developing approaches to support this. One is the All Together Better Sunderland vanguard that has engaged over 18,000 volunteers as community health champions who have, in turn, reached over 104,000 other people in local communities.[120] The framework document also states that all MCP vanguards are developing or operating large-scale social prescribing schemes. Another good example of how these programme are embedding person- and community-centred approaches is found in the emerging framework for the IPC, which includes community and peer support as a key element of the programme (see Figure 2).

While there are many positive features in these initiatives, how they are implemented matters. There are a number of different programmes with often overlapping but distinct objectives. They all include, in different ways, a focus on people and communities – but this is not the only objective. Both across and within programmes, there can be a number of competing objectives. There is not unlimited capacity in the system to focus on this type of change. Why should vanguards and pioneers focus on person- and community-centred approaches when faced with significant and urgent pressures on waiting times or finances that need urgent action driven by other national directives and targets? It is possible to point to the emerging and growing evidence base for these approaches[121] and their potential over time to reduce demand on services, but this is unlikely to be enough unless there is a clearer signal from the centre about their importance, as well as support over time for local sites to implement and stay the course. This issue is likely to be even more prominent in initiatives like Sustainability and Transformation Plans that seek to spread this change to larger areas more quickly and which are also likely to be preoccupied with the financial sustainability of providers given their focus on achieving financial balance.

Perhaps one of the key differences between the current initiatives and those that preceded them in the mid-2000's is the context in which they are operating. This context is important and the current financial climate in particular poses some significant challenges in implementing new models of care and other similar initiatives. In the early evaluation[6] of the Integrated Care and Support Pioneers programme, pioneers identified policymakers exerting pressure on sites to demonstrate success at too early a stage as a perceived barrier. A number of them felt that 5–7 years was the earliest they could be expected to see measurable improvements in outcomes. While the programme is due to run for this long, there is an understandable pressure from both national and local leaders to see results more quickly or risk these types of approaches not being continued.

A key lesson from the RtV programme partner sites is that exemplar providers can engage with national policy and levers like vanguards to further their position locally (and many are often part of more than one national initiative*). However, it is not clear whether what the exemplars do can simply be rolled out to other places that are at a much earlier state of readiness and with less intensive support. There is already anecdotal evidence about the difficulties of this in developing Sustainability and Transformation Plans and it will be an issue as the new models of care are rolled out more widely

Alignment

There are some positive signs that NHS England has recognised the need for greater alignment across the different programmes. The Integrated Care and Support Pioneers programme has recently been brought under the banner of New Care Models with access to the same materials and support. The emerging Self-Care Programme within NHS England is using New Care Models, the General Practice Forward View and the IPC as the key way of spreading self-care approaches (which it defines broadly to include a wide range of approaches for empowering and supporting people and communities). The aim is that this will lead to a consistent package of support, tools and resources to support the various teams in implementing these approaches.

This is a start but much greater coherence is needed both across and within these individual programmes. The policy landscape of national initiatives and programmes is confusing for informed policy observers; far more so for those at the frontline, let alone patients, small voluntary sector partners and the wider community.

Support to address barriers

Many of the barriers that sites who take part in these programmes experience are not within their control to address – they need either national action or combined action at national and local level. Commonly cited barriers by the Integrated Care and Support Pioneers[118] include: contracting arrangements; commissioning structures; competition; information governance and competing national directives. Many of these barriers are not unique to the programme and reflect the experiences of others seeking to implement person- and community-centred approaches, including the RtV programme partner sites.

All of the national programmes involve packages of support to the programme sites but the nature and extent of this support varies considerably. For New Care Models, various arm's length bodies have committed to support a set number of individual vanguards, which arguably brings more focus from these organisations than would a general offer of support. There are also some good examples of how communities of practice are being developed and supported to enable sites to share learning and address common challenges together. Many of the pioneer sites would like more practical support from national bodies, rather than simply more guidance or toolkits. A particular desire was practical support to overcome the barriers that were not solely in their control to address.

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*   For example only three of the 14 first wave and four of the 11 second wave pioneers were not involved in another major national initiative or programme (Vanguard, IPC, Social Impact Bonds, National Technology or Prime Minister's Challenge Fund). Seven of the second wave pioneers were also vanguards or had a vanguard site that included part of their area. See: www.piru.ac.uk/assets/files/Early%20evaluation%20of%20IC%20Pioneers,%20interim%20report.pdf.

National clinical programmes

For person- and community-centred approaches for health and wellbeing to be adopted widely, they need to be prioritised and embedded in individual clinical areas. Since the NHS Five Year Forward View was published in 2014, NHS England has commissioned expert taskforces in cancer,[122] mental health[123] and maternity services and has developed a plan to transform care for people with learning disabilities[124] based on the reports following failings in care at Winterbourne View.[125]

All of these reports emphasise in different ways the important role of patients, carers, service users and often communities in responding to the challenges in the respective areas.

The national Cancer Taskforce report has a set of recommendations focused on empowering people to stay healthy and to self-manage. These should ensure that all cancer patients have access to appropriate recovery support, peer support, shared decision making, and measures to monitor and support improvements in how people are supported to live well after treatment – these should supplement existing measures focused on clinical outcomes or care processes. The maternity review report made clear recommendations on giving women more choice and control over their maternity care, including through personalised maternity budgets. Meanwhile the Five Year Forward View for Mental Health emphasises the importance of co-production, community support and the need to address the wider determinants of health impacting on mental health. The report noted that people particularly valued peer support and further building the evidence base, particularly on the cost-effectiveness of peer support interventions, was a priority.

> For more information on the Realising the Value programme work on peer support, see programme resources including: *At the heart of health: Realising the value of people and communities; Making it happen: Practical learning and tips from the five Realising the Value local partner sites; Impact and cost: Economic modelling tool for commissioners.*

A key challenge is to ensure that the focus on person- and community-centred approaches is maintained as the recommendations of the taskforces are implemented. The implementation plan[126] for the Five Year Forward View for Mental Health sets out common principles that should underpin all local implementation plans. These are:

- co-production with people with lived experience of services, their families and carers

- working in partnership with local public, private and voluntary sector organisations, recognising the contributions of each to improving mental health and wellbeing

- identifying needs and intervening at the earliest appropriate opportunity to reduce the likelihood of escalation and distress and support recovery

- designing and delivering person-centred care, underpinned by evidence, which supports people to lead fuller, happier lives

- underpinning the commitments through outcome-focused, intelligent and data-driven commissioning.

Good as these principles are, there is no further guidance on how they can be embedded in practice. And, while the taskforce noted the importance of peer and community support to people with mental health problems, the implementation plan includes only one mention of peer workers in the context of the staff mix in acute and crisis care. The nature of person- and community-centred approaches often makes it difficult to distil them into easily actionable targets and there are gaps in evidence and metrics available. However, despite this, NHS England must ensure that the taskforce recommendations on person- and community-centred approaches are given the same weight as those that apply to other areas such as access to treatment or clinical outcomes.

Place-based initiatives

Devolution and other place-based initiatives offer opportunities to transform local services through community engagement and strong local leadership. There is no evidence that decentralisation in itself improves health care outcomes, though perhaps the greatest opportunity lies in addressing some of the social determinants of health instead. Devolution can also support a number of enablers that arguably could aid the spread of person- and community-centred approaches, including joint working between agencies, decision makers being closer to their population, and potential for better implementation of policies at a local level (rather than national imposition).[127]

Five devolution deals including health have been made, with a further three announced in the 2016 budget. These deals are not true (political) devolution but instead a form of decentralisation, particularly for health where many levers, including regulation and workforce planning, remain nationally held. In their conception, 'devolution deals' promote aligning areas, empowering local leaders and drawing on existing community assets. Supporting local innovation and enabling collective leadership across health, social care and the voluntary sector through the Greater Manchester Deal were acknowledged by Simon Stevens, the Chief Executive of NHS England, to be helpful mechanisms for implementing the vision of the NHS Five Year Forward View.[128]

However, the start of devolution deals has not been promising, with every deal being made behind closed doors.[129] They have also been criticised for the lack of public engagement, particularly in the early stages of set up.[130] The voluntary sector has raised concerns that the potential for devolution will not be realised because of limited public engagement.[131] To date, only County Durham has been given a vote on whether they want to be part of a devolved system.

Devolution deals can also not be considered in isolation from the broader policy context. The financial and performance pressures that the national system is grappling with remain critical and dominate priority setting. The recent early evaluation of the Integrated Care Pioneer programme stated that the challenging financial context made whole system change difficult.[132] It is not yet clear what impact that will have on devolution deals. Equally, more positive initiatives can also create complexity in the system – for example, the government has announced 184 quality-related policy measures between June 2011 and March 2016 alone. Alignment across these and other initiatives must be considered in relation to competing or conflicting demands but also in terms of leadership capacity to deliver.[133]

Developing Sustainability and Transformation Plans (STPs) offers another opportunity for place-based whole system change across England. In some areas STPs cut across devolution and vanguard footprints. But they do offer the potential for locally led change across health and care agencies, and the community more broadly. Experience from devolution suggests that caution about their possible impact is required.

We need true engagement and co-production, and there has already been criticism about how this has been undertaken with controversy in the national press, and the campaign group 38 Degrees launching an investigation.[134] NHS England remains committed to public engagement and has issued guidance to STPs about how to undertake engagement. This includes using lay representatives and establishing patient reference or advisory groups; considering and carrying out formal consultation with enough time for the public to make their views heard; testing options with local councils and other important stakeholders; and where possible by building on the work of existing bodies such as health and wellbeing boards.[135] Developing STPs is a nationally mandated initiative, with funds released at the discretion of national bodies. It remains to be seen how locally owned these plans will be.

Place-based initiatives for whole system change have the potential to be important enablers of person- and community-centred approaches for health and wellbeing. They offer real opportunity for meaningful community engagement and empowered local decision making. However, evidence so far suggests there is a danger that engagement is overtaken by pressing issues of financial and performance challenges and a lack of alignment between initiatives, causing unnecessary complexity. The national system should support greater engagement but resist the temptation to become overly directive.

Realising the Value programme resources

Realising the value: Ten key actions to put people and communities at the heart of health and wellbeing

Key learning and recommendations from the Realising the Value programme, based on what we think it means to realise fully the value of people and communities at the heart of health and wellbeing.

At the heart of health: Realising the value of people and communities

This report explores the value of people and communities at the heart of health, in support of the NHS Five Year Forward View vision to develop a new relationship with people and communities.

Making the change: Behavioural factors in person- and community-centred approaches for health and wellbeing

Drawing on robust studies of what influences behaviour, this report sets out a number of factors that can lead to greater involvement in self-care.

Spreading change: A guide to enabling the spread of person- and community-centred approaches for health and wellbeing

Guide to how behavioural science can help spread the take-up of person- and community-centred approaches to health and wellbeing.

Making it happen: Practical learning and tips from the five Realising the Value local partner sites

Catalogue of practical learning and examples of good practice from the five Realising the Value local partner sites.
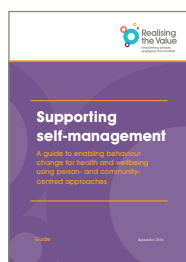
Supporting self-management: A guide to enabling behaviour change for health and wellbeing using person- and community-centred approaches

Guide to how the science of behaviour can help people to self-manage their health and wellbeing.

New approaches to value in health and care

Calls to action to ensure that the approach to understanding, capturing, measuring and assessing value in health and care takes full account of value as it is experienced and created by the people and communities with whom formal systems seek to work.
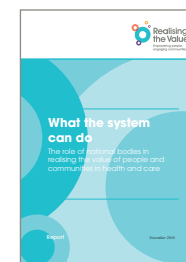
What the system can do: The role of national bodies in realising the value of people and communities in health and care

How national bodies can best remove barriers to progressing person- and community-centred approaches for health and wellbeing.
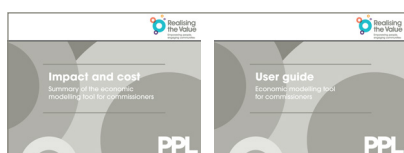
Impact and assessment: Economic modelling tool for commissioners

Economic model, in the form of an excel spreadsheet, a user guide and a report, to help commissioners evaluate the potential impact of investing in person- and community-centred approaches for health and wellbeing in their local area.

Available from: www.realisingthevalue.org.uk;
www.health.org.uk/realising-the-value

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About Realising the Value

Realising the Value was a programme funded by NHS England to support the NHS Five Year Forward View. It ran from May 2015 to November 2016. The programme sought to enable the health and care system to support people to have the knowledge, skills and confidence to play an active role in managing their own health and to work with communities and their assets.

There are many good examples of how the health and care system is already doing this. For example, recognising the importance of people supporting their peers to stay as well as possible or coaching to help people set the health-related goals that are important to them.

Realising the Value was not about inventing new approaches, but rather about strengthening the case for change and identifying evidence-based approaches that engage people in their own health and care. It also sought to develop tools to support implementation across the NHS and local communities. But putting people and communities genuinely in control of their health and care also requires a wider shift. The programme therefore considered the behavioural, cultural and systemic change needed to achieve meaningful transformation.

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