Healthcare Reform in the NHS England: More Lessons for Ontario
**THE CHANGE FOUNDATION**

The Change Foundation is an independent policy think tank, intent on changing the healthcare debate, healthcare practice and healthcare experience in Ontario.

The goal of our strategic plan is to improve the experience of caregivers and individuals as they move in, out of, and across the healthcare system over time.

**Vision**
To be Ontario’s trusted advisor advancing innovative health policy and practice.

**Mandate**
To promote, support and improve health and the delivery of healthcare in Ontario.

**Mission**
- To make caregivers and individuals in need of healthcare part of the healthcare discussion about how to find solutions to improve their experiences.
- To stimulate new ways of thinking, behaving and interacting to foster improved healthcare for people, especially when they are in transitions.
- To generate robust and independent research and policy analysis of healthcare issues relating to improving the experience of individuals and caregivers as they navigate the healthcare system.
- To lead informed discussion and strategic engagement with the stewards, stakeholders and users of the healthcare system.

**Values**
- **Excellence** – we strive for excellence in all we do.
- **Innovation** – we take innovative approaches in developing new ideas.
- **Collaboration** – we work in partnership with others to achieve success.
- **Inclusivity** – we strive to include all voices and views.

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Foreword

Four years ago, when we first looked to England’s integrated health system for fodder for reform in Ontario, the province’s move to regional health planning was still relatively fresh. There was a lot of room for ruminating about the LHINs’ evolution and what other system changes – big, little or, often, in between – were needed to improve healthcare quality and patient-centred care, the newest kid on the healthcare block.

Since then, England’s reflex for healthcare restructuring continued, with a radical shift legislated and an April 1, 2013 implementation date. While the UK government touts the across-the-board changes as an opportunity to stabilize the system (and contain its costs), in Ontario our experimentation with healthcare providers working as one for the people they serve is just getting going, under similar economic constraints.

It is fair to say that there has been a lot of ferment – and some traction for change beyond tinkering – in Ontario since 2009. But on several fronts (for instance, public engagement and patient involvement, and capturing and measuring the patient and caregiver experience) we’ve still got some thinking, studying and deliberating to do with a host of usual and unusual suspects.

We hope this report will help stir your impulse to contemplate, confer and find consensus about the best way forward for Ontario’s healthcare system.

Cathy Fooks
President and CEO
March 2013
Introduction
As part of our commitment to support Ontario’s transition to a more integrated health system. The Change Foundation has looked to other jurisdictions for instructive examples of patient-centred reform. The English National Health Service (NHS) has much to teach us.

We released our first case study, Integrated Healthcare in England: Lessons for Ontario, in 2009. What did we learn? Transformation is messy even with intent, and clarity on key questions is required to support integrated care: Who does what? Are patients and families involved in planning? How are services funded, and who can best deliver care? How is quality determined and reported? How does healthcare integrate with other determinants of health?

The following year, the United Kingdom’s new coalition government proposed sweeping changes for the English health and social care system, and we captured them in an update, Recent National Health Service (NHS) Reform Proposals in England. In both of these earlier reports, we distilled complex NHS system changes, highlighted leading health policies and reform initiatives, and imagined what our system would look like if similar changes were adopted here in Ontario.

Since our 2010 update, England’s health system reforms have evolved and are now embedded in legislation that governs the NHS England. That process took place against a backdrop familiar to Ontarians: a fiscal squeeze, demographic pressures of an aging population, and increasing demand for high-quality healthcare. This report provides an overview of England’s journey to enacting the Health and Social Care Act 2012 and a summary of the transformed delivery of health services within the NHS England. Again, we reflect on the relevance of these reforms for Ontario as quality-focused system initiatives continue here as well.
Policy and political background

The National Health Service was established in 1948 as a universal service for the UK with equal access for all, free at the point of use, provided on the basis of clinical need, and funded mainly by taxation. As with medicare in Canada, healthcare in the UK is widely regarded as a public entitlement and a government responsibility.

Local management has devolved to constituent countries – England, Scotland, Wales and Northern Ireland. Reform of the English NHS to improve service delivery and outcomes was initiated by the Conservative government in the 1990s and continued under the Labour government. Structural and policy changes have been guided by a number of principles: patient choice, competition, economic incentives, mandatory national targets, and an extended network of independent providers in both the public and private sectors.2 Healthcare policy in England also has a long tradition of regionalization and has generally distinguished between those who commission (plan and pay for) services and those who deliver care – the purchaser/provider split.

Just 60 days after the Conservatives and Liberal Democrats formed a coalition government in 2010, they introduced what many have labeled the most unexpected, far-reaching and controversial set of healthcare reforms in the history of the NHS in England.3 In a white paper titled Equity and Excellence: Liberating the NHS, released in July 2010, nearly every aspect of the health service was tagged for change.

Two years of complex, politically charged horse-trading and legislative bargaining would ensue before the Health and Social Care Act 2012 was passed.

Nicholas Timmins, a specialist in health policy and former public policy editor of the Financial Times, summed up the proposed reforms in his excellent study of the passage of the bill:

Family doctors were to take over the commissioning of NHS care. Their work was to be overseen by a new national commissioning board. The entire existing substructure of the NHS (the 10 regional health authorities and the 152 primary care trusts) was to be abolished. A new economic regulator was planned to oversee choice and competition, both of which were to be extended. From the private and voluntary sectors, “any willing provider” was to be allowed to supply NHS care at agreed NHS prices. … Health and Wellbeing Boards were to be created in local government to join up the commissioning of NHS services, social care and prevention. And a new patient’s voice organisation, Healthwatch, was to be created.4
Underpinning the legislation were the Conservatives’ election manifesto on healthcare and the pivotal role played by MP Andrew Lansley, the chief architect of the reforms. Lansley had been Shadow Health Secretary in Opposition (2004–2010), then became Secretary of State for Health (2010–2012) in the coalition government. His unusually long tenure with the health portfolio gave him in-depth, insider knowledge of the NHS.

Decades of change by different governments had shaped England’s healthcare system, and this constant state of reform was, ironically, one of the targets of Lansley’s reforms. The coalition government’s white paper, the by-product of years of policy development while Lansley was in Opposition, gave him the opportunity to turn his six years of preparation into lasting, transformative and arguably revolutionary change in the NHS – change that, in his mind, should not and could not be undone.

Regardless of Lansley’s views, the Conservative election platform was short on specifics about healthcare and gave no hint of the eventual scale of the reforms to come. “We will back the NHS,” said their manifesto. “We will increase health spending every year. We will give patients more choice and free health professionals from the tangle of politically motivated targets that get in the way of providing the best care.” Despite a lack of detail as to how these goals would be achieved, the Conservatives committed to:

- remove all “politically motivated targets that have no clinical justification”
- put more detailed NHS performance data online
- improve cancer and stroke survival rates
- enable patients to rate hospitals and doctors
- give patients the power to choose any healthcare provider that meets NHS standards
- put patients in charge of their own health records
- open up the NHS to new independent and voluntary sector providers
- link general practitioners’ (GPs’) pay to the quality of results they deliver.

The initial agreement between the Conservatives and the Liberal Democrats that formed the basis of their coalition government contained even less detail on the health system. An NHS spending review and a commitment to match healthcare spending increases with inflation were the only items mentioned.

A follow-up document, Our Programme for Government, was released in May 2010 with more detail on plans for NHS reforms (see Appendix A), but it hardly foreshadowed the dramatic changes to come in the white paper just two months later. Some of Lansley’s white paper themes are noted: for example, enabling GPs to commission services and strengthened roles for two existing regulatory agencies, the Care Quality Commission and Monitor.

However, the big structural reforms are not discussed. Not only does Our Programme for Government not even hint that existing structures like primary care trusts (PCTs) may be eliminated, it says that PCTs are to act as champions for patients in commissioning services.

Given that the NHS had not been a major focal point during the election campaign or in the early days of the coalition government, the July 2010 white paper was indeed a shock, even to some in government. It quickly became apparent that the government, and the health secretary in particular, had greatly underestimated the health sector’s reaction to the proposed reforms. The absence of many of the white paper ideas in the government’s program fueled the complaint that Lansley’s reforms had no political mandate. Lansley argued that the bulk of the changes were simply an extension of the market-style policies introduced in the Thatcher years and a continuation of the commissioning reforms of the Blair government. Very few others shared that view.
The government eventually mustered enough political support to introduce an NHS reform bill in Parliament in January 2011. The Liberal Democrats agreed to support the bill only after negotiating a number of compromises. Despite this support, as the bill began its parliamentary journey it became evident that it was still not satisfactory to a large contingent in the sector. The scrutiny of Parliament and in particular the powerful, independent House of Commons Health Select Committee, coupled with growing opposition from patient groups, unions and professional associations, created political pressure too strong for the government to withstand.

In the summer of 2011, the government announced an unprecedented pause in the legislative process and committed to undertake a “listening exercise.” It assembled what it called the NHS Future Forum to bring some structure to all the voices proposing changes to the bill. Although some critics dismissed the Future Forum as window dressing, the process led to the introduction of a substantial set of important amendments and provided the critical compromise required to pass the bill.

The most significant changes in the final act, compared to the original bill, focused on:

- stronger accountability mechanisms and governance for the new commissioning bodies
- a reaffirmed role of the Secretary of State for Health in overseeing the provision of health services in England and being held accountable for them (this had been removed in the earlier drafts, leading to fears that the NHS could be privatized)
- modification of the commissioning reforms
- greater clarity and definition of the new economic regulator’s role in reconfiguring hospital services, setting prices, and licensing providers
- a reduced emphasis on competition and safeguards aimed at addressing concerns around privatization
- promotion of cooperation between providers to enable integration of health and social care
- a more phased implementation process
- embedding the NHS Constitution into the legislation.

The details of the final legislation, its implementation, and comparisons with Ontario are the focus of the rest of this paper. After approximately 50 days of parliamentary debate, the government accepted almost all 2,000 amendments. On March 27, 2012, the act received royal assent. Six months later, Jeremy Hunt replaced Andrew Lansley as Secretary of State for Health and Lansley became House Leader.

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Implementation of the reforms

As in previous NHS reforms, the *Health and Social Care Act 2012* both changed the functions of existing organizations and created new ones. The roles and responsibilities of almost all the players in the system were affected.

Figure 1 depicts the new structure of health and social care in England as an orderly set of boxes identifying the various levels and groups. Whether the system will feel this orderly in actual operation has been the subject of much debate.

The act delineates three systems of care:
- Public Health – to be managed by the newly created Public Health England through local public health departments that moved from the NHS to local government
- The NHS – to be managed by a series of national agencies responsible for purchasing and regulating services and monitoring the quality of care
- Adult Social Care – to continue, unchanged, to be managed by local authorities.

Figure 1. The organization of health and social care in England, 2012

The lines of accountability and funding add considerable complexity to the picture. Figure 2 illustrates what the NHS system is to look like from April 2013, using the London Commissioning Board as an example.

We now take a closer look at the changes to the NHS in four key areas: 1) commissioning of services, 2) quality of patient care, 3) public engagement, and 4) expectations and goals for efficiency and productivity.

1) COMMISSIONING OF SERVICES
Commissioning in the NHS “is the process of planning, agreeing and monitoring services … [It] is not one action, but many, ranging from the health needs assessment for a population, through the clinically based design of patient pathways, to service specification and contract negotiation or procurement, and finally to the ongoing assessment of the quality of service.”

Commissioning or purchasing bodies have existed in the NHS since the early 1990s, when tax funds began to be allocated to local purchasers according to a complex formula which takes into account local levels of healthcare need. From this local budget, hospitals and other providers of health services are paid. The challenge has always been for local purchasing bodies to find ways of spending this money efficiently, particularly
in stemming the growth of the acute care/hospital sector and
boosting community-based, preventative services. The creation
of clinical commissioning groups (described below) was
Lansley’s “big idea”: he believed that local groups of family
doctors would make more appropriate use of their local budgets.

The act creates five organizational structures with responsibility
for commissioning or supporting commissioning, as shown
in Figure 3.

**NHS Commissioning Board**
At the top is the National Health Service Commissioning
Board, a new body at arm’s length to the Department of Health.
The Commissioning Board has authority to manage the entire
NHS budget on behalf of the department, provide national
leadership on commissioning, and set the strategic direction of
the NHS. Notwithstanding the Commissioning Board’s role in
managing the system, the Secretary of State for Health continues
to oversee and be held accountable for the operation of the NHS.

Along with the overall responsibility for strategy and
implementation, the Commissioning Board has retained
a direct responsibility for purchasing services in three areas:
primary care, highly specialized care such as transplant
services, and other services deemed to be more effectively
organized nationally such as cancer services. Commissioning
of primary care was placed at the national level to avoid
conflicts of interest that could arise from GPs commissioning
their own services.

Underneath and accountable to the Commissioning Board
are four other types of organizations involved in commissioning:
• regional commissioning sectors (4)
• local Commissioning Board offices (27)
• commissioning support services (23)
• clinical commissioning groups (212).

We’ll look at each, beginning closest to the front line of care.

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**The creation of clinical commissioning groups was Lansley’s “big idea”:**
he believed that local groups of family doctors would make more appropriate
use of their local budgets.
Clinical commissioning groups (CCGs)

Previously, commissioning was primarily carried out by 152 statutory administrative bodies called primary care trusts (PCTs), which were funded by 10 strategic health authorities (SHAs) and had the power to plan and purchase local healthcare for a defined population. The act abolished the PCTs and SHAs and transferred commissioning of non-primary care to 212 new bodies called clinical commissioning groups (CCGs), which now hold the majority of the NHS budget. The composition of the groups is based loosely on existing family or group medical practices (GPs were allowed to form their own groups) and in some cases the groupings partly reflect previous administrative structures such as PCTs and local government boundaries, though this is far from universal.

The CCGs have full authority to purchase services from local providers based on their enrolled population. While some GPs had commissioned services in the past alongside the PCTs, that role (known as practice-based commissioning) was entirely voluntary. Participation in a CCG will be mandatory for all GPs. It is important to underscore that the CCGs will commission services other than primary care: they are expected to contract with hospitals, community care organizations and other providers, ensuring that their local populations receive the most appropriate, high-quality, efficient care. In their capacity as primary care clinicians, GPs will still maintain their own registered patients and will be directly accountable to the NHS Commissioning Board through a quality outcomes framework, described below (see “Quality of patient care”).

CCGs have a legal obligation to obtain appropriate clinical advice. One source of clinical guidance will be the newly created Clinical Senates – non-statutory, regional bodies – and the Clinical Networks that coordinate and potentially reconfigure particular specialties. CCGs will also be required to engage patients and the public, as well as professionals, to ensure local services reflect the health and social needs of the local population (see “Public engagement,” p. 15).

Each CCG is free to determine its own configuration within a specified framework. CCGs must prove they have five key attributes: the ability to hold a budget (i.e., demonstrate high-quality governance through a board of directors and an “accountable officer”); a strong, engaged relationship with their constituent GPs; solid public accountability systems including conflict-of-interest policies and procedures; good relationships with local providers and other stakeholders; and clear plans for commissioning.

Commissioning support services

To assist the 212 CCGs, a network of 23 geographically based agencies, called commissioning support services, has been created, largely through the movement of staff from the former PCTs. Commissioning support has been broadly described to include six categories of clinical and technical support with a seventh (back-office functions) cutting across all areas:

- health needs assessment (forecast local health needs and identify gaps in service, building on collected data)
- business intelligence (analyze patient activity, clinical outcomes, patient experience, risk stratification, referral assessment, etc.)
- support for redesign (develop clinical specifications and pathway design; conduct service reviews, involving patients and caregivers in co-design of local services)
- communications and public engagement (involve all stakeholders)

The clinical commissioning groups have full authority to purchase services from local providers based on their enrolled population. Participation in a CCG will be mandatory for all GPs.
• procurement and market management (manage contracts, including tendering and negotiation)
• provider management (ensure fulfillment of service contracts, service standards, and key performance indicators)
• back-office functions (handle finance, IT systems and support, legal services, human resources).

The vision for these support services is to inject private sector business models into the delivery of commissioning support. Potential benefits include the pooling of resources to share support services, achieving greater service integration, and commissioning services more efficiently. After a transition period, the support services are expected to become fully privatized, free-standing organizations.

Regional sectors and local offices
Four regional commissioning sectors will carry out the majority of the functions of the NHS Commissioning Board by overseeing the operations of 27 local Commissioning Board offices peppered across the country. The local offices will be responsible for the day-to-day relationships with CCGs: they will support the development and authorization of CCGs and allocate and account for resources transferred for local commissioning. Local offices will also provide clinical and professional leadership and manage relationships with local stakeholders such as local authorities (municipal governments) and Healthwatch groups (described in “Public engagement,” p. 15).

The NHS has been in transition towards the new commissioning regime over the last year and plans to have it fully implemented by April 2013.

2) Quality of Patient Care
The responsibility for quality, performance measurement and improvement in the NHS England is shared across several organizations and provider groups, as depicted in Figure 4 (p. 13).

NHS Commissioning Board
The Health and Social Care Act 2012 establishes the NHS Outcomes Framework as the principal guidepost for quality improvement and performance measurement in the NHS. The Outcomes Framework (shown in Appendix B) provides a set of national goals and performance measures which the Secretary of State for Health will use to hold the NHS Commissioning Board to account. It is constructed around five key domains, each with a series of “overarching indicators” and “improvement areas.” The government’s recently published NHS Mandate instructs the Commissioning Board to focus its improvement activity on the five domains of the Outcomes Framework:

• preventing people from dying prematurely
• enhancing quality of life for people with long-term conditions
• helping people to recover from episodes of ill health or following injury
• ensuring that people have a positive experience of care
• treating and caring for people in a safe environment and protecting them from avoidable harm.

Appendix C lists more specific objectives in the mandate. Adult social care and public health will each operate within their own separate outcomes frameworks.
Aligned directly with the NHS Outcomes Framework is the CCG Outcomes Indicator Set (formerly known as the Commissioning Outcomes Framework) developed by the Commissioning Board to assess the performance of the CCGs. As well, CCGs will try to link quality improvement to payment through two existing tools:

- The Commissioning for Quality Improvement and Innovation (CQUIN) payment framework is designed to financially reward secondary care providers who meet national quality goals in their local communities.\(^\text{13}\)
- The Quality and Outcomes Framework (QOF), part of the general medical services contract between the NHS and the British Medical Association, is a form of performance-related pay for GPs.

**National Institute for Health and Clinical Excellence (NICE)**

NICE has been a fixture on the UK healthcare landscape for more than a decade. It was established in 1999 to develop evidence-based clinical guidelines for providers and to bring greater consistency to treatments offered to patients across the NHS, which tended to vary by area. NICE is seen as a key driver of quality improvement, and the act expands its mandate to include social care. Building on its previous work, NICE has been tasked by the NHS Commissioning Board to develop 150 additional standards over the next five years, which will be incorporated into the NHS Outcomes Framework. Each quality standard will refine the goals of high-quality care, include a set of statements relating to best clinical practice, and describe specific indicators or measures for each step of a patient’s pathway of care.
Since 2004, Monitor has been the independent economic regulator of NHS foundation trusts, self-governing public corporations that provide much of England’s hospital, mental health and ambulance services. The act gives Monitor expanded responsibilities to regulate all NHS-funded services. Its new role includes:

- licensing all providers of NHS-funded care
- regulating prices
- safeguarding choice and preventing anti-competitive behaviour in the NHS
- enabling integrated care
- supporting commissioners to ensure essential services continue if a provider organization gets into financial difficulty (including the power to intervene and replace boards and management if necessary)
- ensuring that boards of provider organizations focus on good leadership and governance.

Monitor now reports directly to Parliament, and the agency is centrally situated in the NHS organizational hierarchy, on par with the NHS Commissioning Board, the Care Quality Commission, and NICE.

**Care Quality Commission (CQC)**

The Care Quality Commission has maintained its role as an independent, statutory quality regulator of providers of health and social care. Historically it was focused on hospitals, long-term care and home care, with expanded powers (prior to the legislation) to include primary care services. Guided by the NHS Outcomes Framework, CQC quality standards will become more focused on outcomes and less on process and policy. CQC will also work closely with Monitor to ensure quality requirements are built into provider licensing and assessment processes, as providers will have to register with CQC and be licensed by Monitor.

**“CHOICE AND COMPETITION”: WHAT DO THEY MEAN?**

A key theme of the Health and Social Care Act 2012 is greater choice and competition in English healthcare. Effectively, the idea is to expand a nascent internal market for NHS services.

The system had already sanctioned some competition among NHS providers and competition involving providers in the private and voluntary sectors. Since 2006, state-owned hospitals and a small number of private facilities had been allowed to compete for patients needing non-urgent surgery, supported by a reformed payment system that reimbursed providers for each episode of care.

A bigger role for private sector and not-for-profit providers in the delivery of health services is now envisioned as the act extends patient choice beyond elective surgery. “Any qualified provider” provisions in the legislation allow any provider (public or private) to compete for patients needing other kinds of care, such as community and mental health services. If qualified, they are then eligible to be reimbursed by the NHS for delivering patient care. In theory, this allows patients to choose from a greater number of qualified providers. (Similar “any willing provider” provisions previously existed for some elective referrals.)

The legislation also sets a deadline for all NHS trusts (provider organizations that are accountable to the Department of Health rather than a community board) to be upgraded into foundation trusts, which are still technically state-owned but have more autonomy to borrow money and function more like private businesses.

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3) PUBLIC ENGAGEMENT

The Health and Social Care Act 2012 aims to take further strides in the area of public and patient engagement by providing additional opportunities for patients and families to express their views about their healthcare system. Figure 5 illustrates the interplay of new and existing mechanisms for public engagement.

Healthwatch England

Within the Care Quality Commission, Healthwatch England is a new statutory committee made up of patients and citizens. It is envisioned as the independent patient voice for the NHS and is mandated to reflect public opinion in all healthcare services, regulations and standards of care.

Healthwatch England provides support and resources to local Healthwatch groups to help strengthen grassroots public engagement. Building on the role of a previous local structure, the act provides Healthwatch groups with authority to incorporate the patient and citizen perspective in local commissioning and planning decisions, engage a wider range of people, be more consistent in practice, and increase awareness of their work. Local Healthwatch groups will formally channel their input into local commissioning decisions through local Health and Wellbeing Boards. These boards are made up of elected officials and representatives from local Healthwatch groups, CCGs, and a variety of professions including clinical care, public health, social services and children’s services. The Health and Wellbeing Boards are to advise CCGs, formally conveying the views of local Healthwatch groups and representing a variety of professional perspectives, ultimately promoting integration between local services.

Figure 5. Public engagement mechanisms for health and social care
Formalizing these new relationships is a framework called the Joint Strategic Needs Assessment (JSNA), which pre-dates the current reforms. The process of conducting these assessments will ensure that CCGs formally engage local communities and consider advice on population-based healthcare planning decisions and strategies. The act further empowers local Healthwatch groups to refer commissioning plans back to CCGs if they fail to take proper account of local needs identified in the needs assessments. However, CCGs are not legally obliged to take any action on the basis of feedback from Healthwatch groups. It will be important to monitor whether these engagement structures are effective at influencing local planning and commissioning decisions.

Healthwatch England is already active, and Health and Wellbeing Boards are operating in shadow form, set to take up their statutory functions by April 2013.

In addition to the current reforms, the Department of Health continues to provide a grant to National Voices, a coalition of approximately 150 charities focused on ensuring that the views of patients and families are part of ongoing discussions about NHS reforms.

**4) EXPECTATIONS AND GOALS FOR EFFICIENCY AND PRODUCTIVITY**

Before the act was drafted, the head of the NHS, Sir David Nicholson, committed to deliver £20 billion in savings by 2014/15 through quality- and innovation-based productivity improvements in the NHS. “The Nicholson Challenge,” as it came to be known, represented the gap between the projected demand for services and the funding available to the NHS between 2010 and 2014/15. The growth in allocations to the NHS had dropped sharply beginning in 2010, compared to the previous decade, as the UK attempted to reduce its public sector spending. The ambitious QIPP program – Quality, Innovation, Productivity and Prevention – found a strong ally in the government’s white paper and subsequent legislation. The government argues that the reforms will pay for themselves by creating efficiencies and thereby will help support the QIPP challenge; others argue the opposite.

The QIPP program included 12 national initiatives to provide support and quality improvement tools to clinicians and NHS organizations to help them reduce costs. In a study of the program, The King’s Fund reported that, “according to the Audit Commission (2011), there were £4.3 billion of productivity gains in 2010/11. For 2011/12, the Department of Health reported that the Quality, Innovation, Productivity and Prevention scheme had generated £5.8 billion of savings. However, it is not possible to ascertain what proportion was actually due to productivity improvements.”

The government argues that the reforms will pay for themselves by creating efficiencies and thereby will help support the QIPP challenge; others argue the opposite.
While the NHS England reforms are still in their implementation phase, a number of potential challenges have been identified:

- The number of players involved in commissioning and the multiple layers of reporting may lead to confusion and duplication. For example, CCGs must deal with the NHS Commissioning Board and its regional and local offices, the commissioning support service office, local Healthwatch groups, and the Health and Wellbeing Boards, as well as all the providers from whom they are purchasing services.

- The linchpin of the system is the ability of the CCGs to hold hospitals and other care providers to account. PCTs had a similar role previously, and views were mixed as to their effectiveness. Complicating the new model is the fact that the CCGs, who commission non-primary care services, also provide primary care services. It is possible that decisions about what gets provided in primary care (which inherently financially benefits the primary care practice) may influence what gets commissioned elsewhere.

- The NHS Commissioning Board risks over-centralization which may discourage and stifle local innovation.

- The NHS Commissioning Board may have difficulty picking standards, developing consistent definitions of the various pathways of care, and ensuring appropriate utilization and interpretation of standards.

- There is clear alignment between the NHS Mandate, the NHS Outcomes Framework and the CCG Outcomes Indicator Set. It is less clear how these relate to the financial incentives frameworks used by the CCGs (Commissioning for Quality Improvement and Innovation [CQUIN] and the Quality and Outcomes Framework [QOF]).

- The structures for patient and public engagement overlap with local groups and boards and with the local CCGs and foundation trust boards.

- There is some question as to whether too much pressure is being placed on staff to find innovative solutions in the midst of restructuring. In an annual survey of healthcare finance managers, The King’s Fund found that most felt confident they could meet planned cost-reduction targets (just under 5%, on average) in 2012/13, but were less positive about being able to deliver savings and productivity gains after April 2013, partly due to the end of a two-year wage freeze in the public sector. Although managers stated that the budget pressure had not affected patient services to date, they thought it was only a matter of time before it would.

- Questioning whether further savings can be identified, some experts have suggested that the government will need to consider either new financing measures or charging patients directly for some services.
Reflections for Ontario

As Ontario continues on its own journey of system reform to improve the quality of healthcare, it is useful to look at how recent developments in this province compare with those in the NHS England.

We find five areas of comparison that are particularly instructive; they are discussed below and summarized in Table 1 (p. 23).

**SYSTEM MANDATE FROM GOVERNMENT**

The *Excellent Care for All Act, 2010* provides a legislative framework for quality improvement in Ontario’s healthcare system. Starting with hospitals, the act requires that healthcare organizations establish quality improvement plans and quality committees to monitor and report on the quality of their services. They must also report on patient safety indicators at the organizational and board levels, along with other quality initiatives. The act gives the government the ability to extend these obligations to other publicly funded provider organizations (beyond hospitals) through regulations. The *Excellent Care for All Act* also expanded the mandate of Health Quality Ontario (HQO) to measure performance, support quality improvement and make recommendations on best practices and the funding of care.

In 2012, the provincial government released *Ontario’s Action Plan for Health Care* which could be viewed as a “mandate” to the system. The broad goal of the action plan can be summed up in the government’s catch-phrase, “the right care at the right time in the right place.” The plan also identified “a stronger link to family healthcare” as a priority, including a quality focus for family/primary healthcare and bringing this sector into the responsibilities of Local Health Integration Networks (LHINs). The action plan advocates for a transition to a more patient-centred system and away from a provider-centred system.

As part of the Action Plan for Health Care, the Ontario government recently announced funding support for 19 Health Links communities, a model that it plans over time to expand across the province. Health Links are community partnerships of healthcare providers, with family healthcare at the centre and one of the partners playing a coordinating role for care as patients transition between providers, organizations and sectors. The partners will share information and measure results for a number of outcomes related to patients with complex needs (high users) in their local health systems. They will also measure the impact of quality improvements in the delivery of care.
of services, particularly from the perspectives of patients and families. The Health Links initiative signals a direction from the government supporting local innovation to address system integration and the patient experience.

The province released another health-related action plan in January 2013. Ontario’s Action Plan for Seniors presents three goals related to healthy seniors, senior-friendly communities, and safety and security, with a range of programs and initiatives to realize them. The plan was informed by a report by Dr. Samir Sinha, the government’s lead on developing a provincial seniors’ strategy. His wide-ranging report, *Living Longer, Living Well*, includes 167 recommendations, many of which address quality issues and a system-wide framework for accountability and performance measurement. For example, he calls for Community Care Access Centres (CCACs) to develop consistent service quality across the province; functional integration and alignment of performance assessment processes within and across sectors; and accountability agreements and quality improvement plans with mandatory and voluntary performance measures aligned within and across sectors.

As the government notes in the action plan, Dr. Sinha’s report includes many recommendations that address issues beyond healthcare, “issues like housing, transportation and safety, as well as those broader community support services that contribute directly to health care.” The *Health and Social Care Act* in the NHS England provides the legislative framework for addressing both health and social care and the broader determinants of health. While the Ontario government states that it is “studying [Dr. Sinha’s] report and will be implementing other recommendations in the months to come,” it is not yet clear how far it will go with the broad scope of changes recommended.

**Quality Priorities and Measurement Frameworks**

Many measurement initiatives are currently underway within the Ontario healthcare system. For example, individual provider organizations report on various aspects of their operations both publicly and to the LHINs. There are reporting metrics in accountability agreements between LHINs and providers. Funding agreements between the Ministry of Health and Long-Term Care and primary care organizations specify financial, operational and clinical indicators. And two provincial agencies – Health Quality Ontario and Cancer Care Ontario – produce public reports on system quality.

These are good places to start but we need to do more. The approach has been more haphazard than strategic. We see three problems. First, there has not been a strategic discussion on high-priority areas for improvement with a subsequent focus on measurement. Second, the measurement exercises are not aligned and joined-up so that all providers can be assessed on a common set of indicators and system-level quality can be clearly understood. Third, past efforts have focused largely on hospitals and acute care. Other parts of the system are just beginning to develop the infrastructure required for ongoing quality measurement.

The emerging focus on quality in family healthcare is welcome given that primary care has not been a high priority for the development of standardized quality metrics. As others have said recently, “the province lacks a coordinated and sustainable approach to collect, analyze and report on the performance of the primary care system.”

In February 2013, the Ministry of Health and Long-Term Care and HQO released requirements and guidance for quality improvement plans (QIPs) for primary care. Team-based primary care models (family health teams, community health centres, nurse-practitioner-led clinics and aboriginal health access centres) will be required to develop quality improvement plans starting April 1, 2013. Other primary care models are “encouraged” to develop QIPs. A QIP template and guidance materials have been developed in consultation with primary care stakeholders. HQO will provide additional supports including learning opportunities, access to QIP specialists, a community of practice infrastructure, and governance training and tools for boards on how to improve quality in their organizations.
Additional efforts to develop performance measurement frameworks for primary care include a recent summit sponsored by HQO and the Canadian Institute for Health Information (CIHI), with plans to finalize a framework by the fall of 2013. Given the role of family/primary healthcare at the centre of our system – a role articulated in the government’s action plan – it is imperative that planning for quality improvement in primary care be integrated with a performance measurement framework for this sector, and that these are connected and aligned with performance measurement for the broader healthcare system.

We know that evidence-based clinical guidelines are a key driver of quality improvement. The NHS England has a dedicated agency, NICE, with a mandate to develop evidence-based clinical guidelines. NICE has an ambitious plan to develop 150 additional standards for best clinical practice in health and social care over the next five years, including indicators and measures that will be incorporated into the NHS Outcomes Framework.

In Ontario, HQO has a four-pronged mandate – public reporting, supporting quality improvement, making recommendations on funding, and making recommendations on evidence-based practice. The Ontario Health Technology Advisory Committee (OHTAC), a standing advisory subcommittee of the HQO board, “makes recommendations about the uptake, diffusion, distribution, or removal of health interventions in Ontario. OHTAC’s recommendations are based on a careful review of results from … analyses [which consider] the overall clinical benefit, value for money, societal and ethical considerations, and the economic and organizational feasibility of the intervention.” Using OHTAC’s recommendations and advice, the HQO board formulates final recommendations to the healthcare system and the Minister of Health and Long-Term Care. HQO is also working with the ministry, Cancer Care Ontario and the Cardiac Care Network to develop quality-based procedures (QBPs) – a shift in hospital funding designed to standardize care and encourage investments in quality improvement. With QBPs, hospitals are paid for episodes of care covering the patient journey (the part that involves hospital services). Evidence-based guidelines will be developed for approximately 30 QBP areas (e.g., chemotherapy, congestive heart failure, stroke, and treatment for chronic kidney disease), with the goal of having QBPs account for 30% of hospital funding by April 2014.\footnote{28, 29}

A significant difference in the NHS and Ontario models of developing clinical guidelines is the level of patient and public engagement. NICE has a history of involving patients, service users, informal caregivers and the public in the development and implementation of its healthcare guidance and quality standards.\footnote{30} With the advent of the \textit{Health and Social Care Act}, NICE is extending its guidance into social care topics and will be expanding its relationships with organizations and communities in the social care sector. HQO’s recently released \textit{Strategic Plan 2012} recognized the need to focus on priorities and to integrate quality activities.\footnote{31} However, implementing the plan requires the design of an overarching quality outcomes framework with a robust, integrated, cascading set of measures – something the NHS England has tried to achieve through the NHS Mandate and its connection to the NHS Outcomes Framework. In contrast, Ontario’s quality improvement and performance measurement efforts are currently disconnected, organization-specific, and in some sectors, under-developed. The \textit{Excellent Care for All Act} provides the legislative framework for just such an accountability and measurement framework and should be leveraged to that end.

\begin{quote}
\textbf{A significant difference} in the NHS and Ontario models of developing clinical guidelines is the level of patient and public engagement.
\end{quote}
**PURCHASE OF CARE BY CLINICAL GROUPS**

Authority for clinical groups to purchase publicly funded services is currently not a feature of Ontario’s healthcare system. Historically, reform discussions in this province have focused on the governance and accountability structures of clinical groups and on the funding models. GP practices have always been responsible for utilization decisions regarding referrals to specialty care, diagnostics and home care services, but they have not been responsible for the payment end of the equation. The skills required to commission services on behalf of patients and the infrastructure required to commission effectively are not in place in Ontario at present.

**MANDATORY ACCOUNTABILITY OF GPS FOR SERVICE PROVISION, QUALITY AND PAYMENT**

Mandatory participation in a specific primary care model is not a feature of Ontario’s healthcare system. In the NHS England, all GPs must be part of a CCG group practice. In Ontario, GPs have been encouraged to join team-based practice models (family health teams and their various iterations) and some GPs have opted to join other team-based models, such as community health centres and aboriginal health access centres. However, there are GPs who continue to provide services through a solo-practice model.

In Ontario, all physicians are accountable to their regulatory college for the provision of care and the maintenance of clinical standards. GPs in family health teams and other group models funded directly by the ministry are, as part of their funding agreements, accountable for specified outcomes such as access to after-hours care and use of electronic health records.

Participation in these team-based models remains voluntary, however, and very little is published on their clinical or financial outcomes. As noted above, team-based primary care models will now be required to develop quality improvement plans and submit them to HQO, but these QIPs will not be required of solo-practice providers.

Ontario does not yet have the linkage between quality, performance and payment for GPs that is apparent in the NHS England. In England, the NHS Outcomes Framework aligns with the CCG Outcomes Indicator Set, which will be used to assess GPs’ performance in commissioning, and quality improvement is linked to payment through existing tools (Commissioning for Quality Improvement and Innovation [CQUIN] and Quality Outcomes Framework [QOF]). In Ontario, fees are set through negotiation between the ministry and the Ontario Medical Association, just as the QOF is negotiated between the NHS and the British Medical Association, but with fewer performance-related payments.
Public Funding for Patient Engagement Infrastructure

Interest and activity in community engagement in healthcare are growing in Ontario. However, none of the existing structures or processes in this province are comparable to the role, profile and impact that the forums for public engagement in the NHS England have the potential to play.

Ontario’s *Local Health System Integration Act, 2006* includes requirements for patient and public engagement. Some LHINs have established ongoing public engagement bodies to advise on planning and integration of health services. And there are examples of provider organizations that involve patients and the public and seek their input in making tough decisions about the provision of services. However, critics have argued that community engagement in Ontario is “undefined and inconsistent” and has not been used effectively to involve the community in decisions about the integration of health and social services or to push the quality agenda across organizations and sectors.

The Ministry of Health and Long-Term Care does support a provincial Citizens’ Council that provides advice on drug policy at the request of the government. The scope of this council is limited to drug policy, and its authority to influence change is modest given the advisory nature of its role.

Agencies of the provincial government increasingly see the value of engaging patients, informal caregivers and the public and are taking steps to do so. For example, Cancer Care Ontario has developed a patient and family advisory council toolkit to assist organizations that want to engage patients and their families as a means to improve patient experiences with health services. Similarly, eHealth Ontario is creating a patient advisory panel to provide input on specific projects and solutions and advise on the agency’s work.

While publicly funded provider organizations usually have representatives of the local community as public members on their boards of directors, their primary role is governance and organizational oversight, not patient advocacy. Some hospitals have set up patient and family advisory councils as part of the patient relations process required by the *Excellent Care for All Act*. Across hospitals, these councils play a variety of roles and the impact of patient and family engagement may also vary.

An interesting potential development comes from the seniors’ strategy report, *Living Longer, Living Well*: it recommended that each LHIN be required to establish a steering committee with a broad base of representation from local health, social, and community care providers. These bodies, which sound similar to the NHS England’s Health and Wellbeing Boards, would include public health and paramedical providers, local municipal officials, patients and caregivers and would discuss and plan opportunities to develop and implement services for older Ontarians in their regions.

**Community engagement** in healthcare is growing in Ontario, but none of our structures or processes compare to the role, profile and potential impact of public engagement forums in the NHS England.
Table 1. Summary of key changes to the NHS England, with reflections for Ontario

<table>
<thead>
<tr>
<th>System features and what they mean in England</th>
<th>How Ontario compares</th>
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<tbody>
<tr>
<td><strong>System mandate from government</strong></td>
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<tr>
<td>• A national mandate for the whole health system underpins system quality, performance measurement and accountability.</td>
<td>• Excellent Care for All Act 2010 provides legislative framework for quality focus.</td>
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<tr>
<td>• The mandate sets national priorities for focused improvement in five key domains, taken from the NHS Outcomes Framework, under which a set of specific indicators will be used to assess progress.</td>
<td>• 2012 Action Plan for Health Care aims to improve accountability, particularly in primary care, but lacks explicit connection to system-wide quality priorities.</td>
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<td><strong>Quality priorities and measurement frameworks</strong></td>
<td></td>
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<tr>
<td>• Multiple outcomes frameworks are linked and cascade. Each has targets, indicators and stretch goals. These are to be measured at the national, regional, local and individual-provider levels.</td>
<td>• Numerous measurement initiatives are underway but remain largely disconnected.</td>
</tr>
<tr>
<td>• The outcomes measures are designed by a respected national clinical excellence organization that is not involved in the management or delivery of direct care.</td>
<td>• HQO’s expanded mandate includes supporting quality improvement, public reporting on quality outcomes, recommending evidence-based practice, and recommending funding reforms. An overarching outcomes framework with integrated, cascading measures is needed.</td>
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<tr>
<td>• NHS has a history of public engagement in the development of healthcare guidance and quality standards.</td>
<td>• There is limited public engagement in the development of healthcare guidance and quality standards.</td>
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<td><strong>Purchase of care by clinical groups</strong></td>
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<tr>
<td>• The purchasing of non-primary care services is in the hands of clinical groups, largely GP led.</td>
<td>• Clinical groups are not responsible for purchasing services.</td>
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<tr>
<td>• Clinical groups are accountable through local and regional offices to a national Commissioning Board.</td>
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<tr>
<td><strong>Mandatory accountability of GPs for service provision, quality and payment</strong></td>
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<tr>
<td>• GPs must be part of a clinical group with a registered population.</td>
<td>• Participation in team-based models is voluntary and only some practices participating in these models are required to develop quality improvement plans and submit them to HQO.</td>
</tr>
<tr>
<td>• They are accountable to the NHS Commissioning Board for providing appropriate care, to Monitor for the pricing of care, and to the Care Quality Commission for the quality of care.</td>
<td>• GPs are accountable to their regulatory college for maintenance of clinical standards.</td>
</tr>
<tr>
<td><strong>Public funding for patient engagement infrastructure</strong></td>
<td></td>
</tr>
<tr>
<td>• A strong emphasis on patient and public engagement and significant public infrastructure supports public input at multiple entry points.</td>
<td>• Growing interest in patient/public engagement is fueled in part by recent legislative requirements. But existing structures and processes are not yet comparable to the forums for public engagement that are integral to the NHS England reforms.</td>
</tr>
<tr>
<td>• A national patient organization (Healthwatch England) is supported along with two different local citizen groups (local Healthwatch groups and the Health and Wellbeing Boards).</td>
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</table>
Conclusion

The jury is still out on whether England’s latest reform package will put the NHS on sturdy ground, both financially and clinically. When the process of passing the legislation was all said and done, the general reaction was “never again” – but, as Nicholas Timmins describes, with two very different meanings.

One “never again” group are adamant that the NHS never again “be subjected to such a car crash of policy making. One that has caused both its proponents and opponents within government huge political damage while creating an act that is, in many people’s eyes, a complex mess.”

Others take the view that the NHS is now structured such that ministers “could stand back from day-to-day involvement, with a duty to ‘promote autonomy’ among NHS organisations because this perfectly oiled machine would itself deliver better outcomes and better value for money. As a result, never again – or at least not for many years – would politicians need to fiddle with the structure. And if they did, they would have to legislate to do it.”

In terms of broader public opinion, judgment day for the NHS England reforms will come in the form of the next general election in April 2015. The consensus currently seems to be that the financial difficulties facing the NHS will supersede the finer points of transforming healthcare and that, yet again, the service will still be grappling with how to get the purchaser-provider equation right.

Ontario also faces financial pressures and will be challenged to reform its healthcare system to achieve better outcomes, improved patient experience and financial sustainability. The province’s Excellent Care for All Act provides the legislative framework for quality improvement and the Action Plan for Health Care provides a policy framework for patient-focused care. The emerging focus on quality improvement in primary care is a welcome development. But we need to get it right.

Quality improvement in primary care must be integrated with a performance measurement framework which is connected and aligned with performance measurement for the broader healthcare system. We need an overarching quality outcomes framework with an integrated, cascading set of measures. Ontario can learn from England’s experience with the NHS Mandate, its closely linked Outcomes Framework, and the integration of performance measurement with payment.

We can also learn from the NHS England’s experience with patient and public engagement. They have a history of involving patients, informal caregivers and the public in the development of healthcare guidance and quality standards, and the Health and Social Care Act provides additional opportunities for patients and families to express their views about their healthcare system. However, in community engagement, the type of engagement envisioned is as important as the structures and processes that support it. Providing input and advice can be quite different than shared decision-making. In all healthcare systems, there is huge potential for patients, informal caregivers and the public to broaden the impact of quality improvement.
Appendices

Appendix A. Our Programme for Government (section on the NHS)

In May 2010 the UK’s new governing coalition released Our Programme for Government, its detailed plans for key policy areas. Following is the section on healthcare and the NHS:

The Government believes that the NHS is an important expression of our national values. We are committed to an NHS that is free at the point of use and available to everyone based on need, not the ability to pay. We want to free NHS staff from political micromanagement, increase democratic participation in the NHS and make the NHS more accountable to the patients that it serves. That way we will drive up standards, support professional responsibility, deliver better value for money and create a healthier nation.

• We will guarantee that health spending increases in real terms in each year of the Parliament, while recognizing the impact this decision will have on other departments.

• We will stop the top-down reorganizations of the NHS that have got in the way of patient care. We are committed to reducing duplication and the resources spent on administration, and diverting these resources back to front-line care.

• We will significantly cut the number of health quangos [quasi-autonomous non-governmental organisations].

• We will cut the cost of NHS administration by a third and transfer resources to support doctors and nurses on the front line.

• We will stop the centrally dictated closure of A&E [accident and emergency] and maternity wards, so that people have better access to local services.

• We will strengthen the power of GPs as patients’ expert guides through the health system by enabling them to commission care on their behalf.

• We will ensure that there is a stronger voice for patients locally through directly elected individuals on the boards of their local primary care trust (PCT). The remainder of the PCT’s board will be appointed by the relevant local authority or authorities, and the Chief Executive and principal officers will be appointed by the Secretary of State on the advice of the new independent NHS board. This will ensure the right balance between locally accountable individuals and technical expertise.

• The local PCT will act as a champion for patients and commission those residual services that are best undertaken at a wider level, rather than directly by GPs. It will also take responsibility for improving public health for people in their area, working closely with the local authority and other local organisations.

• If a local authority has concerns about a significant proposed closure of local services, for example an A&E department, it will have the right to challenge health organizations, and refer the case to the Independent Reconfiguration Panel. The Panel would then provide advice to the Secretary of State for Health.

• We will give every patient the right to choose to register with the GP they want, without being restricted by where they live.

• We will develop a 24/7 urgent care service in every area of England, including GP out-of-hours services, and ensure every patient can access a local GP. We will make care more accessible by introducing a single number for every kind of urgent care and by using technology to help people communicate with their doctors.
• We will renegotiate the GP contract and incentivise ways of improving access to primary care in disadvantaged areas.

• We will make the NHS work better by extending best practice on improving discharge from hospital, maximising the number of day care operations, reducing delays prior to operations, and where possible enabling community access to care and treatments.

• We will help elderly people live at home for longer through solutions such as home adaptations and community support programmes.

• We will prioritise dementia research within the health research and development budget.

• We will seek to stop foreign healthcare professionals working in the NHS unless they have passed robust language and competence tests.

• Doctors and nurses need to be able to use their professional judgement about what is right for patients and we will support this by giving front-line staff more control of their working environment.

• We will strengthen the role of the Care Quality Commission so it becomes an effective quality inspectorate. We will develop Monitor into an economic regulator that will oversee aspects of access, competition and price-setting in the NHS.

• We will establish an independent NHS board to allocate resources and provide commissioning guidelines.

• We will enable patients to rate hospitals and doctors according to the quality of care they received, and we will require hospitals to be open about mistakes and always tell patients if something has gone wrong.

• We will measure our success on the health results that really matter – such as improving cancer and stroke survival rates or reducing hospital infections.

• We will publish detailed data about the performance of healthcare providers online, so everyone will know who is providing a good service and who is falling behind.

• We will put patients in charge of making decisions about their care, including control of their health records.

• We will create a Cancer Drugs Fund to enable patients to access the cancer drugs their doctors think will help them, paid for using money saved by the NHS through our pledge to stop the rise in Employer National Insurance contributions from April 2011.

• We will reform NICE and move to a system of value-based pricing, so that all patients can access the drugs and treatments their doctors think they need.

• We will introduce a new dentistry contract that will focus on achieving dental health and increasing access to NHS dentistry with an additional focus on the oral health of schoolchildren.

• We will provide £10 million a year beyond 2011 from within the budget of the Department of Health to support children’s hospices in their vital work. And so that proper support for the most sick children and adults can continue in the setting of their choice, we will introduce a new per-patient funding system for all hospices and providers of palliative care.

• We will encourage NHS organizations to work better with their local police forces to clamp down on anyone who is aggressive and abusive to staff.

• We are committed to the continuous improvement of the quality of services to patients, and to achieving this through much greater involvement of independent and voluntary providers.

• We will give every patient the power to choose any healthcare provider that meets NHS standards, within NHS prices. This includes independent, voluntary and community sector providers.
Appendix B. NHS Outcomes Framework 2013/14

1. Preventing people from dying prematurely

**Overarching Indicators**
- 1a. Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare
- 1b. Life expectancy at 75
- 1c. Males
- 1d. Females

**Improvement Areas**
- Reducing premature mortality from the major causes of death
  - 1.1 Under 75 mortality rate from cardiovascular disease*
  - 1.2 Under 75 mortality rate from respiratory disease*
  - 1.3 Under 75 mortality rate from liver disease*
  - 1.4 Under 75 mortality rate from cancer*
- One-and-a-half-year survival from all cancers
- One-and-a-half-year survival from breast, lung and colorectal cancers

**Improvement Areas**
- Reducing premature death in people with serious mental illness
  - 1.5 Excess under 75 mortality rate in adults with serious mental illness*
- Reducing deaths in babies and young children
  - 1.6 Infant mortality*
  - 1.7 Neonatal mortality and stillbirths
  - 1.8 Five-year survival from all cancers in children

**Improvement Areas**
- Reducing premature death in people with a learning disability
  - 1.7 Excess under 60 mortality rate in adults with a learning disability

2. Enhancing quality of life for people with long-term conditions

**Overarching Indicator**
- 2 Health-related quality of life for people with long-term conditions**

**Improvement Areas**
- Improving functional ability in people with long-term conditions
  - 2.1 Proportion of people feeling supported to manage their condition**
- Improving service responsiveness to patients’ personal needs
  - 2.2 Employment of people with long-term conditions**
- Improving the experience of care for people with mental illness
  - 2.3 Proportion of stroke patients reporting an improvement in mobility/walking ability at 30 and 120 days
  - 2.4 Proportion of people with mental illness feeling supported to manage their condition**
- Improving the experience of care for people with dementia
  - 2.5 Proportion of people with dementia*feeling supported to manage their condition**

Alignment across the Health and Social Care System

- * Indicator shared with Public Health Outcomes Framework
- ** Indicator complementary with Adult Social Care Outcomes Framework (ASCOF)
- *** Indicator shared with Adult Social Care Outcomes Framework
- **** Indicator complementary with Adult Social Care Outcomes Framework and Public Health Outcomes Framework

3. Helping people to recover from episodes of ill health or following injury

**Overarching Indicators**
- 3a. Emergency admissions for acute conditions that should not usually require hospital admission
- 3b. Emergency readmissions within 30 days of discharge from hospital*

**Improvement Areas**
- Improving outcomes from planned treatments
  - 3.1 Total health gain as assessed by patients for elective procedures
  - 3.2 Gastroenteritis
  - 3.3 Vomiting
  - 3.4 Psychological therapies
- Preventing lower respiratory tract infections (LRTI) in children from becoming serious
  - 3.5 Proportion of stroke patients recovering an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months
  - 3.6 Proportion of patients recovering to their previous levels of mobility/leaking ability at 130 and 120 days

4. Ensuring that people have a positive experience of care

**Overarching Indicators**
- 4a. Patient experience of primary care
  - 4b. GP Out of Hours services
  - 4c. NHS Dental Services
  - 4d. Patient experience of hospital care
  - 4e. Friends and family test

**Improvement Areas**
- Improving people’s experience of outpatient care
  - 4.1 Patient experience of outpatient services
- Improving hospitals’ responsiveness to personal needs
  - 4.2 Responsiveness to in-patients’ personal needs
- Improving people’s experience of accident and emergency services
  - 4.3 Patient experience of A&E services
  - 4.4 Access to GP services and 24/7 NHS dental services
- Improving women and their families’ experience of maternity services
  - 4.5 Women’s experience of maternity services
- Improving the experience of care for people at the end of their lives
  - 4.6 Bereaved carers’ views on the quality of care in the last 3 months of life
  - 4.7 Patient experience of community mental health services
- Improving children and young people’s experience of healthcare
  - 4.8 An indicator is under development

5. Treating and caring for people in a safe environment and protect them from avoidable harm

**Overarching Indicators**
- 5a. Patient safety incidents reported
  - 5b. Safety incidents involving severe harm or death
  - 5c. Hospital deaths attributable to problems in care

**Improvement Areas**
- Reducing the incidence of avoidable harm
  - 5.1 Incidence of hospital-acquired pressure ulcers (VTE)
  - 5.2 Incidence of healthcare-associated infection (HCAI)
  - 5.3 Incidence of newly-acquired category 2, 3 and 4 pressure ulcers
  - 5.4 Incidence of medication errors causing serious harm
- Improving the safety of maternity services
  - 5.5 Admission of full-term babies to neonatal care
- Delivering safe care to children in acute settings
  - 5.6 Incidence of harm to children due to ‘failure to monitor’

Appendix C. NHS Mandate Objectives

On 13 November 2012, the UK government released its first mandate for the new NHS Commissioning Board, setting out the ambitions for the health service for 2013 – 2015. That announcement laid out the following objectives for the NHS:

• improving standards of care and not just treatment, especially for the elderly

• better diagnosis, treatment and care for people with dementia

• better care for women during pregnancy, including a named midwife responsible for ensuring personalized, one-to-one care throughout pregnancy, childbirth and the postnatal period

• every patient will be able to give feedback on the quality of their care through the Friends and Family Test starting April 2013 – so patients will be able to tell which wards, A&E departments, maternity units and hospitals are providing the best care

• by 2015, everyone will be able to book their GP appointments online, order repeat prescriptions online and talk to their GP online

• putting mental health on an equal footing with physical health – this means everyone who needs mental health services having timely access to the best available treatment

• preventing premature deaths from the biggest killers

• by 2015, everyone should be able to find out how well their local NHS is providing the care they need, with the publication of the results it achieves for major services.
Endnotes

1 The UK Department of Health uses the term “social care” as an umbrella for services aimed at “enabling people to retain their independence, control and dignity.” Policy areas include care for chronic conditions, mental health, dementia, and end of life, among others.


3 The King’s Fund and Nuffield Trust each summarized and assessed the proposed reforms:


7 The NHS Constitution, produced under the previous Labour government, was designed to articulate the key values of the NHS, and the rights and responsibilities of patients, the public and staff.


13 Commissioners and providers must agree how to translate the national goals into improvement schemes at the local level.

14 The act gives Monitor and the NHS Commissioning Board power to regulate all pricing arrangements through the national tariff (fee schedule). The Commissioning Board is responsible for defining the services required and Monitor will design the methodology for pricing them.

15 CCGs and the Commissioning Board will decide where choice and competition are to be used. The rules will be incorporated into Monitor’s licensing process.


17 The following resources on the potential challenges in implementing the Health and Social Care Act can be found on The King’s Fund and Nuffield Trust websites:


33 Section 6 of Ontario’s Excellent Care for All Act requires healthcare organizations to have a patient relations process, make information about that process available to the public, and ensure that the process reflects the organization’s patient declaration of values.

34 The Change Foundation is undertaking a qualitative review of the functioning of patient and family advisory councils including interviews with staff responsible for the councils and patient and family representatives on the councils.


36 Patients will be asked the following question: How likely are you to recommend this service to your friends or family if they needed similar care or treatment?