

## HEALTH REFORM EVALUATION PROGRAMME

### *High Quality Care For All (Next Stage Review)* Research Brief

#### Summary

*High Quality Care For All*<sup>1</sup> (HQCFA), the final report of the NHS Next Stage Review (NSR) led by Lord Darzi KBE, was published on 30 June 2008. The purpose of the Next Stage Review (NSR) was to build on progress made in delivering the NHS Plan and the Government's reform agenda, to identify the way forward for a 21st Century NHS which is clinically-driven, patient-centred, responsive to local communities and to deliver high quality of care for everyone in all aspects. The Department of Health, through its Policy Research Programme (PRP), has commissioned a Health Reform Evaluation Programme (HREP) to support the implementation and subsequent development of each of the main stages in the reform of the English NHS undertaken since 2002. **The DH now wishes to commission a major new wave of research to evaluate the NHS's readiness to deliver the next stage of reform, and the implementation and impact of key elements.**

#### POLICY CONTEXT

##### The need for ongoing change

1. The latest stage of the NHS journey is one of ambitious change. Government is seeking to move the NHS from what was essentially a top down, one-size fits all service, to a locally-led, responsive system with empowered staff focused on providing high quality care wrapped around the needs of individual patients. In doing so, the NHS needs to respond to the wider drivers of change - greater, and better informed, public expectations; an aging population; advances in medical technology and information technology; public health challenges; as well as the challenge of providing a working environment that frees staff to focus on providing the highest quality of care for patients.

##### The Next Stage Review - quality as an organising principle

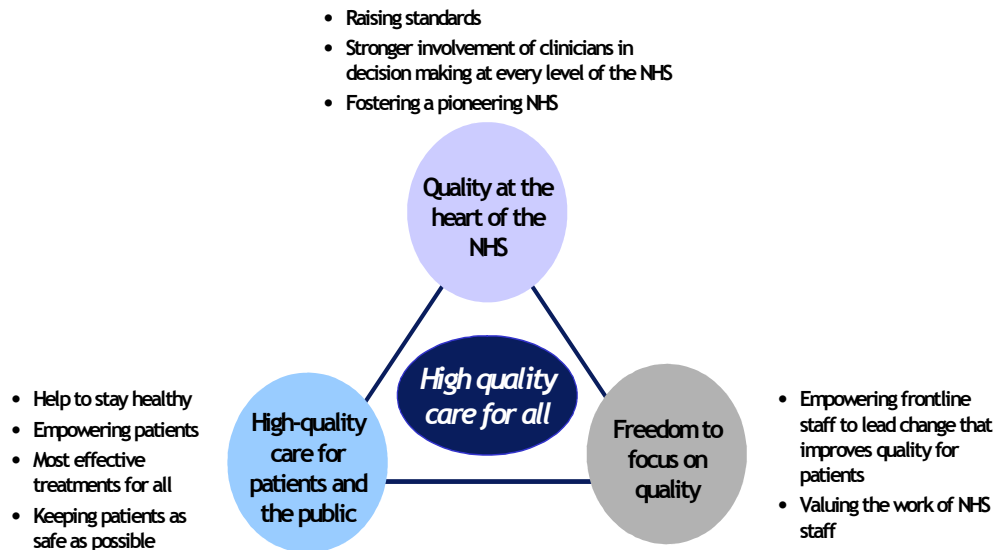
2. The publication of *HQCFA* in June 2008 set out how the NHS plans to address these challenges by completing the third stage of the current reform journey which began with the 2000 *NHS Plan*. The first stage was about increasing capacity and investment across the NHS. The second stage was about introducing levers to enable reform: choice, contestability, more freedom for more diverse providers, and better financial systems. And the third stage, strengthened by the Next Stage Review, is about putting the additional capacity and the reform levers together to transform services and to focus on delivering high quality care for patients, and value for money for the taxpayer.

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<sup>1</sup>[http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationsandguidance/DH\\_085825](http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationsandguidance/DH_085825)

3. The overall vision set out in *HQCFA* was to make quality the organising principle of the NHS.

**Next Stage Review - Overview of proposals to deliver high-quality care for patients and the public**



4. In doing so, it provided a structure and national enabling framework to focus improvements under the themes of:
  - Quality
  - Innovation
  - Workforce
  - Leadership
  - Informatics
  - Prevention
  - Primary and Community Care
  - The NHS Constitution
5. It also set out a definition of quality spanning three areas - patient safety; patient experience; and effectiveness of care.
6. The reality of achieving that vision requires large-scale, complex change in order to achieve improvement. The specifics of the challenge are set out in 10 regional visions that look out over a 10-year timescale to describe how regions will transform services to deliver consistently high quality care for their patients and public.
7. The deep cultural change required by *HQCFA* - to successfully align the entire system so that quality is the organising principle - requires changes in behaviour at an individual, team, organisation and system level. A significant focus of the NHS leadership community, and Strategic Health

Authorities (SHAs) in particular, will be to support the changes in behaviour required to make the vision real.

### Approach to implementation

8. PCTs have been developing their Commissioning Strategies and Operational Plans to reflect both the vision of their local SHA and *HQCFA*. There are national plans and accountability arrangements in place for delivering the *HQCFA* proposals, much of which are set out in the NHS Operating Framework for England 2009-10.<sup>2</sup>
9. There will be a range of mechanisms for reviewing implementation of the regional visions and *HQCFA* - over the short, medium and long term. Local and regional managerial routes will provide real time feedback to SHAs on the implementation and delivery of their visions.
10. The NHS management board is currently articulating the mindset changes and associated interventions required to make a reality of the *HQCFA* vision. There is also work underway on the underpinning metrics of the SHA assurance framework, including those on the health of the system, that will allow comparisons between regions and over time. This work should provide a set of measures to which can inform an assessment of the extent to which mindsets are changing and resulting in the desired behavioural and cultural change.
11. Local and regional organisations also commission formal research to support long-term assessment of implementation. The National Institute for Health Research is the framework that supports the research programmes and research infrastructure of the NHS. NHS organisations and research partners have access to a range of funding streams that support research activity. For example, the Service Delivery and Organisation (SDO) research programme commissions research to address operational issues in the NHS and the Research for Patient Benefit (RfPB) research programme operates a responsive mode of research funding on a regional basis.

### Evaluative research of *HQCFA*

12. The Department of Health wishes to complement the range of feedback mechanisms identified above with a programme of formal academic evaluation focused on *HQCFA* - particularly to inform learning over the longer term. At its core will be an assessment the extent to which mindsets are changing and resulting in behavioural and cultural change.
13. The programme will also include a number of research projects looking at specific policy areas in *HQCFA* with a view to informing the modification of either the content of policy or processes of implementation ('formative' evaluation) in the short to medium term, as well as providing summative findings. The proposed projects focus on either major system changes of strategic importance with sufficient critical mass to produce meaningful results or specific initiatives that carry policy uncertainties with potentially significant benefits and risks.

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<sup>2</sup> [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_091445](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091445)

14. Rather than commissioning stand alone research projects, we expect there to be co-ordination between these projects, as well as with some pre-existing research projects. The evaluation will therefore be incorporated into an existing Health Reform Evaluation Programme (HREP)<sup>3</sup>, which exists to support the implementation and subsequent development of each of the main stages in the reform of the English NHS undertaken since 2002. This is to ensure the new projects being commissioned benefit from the methods and early learning from the existing projects, as well as from the existing programme infrastructure, which includes an independent scientific co-ordinator.
15. The first evaluation project resulting from HQCFA has recently been commissioned by DH, focusing on the programme of Integrated Care Pilots which are due to begin in Spring 2009. This study is a collaboration between Ernst and Young and RAND Europe, and will link with the HREP framework.
16. Future applicants should set their proposals in the context of existing research findings and other ongoing research to avoid the risk of unnecessary duplication. The new evaluative research should use existing data sources wherever possible.
17. We are able to draw upon a total funding envelope of £5m for the overall programme of projects to be undertaken within the period April 2009 - March 2012. Applicants should consider the detailed specifications set out in the appendices when considering the duration, scope and scale of their projects together with appreciation that the Department will be looking for well-focused studies at a cost that will enable us to fund the full range of research identified in this brief and potentially to have scope to add other projects later. It is open to applicants to consider projects that span more than one of the key research topics, provided that they still meet the requirements of each topic. The content of the bids submitted will inform the number of projects to be commissioned.

#### ***High Quality Care for All - Key research topics***

18. The new research topics of current interest to the Department are set out below. Researchers should indicate clearly in their applications which of these research topics will be met by their proposal. Bearing in mind the points in para 15 above, broader, larger-scale rather than narrowly focused proposals are preferable, including proposals that explore the links between the different initiatives in HQCFA, though proposals that make a good case for a more restricted focus will also be carefully considered.
19. The Department is also interested in understanding how the different reform initiatives combine and interact with each other at the local level. Researchers are asked for proposals that take this into account, and may wish to consider the interactive effects at specific patient group or service level.
20. **The keystone project of the programme will be focused on**

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<sup>3</sup> <http://www.lshtm.ac.uk/hsru/hrep>

## **A1 Assessing the extent of behavioural and cultural change in the NHS.**

21. We regard this as fundamental to deliver the wider vision of HQCFA. Successful applicants will be expected to work with the Department to determine the most suitable approach to assessing behaviour change. Annex 1 sets out the process and timescales for this project. For this piece of work we are inviting Expressions of Interest at this stage rather than full proposals.
22. Annexes 2 - 7 set out details on the current evaluative research topics on major innovations in *HQCFA*:

**A2 Impact of key elements of *Transforming Community Services Programme* on delivery and outcomes of community health services**  
**A3 Implementation and outcomes of care planning**  
**A4 Implementation and outcomes of personal health budget pilots**  
**A5 Implementation and impact of the NHS Quality Framework**  
**A6 Implementation and impact of the *Commissioning for Quality and Innovation* (CQUIN) payment framework**

23. In addition to the above, this research programme will also include an evaluation of **Academic Health Science Centres**. This will consist of an evaluation of the individual partnerships that have achieved Academic Health Science Centre status and a comparative study. The specification for this project will be available in due course and at this stage the research community is simply invited to note that a call for proposals will be forthcoming.
24. **The theme of behavioural and cultural change will need to be addressed in each of the these projects.** Additionally, consideration should be given to the cross-cutting themes of:

*(i) Clinical leadership*

There is considerable emphasis in HQCFA on the role of clinical leadership in making change happen in the NHS. Researchers should identify the contribution this makes to the processes and outcomes observed in the context of each evaluation.

*(ii) Equality*

All evaluations should pay attention to any differential impact of policies on people from different socio-economic groups, ethnic backgrounds, disabled and non-disabled people, women and men, people with different sexual orientations, people in different age groups, and people with different religions or beliefs.

*(iii) Innovation*

HQCFA policies aim to promote innovation (e.g. new forms of care, use of new or adapted technologies) and evidence for this should be considered by all projects as a cross-cutting theme.

25. Further reference materials are available at Annex 8.

## Governance and working arrangements

26. The HREP, which the new projects will form part of, is a defined research programme within the Department's Policy Research Programme and is governed by a set of key principles:
- Quality assurance
  - Integration and synergy across the programme
  - Timely reporting and actionable learning
  - Active communication strategy
27. Nicholas Mays, Professor of Health Policy at the London School of Hygiene and Tropical Medicine, is the scientific coordinator for the programme. Professor Mays will also chair the commissioning group for this call for proposals.
28. The existing programme currently comprises six major studies focused on the impact of the main policy mechanisms put in place between 2002/03 and 2006/07, and supported by a series of systematic reviews of evidence on the reforms:
- How patients choose and how providers respond - lead, Anna Dixon (King's Fund)
  - Investigation of competition under fixed prices - lead, Carol Propper (University of Bristol)
  - Provider diversity in the NHS: Impact on quality and innovation - lead, Will Bartlett (University of Bristol)
  - Comparative case studies on the impact of the health reforms in England - lead, Martin Powell (University of Birmingham)
  - Competencies for "World Class Commissioning": the readiness of PCTs and PBCs - lead, Cam Donaldson (University of Newcastle)
  - Evaluating PCT and practice based commissioning: identifying which commissioning processes produce successful outcomes - lead Alicia O'Cathain (University of Sheffield).

### *Quality assurance*

29. At all stages in the commissioning and implementation of the evaluation programme, mechanisms will be in place to secure high quality research and to provide robust evidence for health reform. Research proposals submitted under the programme will be subject to independent peer review. Research teams will be expected periodically to report on progress and emerging findings to the scientific coordinator, the Department and the independent advisory group. Outputs from the programme will be submitted to the Department for comment and for comment from the scientific coordinator and advisory group. Research teams will be expected to take these comments into account.

### *Collaboration and integration*

30. A key feature of the HREP is a requirement on the part of research teams to participate in a *programme*, rather than simply undertaking entirely self-contained studies. This could involve collaboration with one another to the extent of agreeing sampling strategies and sharing relevant datasets to

enable analysis of distinct but overlapping questions. It is envisaged that there will be interactive relationships, and, at the very least, discussions between study teams in the programme with the aim of achieving synergies - i.e. delivering a programme as a whole that is greater than the sum of its components.

31. The scientific coordinator has a key role to play in this respect. It is a prerequisite for participation in the evaluation programme that researchers are committed to supporting the role of the scientific coordinator in securing programme cohesion, synthesis of findings and learning across studies in the programme. The coordinator will convene discussions on the progress and implications of the programme of studies at regular intervals as well as arranging for interactions between the researchers and DH/NHS policy makers and managers. He will produce overviews and summaries of the emerging findings and policy implications for policy makers and others from time to time. The research teams will be required to provide the programme coordinator with material from their projects to assist with this process.

#### *Timely reporting*

32. Research teams will be expected to produce findings and analyses that provide actionable learning during the course of the evaluation programme (e.g. identifying the enabling and constraining factors influencing reform progress in different contexts and how local actors are overcoming problems, with a view to making such learning available to other parts of the health system). In particular, it is integral to the character of this research initiative that emerging findings should be framed in a way to feed into policy development and implementation so that the lessons can be applied as they emerge. There is expected to be frequent and open two-way communication between researchers and policy sponsors. Applicants should identify in their proposals what forms of real-time feedback and early findings they anticipate.

#### *Departmental clearance of research publications*

33. Publication of any material or data deriving from the research is subject to the prior consent of the Department (which consent shall not be unreasonably withheld and shall not for any reason be withheld for more than three months from the time the version proposed for publication is first submitted). Researchers will be expected to always consider any representation from the policy sponsors for the revision of elements of detail in such publications. Researchers will be required to submit any proposed publications to policy sponsors and the scientific co-ordinator at least 28 days before the date intended for submission for publication.

#### *Active communication and dissemination strategy*

34. There is considerable emphasis in this programme on a strong communications strategy to ensure that the results of the evaluation programme reach stakeholders in appropriate forms and in a timely manner. Part of the scientific coordinator's role is to produce, periodic newsletters and accessible updates for regular communication of progress and findings that will be readily accessible to a wide range of audiences.

35. Researchers participating in the evaluation programme will be expected to contribute material either directly for these publications or for Professor Mays to draw upon. Researchers will be required to provide accounts written to reach audiences with different kinds of interests and needs, including health service managers and service users as well as academics and Department policy makers.

#### *Research governance*

36. Research leaders and their employers should ensure that they identify and plan to discharge effectively their obligations under the Research Governance Framework for Health and Social Care.

#### **Application and decision process**

37. Proposals are invited from suitable teams to tackle the questions outlined in the detailed research briefs in the annexes below. Teams should state clearly which questions are covered by their proposed projects.
38. It is envisaged that projects will start as soon as possible and no later than late Summer of 2009. The annexes highlight where teams are needed earlier.

#### *Timetable*

39. For project **A1 Assessing the extent of behavioural and cultural change in the NHS**, detailed in Annex 1, there are a number of stages in the tender process. A preliminary Expression of Interest is required **by 5.00pm on 8 May 2009**. Following assessment of the expressions received, we will provide briefing to guide preparation of outline approaches to the project and shortlisted applicants will then be invited to present their approaches to a senior DH team for consideration in June.
40. For projects **A2-A6** detailed in annexes 2 - 7, there is a single stage tender process. The deadline for receipt of **full proposals** is **5.00pm on 1 June 2009**. Following the peer review process and consideration of proposals by the commissioning group which will comprise DH policy leads and external experts, it is hoped to be able to notify applicants of the outcome by the end of June.

#### *Assessment criteria*

41. The key criteria against which proposals will be assessed are set out below:
- understanding of the policy context, and the interactions between the policies and cross-cutting themes
  - familiarity with relevant research
  - clear and appropriate research plan, with objectives, design and methods robustly specified
  - project leadership and management arrangements to ensure delivery to time and budget
  - appropriate (multidisciplinary) expertise in the research team
  - value for money
  - ability to provide accessible and timely reporting that can inform policy development in both the short and long term

- ability to start promptly.

*Further enquiries*

42. All applications are to be submitted electronically through the NIHR Central Commissioning Facility, which manages the application process, acts as secretariat for the PRP, and provides a point of contact for queries. Call 0208 943 8979, email [prp@nihr-ccf.org.uk](mailto:prp@nihr-ccf.org.uk), or visit <http://www.nihr-ccf.org.uk>.

## **Annex 1: Assessing the extent of behavioural and cultural change in the NHS to support delivery of HQCFA**

### **Background**

The overarching Invitation to Tender makes clear the centrality of behavioural and cultural change to delivering the vision of *HQCFA*. To successfully align the entire system so that quality is the organising principle requires changes in behaviour at an individual, team, organisation and system level. Behavioural and cultural changes are regarded as prerequisites to deliver the improved outcomes set out in the 10-year regional visions coming out of the Next Stage Review. A significant focus of the NHS leadership community, and Strategic Health Authorities in particular, will be to support the changes in behaviour required.

### **Scope**

The Department wishes to commission research over a 2-3 year period on the extent to which the necessary behavioural and cultural changes are happening. The evaluation project addressing this issue will form the cornerstone of a wider evaluation programme.

There is considerable uncertainty about the methods and measures that would be most appropriate in this context and we are planning to commission this work through a 2-stage process. At this stage a preliminary Expression of Interest is required by **5.00pm on 8 May 2009**.

Following assessment of the expressions received, we will provide briefing to shortlisted applicants to guide preparation of more detailed outline approaches. Shortlisted applicants will then be invited to present their approaches to a senior DH team for consideration in June. We will expect those proposals to demonstrate expertise in the field of organizational and professional culture not limited to the health sector. Those sessions will lead to the final selection of the preferred partner to undertake the project.

## Annex 2: Transforming Community Services programme

### Background

1. *The Next Stage Review: Our vision for primary and community care* outlined the intention to support the NHS and community clinicians and staff in transforming community health services, via the Transforming Community Services Programme.
2. As part of the evaluation programme to determine the impact of *The Next Stage Review*, we wish to commission an evaluation of the Transforming Community Services Programme. This offers an opportunity to assess the impact of the programme from an early stage, whilst some policies are still being introduced, in order to track their impact. The evaluation will look at the specific initiatives within the programme as well as providing a whole-system examination of the combined effect of the reforms. There will be a strong focus on feeding early results into policy development, to allow the programme to evolve in the light of feedback from implementation.
3. Annex 8 provides detail of additional reference material.

### Areas for evaluation and associated key research questions

4. The relevant research questions for each of the Transforming Community Services initiatives are set out below. The questions given should not be thought of as an exhaustive list, but as a guide, and applicants will be expected to be able to demonstrate how their proposals will answer these and any other issues they may deem relevant.
5. Researchers will also need to consider the wider work on behavioural change referenced in the overarching Invitation to Tender, and potentially incorporate additional research questions on behaviour change as they are developed.
6. The nature of the programme means that the majority of the evaluation will be qualitative in nature. The research proposal should focus on how good quality evidence will be obtained in this way. As the programme continues, and the information models and quality framework develop, it will be possible to monitor more quantitatively the effects on services, and this information may be used for evaluation of the programme as a whole.

#### 1) Whole-programme evaluation

7. There are a number of key questions relevant to the Transforming Community Services programme as a whole. These may be answered through consideration of the delivery of specific clinical services that have received particular focus.

1A How successful has the programme been when taken as a whole, and conversely which specific initiatives have had the most impact on improvement of services, looking across the aims to:

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1B How have initiatives contributed to the above aims?

**1C** Have any initiatives had a negative impact? If so, is the issue with their implementation or intent? Are there any key messages from the service on how we can resolve any issues?

**1D** Has the impact varied greatly between services?

**1E** Are clinicians actively engaged in improving, leading, and delivering high quality service?

**1F** Do clinicians feel empowered to make the changes required to transform community services?

**1G** How have initiatives helped to deliver better value?

## **2) Enabling new patterns of provision**

*Enabling new patterns of provision* guidance published January 09

Executive Summary of the *Business readiness guidance* published March 2009

**2A** Does separation of the provider and commissioning functions of a PCT improve the management of community services?

**2B** Does separation of the provider and commissioning functions improve the commissioning of provider services?

**2C** Is there great diversity in the way services are provided across and between PCTs?

**2D** Looking specifically and comparatively at the different patterns of provision, including social enterprise, does a change in the way community services are provided support the aims to:

- Promote better health and well-being
- Improve the responsiveness of services and patient experience, including engagement of the service user with their care
- Increase clinical quality, safety and effectiveness
- Reduce inequalities in access to services and outcomes, across geographical areas and between social groups
- Promote equality
- Improve efficiency - both allocative and technical
- Develop leadership
- Support development of clinical staff
- Promote all stages of innovation

**2F** In the new enabling guidance, DH do not favour one organisation option over another for PCTs, decisions must be locally led. How has this worked at ground level? Are there any lessons learnt from this approach that could be used for future policy initiatives?

## **3) Social Enterprise - Right to Request**

Staff 'Right to Request' to set up social enterprises to deliver services was introduced in June 2008. The guidance document *Social enterprise: making a difference* was published in November 2008.

**3A** What understanding do commissioning and provider staff have of the right to request?

**3B** Are there any barriers to staff exercising their right to request, eg concerns about a change in culture between the NHS and private sector organisations, pensions, TUPE?

**3C** What stops PCTs supporting right to requests, eg PCTs have already decided on their plans, lack of understanding around social enterprise?

#### **4) Informational model and dataset**

Guidance on information models for community services to be published Spring 2009.

**4A** How useful is the information obtained for:

- Contracting and pricing
- Quality improvement
- Performance management
- Increasing productivity
- Supporting choice
- Local benchmarking
- Gauging improvement at national level
- and what improvements could be made?

**4B** Do members of staff feel that they own the data?

#### **5) Quality Framework for Community Services**

Quality framework document for Community Services to be published June 2009.

**5A** To what extent does the quality framework meet its aims to:

8. Secure continuous improvement in patient outcomes
  - Set minimum standards for community services
  - Enable commissioning decisions
  - Inform user choice, behaviours and expectations
  - Drive change in the provider landscape (see *Enabling new patterns of provision* guidance published January 09)
  - Provide a fair playing field
  - Be flexible to adjust focus and priorities
  - Incentivise performance
  - Address the needs of the individual and community, including addressing health inequalities and promoting equality
  - Enable and support innovation to meet local circumstances

**5B** Are teams more likely to measure and act on aspects of their quality of care than before?

**5C** Do Boards devote more time and effort to assuring the quality of care provided by their community services?

**5D** Has the impact differed across different services?

## **6) Six transformational guides**

Six transformational guides will be published in June 2009 across six clinical areas.

**6A** Are the high impact changes all being implemented by the service? Where they are not, what are the reasons behind this?

**6B** Is introduction of the high impact changes uniform across the country?

**6C** What impact have the changes had on the service?

**6D** How have the changes met the aims to:

- Promote better health and well-being
- Improve the responsiveness of services and patient experience, including engagement of the service user with their care
- Increase clinical quality, safety and effectiveness
- Reduce inequalities in access to services and outcomes, across geographical areas and between social groups
- Promote equality
- Improve efficiency - both allocative and technical
- Develop leadership
- Support development of clinical staff
- Promote all stages of innovation

**6E** Are the changes locally owned by clinicians on the ground?

**6F** Are there any key service areas that have suffered due to their being omitted from the programme?

**6G** Have the transformational attributes been adopted? Again, if not, why not?

**6H** Has their implementation been widespread across different services or concentrated in a small number of areas?

**6I** Is this staff development owned by those on the ground?

## **7) Allied Health Professionals (AHP) service offer**

*Framing the contribution of allied health professionals - delivering high quality healthcare* published October 2008

**7A** Is self-referral to AHPs becoming more widespread? Where it has not been introduced, what are the reasons for this?

**7B** Is there clarity for patients over when and how to self-refer?

**7C** Does uptake of self-referral differ across different societal groups? If so, are initiatives in place locally to address this?

**7D** What benefits have been seen in terms of quality and efficiency of care?

**7E** Are there any non-AHP community services that would benefit from a self-referral approach?

## Annex 3: Implementation and outcomes of care planning

### Background

1. The 2006 White Paper, *Our Health Our Care Our Say*, included the commitment that by 2008 everyone with long-term health and social care needs should have an integrated care plan if they wanted one. By 2010, the expectation set out in HQCFA is that all people with long-term conditions will be offered a personalised care plan, developed, agreed and regularly reviewed with a named lead professional from among the team of staff who help to manage their care.
2. The government's aim is to deliver these commitments and to improve the coordination and effectiveness of health and social care provision to individuals with long term conditions by developing tailored plans for their care. It is expected that this should lead to new patterns of care, more personalised care, improved health outcomes and efficiency savings in reduced service usage in other parts of the health and social care systems (e.g. accident and emergency attendances and emergency bed days). New ways of working will require new skills on the part of health and social care staff.
3. The expected outcomes of the roll-out of care planning are:
  - improved patient experience
  - improved health outcomes including those reported by patients themselves
  - reduction in the levels of 'avoidable' use of primary and secondary health care services through contingency planning, including accident and Emergency attendances and emergency bed days
  - Workforce delivering better care to people with a long term condition (LTC) by developing new skills and new ways of working.

### Scope

4. Ideally, the evaluation should include a comparison between similar people with long term conditions who either do or do not experience 'care planning'. In addition, it would be helpful to find a way of comparing the era of routine care planning with the general situation before care planning as currently defined was introduced. However, 'care planning' or something like it has existed in health and social care for many years. Though it will be difficult to construct some sort of pre-care planning baseline for comparison, it will be important to attempt this as part of the evaluation. It may be easier to include comparisons at the level of selected groups of people with long term conditions between those currently involved in care planning and those who have either yet to receive the opportunity or those who have refused to take part. It may be possible to follow a cohort of people over time as the number of people with long term conditions involved in care planning increases, comparing those who enter the programme early versus those who enter later. Clearly, none of these comparisons is ideal methodologically - we would welcome innovative proposals on how treatment of LTCs has changed with the implementation of care planning.

5. In addition to primary research, it is envisaged that the evaluation will include a systematic review of the literature on care coordination and care planning to update and refine a literature review undertaken by the Department in support of the current policy and assist at an early stage with the detailed design of the study. This should include the findings of the evaluations of recent relevant initiatives in the UK such as the Evercare programme and Modern Matrons.
6. The successful evaluation team will also be expected to establish close links and communicate regularly with the evaluators of the related initiatives, in particular, the Information Prescriptions Pilots evaluation, the Expert Carer Programme evaluation and the evaluation of the Whole Systems Demonstrators Programme.
7. Researchers will also need to consider the wider work on behavioural change referenced in the overarching Invitation to Tender, and potentially incorporate additional research questions on behaviour change as they are developed.

The Department requires the evaluation of care planning to start as soon as possible with a major interim report in December 2010 after approximately 12 months of implementation of routine care planning as set out in HQCFA. A report is also required by the end of 2009 summarising the literature search and the main commissioning/delivery mechanisms for care planning.

#### **Questions to be addressed**

A - What are the main differences in the organisation and nature of care received by people with long term conditions when comparing current (pre-HQCFA) practice and the period after the widespread implementation of 'care planning'?

B - What are the costs and benefits (impact on user outcomes and experience of care, but also of choice) of implementing care planning on a routine basis, compared with the situation before the widespread adoption of care planning?

C - What are the costs and benefits of care planning for people who have a care plan compared to those who want a care plan but do not have one and those who neither have nor want a care plan?

D - How do the costs and benefits of care planning vary depending on the nature, range and severity of long-term conditions experienced by beneficiaries of care planning?

E - How do the costs and benefits of care planning vary with the design and delivery of different approaches to care planning (e.g. the frequency with which plans are reviewed, the degree of user involvement in the process of care planning, the identity of the professional responsible for the process, the level of training received by staff, etc.)?

F - How do people with long term conditions define aspirations such as 'personalisation' and how important do they regard such attributes of their care compared with other desirable features such as humanity and choice?

G - What are the challenges faced by staff both in implementing care planning and in delivering the packages of care developed through care planning processes?

H - What role does information on care options, on the quality of different providers, and on the evidence related to the effectiveness and cost-effectiveness of different forms and packages of care have on the care planning process?

## Annex 4: Personal Health Budgets Pilots

### Introduction

1. Personal health budgets are part of the overall programme of personalisation, aimed at giving individuals, their families and carers more of a say in the services they use. The purpose is to improve health and wellbeing outcomes, increase satisfaction with services, and to make the provision of services more responsive and flexible.
2. This policy builds on the Individual Budgets work in social care, and the Care Planning policy, which was originally focused on individuals with long-term conditions who had complex care needs, as set out in the 2005-8 Public Services Agreement. The policy was then extended to all individuals with long-term conditions in *Our Health, Our Care, Our Say*,<sup>4</sup> a pledge that was reiterated in *High Quality Care for All*.<sup>5</sup> Annex 8 provides detail of additional reference material.

### Background

3. We will be piloting personal health budgets from summer 2009 for three years. Piloting is a commitment set out in *High Quality Care for All*. Personal health budgets build on care planning, involving the individual more actively in selecting the services and providers that will best suit their needs and preferences. Unlike care planning, however, personal health budgets will not be limited to long-term conditions, and conditions such as maternity and end of life care have been suggested as possible areas to explore. The conditions, services and care groups that will be covered depend upon the applications received from PCTs.
4. Personal health budgets could improve both the quality of patient experience and the effectiveness of care, by giving people greater choice and control over the services they receive. However, there are challenges in striking the right balance between getting the best outcomes for the individual and for the wider NHS.
5. There is already considerable interest in this area, with 37 PCTs signed up to a programme of work called '*Staying in Control*', run by *In Control*. We are building a partnership with *In Control* to ensure that learning from '*Staying in Control*' informs the development of the pilot programme. Some of those sites would want to become part of our pilot programme: others will not. Our intention is to build a learning community, with *In Control* as a key partner, which encompasses all those sites who are actively working on the idea of personal health budgets but who may or may not be a DH pilot site. Pilot sites are not expected to restrict themselves to the *Staying In Control* approach, and innovative approaches will be welcomed.
6. A personal health budget could work in many ways, including by having a notional budget held by the commissioner or a budget managed on the

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<sup>4</sup> <http://www.dh.gov.uk/en/Healthcare/ourhealthourcareoursay/index.htm>

<sup>5</sup> [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_085825](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825)

patient's behalf by a third party. PCTs already have extensive powers to offer these. We are also seeking powers in the Health Bill (currently before Parliament) to allow piloting of direct payments for healthcare, i.e. cash payments to an individual. The decision about the way in which the budget is controlled will depend on the needs, circumstances and preferences of the individual.

7. Working with a range of stakeholders, including people who use services, carers, NHS professionals and managers, we have developed a small set of principles that we believe should be respected in any use of personal health budgets. These are:
  - upholding NHS values;
  - safeguarding and improving quality - safety, effectiveness and experience;
  - tackling inequalities and protecting equality;
  - ensuring that personal health budgets are purely voluntary;
  - making decisions as close as possible to the patient; and
  - working in partnership.
8. As there is significant uncertainty in this area, and because we want to understand the effects of personal health budgets, a rigorous evaluation will run alongside the pilots to provide continuous feedback. This will provide information on how personal health budgets are best implemented, where and when they are most appropriate and what support is required for individuals. We also expect the evaluation to provide information about what would happen were personal health budgets to be used more widely.
9. We are interested in both health and wellbeing outcomes and what drives these outcomes. Evidence from social care suggests that offering control on its own can be beneficial. Further, it may act as a catalyst for changing attitudes and behaviour on the part of both the individual and NHS staff, commissioners and providers, increasing the scope for beneficial self-direction. We are particularly interested in the effects of potential changes in behavioural and institutional psychology.
10. Personal budgets are also aimed at improving integration between health and social care. While it is unlikely we will be able to join the funding streams from the system perspective, this should appear as seamless as possible to the individual. Pilot sites are expected to investigate ways of achieving this.
11. We aim to have the evaluation team in place before as soon as possible. This will help with the ongoing development of the pilots, especially around how the personal health budgets are introduced and what data is collected, as well as optimising the design of the evaluation, and facilitating learning across sites. The selected evaluation team will need to work with the pilot sites to finalise the details of the evaluation to ensure it provides relevant and timely information to meet key local as well as national needs.
12. We anticipate substantial interest in becoming a pilot site. Based on the discussions we have had with external stakeholders, we should be as inclusive as possible. Therefore, our proposal would be that all those who meet the selection criteria, including recognition of the likely challenges that will be faced, are enrolled on to the DH pilot programme. The

evaluation team may then have some scope to select a representative sub-sample of DH pilot sites to evaluate in more detail than the rest: that is to say while all sites are evaluated to some extent, the evaluation team will concentrate on a subset of these. We anticipate this covering around 20 sites, and expect the evaluation team to select this subset. DH will be giving evaluation sites some financial support towards the demands of setting up and managing the project and reporting on progress.

13. Separately, we will be setting up a support function. The intention is that they will provide advice and support on the practical aspects of implementing personal health budgets and flag any problems as they arise. We will develop a clear definition of the differing roles of the evaluation and support teams, but it is clear that there needs to be good communication between the teams. In particular, this will enable the support function to focus on aiding the pilot sites, and it will allow the evaluation team to focus upon the effects of the policy, thereby providing timely and helpful information to the pilot sites and wider learning community.
14. The data that will be collected by pilot sites has not yet been decided. This will depend upon what conditions and services pilots are covering, and will be co-produced by the pilot sites themselves, the support function and the evaluation team.
15. We envisage the evaluation providing ongoing information and feedback, which will help to improve the delivery of personal health budgets within the pilot sites as they progress.
16. To enable rigorous evaluation, both formative and summative, controls will be established. These might be within a pilot site (e.g. individuals registered with some General Practices within a PCT), or across pilot sites (e.g. where people with particular conditions are offered personal health budgets in some sites but not others), or between pilot and non-pilot areas. Applicants for the evaluation should include proposals for control groups.
17. The evaluation will both feed back relevant information in a timely manner, and generate findings that are robust. Proposals will be expected to demonstrate how they can balance the twin criteria of an informative comparator group and the appropriate sharing of information.

### **Research questions to be addressed in the Evaluation**

18. Proposals will be expected to demonstrate how the evaluation will address the broad categories of paragraph 19, in each case noting differences between different patient groups, including breakdown by:
  - a. condition
  - b. age
  - c. socio-economic group
  - d. patient characteristics, including ethnicity
19. The evaluation is expected to consider the impact upon the individual recipients of personal health budgets and their families and carers, and

upon the wider health system, including staff groups, different organisations or settings and overall efficiency. This is expected to be split as per paragraph 18. The following areas should be considered in particular - please note that the overall categories (a-e: outcomes and quality, behavioural change, finance, system effects and implementation) must be covered. The sub-categories within each heading are to serve as a guide only - applicants are very welcome to make their own judgements about the most important areas for consideration.

- a) What is the impact of personal health budgets upon quality of care, relative to the care planning baseline (and/or traditional NHS baseline, depending upon controls available), including:
  - (i) Patient, carer and informal carer (where applicable) outcomes, and whether the definition of 'outcomes' differs between individuals and professionals
  - (ii) Patient experience of care (based upon individual reports designed for the evaluation, or other data)
  - (iii) Patient safety, considering frequency of unexpectedly adverse outcomes, including the potential for exploitative or fraudulent behaviour by advocates or service providers
  - (iv) Engagement of the individual in decisions about their care and choices made by individuals
  
- b) Behavioural effects, including both individuals and staff - these should be considered both within and beyond recipients of personal health budgets, to pick up any potential spillover effects:
  - (i) Have individuals had and exercised choice over decisions about their care, including type of care, timing, service provider and location, as well as support services?
  - (ii) The extent to which individuals' involvement in the budget-setting process has an impact upon their behaviour, for example through greater compliance with clinical prescriptions and advice. This should also cover non-traditional outcomes where appropriate (linked to a) (ii) above)
  - (iii) How have staff and individuals worked together to make decisions about the care plan is met? Has this extended beyond individuals within the pilot samples?
  - (iv) To what extent are decisions about care now a collaborative process?
  
- c) Finance, including:
  - (i) Changes in costs and cost-effectiveness of treatment
  - (ii) Transitional costs, including IT costs, staff training and related and potential double-running costs
  - (iii) Cost of supporting individuals in managing their budgets and monitoring the use of their budgets
  
- d) Effects upon the NHS, including organisations, staff and the wider health and social care system:
  - (i) Integration of different organisations, including the health and social care systems and across health settings (for example primary, community and acute care)
  - (ii) Changes in where services are provided

- (iii) Market effects, on both providers and types of services provided
- (iv) Introduction of support organisations, or extent to which pilot sites are providing the necessary support themselves
- (v) Staff effects, including flexibility, responsiveness, training and support
- (vi) Impact upon existing services, especially the demand for them and their efficiency and cost, and distinguishing short and expected long-term effects
- (vii) Whether overall demand for health services has increased, and the extent to which this has been caused by personal health budgets or supplier-induced demand

e) Implementation of personal health budgets:

- (i) The ease with which individuals can access personal health budgets and work through the process, and the support they require to do so
- (ii) How the pilots have linked up with other pilots, development sites and policy areas
- (iii) How effects of personal health budgets vary by readiness for implementation at the outset
- (iv) The ease with which PCTs and Local Authorities can prepare and train staff and agencies to support people as they make their choices about the form of personal health budget, treatment options setting for treatment and any others deemed relevant
- (v) Did service providers, both existing and new entrants, find it easy to meet the service packages of budget holders?

20. The evaluation team will also be expected to produce a classification of models of deploying personal health budgets, including description of:

- the mode of budget setting;
- the holding of budgets and how they are paid out;
- the construction of care options for consideration;
- the support of individuals in making choices;
- the vetting of agreed care plans for appropriateness;
- the monitoring of use of budgets; and
- methods and success of pooling budgets across different sources.

21. The pilots and the evaluation are not expected to fully answer the question about the impacts upon the wider NHS if full rollout of personal health budgets were to follow the pilots - it is unlikely that this question will be answerable from the pilots alone. The pilots will, however, provide a significant amount of information, and evaluation proposals are expected to demonstrate economic modelling methods by which the information from the pilots can be used to infer the likely impacts on the overall NHS if personal health budgets were to become the norm. This applies to both the impacts upon the system (including existing services and market entry, for example) and wider behavioural change of NHS staff, moving from a paternalistic approach to one where the individual is intimately involved in decisions about their care.

22. These questions should serve as a guide, not be thought of as an exhaustive list, and applicants will be expected to be able to demonstrate how their proposals will answer the broad categories (outcomes and quality, behavioural change, finance, system effects and implementation) and any other issues deemed to be relevant.
23. Applicants should also make proposals about how they will work with the team supporting the implementation of the pilots and linked evaluations, such as that for *Care Planning*, in order to help with the dissemination of learning between pilot sites.

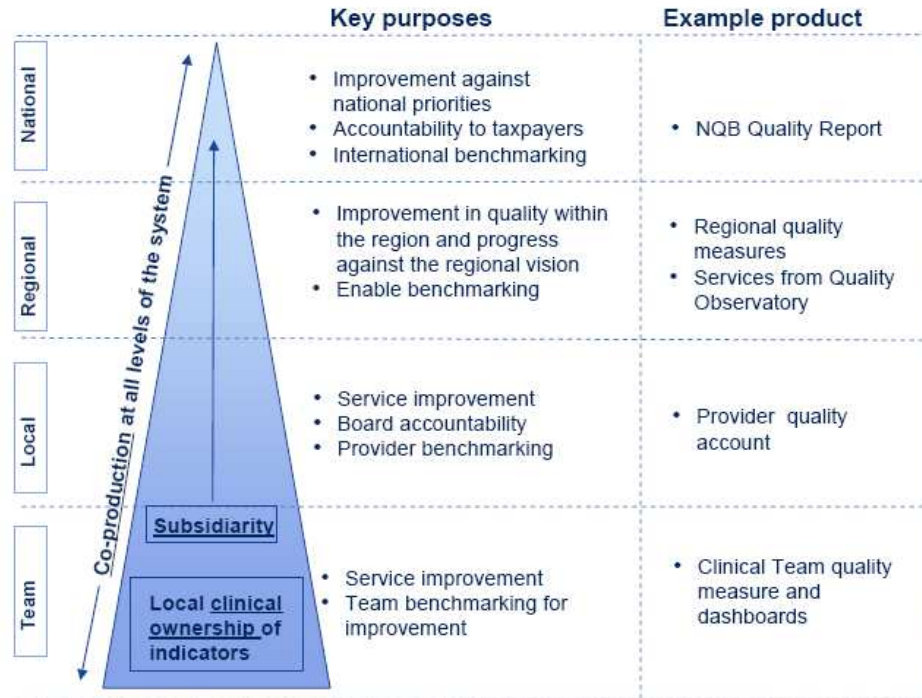
## Annex 5: Implementation and impact of the NHS Quality Framework

### Background

1. David Nicholson, Bruce Keogh, and Christine Beasley wrote to all Chief Executives, Medical Directors, and Nursing Directors of all NHS organisations and all organisations providing NHS services, asking them to begin implementation of the vision set out in *HQCFA*, and setting out the approach necessary to embed quality improvement and measurement in all that the NHS does.
2. *HQCFA* defines quality as having three dimensions: ensuring that care is safe; effective; and that it provides patients with the most positive experience possible. The vision is to place improvement across all three dimensions of quality at the core of everything the NHS does - both as ends in themselves and because delivering the best quality of care should ultimately yield the best value from the whole system.
3. The vision is for an NHS where teams consistently measure what they do, using good and timely information as a basis both to improve the care they provide and to compare themselves with other teams. Measurement should guide local innovation and improvement efforts - it is not an end in itself, only a means to the end of better quality care. At the same time, patients should be able to use some of this information to have greater control over their care and support decisions they make with their clinicians.
4. Local teams and organisations will have the freedom to determine which metrics they want to measure internally, supported by valid and appropriate measures for benchmarking regionally, nationally and - where possible - internationally.
5. Annex 8 provides detail of additional reference material.

### *The framework for measurement and improvement*

6. The approach to measurement and improvement should be within the framework set out in *Measuring for Quality Improvement*. The diagram below presents the key features of this framework at each level of the NHS



### Scope of the evaluation

- The Quality Framework represents a multi-faceted programme of changes designed to bring about a cultural change in the NHS that leads to a major increase in the attention given to the quality of care across the entire range of NHS services (acute hospital, community health services, primary care and mental health services). It comprises initiatives on the measurement, analysis, presentation, dissemination and use of performance and quality indicators which should affect the reputations and thence the behaviour of everyone from governance board members to individual clinicians and clinical support staff in provider organisations. It is also designed ultimately to affect the behaviour and decision making of patients and their agents, as well as of the regulators.
- The perceptions of the Framework and responses to it of all these actors should be part of the evaluation. It will also be important to attempt to tease out which parts of the Framework (e.g. Quality Accounts, Clinical Dashboards, Quality Observatories) make the greatest contribution to any quality gains observed.

### Research questions

A How have provider organisations of different types (e.g. NHS Trusts, social enterprises, for-profits, primary care practices etc.) responded to non-financial (e.g. reputational) incentives inherent in the Quality Framework at governance, non-clinical and clinical management, operational and service delivery (clinical) levels?

B - Have provider organisations that appear to have taken the implementation of the Quality Framework more seriously (e.g. spending more time, effort and resources) made greater improvements in quality than those that have not?

C - Which features of provider organisations appear to have facilitated or impeded a positive response to the Quality Framework and why?

D - To what extent has access to external support (e.g. Quality Observatories, improvement specialists etc.) led to greater improvements in quality?

E - Which factors at the clinical team level appear to have led to a positive response to the Quality Framework and improvements in care, and why?

F - What use have patients and patient organisations made of the information generated by the Framework? Has the Framework or any part of it influenced patient behaviour and in which ways?

G - What use have regulators made of the information generated by the Framework and with what consequences?

H - Has the likelihood of individual clinical teams measuring and acting on evidence of the quality of their care increased and with what consequences?

I - Specifically, what impact has the publication of Quality Accounts and other forms of published quality data relating to each provider had on behaviour at governance, management and clinical levels in provider organisations? By what mechanisms have these impacts operated?

J - What impact have Quality Accounts had on individual patient and public perceptions, behaviours and choices?

K - Overall, what have been the costs and benefits of introducing and operating the Quality Framework?

L - To what extent has the Quality Framework ultimately evolved as a coherent and mutually reinforcing set of policies?

M - Which individual mechanisms underlying the Quality Framework have been most influential in changing behaviour and quality of services? Which have been least influential / effective?

## Annex 6: Implementation and impact of the *Commissioning for Quality and Innovation (CQUIN)* framework

### Background

1. HQCFA included a commitment to make a proportion of providers' income conditional on quality and innovation, through the Commissioning for Quality and Innovation (CQUIN) payment framework.
2. The aim of the new CQUIN payment framework is to support a cultural shift and to improve patient care by embedding quality improvement and innovation as part of the commissioner-provider discussion everywhere. The framework is intended to ensure that contracts with providers include clear and agreed plans for achieving higher levels of quality by allowing PCTs to link a modest proportion of providers' contract income to the achievement of locally agreed goals.
3. The CQUIN framework forms one part of the overall approach to quality improvement in the next phase of English NHS reform, which also includes defining and measuring quality, publishing quality information, recognising and rewarding quality, improving quality and safeguarding quality. The CQUIN framework is intended to support and reinforce other elements of the approach to quality and existing work in the NHS by embedding the focus on improved quality of care in commissioning and contract discussions.
4. Guidance on the CQUIN payment framework was published in December 2008,<sup>6</sup> alongside an Impact Assessment.<sup>7</sup> Providers are required to publish their CQUIN schemes and achievement against them; the most likely vehicle for this will be the provider's Quality Accounts. It is also suggested that and the NHS Institute's PCT Portal<sup>8</sup> would provide a useful vehicle for bringing the schemes together in one place. Further information on some current quality incentive (non-CQUIN) schemes can be found on the PCT Portal, along with CQUIN schemes, as they become available. Annex 8 provides detail of additional reference material.

### Scope

5. While the development of the CQUIN payment framework has been guided by the academic evidence available, this evidence is thin - hence the need for careful evaluation. It is essential that the evaluation be capable of identifying potential problems as well as factors associated with a successful framework for payment for quality. The framework will inevitably follow a developmental process, and we are cognisant of the fact that people will move at different paces around the country.
6. It is expected that the successful evaluation team will work closely with the evaluations of other key initiatives within HQCFA, in particular, the Quality Framework evaluation, to assess the contribution and role of the CQUIN payment framework as part of this wider Quality Framework (see annex 5 for

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<sup>6</sup> Using the Commissioning for Quality and Innovation (CQUIN) payment framework ([www.dh.gov.uk](http://www.dh.gov.uk))

<sup>7</sup> Impact Assessment of the Commissioning for Quality and Innovation payment framework ([www.dh.gov.uk](http://www.dh.gov.uk))

<sup>8</sup> See [www.institute.nhs.uk/CQUIN](http://www.institute.nhs.uk/CQUIN)

more detail on this evaluation). The study should also be cognisant of the evaluation of the North West *Advancing Quality* programme.<sup>9</sup>

#### *Focus on behavioural change*

7. The main aim of the evaluation is to assess the extent to which the CQUIN payment framework, in the context of the broader quality strategy, has achieved its intermediate goals of behavioural change in providers and commissioners in the NHS; and that these changes are conducive to improved quality of care for the patients in their health economies. See the questions under *Behavioural change*, below, for more details.
8. It is essential that researchers should demonstrate how their choice of behavioural measures is linked to relevant aspects of quality (see the questions under *Impact on quality*, below, for more details) and potential longer term impacts on outcome for patients.

#### *Literature review*

9. A literature review of the impact of reputational and financial institutional incentives upon performance should be provided (building upon the references that supported development of the CQUIN scheme, available from the Impact Assessment), from which hypotheses for testing can be drawn.

#### *Comprehensive approach to analysis*

10. The Department would like the study to evaluate all CQUIN schemes to some extent in order to be able to assess the national impact. It will be desirable to access and analyse data on all CQUIN schemes (individual providers involved in CQUIN are required to produce their own routine reports on the schemes and their related achievements, as mentioned above, which should provide a useful research resource). Researchers should also compile a trend dataset of salient measures of impact that will enable long run comparisons from the inception of the CQUIN payment framework. See the questions under *National dataset*, below, for more details.
11. However, to understand the mechanisms behind any change, the evaluation will include qualitative work and case studies of individual health economies. We are interested in how these differ across different organisational types, so an appropriate sampling strategy is important. Research teams are invited to propose methods of showing both the national picture and the underlying mechanisms that influence it.

#### *Unintended consequences*

12. In answering the above questions, researchers should also consider any wider consequences of the payment framework, behavioural change and financial flows. As these wider system effects are more long-term, researchers should propose how to measure any early signs of these changes.

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<sup>9</sup> Evaluation tender for the North West Advancing Quality programme (see [www.sdo.nihr.ac.uk/files/researchcall/256-brief.pdf](http://www.sdo.nihr.ac.uk/files/researchcall/256-brief.pdf))

### *Comparative evaluation design*

13. It is worth noting that the flexibility of the CQUIN framework at the local and regional level should create much variation in measures chosen for reward, and in modes of implementation, and thus much scope for revealing comparisons between goals included in some CQUIN schemes and excluded in others, as well as comparisons with providers not currently involved. There may also be scope to compare CQUIN with other payment for performance initiatives developed separately at the local level.

### **Research questions to be addressed**

14. Research proposals will be required to demonstrate a comprehensive evaluation of the issues identified above, and indicate where their emphasis lies. They should also demonstrate how their projects address some or all of the suggested research questions below. They are invited to suggest other questions consistent with the aims of the evaluation, in order to address the identified research issues or others shown to be of importance. Researchers are asked to indicate clearly in their applications which of these research questions will be met by their proposal.

### *Literature review*

- a. Review of additional literature not covered in Impact Assessment, on national and international evidence on the impact of reputational and financial institutional incentives upon performance

### *Nature of CQUIN schemes*

- b. What goals are commissioners and providers agreeing? In answering this question, researchers are invited to provide an in depth taxonomy of goals agreed by providers and commissioners, based on the broad taxonomy explicit in the CQUIN framework (patient experience, effectiveness and safety in the quality domain, and innovation), but providing further detail.
- c. At what thresholds will achievement against these goals trigger payment, and how do these thresholds compare with current performance, trend performance, and performance of comparable institutions? Do these differ systematically by provider type or other characteristics?
- d. How do these goals align with or reinforce the wider quality and innovation goals of commissioners and providers (including other incentive systems at local, regional and national levels)?
- e. How are NHS organisations going about the agreement process for setting goals and payment thresholds and learning from previous discussions around goals; what are the costs (both time and financial) of this agreement process?
- f. How do goals change over time; to what extent is there natural convergence in goals across areas?

### *Behavioural change*

- g. What changes have commissioners and providers made, due to the focus on CQUIN goals? Are there any financial, time or opportunity costs associated with the introduction or with the implementation of these changes? Are these perceived as a potential barrier to entry for new entrants, particularly small providers?
- h. How has the CQUIN payment framework affected the relationship within organisations - between clinicians and the Board within organisations and their focus on quality and innovation?
- i. How has the CQUIN payment framework affected the relationship between organisations in their focus on quality and innovation?
- j. According to plausible criteria for researchers to establish, which behavioural changes are more likely to yield improved quality of care?
- k. Where commissioners are offering additional money to CQUIN schemes, how does this affect the extent of behavioural change?
- l. Which types of CQUIN metrics, settings of targets, organisational processes and methods for discussion & agreement generate behavioural change most likely to be conducive to improved quality of patient care?

*Impact on quality and the wider NHS*

- m. To what extent are providers improving quality and achieving their quality and innovation goals in their CQUIN schemes, how and why? Does this differ between providers and from wider metrics that are not included in CQUIN schemes? Has this led to any early systematic impact on the resources of providers.
- n. To what extent have behavioural change led to wider perceived impacts on quality, from the perspective of providers and commissioners?
- o. Do changes implemented promise broader gains in quality? To what extent does this include aspects of quality not included in a CQUIN scheme?
- p. Are there significant impacts on inequalities (by socioeconomic group and location)? Is there patient selection to improve measured outcomes?

*A dataset on CQUIN schemes in England*

- q. Provide a simple dataset of appropriate and relevant measures that will enable long run comparisons of the use of the payment framework. These can include, but are not limited to, the content of local schemes, the process of their development, appropriate measures of behavioural change, quality and innovation.
- r. Develop recommendations on any further *relevant* data to collect, in order to maintain the dataset and enable evaluation of the full impact of the CQUIN payment framework in the fullness of time.

## Annex 8: Key policy documents and guidance related to health reform

### *General*

The reform direction for health and social care in England is set out in the following key documents:

*The NHS Plan: A plan for investment, a plan for reform* (July 2000), which identified the need for a programme of sustained investment in and reform of the NHS to ensure that it could deliver its core aim: providing high-quality care for every patient, responding to need, not ability to pay

*Delivering the NHS Plan: next steps on investment, next steps on reform* (April 2002) which set out for the first time the four main mechanisms for current reform

*Health reform in England: update and next steps* (December 2005), which set out a high-level framework for the next stage of reform of the health system

*Our health, our care, our say* White Paper (January 2006), which considered how the delivery of NHS and social care services could adapt to provide individuals with the services they need closer to their homes

*Health Reform in England: update and commissioning framework* (July 2006), which focused on the development of first-rate commissioning to create an NHS where patients have more choice as well as a real voice in the design of their services

*The Future Regulation of Health and Adult Social Care in England* (November 2006) which looks at the role of regulation in the reformed system

*The Code of Practice for Promotion of NHS services* (November 2006) which sets out the rules around advertising NHS services

*High Quality Care For All: NHS Next Stage Review Final Report* (July 2008) which sets out the main elements in the third stage of NHS reform in England

*High Quality Care For All, NHS Next Stage Review: A Quality Workforce - a workforce strategy to support the NHS Next Stage Review final report*

*The Next Stage Review: Our vision for primary and community care* (July 2008)

### Transforming Community Services

- *A background briefing note is available on request*
- *Enabling new patterns of provision guidance published January 09*

- *Executive Summary of the Business readiness guidance published March 2009*
- *Staff 'Right to Request' to set up social enterprises to deliver services was introduced in June 2008. The guidance document Social enterprise: making a difference was published in November 2008*
- *NHS Standard Contract for Community Services published December 2008*
- *Currency and pricing options for community services published January 2009*
- *Transforming Community Services & World Class Commissioning: Resource Pack for Commissioners of Community Services published January 2009*
- *Guidance on information models for community services to be published Spring 2009*
- *Six transformational guides will be published in June 2009 across the six clinical areas:*
  - *Transforming Community Services: High Quality Care for Children, young people and Families*
  - *Transforming Community Services: High Quality Care in Services for Long term Conditions*
  - *Transforming Community Services: High Quality Care in Acute Services Closer to Home*
  - *Transforming Community Services: High Quality Care in Services for Rehabilitation and Long Term Neurological Conditions*
  - *Transforming Community Services: High Quality in End of Life Care*
  - *Transforming Community Services: Promoting Health and Well Being and Reducing Inequalities*
- *Framing the contribution of allied health professionals - delivering high quality healthcare published October 2008*

#### The Quality framework

*Measuring for Quality Improvement: the approach*

*Measuring for Quality Improvement - our vision*

*Quality pyramid*

*Quality Accounts*

*All available at:*

[www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH\\_090444](http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_090444)

#### The CQUIN payment framework

*Using the Commissioning for Quality and Innovation (CQUIN) payment framework (2008) Department of Health (see [www.dh.gov.uk](http://www.dh.gov.uk))*

*Impact Assessment of the Commissioning for Quality and Innovation payment framework (2008) Department of Health (see [www.dh.gov.uk](http://www.dh.gov.uk))*

Information on existing (non-CQUIN) incentive schemes for quality and proposed CQUIN schemes (see [www.institute.nhs.uk/CQUIN](http://www.institute.nhs.uk/CQUIN))

Evaluation tender for the North West Advancing Quality programme (see [www.sdo.nhr.ac.uk/files/researchcall/256-brief.pdf](http://www.sdo.nhr.ac.uk/files/researchcall/256-brief.pdf))

### Personal health budgets

Individual Budgets Evaluation Network (IBSEN) - *Evaluation of the Individual Budgets Pilot Programme: final report*<sup>10</sup>

*Personal health budgets: first steps* - personal health budgets guidance document including invitation to submit expressions of interest in becoming a pilot site<sup>11</sup>

Staying In Control materials<sup>12</sup>

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<sup>10</sup>

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_089505](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_089505)

<sup>11</sup>

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_093842](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093842)

<sup>12</sup> <http://www.in-control.org.uk/site/INCO/Templates/Home.aspx?pageid=1&cc=GB>