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# Evidence scan

Do system levers impact  
on efforts to engage  
people in their care?

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## About this report

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This evidence scan was commissioned to support the Realising the Value programme.

It was undertaken by Dr Debra de Silva of the Evidence Centre in September 2015.

The evidence scan provides a rapid collation of empirical research about the topic. Although all of the evidence is sourced and compiled systematically, it is not a systematic reviews. It does not seek to summarise theoretical literature or to explore in any depth the concepts covered by the scan or those arising from it

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# Key messages

This scan summarises research about the impact of macro-level or system levers on efforts to engage people in managing their own health and care.

## Identifying research

Health and social care services are striving to provide more person-centred care. A key component of this involves engaging people in managing their own health and care. This evidence scan explored research about the potential impact of national levers and system-level incentives on efforts to engage people in their care.

Ten bibliographic databases were searched for journal articles from England published between January 2000 and September 2015. Findings from **68 studies were summarised**.

Most research focused on the following levers:

- Policies and guidelines
- Payment by results
- Public health campaigns

Many other studies were available about levers such as targets, laws, payment approaches, revalidation and policies relating to premises, but these did not examine the impacts of these levers on engaging people in their own care.

## Key levers

A key finding is that very little empirical research has been published about the direct impacts of system levers on supporting self-management and engagement in England. Policies and regulations may be cited as facilitators or barriers for commissioners and providers, but there is little research to support this.

The greatest quantity of relevant research focused on **public health campaigns**. Such campaigns may impact on people’s health behaviours and encourage greater self-care. **Nationally supported** patient education programmes were also found to be useful, though evidence was sparser.

Studies have explored the value of specific **policies and payment by results**, but almost none of this research found that these levers improved efforts to engage people in their care. In fact some levers were found to have the opposite effect.

### Impact of levers on engaging in own health

Levers	Studies that found benefit
Public health campaigns	22 of 29 studies
Nationally supported patient education	4 of 4 studies
Policies and guidelines	1 of 16 studies
Payment by results	0 of 11 studies

# System levers

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This section defines what we mean by system levers and outlines the approach used to collate research about the potential impacts of these levers.

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## Background

Efforts are underway in the UK and elsewhere to build more person-centred health and social care systems. A number of policies, regulations and macro system-level approaches have been implemented to support person-centred care. However, the extent to which such levers facilitate or act as barriers at the front line remains uncertain.

As one component of facilitating more person-centred care, the Health Foundation wanted to understand what was known about whether system levers helped or hindered efforts to involve people with long-term conditions in their own care.

A rapid scan of empirical literature was conducted, focusing on the following question:

- What research evidence is there about the impact (either positive or negative) of macro levers and incentives on efforts to implement and spread approaches to engaging people with long-term conditions in managing their own health and care?

## Focus – potential system levers

System levers are macro-level mechanisms to support and drive change in systems of care. The Health Foundation defined the items below as potential system levers. It is possible to debate whether initiatives such as campaigns and national patient education programmes are system levers, but the Health Foundation wished to take a broad view. The focus was on national system levers in England, including:

- **policy priorities** such as waiting time targets, choice and patient education
- **regulations** about volunteering, regeneration, training, revalidation and the use of NHS premises
- **commissioning** approaches
- **payment systems** such as tariff-based payments, capitation, Commissioning for Quality and Innovation payments (CQUIN) and the Quality and Outcomes Framework (QOF)
- **personal health budgets**
- **public health campaigns**
- **performance management** such as mandatory inspection and audit

## Approach

To identify the potential impacts of system levers, readily available research was compiled. To be eligible for inclusion, studies needed to examine the impact of one of the system levers identified on page 5 on efforts to engage people in their own health or care; include empirical data; be published in a print or online journal between January 2000 and September 2015; and focus on England.

Two reviewers independently searched 10 bibliographic databases for studies of any design. The databases were CINAHL, the Cochrane Library and Controlled Trials Register, EMBASE, Google Scholar, Health Systems Evidence, Mendeley, PsychInfo, Pubmed/Medline, Scopus and Web of Science. Search terms included: person-centred, self-management, engagement, shared decisions, wellbeing, macro, systems, lever, driver, policy, regulations, volunteering, commissioning, purchasing, mandatory, revalidation, payments, payment by results, QOF, tariff, health budgets, financial, penalty, target, awards, contract, CQUIN, regeneration, training, constitution, restrictions, premises, campaign, performance management, audit, workforce, planning, constraints, long-term conditions, UK and similes.

The reference lists of identified studies were examined for further citations. In addition, experts in the field and authors of relevant studies were contacted.

Abstract and title searches and suggestions from experts identified more than 2,000 articles. These were scanned for relevance. Most were not empirical studies or did not focus on the outcome of interest so were excluded from the scan.

**Sixty-eight studies were included.** All were non-randomised. Other studies were used to provide contextual information.

Findings were extracted from all studies using a template and results were summarised narratively. Findings were grouped according to the main types of levers identified.

**All of the evidence was sourced and compiled systematically, but the scan is not a systematic review and did not seek to summarise every study.**

The Health Foundation linked engaging people in their care with a more person-centred approach and so related terminology has been used throughout. It is acknowledged that active participation can occur in the absence of a more person-centred approach, so the two things are not necessarily interchangeable. The scan focused on whether system levers can support efforts to get people more actively involved in their care, but the Health Foundation was ultimately interested in this as an indicator of bringing about more collaborative care.

Most studies did not examine the impact of levers on efforts to engage people in self-care as a primary outcome. This was usually reported as a secondary outcome. An exception was in studies about public health campaigns where the focus was on engaging people in behaviour change.

When interpreting the findings, it is important to recognise that many other studies and non-empirical articles have focused on system levers. Only those explicitly exploring impacts on engaging people in their own health and care are summarised in the scan.

# Policies and guidelines

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This section summarises studies about the impact of policies and guidelines on efforts to involve people in their own health and care.

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## Policies

Research has explored the impact of health and welfare policies in England and the influence of the voluntary sector on such policies,<sup>1</sup> but most studies have not explicitly examined the impact of policies on engaging people in their own care.

A review of 131 studies, not all of which were from England, noted that policies to involve people in system-level planning have been implemented but the impact remains unclear.<sup>2</sup> This includes the impact of policies related to choice, waiting times for treatment and A&E waiting times, among others.<sup>3,4</sup>

A systematic review concluded that patients may make limited use of choice, unless provision is poor.<sup>5</sup> Other studies have noted that patient choice approaches such as Choose and Book have not been well implemented.<sup>6</sup>

Case studies conducted in all four countries of the UK suggested that policies relating to patient choice had not necessarily improved person-centred care. There was a lack of clarity in the options available, limited discussion about choices and tension between offering choice and managing waiting lists.<sup>7</sup>

Another study about choice in maternity care found no differences in psychological wellbeing depending on the extent of choice offered or the choices made.<sup>8</sup>

In another study, interviews with 48 people using NHS services suggested that patients were concerned about patient choice policies and the creation of quasi-markets.

*‘Some NHS users are exhibiting an ambivalent or anxious response to aspects of market reform such as patient choice, the use of targets and markets and the increasing presence of the private sector within the state healthcare sector. This has resulted in a sense that current reforms are distracting or preventing NHS staff from delivering quality of care and fail to embody the relationships of care that are felt to sustain the NHS as a progressive public institution.’<sup>9</sup>*

Some UK policies have sought to support people with health problems into paid work as a form of empowerment and to reduce joblessness.<sup>10</sup> A systematic review of UK ‘welfare to work’ policy initiatives included 16 studies; not all of these were from England. The review found mixed results and suggested that there were a number of implementation barriers.<sup>11</sup>

The scan found no other empirical research directly assessing the impact on engaging people in their care of policies such as waiting time targets, revalidation, premises usage and so on.

## Laws

Laws and regulations such as food labelling, advertising bans and public health regulations have mixed effects.<sup>12–15</sup>

For instance, a study about laws to prevent the sale of alcohol to people who are inebriated found that these laws did little to engage people in healthier behaviours and that prosecutions for selling alcohol were rare.<sup>16</sup>

## Guidelines

National service frameworks and official guidelines help to shape policy and practice in England. The National Institute for Health and Care Excellence (NICE) releases guidelines based on good practice. It is expected that commissioners and provider organisations will implement the guidelines, but this is not mandatory.

Research has explored the implementation of NICE guidelines in England, but most does not examine the impacts on efforts to engage people in their care.<sup>17,18</sup>

An exception is a study where focus groups explored the views of front-line primary care teams and managers about implementing NICE guidance. The teams viewed the principles of NICE guidelines positively, but believed they were sometimes difficult to implement in practice due to resource and practitioner barriers. Teams said that the guidelines could result in consultations that focused on ‘ticking boxes’. Not having enough time in consultations to engage people in discussions about self-management was identified as an issue.<sup>19</sup>

Another study interviewed GPs about specific prescribing guidelines. GPs said that they felt under pressure to meet clinical need while also adhering to guidelines to reduce the cost of prescribing. They felt that guidelines took a ‘one size fits all’ approach, rather than encouraging GPs to respond to and engage with patient perspectives of their condition and treatment.<sup>20</sup>

An important point is that guidelines are often released in tandem with other interventions such as financial incentives or educational programmes. It is thus difficult to examine the impacts of guidelines alone.

**Overall there is no evidence that policy and guideline levers have supported engaging people in their own care. If anything, some studies suggest that policies and guidelines can have negative impacts.**

# Payment levers

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This section summarises studies about the impact of payment levers on efforts to involve people in their own health and care.

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A number of studies have examined market-based reforms and payment levers.<sup>21,22</sup> A systematic review of financial incentives of various sorts found that payment for each service, episode or visit and payment for providing a pre-set level of service may influence care practices, but that such incentives have mixed effects.<sup>23</sup> In England, the most research has been published about payment by results schemes.

## Payment by results

### General practice

The Quality and Outcomes Framework (QOF) is a financial incentive scheme that rewards general practices for providing guidelines-based care. A number of studies have explored the impact of QOF, with mixed findings.<sup>24–26</sup>

For example, a systematic review of 11 studies found that QOF initially improved health outcomes for some people with long-term conditions but these improvements were not sustained. Adverse effects were reported for some sub-population groups so there may be issues with widening health inequalities.<sup>27</sup> Another systematic review of 27 studies suggested that QOF did not impact on equity, positively or negatively.<sup>28</sup>

Research generally suggests that QOF is associated with improved quality of documentation and care processes;<sup>29</sup> however, the extent to which this helps to engage people in their care remains uncertain.<sup>30</sup>

It could be argued that improved provision of primary or secondary preventive care, such as smoking cessation support or better blood pressure control, is a form of engagement. Even so, the benefits associated with QOF in this regard are mixed, with some studies finding benefits<sup>31</sup> and others not.<sup>32</sup>

More localised payment by results schemes for primary care have been tested in England, including local enhanced services.<sup>33,34</sup> Again, there are mixed results. One study found no evidence of increased practitioner ownership or motivation towards a localised scheme and little change in care processes.<sup>35</sup> Another found more prioritising of preventive care, but did not comment on whether this impacted on engagement of service users.<sup>36</sup>

Another study found mixed impacts on care processes from a local enhanced service payment by results scheme for diabetes. Some outcomes improved compared to practices not taking part in the scheme, but there were no reported impacts on efforts to engage people in their own care.<sup>37</sup>

Other studies suggest that payment for results in primary care may be detrimental to engaging people in their care.<sup>38</sup> For example, one study followed people with long-term conditions for three months and recorded their primary care consultations. The researchers suggested that the target-driven approach of QOF undermined people's involvement.

*'Routine review consultations in primary care focus on the biomedical agenda set by QOF where the practitioner is the expert, and the patient agenda unheard. Review consultations shape patients' expectations of future*

*care and socialise patients into becoming passive subjects of ‘surveillance’. Patient needs outside the narrow protocol of the review are made invisible by the process of review.’<sup>39</sup>*

Interviews with GPs and practice nurses have also suggested that QOF moves the focus away from patient-led consultations and listening to patients’ concerns. Loss of patient choice was also described.<sup>40</sup>

Another study found that QOF did not reward practices that offered good patient access or other processes that may be associated with increased engagement.<sup>41</sup>

Interviews with 52 people with long-term conditions found that most people had not heard of QOF or noticed any changes after its introduction. Where changes were noted, these focused on health checks and increased use of computers. However, some patients raised concerns about incentivising ‘basic’ processes and the potential for unintended consequences such as a reduced focus on non-incentivised aspects of care.<sup>42</sup>

### Other care

Other payment by results approaches have been researched, with mixed findings. It is important to re-emphasise that the focus here is on research about the effects on engaging people in their care, not on other outcomes of payment by results, which have also been researched.<sup>43</sup>

A study of the first year of the ‘Payment by Results for Drugs Recovery’ pilot compared changes over time in eight commissioning areas taking part in the programme versus all 141 other commissioning areas in England. The programme linked provider payments to performance indicators for drug misuse treatment and recovery. Following the introduction of the scheme, people treated in pilot areas were **less** likely to complete treatment and **more** likely to decline to continue with treatment compared with those in other areas.<sup>44</sup>

Some researchers suggest that payment by results tariffs do not encourage providers to change their practice, but Commissioning for Quality and Innovation (CQUIN) targets and best practice tariffs may motivate changes in practice. In short, incentives based on improving ‘profit margins’ may have less impact on service delivery than incentives that provide an additional direct payment, even if this extra financial support is relatively small. However, these studies have not explored the impact of such changes on efforts to involve people in their care.<sup>45</sup>

Other research highlights that there may be contradictions between the ‘payment by volume system’ of health care resource groups and the ‘payment by results’ system of CQUINs.<sup>46</sup>

Some research suggests that the impact of payment by results, contracting and other financial levers depends on local context, the organisational culture of providers and the relationship they have with commissioners and other key stakeholders.<sup>47,48</sup> Payment mechanisms alone may not support efforts for engaging people in their care, but may be one component of a broader toolkit that is used depending on the culture and priorities of providers and commissioning organisations.

### Fee for service payments

A systematic review of six studies, some from England and some from elsewhere, explored the impact of payment systems on GP behaviours. The review found that fee-for-service payments were associated with a greater quantity of primary care services provided than capitations were. Fee-for-service models resulted in more patient visits, greater continuity of care, higher compliance with the recommended number of visits, but lower patient satisfaction with access to a doctor compared with salary payments.<sup>49</sup> These findings are not necessarily focused on efforts to engage people in their health and care, but have some applicability.

Research is also available about capitation, fee-for-service payments and payment by results for other types of care, such as dental care.<sup>50</sup> However, the impact of these approaches on efforts to engage people in their own care has not been explored.

## Other mechanisms

### Contracts

The general medical services contract, contracts for dentists and other mechanisms for reimbursing primary care professionals are system levers. Studies have explored the impact and rationale for contracts and payment approaches but have not directly examined the impact on efforts to engage people in their own care.<sup>51-56</sup>

### Primary care fundholding

Research has also explored the benefits of primary care fundholding, whereby general practices purchase services on behalf of their patients. While other impacts have been noted,<sup>57</sup> this approach was not associated with improved engagement of people in their own care.<sup>58</sup>

**Overall there is no evidence that payment levers have supported engaging people in their own care. If anything, some studies suggest that payment levers can have negative impacts.**

# Campaigns

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This section summarises studies about the impact of public health campaigns on efforts to involve people in their own health and care.

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The Health Foundation defined public health campaigns as a system lever that may impact on engaging and ‘activating’ people.

A wide range of educational and promotional campaigns have been implemented in England to engage people in healthy behaviours or help them recognise the symptoms of conditions.<sup>59–63</sup>

Campaigns to improve recognition of conditions such as stroke and cancer; improve physical activity and immunisation levels; reduce stigma of mental health; and reduce salt intake, sun exposure and smoking have all been found to impact on people’s engagement in their own wellbeing.<sup>64–78</sup>

For example, a study found that televised anti-smoking messages increased the number of calls to NHS smoking cessation services.<sup>79</sup>

A national salt reduction campaign was associated with significantly less use of salt.<sup>80–82</sup> The five-a-day campaign to increase intake of fruit and vegetables has also been found to be effective.<sup>83</sup>

Mandatory Baby Friendly Initiative training for health visitors and nursery nurses was implemented to support breastfeeding. Research suggests that training in the community impacted on the attitudes and behaviours of both health professionals and parents.<sup>84</sup> Mothers who gave birth in Baby Friendly accredited units were more likely to start breastfeeding than those in other units.<sup>85</sup>

Not all campaigns are associated with benefits. For example, some cancer awareness campaigns were found to significantly increase resource use for the ‘worried well’ with no change in the number of people diagnosed with cancer and no increase in survival rates.<sup>86–90</sup>

Other campaigns, including the large Change4Life campaign, were found to increase awareness but not necessarily impact on behaviour.<sup>91,92</sup>

**Overall there is some evidence that public health campaigns can raise awareness and motivate people to engage in their care.**

# Other levers

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This section summarises studies about the impact of other levers on efforts to involve people in their own health and care.

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## Restructuring

Organisational mergers or restructuring may occur due to the policy context or market mechanisms. While there have been studies of health care mergers in England, these have not explored the effects on efforts to engage people in self-care.<sup>93</sup>

There are plans to widen patient choice by removing primary care practice boundaries. This will mean a type of restructuring, whereby practices accept people for registration outside current geographic boundaries. A pilot study found that patients were positive about this, but it did not improve engagement in their health and care.<sup>94</sup>

## Third sector involvement

A systematic review of five studies from the UK and elsewhere explored the potential of social enterprise to improve health and wellbeing. Social enterprise was defined as the component of the third sector engaged in trading. The review found some limited evidence that social enterprise activity can impact positively on mental health, self-reliance, self-esteem and health behaviours and can build social capital.<sup>95</sup>

On the other hand, a case study in England analysed how one third sector organisation provided an advocacy and support function alongside the NHS. It suggested that the third sector had been co-opted into NHS ways of working rather than being able to effectively champion patient engagement.

*‘Rather than prioritising wider stakeholders’ views in the design and delivery of public services, placing third sector organisations at the centre of governance networks may do more to co-opt these organisations in reproducing predominant priorities.’<sup>96</sup>*

## Patient involvement

A systematic review of studies of patient and public involvement activities described how people can be involved in shaping health care, but the overall impacts were uncertain.<sup>97</sup>

A case study about an NHS foundation trust found mixed evidence about whether public involvement in decision-making occurred or impacted on wider levels of engagement.<sup>98</sup>

## Education

A number of nationally supported or mandated patient education programmes have been implemented in England.<sup>99</sup> For instance, the Expert Patients Programme is a six-week course helping people with long-term conditions develop skills to manage their condition on a day-to-day basis. There are mixed results about the benefits of such approaches, but in general they are thought to be useful for engaging people in their own care.<sup>100,101</sup>

A review of 18 studies examining ways to support self-care for older people with long-term conditions in the UK concluded that nationally supported patient education programmes are often associated with improved self-efficacy, knowledge and physical functioning.<sup>102</sup>

Feedback from focus groups, interviews and observation of the Expert Patients Programme found that this approach had the potential to involve people at both an individual and a wider group level.

*'Whilst the policy emphasis has been on individual empowerment within the Expert Patients Programme, there is some evidence that it may be triggering a health consumer movement.'*<sup>103</sup>

It is important to note that this section does not comment on the impacts of patient education in general, only the impact of national policy drivers on specific types of patient education.

## Surveys

Patient-reported outcome measures, patient-reported experience measures and other tools may be used to help shape practice.<sup>104</sup> Where nationally mandated, these may be seen as a macro-level driver.

Research has explored the impact of national patient survey programmes on quality improvement. For instance, interviews with 24 patient survey leads from NHS hospitals found that benchmarking and repeating surveys over time helped to incorporate patient feedback into action planning. There was a perception that this supported organisational person-centred care. Barriers to use included difficulty engaging clinicians in using the results due to scepticism, lack of knowledge about ways to use the results to support change and lack of specificity to departments or smaller units.<sup>105</sup>

## Improvement tools

Nationally mandated improvement tools have also been introduced. For example, the NHS has introduced the NHS Safety Thermometer using the CQUIN scheme. Providers of NHS care that measure four common harms with the Safety Thermometer on one day each month receive a financial reward. There are further incentives offered for achieving improvement goals in subsequent years. This is an example of multiple system levers being used simultaneously: a measurement tool plus financial incentives. It is difficult to distinguish the relative contribution of the different levers. Studies have documented changes in care processes as a result of these levers,<sup>106</sup> but research has not explored whether this impacts on efforts to involve people in their care.

**Overall there is little robust evidence about other levers that may impact on efforts to engage people in their care. Nationally supported patient education programmes have been found to have some effect.**

# Summary

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There is little research exploring direct links between system levers and efforts to engage people in their own health and care, but approaches that target people directly may have merit.

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In England many policies and regulations have been implemented to support person-centred care, which includes engaging people in their care. These include policies designed to increase people's choice about the place of elective hospital care; encourage competition among public and private providers; improve responsiveness and efficiency; and provide financial incentives.

However, research evidence about the effectiveness of these system levers is sparse, at least on engaging people in their care. This is not to say that system levers do not act as facilitators or barriers, but rather that there is little empirical research documenting the impacts.

There is very little specific literature about the direct impacts of system levers, and what is available is of variable and often poor quality. Few firm conclusions can be drawn, but this in itself is an important finding. It remains uncertain how system levers might promote or hold back aspirations to develop more person-centred approaches to care, in particular ways to engage people in their own health and care.

Page 5 of this document lists the range of system levers that the Health Foundation is interested in. The scan searched for evidence about all of these – but for many, no relevant empirical evidence was identified. These include revalidation, performance measurement regimes, personal health budgets, waiting time policies and initiatives which may impact on clinical behaviours. The fact that evidence about these levers is not described does not mean that they were omitted; it means that no relevant evidence was identified. To be clear, there are studies published about these things, but not focused on the impact on supporting people to be involved in their own health and care.

When interpreting the findings, it is important to emphasise that the scan focused solely on England. Research is available about system levers from other parts of the UK and internationally. The Health Foundation wanted to ensure findings were relevant to England and thus excluded this material. While health systems differ in other parts of the world, this means that evidence about potential links was not explored more exhaustively.

One study elicited feedback from 90 senior stakeholders from the UK and elsewhere about meso-level factors shaping self-management. The researchers found that stakeholders believed that political decision-makers, the socio-economic and policy environment, and the ethos and delivery of health care systems all shaped efforts to engage people in their care.<sup>107</sup> However, this scan has found that there is little empirical research about these system levers.

Research from England has most commonly focused on:

- public health campaigns
- policies and regulations
- payment approaches, including financial reward schemes

Table 1 summarises the number of studies that have linked these levers to engaging people in their care.

The most evidence is available about the impact of public health campaigns on efforts to involve people in their care. Research suggests that such campaigns can motivate people to be more engaged and that this can have a direct effect on wellbeing.

There is some evidence about the impact of payment approaches, particularly payment by results, on efforts to involve people in their care. However, here research tends to suggest that QOF may lead to ‘box ticking’ rather than increasing engagement.

There is little evidence about the impact of policies and regulation on efforts to involve people in their care.

**Table 1: Number of studies that found a benefit of involving people in care**

Levers	Studies
Campaigns	22 of 29
National patient education programmes	4 of 4
National patient surveys	1 of 1
Policies and guidelines	1 of 16
Fee for service payments	1 of 1
Payment by results	0 of 11
GP fundholding	0 of 1
Third sector involvement	1 of 2
Public involvement initiatives	0 of 2
Removing practice registration areas	0 of 1

Evaluations of policies on care planning for people with long-term conditions, personal health budget pilots, the CQUIN framework and NHS cultural change have been completed, but are not necessarily published as journal articles. These evaluations suggest mixed impacts. Personal health budgets have been found to support improved involvement in care to some extent, but CQUIN and care planning for people with long-term conditions have not.<sup>108</sup>

Interestingly, levers that target people with long-term conditions directly (campaigns and nationally mandated education) have more evidence of impacting on self-management and engagement than levers that target clinicians and organisations (payment by results and regulations).

This is not to say that campaigns are more effective than other levers, as no comparative research exists. It is also true that regulations, payment by results and other levers are set up to achieve multiple objectives, not merely engaging people in their own care. Therefore the relative success of system levers cannot be judged on this outcome alone. Nonetheless, the amount of research about the effectiveness of campaigns in England does suggest that levers that directly target people to get involved may be worthwhile.

Apart from QOF, the scan did not find evidence that particular levers get in the way of engaging people in their own care, though that does not mean that this is not the case. Anecdotal evidence suggests that commissioners and provider organisations note competing priorities and systems drivers that may not always support person-centred care. Further exploration of how organisations and professionals navigate different system levers and which are prioritised may increase understanding of the trade-offs needed in practice.

The scan focused on the impact of system levers on people’s willingness and ability to engage in their own care. Professionals are crucial to this as they need to a) understand the value of people being active participants in their care, b) want to practice in this way and c) have the skills to do so. The scan did not examine whether system levers have been found to impact on professionals’ mindsets, capacity or capability to engage people in their care, but this is acknowledged as an important area of enquiry.

An implication of the scan is the need for more direct evaluation of the impact of system levers on engaging people in their care and the broader contextual and professional aspects that may contribute to this. Person-centred care, supporting self-management and integration are at the heart of priorities for the NHS so it is essential that robust strategies are put in place to track the impact of related policy and practice.

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