Department of Health

Our NHS care objectives

A draft mandate to the NHS Commissioning Board

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Our NHS care objectives

A draft mandate to the NHS Commissioning Board

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Annexes

Consultation questions

There are twelve consultation questions in this draft mandate (these are also listed in the accompanying consultation document), five of which are overarching:

1. Will the mandate drive a culture which puts patients at the heart of everything the NHS does?

2. Do you agree with the overall approach to the draft mandate and the way the mandate is structured?

3. Are the objectives right? Could they be simplified and/or reduced in number; are there objectives missing? Do they reflect the over-arching goals of NHS commissioning?

4. What is the best way of assessing progress against the mandate, and how can other people or organisations best contribute to this?

5. Do you have views now about how the mandate should develop in future years?

1. The strategic context

The challenges facing the health and social care system

1.1 As a nation, we are living longer. Over the last 30 years, life expectancy has risen significantly, and deaths from major causes of mortality such as heart disease have fallen. However, there is room for further improvement. Compared with other countries we continue to perform poorly in some key areas, including rates of premature mortality for women, reducing ill health from conditions related to obesity, and the treatment of some cancers. There are also persistent inequalities in life expectancy and healthy life expectancy between communities: a challenge that is common to most countries.

1.2 Demographic change and changes in disease patterns will continue to increase the demands on the health and care system. An ageing population will mean rising numbers of frail older people, and of people living with one or more long-term conditions, such as dementia. Several major diseases are also expected to become more common, in part reflecting lifestyle changes. For example, higher rates of obesity and alcohol consumption are leading to an increase in the incidence of diabetes, arthritis and chronic liver disease. Poor mental health is also responsible for a high proportion of ill health, and prevalence has continued to rise. Stronger public health interventions are planned, but they are unlikely to arrest these trends dramatically in the near term.

1.3 Meanwhile, because of the wider economic and fiscal position, the NHS is facing one of the tightest funding settlements in its history. This Government has protected the NHS budget and is continuing to increase it in real terms. But simply doing the same things in the same way will no longer be affordable in future.

1.4 It will be vital to continue to focus on the urgent and pressing challenges faced by the health service: helping people to stay well for as long as possible, harnessing new ways of delivering care, and managing resources well, in order to continue to deliver safe, effective and compassionate care.

The Government's vision for the NHS

1.5 This Government's vision is of an NHS which promotes health and wellbeing; which is genuinely centred on patients and carers; which is evidence-based and innovative; which achieves quality and outcomes that are among the best in the world; which refuses to tolerate substandard and unsafe care; which is open and transparent, and shares learning; and which eliminates discrimination and reduces inequalities in care.

1.6 In order to achieve this vision, the Government is putting clinicians in the driving seat and enabling healthcare providers to steer improvements in quality. These reforms will shift decision-making as close to patients as possible, devolving the power and responsibility for the commissioning of safe, high quality health services to local health professionals, working with local partners. The Government's aim is that this will result in services that are more innovative and more responsive to patients and carers.

1.7 The NHS is being liberated from day-to-day top-down interference in its operational management. The creation of an autonomous and accountable NHS Commissioning Board is a key component of the modernised NHS. This, the first mandate to the Board, sets out the Government's objectives for the Board.[1]

1.8 The Mandate is a multi-year document: this Mandate sets objectives for the period from April 2013 to March 2015, and will set ambitions for improving outcomes over five and ten years. It will be revised each year to ensure it remains up to date, but the Government's intention is that objectives will roll forward until they have been achieved. This will provide continuity for the NHS commissioning system, while recognising that many outcomes may take several years to deliver.

1.9 To reinforce this continuity, the mandate may only be changed in-year in certain circumstances: by agreement with the Board, if there is a general election, or in exceptional circumstances. Any changes would have to be reported and explained to Parliament.

Accountability of the NHS Commissioning Board

1.10 Through the Health and Social Care Act 2012 the Government made clear its commitment to the founding principles of the NHS – that it should be a comprehensive service free at the point of use, based on need, not ability to pay, and funded from general taxation. The Secretary of State's duty to promote a comprehensive health service remains unchanged in legislation, as it has since the founding NHS Act 1946.

1.11 The 2012 Act makes clear that the Secretary of State remains ultimately accountable for the health service. The Secretary of State, through the Department of Health, will provide strategic direction for and stewardship of the NHS, holding all of the national bodies to account for their operational and financial performance, and ensuring that the different parts of the system work properly. The Secretary of State will hold the Board to account – including through this mandate, which forms part of

1 The NHS Commissioning Board will be established on 1 October 2012. The NHS Commissioning Board Authority, a Special Health Authority set up to prepare for the establishment of the Board, is being abolished at the same time as the Board is created.

a transparent system of accountability. The Secretary of State will also ensure strategic "fit" in relation to public health and social care.

1.12 Along with the Secretary of State, the Board has a matching duty to promote a comprehensive health service, except for those parts of the health service that relate to the Secretary of State's and local authorities' public health duties. This supports the principle enshrined in the NHS Constitution that the NHS provides a comprehensive service, available to all.

1.13 In support of its overarching duties and defined functions, the Board has cross-cutting duties in a number of areas, including duties relating to: promoting the autonomy of commissioners and health service providers; securing continuous improvement in the quality of health services; tackling health inequalities; promoting the involvement of patients and carers in decisions about care; promoting innovation in the provision of services; promoting research on health-related matters; enabling patients to make choices; and ensuring that services are provided in an integrated way, where that would improve outcomes or reduce inequalities. Annex C summarises the Board's statutory duties.

The NHS Commissioning Board as part of the health and social care system

1.14 The Board will operate as part of a wider system, of which the Department, on behalf of the Secretary of State, is the steward. The Board will need to form productive and enduring relationships with a wide range of organisations within and beyond the NHS. At national level, these include bodies such as the regulators, NICE, Public Health England, Health Education England and HealthWatch England. Locally, the Board will support and work with clinical commissioning groups (CCGs); and work together with Health and Wellbeing Boards; local authorities; and Local HealthWatch.

1.15 The Department will expect all of its arm's-length bodies, including the Board, to work effectively in collaboration: working to a shared set of underlying principles, values and a common purpose that always puts the needs of patients and the public centre stage. For example, we will expect the Board to share information and intelligence on both operational and financial performance with other bodies in the system, where appropriate to the exercise of their respective functions.

2. Improving our health and our healthcare

2.1 This Government's ambition is for an NHS which provides high quality, safe and effective care, treating patients with compassion, dignity and respect. The core role of the NHS Commissioning Board is to use the money it is given to help realise this ambition, through its general function of promoting a comprehensive health service, its support and stewardship of CCGs, and its own commissioning of services.

Better healthcare outcomes

2.2 The Government believes that the NHS should focus on achieving even better outcomes for patients, to improve health and healthcare for everyone, including NHS staff. The objectives in this mandate for improving the outcomes of healthcare are drawn from the indicators in the NHS Outcomes Framework, which provide an overview of the performance of the NHS (see Annex A). The Framework describes the outcomes that people care about most, grouped in five "domains":

- 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 people have a positive experience of care; and
- treating and caring for people in a safe environment and protecting them from avoidable harm.

2.3 The Framework includes 60 outcome indicators across the five domains, as a way of measuring progress and reporting on it transparently.

2.4 The choice of indicators reflects the challenges that the NHS will face in the future. In particular, as our population ages, rising numbers of people will be living with long-term conditions and multiple, complex healthcare problems.

2.5 To meet these challenges, the NHS will need to coordinate care more effectively around the needs of patients and carers, and to join up with social care, public health and other public services to ensure that services are seamless and no-one slips through the gaps. The NHS Outcomes Framework sits alongside similar Outcomes Frameworks for public health and adult social care. Many indicators are shared between the Frameworks in the key areas where the different services need to work together.

2.6 The quality of nursing plays a particularly important role in improving outcomes in all domains of the Framework, especially in ensuring that patients are treated safely and with dignity. With input from the Nursing and Care Quality Forum, the Government aims to support high standards of patient care, with nurses supported to deliver better care through a new emphasis on recruitment and training, and much greater power for ward and department sisters, charge nurses and community nurse leaders. Nurse leadership at every level in the NHS should be encouraged and supported.

2.7 Objectives 1-5 set out the Government's ambitions for progress on the five domains of the NHS Outcomes Framework. This draft mandate does not include actual levels of ambition against the Outcomes Framework; the Government intends to publish these in the final mandate, in the light of consultation responses and further analysis (see the technical annex on the NHS Outcomes Framework for details of our proposed approach).

Domain 1: Preventing people from dying prematurely

2.8 High quality care, whether for a common or a rare condition, can make the difference between life and death. In some areas, the NHS consistently provides care to the highest standards, but there is still room for improvement. This domain captures the role of the NHS in reducing the number of avoidable deaths, recognising the complementary role of public health organisations and of individuals in improving their own health. For example, the methodology for setting the level of ambition assumes that it is possible to halve the gap between cancer survival rates in England and those in the best performing countries by 2014/15. This will involve, working alongside Public Health England, delivering the commitment to save 5000 additional lives from cancer by 2014/15 as set out in *Improving Outcomes: a Strategy for Cancer*.[2]

- **Objective 1: Secure an additional X life years for the people of England, through the reduction of avoidable mortality, by 2015; X life years by 2018 and X life years by 2023.**

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

2.9 Today there are over 15 million people in England living with at least one long-term condition. This will increase to around 18 million by 2025/30. Seventy percent of NHS and social care funding is spent on caring for people with long-term conditions. This domain captures how well the NHS is supporting people with long-term conditions, and their carers, to live as normal a life as possible. Progress in this area is

2 Department of Health, 12 January 2011, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_123394.pdf

particularly challenging given increasing life expectancy and the growing number of people with more than one long-term condition; this will be reflected in the Government's expectations of improvement.

- **Objective 2: Increase the number of Quality Adjusted Life Years[3] for people in England with long term conditions to X by 2015; X by 2018; and X by 2023.**

Domain 3: Helping people to recover from episodes of ill-health or following injury

2.10 This domain captures the importance of helping people to recover as quickly as possible from illness or injuries. A fast recovery is not only good for patients, it is also good for the NHS – curable conditions can become more serious than they need to be if recovery is slow or limited, leading to an increase in the numbers of emergency hospital admissions. By supporting people to recover quickly, the NHS can also contribute towards wider goals – supporting the economy by helping people to stay in or return to employment.

2.11 This domain is particularly important for older people: a specific indicator measures how well the NHS helps people to recover independence after illness and injury, and indicators measure improvements in health resulting from elective procedures such as hip replacements, knee replacements and treatment for varicose veins.
The overarching indicators in this domain concern emergency admissions to hospitals – to improve performance for these indicators, it is important for health services to work closely with social care services.

- **Objective 3: Improve recovery from illness or injury through increasing the number of Quality Adjusted Life Years for NHS patients in England by X by 2015; X by 2018; and X by 2023.**

Domain 4: Ensuring that people have a positive experience of care

2.12 Compared with other aspects of care, the NHS scores poorly on being responsive to the patients and carers it serves. Patients and carers repeatedly report that they feel they have to fit around services, rather than services fitting around them. There is greater scope for the NHS to ensure that patient and carer experience is seen as being as important as patient safety and clinical effectiveness. This domain therefore reflects the importance of providing a positive experience of care, including treating patients with dignity and respect.

3 Quality Adjusted Life Years (QALYs) attempt to capture the importance of quality of life as well as the length of life. This means that increased quality of life will be reflected in the number of QALYs for people with long-term conditions, even if life is not extended.

2.13 The quality of services provided needs to be reflected not only in measurable outcomes of recovery, but also in the experiences of those cared for: whether they were treated as well as, or better than, they expected, and whether they would be happy for their family and friends, to be treated or cared for similarly.

2.14 Doctors, nurses, and other clinical and non-clinical NHS staff are well-placed to judge the quality of hospital care overall – we all want to know that staff at the hospital where we are treated would recommend it to someone they care about. Equally, it is important to know whether patients would recommend their hospital to friends and family as a high quality place to receive treatment and care. This "friends and families test" provides a good overview of improvements across the NHS Outcomes Framework, and the Government would like to see NHS commissioners using the insights it provides from both staff and patients, to tackle poor performance.

- **Objective 4: i) Increase the proportion of NHS patients in England who would rate their experience as "good" (an additional X patients by 2015); ii) increase the proportion [4] of patients who would recommend their hospital to a family member or friend as a high-quality place to receive treatment and care; iii) increase the proportion of doctors, nurses and other staff who would recommend their place of work to a family member or friend as a high-quality place to receive treatment and care; and iv) provide evidence that poor performance is being tackled where patients and/or staff say they would not recommend their hospital to family members or friends as a high-quality place to receive treatment and care.**

Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

2.15 People should expect to be treated in a safe and clean environment and to be protected from avoidable harm. This means getting the basics right – ensuring that the principle of "do no harm" is fully embedded in the NHS, and learning when things go wrong. There is a long history of efforts to embed patient safety more systematically in the NHS – issues of culture and behaviour need to continue to improve to ensure that patients in all care settings are always as safe as they should be.

2.16 Like domain 4, this domain is partly about treating patients with dignity and respect, underpinned by high-quality nursing care: reflected for example in the reduced

4 This is subject to establishing meaningful data and a baseline. The patient aspect of the "friends and family test" current only applies to acute inpatient and A&E services. We will be undertaking further work to establish the feasibility and costs of implementing it more widely.

incidence of new pressure ulcers in hospitals. This domain also reflects the importance of continuing the reduction in healthcare-acquired infections.

- **Objective 5: Improve patient safety, reducing Quality Adjusted Life Years lost to NHS patients in England through avoidable harm by X% by 2015; X% by 2018; and X% by 2023.**

2.17 In domain 5, it will be vital that the Board ensures significant improvements in both the comprehensiveness and accuracy of the reporting of safety incidents. The Board may want to explore the creation of a new National Statistic as a possible means of collecting more robust data on patient harm.

Maintaining progress across the Outcomes Framework

2.18 The NHS Outcomes Framework is an evidence-based way of measuring health outcomes. In this mandate, the Government has set objectives for each of the five domains of the Framework. On this approach, no particular clinical conditions or patient groups have been singled out, in order to avoid distorting clinical priorities. The domain-level objectives allow flexibility for the Board and CCGs to decide where to focus their efforts, based on local needs and local circumstances, as identified through joint strategic needs assessments. At the same time, the Board should ensure continued improvement of health outcomes as measured by the indicators in the Framework.[5]

- **Objective 6: Ensure continued improvement of health outcomes, as measured by the indicators in the NHS Outcomes Framework, in relation to baselines set out in the technical annex.**

Reducing inequalities and promoting equality

2.19 In order to make improvements in healthcare outcomes, the Board will need to focus on tackling health inequalities – including those attributable to social deprivation – and improving outcomes for people of all ages. The Government expects this to be a central priority for the Board, in line with its duty in the Health and Social Care Act 2012 to have regard to the need to reduce inequalities both in access to and the outcomes of healthcare.

2.20 There is currently an eight-year gap in life expectancy between men in the most and least deprived areas of England, and a six-year gap for women. The NHS has a key role in reducing this gap, and the mandate will set out an ambition for this work in

5 With the exception of indicators for which performance is currently declining or flat. For these indicators, the Government will expect to see performance improving against a projected trend, as set out in the technical annex.

relation to domain one. For domains two to five of the NHS Outcomes Framework, there is not yet a sufficiently detailed understanding of the drivers of inequalities to set specific ambitions for the Board, but the Government intends to set such ambitions in future mandates.

2.21 In the meantime, the Government expects the Board as far as possible to make progress towards reducing inequalities across all NHS Outcomes Framework indicators, and to work towards a greater understanding of what actions are effective in reducing health inequalities. The Board's statutory duty to have regard to the need to reduce health inequalities should be reflected in all its functions, including its approach to allocating resources to CCGs, and the Board will need to seek to secure equivalent access to NHS services relative to the burden of disease and disability.

2.22 The NHS cannot achieve world-class health outcomes for all without a particular focus on those who are disadvantaged, vulnerable or socially excluded. Those who have historically been under-served by the health service – for example those with learning disabilities, the homeless, and older people – must not be neglected. The Government's interim report on the failings at Winterbourne View private hospital demonstrates how seriously it takes the protection and care of vulnerable people with learning disabilities and autism.[6] While the Government's Inclusion Health programme provides a framework for addressing the health needs of those most vulnerable to poor health outcomes.[7]

2.23 The Board and CCG's legal duties about reducing health inequalities build on the existing duties of all public bodies in relation to promoting equality. For example, the NHS will need to comply with legislation about age discrimination in services, due to come into force in October 2012.[8]

- **Objective 7: Provide an assessment of progress in narrowing inequalities for all domains of the NHS Outcomes Framework, and work towards a greater understanding of effective interventions to narrow health inequalities.**
- **Objective 8: Ensure continuous improvement in reducing inequalities in life expectancy at birth (as measured by the Slope Index of Inequality[9]) through greater improvement in more disadvantaged communities.**

6 See http://www.dh.gov.uk/health/files/2012/06/Department-of-Health-Review-Winterbourne-View-Hospital-Interim-Report1.pdf

7 See http://webarchive.nationalarchives.gov.uk/+/http://www.cabinetoffice.gov.uk/media/346571/inclusion-health.pdf

8 See http://www.legislation.gov.uk/ukpga/2010/15/contents

9 The Slope Index of Inequality (SII) summarises social inequalities across a whole population in a single number, which represents the gap in health status (e.g. as measured by life expectancy) between the most and least deprived within the population. It is based on a statistical analysis of the relationship between the indicator and deprivation across the whole population.

Putting mental health on a par with physical health

2.24 At least one in four of us will experience a mental health problem at some point during our lifetimes and at any one time, one in six of us experience symptoms of mental illness – making this the largest single cause of disability in our society, and a key challenge for the Board. The indicators within the NHS Outcomes Framework reflect the equal importance of mental and physical health, and each domain captures important measures of progress for those with mental health problems. For example, in relation to domain one of the Framework, recent research has found that the life expectancy of people living with schizophrenia is fifteen to twenty years lower than that of the general population.[10]

2.25 The Department is committed to developing the NHS Outcomes Framework to improve the way it tracks outcomes, including recovery, for people with mental health problems. The Mental Health Strategy Implementation Framework[11] due to be published shortly sets the context for this work, focusing on supporting recovery for people with mental health problems, as well as promoting better mental health for all.

2.26 Objective 2 sets an ambition for improving the quality of life for people with long-term conditions. This reflects the importance of achieving better outcomes for people living with mental illness. For example, the level of ambition reflects the scope to achieve better outcomes for people with mental illness by extending the Improving Access to Psychological Therapies (IAPT) programme to children, young people and adults who would benefit. The Government has committed to fully rolling out the programme by 2014/15 so that at least 15% of those with relevant disorders can access services, with a recovery rate of at least 50% in fully established services.

2.27 Dementia is one of the biggest challenges we face today: one in three people over the age of 65 will develop dementia. This Government believes that the UK can be a world leader in dementia care and research, and the Prime Minister's Challenge on Dementia[12] aims to drive up the quality of care, focusing on three areas: improving health and care, creating dementia-friendly communities that understand how to help, and promoting better research.

2.28 For the NHS, the key goals are to improve diagnosis rates, and support and treatment for people with dementia. The placeholder indicator in the NHS Outcomes

10 Brown, S. Kim, M. Mitchell, C. and Inskip, H (2010) 'Twenty-five year mortality of a cohort with schizophrenia.' British Journal of Psychiatry; 196(2): 116-21.

11 See the Mental Health strategy, *No Health without mental health*, Department of Health, February 2011, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123766

12 Department of Health, March 2012, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_133176.pdf

Framework will measure quality of life for people with dementia, and a further indicator (to be published alongside the final mandate) will measure early diagnosis of people with dementia. The Government will be keen to ensure that improvements in the quality of life for patients with dementia are reflected in the ambition for the Board to improve the quality of life for people with long-term conditions.

2.29 Increased coordination between mental and physical health services will be essential to making progress. For example, improved physical healthcare is important for people with mental health problems; while many people with physical conditions would benefit from identification and treatment of mental health problems, and emotional and psychological support. This would require a culture change in the NHS but should both improve physical health and reduce overall NHS costs.

2.30 Promoting good mental health and intervening early, particularly in the crucial childhood and teenage years, can help to prevent mental illness from developing, and mitigate its effects when it does. This complements the actions the Government is taking in public health, to put new emphasis on improving mental health for all ages.

- **Objective 9: Develop a collaborative programme of action to achieve the ambition that mental health should be on a par with physical health.**

Developing the NHS Outcomes Framework

2.31 The NHS Outcomes Framework represents a breakthrough in the way the NHS will track progress on improving health outcomes for patients. The Department, working with the Board, will continue to develop and improve it over the coming years.

2.32 For example, further work is needed to track outcomes for those with mental health problems, as mentioned above, and for children.[13] There is also a need for better ways of capturing patients' and carers' experience of healthcare, including through the use of patient-reported outcome measures, and the extent to which they feel involved in decisions about healthcare – focusing particularly on patients' experience of integrated care and of choice. Because this is such an important aspect of NHS care, it is the focus of specific objectives in Chapter 3 which reflect the Government's aims for developing the NHS Outcomes Framework in future.

The NHS Constitution and service performance standards

2.33 The NHS Constitution brings together in one place the rights and responsibilities of NHS patients, the public and NHS staff, together with the values and principles of the

13 A children and young people's health outcomes report will be published shortly.

NHS.[14] The Board and CCGs have a legal duty to act with a view to securing that health services are provided in a way which promotes the NHS Constitution and to promote awareness of it among staff and the public. This is over and above the duty on all NHS bodies and providers to have regard to the Constitution.

2.34 The importance of treating patients and staff with dignity and respect touches on the very purpose of the health service described in the Constitution – to support people "at times of basic human need, when care and compassion are what matter most". This must include, for example, providing adequate nutrition, continence care, effective pain relief and compassionate communication, particularly for vulnerable and older people.

2.35 The Government wants to ensure that the NHS maintains its current high levels of performance, particularly while the new commissioning system is being implemented. Patients and the public expect high quality treatment from the NHS, but they also want to access services quickly, and to be treated with dignity and respect. This is not only clinically desirable, it is also an important way of ensuring that patients have a positive experience of care, which the Government believes is as important as clinical effectiveness and safety.

2.36 The Board will have a role in maintaining or improving performance on existing service standards – for example standards relating to maximum waiting times (for diagnostic, acute, secondary care and mental health services), and single sex accommodation – and in ensuring that patients and carers are offered the rights that they are entitled to, and that commitments are honoured under the NHS Constitution. These patient rights include the right to access services within certain maximum waiting times, and the right to drugs and treatments that have been recommended by NICE.

- **Objective 10: Uphold, and where possible, improve performance on the rights and pledges for patients in the NHS Constitution and on the service performance standards set out in Annex B.**

Improving health and preventing illness

2.37 The NHS has a vital role to play in improving the public's health, by helping us to stay healthy and independent and to avoid ill-health, as well as in treating us when we are sick. As the country's largest employer, the NHS can also make an important contribution by promoting the health of its own workforce.

14 See http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132961

2.38 Better prevention of illness will significantly contribute to better outcomes and reduced inequalities, while reducing long-term costs for the health service and for society as a whole.[15] The UK has one of the highest rates of obesity in the developed world – 61% of the adult population is either overweight or obese, resulting in a wider economic cost of around £16 billion a year.[16] Our ageing population makes it particularly important to tackle the causes of ill-health at every stage of life. The proportion of the population aged 65 and over will rise to an estimated 24% by 2046, from 14% in 2005. Early interventions for all ages will ensure that we remain as healthy as possible for as long as possible.

2.39 The NHS Future Forum's January 2012 report on public health[17] set out a clear case for changing the culture of the NHS so that healthcare professionals take every opportunity to talk to patients and carers about how to improve their health – making "every contact count". The Carers Strategy[18] also prioritises the early identification of carers and helping them to stay healthy.

2.40 The Government has welcomed the Future Forum's recommendation of a collaborative approach between Health Education England, Public Health England, the Board and professional bodies to promote the broader role of healthcare professionals.[19] This culture change will rely on collaboration and partnerships, particularly with Public Health England and Health and Wellbeing Boards, with the Board playing an important part.

- **Objective 11: Develop a collaborative programme of action (to commence by April 2014) to further the ambition that healthcare professionals throughout the NHS should take all appropriate opportunities to support people to improve their health.**

2.41 Besides the general role that the Board will play in embedding public health in NHS commissioning, the Board will be responsible for carrying out some specific public health functions on behalf of the Secretary of State for Health. These functions, and the funding granted to support them, will be set out in an agreement made under

15 Health England (2009). *Prioritising investments in preventative health*. Matrix Insight. Available at: http://help.matrixknowledge.com/page/Full-Report-Listing.aspx

16 See *Our Health and Wellbeing Today* (2010) and *A call to action on obesity in England* (2011)

17 *The NHS's role in the public's health: A report from the NHS Future Forum*, Department of Health, January 2012, available at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_132114.pdf

18 See http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122077

19 Government response to the NHS Future Forum's second report, Department of Health, January 2012. Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132075

section 7A of the National Health Service Act, which will be published alongside the final mandate.

2.42 The Agreement will include services such as immunisations, screening, and providing public health services for children aged 0-5 and for people in custody. It will also set out the Board's role in ensuring that there are an additional 4,200 health visitors by 2015, so that new families are supported to have the best possible start. The numbers of health visitors working with families will increase by just over 50%. One of the focuses of the new health visitor model is to ensure that all health visitors are able to identify and help women who need support with their emotional or mental health, including postnatal depression.

2.43 The Board will also have important public health responsibilities with regard to emergency preparedness and health protection. The Board has a power to facilitate a coordinated response to an emergency by CCGs and providers of NHS services, and a duty to take steps to ensure that CCGs and providers of NHS services are properly prepared for such events. It will be responsible for leading the NHS response (at an appropriate level) to any emergencies or health protection incidents which might affect service delivery. This might include ensuring that resources are available to address risks to health, for example through emergency vaccination campaigns. The Board will also play a part in local and regional emergency planning forums. This would include operational issues, such as pandemic influenza or prolonged severe weather events that threaten wider than local delivery of NHS services, as well as civil contingencies and emergencies.

Consultation questions

6. Do you agree that the mandate should be based around the NHS Outcomes Framework, and therefore avoid setting separate objectives for individual clinical conditions?

7. Is this the right way to set objectives for improving outcomes and tackling inequalities?

8. How could this approach develop in future mandates?

3. Putting patients first

3.1 The Government's vision is of an NHS that puts patients, carers and the public first, where shared decision-making – "no decision about me without me" – is the norm. All patients and carers should have the opportunities, information and support to take an active role in decisions about care and treatment. This is reflected in the Health and Social Care Act 2012, which will help give people more control over the care they receive. Similarly, the Care and Support White Paper, to be published shortly, sets out plans for better supporting people to make informed decisions, to be in control and to choose the care and support options that are best for them.

3.2 The Board will need to lead a renewed focus on patients' experience of their care, making patient experience genuinely as important as safety and clinical effectiveness. Patient feedback – including real-time feedback where possible, and use of complaints – is critical to ensure NHS commissioners identify poor performance and take swift action.

3.3 Compared with many other sectors, healthcare systems are in their infancy in putting the experience of the user first. They have barely started to realise the potential of patients as joint participants in their own care and recovery. The future challenges facing the NHS – an ageing population with more long-term conditions – call for care to become more personalised, supporting people to take an active role in managing their health conditions. Care plans – encompassing healthcare, social care and preventive care – should be available to all with long-term health needs. They should be developed and agreed with a named professional, to ensure that people feel in control of their own care, and know how to manage their condition and who they can go to when they need support.

3.4 As described in Chapter 2, the Government wants to develop the NHS Outcomes Framework so it better captures the experience of those who use the health service, the extent to which they feel genuinely empowered and involved in decisions about their care, and their view of their outcomes. In the meantime, the objectives in this chapter reflect the importance of shared decision-making and empowering patients.

Securing shared decision making

3.5 The NHS Commissioning Board and CCGs will play a valuable part in promoting shared decision-making in the services they commission. Genuine shared decision-making requires patients to be listened to at all times, and to have more opportunities to make choices about their care and treatment, with appropriate information and support from professionals. The Health and Social Care Act 2012 requires the Board

and CCGs to promote the involvement of patients and carers in decisions about their treatment and care, and to act with a view to enabling patients to make choices about their healthcare.

3.6 As one key way of ensuring patients are more involved in their care, the Government has committed to extending the range of choices available at every stage of patients' care: with more choices in primary care, before a diagnosis is made, when they are referred for specialist care and after a diagnosis. Choice should be about more than the current right to choose which hospital to go to when referred by a GP. Increasingly, people will have a choice of provider in other types of services, and be able to choose a lead clinician. Patients should also have choices over their treatment and the setting in which it is received. The Department recently published for consultation its detailed proposals to give patients more opportunities for choices about their care and treatment all along the patient pathway.[20]

3.7 These proposals take account of the recommendations of the NHS Future Forum in its report "*Choice and competition: Delivering Real Choice*".[21] In particular, that choice should be pursued where it is in patients' interests and not as an end in its own right.

3.8 Many people want greater clarity over when and how they can make choices about the services they use. As part of the "Open Public Services" agenda, the Government will publish "Choice Frameworks" for different public services setting out this information.[22] The draft Choice Framework for health services is published as annex D to this mandate. It summarises what choices patients can expect to be able to make and what they can do if they are not offered those choices.

3.9 Another way of offering people choice, and enabling shared decision-making, is through a personal health budget. As the NHS Future Forum highlighted, personal health budgets extend choice and can empower people to have even more control over their NHS-funded care. Subject to the results of the current pilot programme[23], the Government wants commissioners across the country to offer personal health budgets wherever appropriate, including the option of direct payments, and joint budgets across health, social care and other services.

20 Department of Health, 23 May 2012, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_134218.pdf

21 Department of Health, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_127541.pdf

22 http://www.openpublicservices.cabinetoffice.gov.uk/

23 The evaluation report for the pilot programme is due to be published in October 2012, in time for the publication of the final mandate.

3.10 Over time, the Government's aim is to create a right to ask for a personal health budget for all those who would benefit from one. This right would first apply from April 2014, to people receiving NHS Continuing Healthcare,[24] and to parents of children with special educational needs or disabilities, who will be able to ask for a personal budget based on a single assessment across health, social care and education.

- **Objective 12: Enable shared decision-making, and extend choice and control for NHS patients. This includes:**
  - **ensuring that commissioners support people to be involved in decisions about their care and treatment;**
  - **extending the availability of personal health budgets to anyone who might benefit; and**
  - **subject to the outcome of pilots during 2012/13, ensuring that patients are able to choose from a range of alternative providers if they either have waited, or are likely to wait, for more than 18 weeks after referral to start consultant-led treatment for a non-urgent condition.**

Integrating care around patients

3.11 We need a health and care system that is truly responsive to the needs of patients, carers and their families, and that delivers services designed around individuals, not organisations. People with long-term conditions and multiple complex needs, in particular, report too often that their interactions with the health and social care system feel confusing and poorly coordinated.

3.12 Greater integration involves recognising that healthcare outcomes are frequently interdependent, and that services must join up for those who use them. It is not necessarily achieved by combining organisations, but by designing services that respond to, and fit around, the needs and wishes of patients or care users. It involves promoting overall well-being; focusing on mental as well as physical health; and preventing illness or dependency rather than focusing solely on treatment.

24 NHS continuing healthcare is a package of continuing care arranged and funded solely by the health service for a person to meet physical or mental health needs which have arisen as a result of illness.

3.13 Evidence suggests that integrating services can improve outcomes significantly, and reduce costs.[25] This is not a question of reducing choices for patients; it is about organising care that fits seamlessly around them. This is particularly important for those who are vulnerable or who have complex needs which span both health and other services, such as social care. In an ageing population, increasing numbers of people will suffer from dementia, for example, and proper coordination of care will lead to improved outcomes and a reduction in unnecessary time spent in hospital. The Care and Support White Paper, to be published shortly, demonstrates this Government's commitment to integrated care: care that is coordinated, continuous and person-centred.

3.14 Health and Wellbeing Boards provide one key way of rising to these challenges. For the first time, leaders of the local health and care system – NHS commissioners, councillors, social care, public health and local HealthWatch at the core – will work together, with their communities, to drive improved services and outcomes and tackle health inequalities. Through this collaboration, there is a real opportunity to create a new balance between prevention, treatment and care, which best meets the needs of their local community. This is not only an issue of integration between the NHS and social care or public health, but also of how the NHS works with the broader range of public services.

3.15 The Board should promote joint commissioning, supporting CCGs to work in partnership with other organisations to get the best possible outcomes – particularly for vulnerable groups and people with complex needs, including children with special education needs or disabilities, and the frail elderly.[26] The Government has already committed to legislating to ensure that services for disabled children and young people and those with special educational needs are planned and commissioned jointly and that clear duties apply to all organisations involved.[27]

3.16 While shared local leadership will be essential, the Board will also have an important role to play in encouraging and facilitating integrated working, both as a national and

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25 E.g. see Singh D, Ham C (2005). *Transforming Chronic Care: Evidence about improving care for people with long-term conditions.* Birmingham: University of Birmingham, Health Services Management Centre; Curry N, Ham C (2010). *Clinical and Service Integration: The route to improved outcomes*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/clinical_and_service.html; Goodwin N, Smith J (2011). *The Evidence Base for Integrated Care*. Slidepack. Available at: www.kingsfund.org.uk/current_projects/integrated_care/integrated_care_work.html; Rosen R, Mountford J, Lewis G, Lewis R, Shand J, Shaw S (2011). *Integration in Action: Four international case studies*. London: Nuffield Trust.

26 CCGs and local authorities have a joint and equal statutory duty to develop, through Health and Wellbeing Boards, Joint Health and Wellbeing Strategies (JHWSs) to set out how health and care services plan to meet the needs of the local community identified in the relevant Joint Strategic Needs Assessments – the JHWSs should inform local commissioning activities, creating services to meet those needs.

27 See *Special Educational Needs and Disability Green Paper: Progress and Next Steps*. Department for Education, 25 May 2012, http://www.education.gov.uk/childrenandyoungpeople/sen

local commissioner of services and through the way it supports CCGs. The Health and Social Care Act 2012 places a duty on the Board concerning promoting integration in the way in which services are provided, where this will lead to better outcomes and reduce inequalities.

- **Objective 13: Ensure that the new commissioning system promotes and supports the integration of care (including through joint commissioning) around individuals, particularly people with dementia or other complex long-term needs.**

Improving information

3.17 If people are to share in decisions and make informed choices, they need far better information about all aspects of their healthcare. Better information, backed by the right technology or support, can help people to manage their conditions better, remain independent longer, and find out much more easily about available services and their quality. It can also enable commissioners and clinicians to design services that better meet the needs of their populations, and support more efficient and more integrated care. For example performance data, including clinical audits, can support the commissioning of services which will achieve the best possible outcomes for patients.

3.18 The Government's new information strategy *The Power of Information*,[28] provides the principles and overall context for the Board's work in this area. Collaboration between the Department of Health and the Board to set national information standards, to support integration and to implement electronic patient and user records, will be critical to delivering this vision for the whole health and care system.

- **Objective 14: Improve the quality and availability of information about NHS services, with the goal of having comprehensive, transparent, and integrated information and IT, to drive improved care and better healthcare outcomes.**

Supporting carers

3.19 Many people who are frail or who have long-term health conditions receive a significant amount of care from their families or friends, often for many years: 18% of respondents to the 2011 GP patient survey identified themselves as carers. It is estimated that 2 million people become carers every year, and around 2 million cease to be carers.

3.20 Both new and experienced carers need access to information, advice and support, including appropriate respite care. In the past the NHS has not always attached sufficient priority to identifying and meeting the needs of carers. This has led to a

28 Department of Health, 21 May, http://informationstrategy.dh.gov.uk

wide variation in access to respite and other support. As part of the Spending Review, the Government provided £400 million to increase access to respite breaks for carers.

3.21 There is a wide range of innovative practice in support of carers, for example, as highlighted in the forthcoming publication from the Standing Commission on Carers.[29] Alongside local authorities and the voluntary and community sector, the NHS has an important role in supporting carers both to care effectively and to look after their own health and wellbeing.

- **Objective 15: Improve the support that carers receive from the NHS, in particular by:**
  - **Early identification of a greater proportion of carers, and signposting to information and sources of advice and support; and**
  - **Working collaboratively with local authorities and carers' organisations to enable the provision of a range of support, including respite care.**

Consultation questions

9. Is this the right way for the mandate to support shared decision-making, integrated care and support for carers?

10. Do you support the idea of publishing a "Choice Framework" for patients alongside the mandate?

29 See also *Carers and personalisation: improving outcomes:* http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122383.pdf and *New Approaches to Supporting Carers' Health and Well-being: Evidence from the National Carers Strategy Demonstrator Sites programme*: http://www.sociology.leeds.ac.uk/circle/news/new-approaches.php

4. The broader role of the NHS

4.1 The NHS has responsibility for providing healthcare services for the entire population. This involves understanding the individual needs of different groups of people, such as children or veterans, and tailoring services to meet these needs. Over and above this core responsibility, the way that the NHS works in partnership with other public services can have a major impact on achieving better social outcomes overall.

4.2 For example, high quality health services, along with strong partnerships with schools and local authorities, can improve children's chances of achieving a good education and fulfilling their potential; and good cooperation between health services, the criminal justice system, and policing organisations can help reduce the risk of crime and reoffending. Moreover, commissioners can do more to help identify those with complex needs such as victims of crime, or people dependent on drugs and alcohol.

4.3 The way that the NHS works with other services is often an area that needs improvement to prevent hard-to-reach groups falling through the gaps. Partnership working with other public services should be seen as a core part of what the NHS does, not an optional extra.

4.4 The current reforms provide a significant opportunity to join up public services better. CCGs will be able to work with local partners to find innovative ways of tackling health challenges and wider issues such as community safety in their areas, and indeed have statutory duties to engage in Health and Wellbeing Boards and other collaborative arrangements such as Community Safety Partnerships.[30]

4.5 The Board has a vital contribution to make to this agenda, both as a commissioner and as the steward of the new NHS commissioning system. In addition, its duties as to reducing health inequalities, and promoting integration and research will actively require it to work creatively with other organisations both within and beyond the public sector – making best use of partnership working and joint commissioning.

4.6 There is significant scope for the NHS to work better with other public services, and it is up to local areas to identify opportunities to take action. However, there is evidence that there is a particular need for NHS commissioners to improve the way that the NHS works with other services in order to achieve better outcomes in the areas outlined below.

30 CCGs are statutory members of Community Safety Partnerships

Supporting children, young people and families

4.7 Through its responsibilities for improving children's health, the NHS has a closer involvement with families than any other service. During the early years of a child's life, the NHS is uniquely placed to support families, working with local authorities and other services. The Board will play a key role in this by commissioning the Healthy Child Programme from pregnancy to age 5 until 2015, when responsibility will move to local authorities.

4.8 Along with the Government's commitment to increase the number of Health Visitors, the Board will expand the Family Nurse Partnership programme to improve outcomes for the most vulnerable first time teenage mothers and their babies. However, there is more that NHS commissioners can contribute.

4.9 There is also scope to improve the way that the NHS, schools and children's social services work together, for example to support looked-after children within the care planning framework; children with special needs or disabilities through the integration of planning and commissioning of the care packages developed through Education, Health and Care Plans; and to safeguard children and young people in vulnerable situations.

4.10 Following the Munro review,[31] the Government also recognises that more should be done to safeguard children and young people in vulnerable situations – promoting early identification and increasing early intervention. The NHS is a key partner in helping to deliver these improvements.

4.11 There is wide recognition that a multi-agency approach to working with vulnerable families including those that are most troubled can be highly effective and save resources. The NHS, along with key public agencies, has a vital contribution to make through identifying parents and families who need more support, and working with local authority family support services and troubled family coordinators to address families' health needs – whether in relation to primary care, specialist mental health or substance misuse services.

Tackling crime and improving community safety

4.12 The NHS plays a key role in improving community safety. The Board and CCGs can help local communities address the causes and consequences of crime and anti-social behaviour through the services that they commission, and by working with other partners to develop strategies for preventing crime, reducing reoffending, and identifying and meeting the needs of victims.

31 Department for Education, May 2011, available at https://www.education.gov.uk/publications/standard/AllPublicationsNoRsg/Page1/CM%208062

4.13 From November, Police and Crime Commissioners (PCCs) will be key partners, and local health leaders will need to work collaboratively with them to improve crime and health outcomes.

4.14 The total cost of violent crime in England and Wales is estimated to be around £30 billion a year. Most of these costs fall on the victims of crime, but the consequences of violent crime cost the health service around £3 billion a year. The NHS can help to reduce violent crime, for example by influencing alcohol licensing decisions through sharing anonymised assault data with Community Safety Partnerships.

4.15 Offenders and ex-offenders typically have high health and social care needs and have difficulty accessing appropriate services. Ninety per cent of prisoners have at least one significant mental health problem, including alcohol misuse and drug dependence.[32]

4.16 The Government aims to promote community safety by ensuring that offenders of all ages can access health and social care services, appropriate to their needs, and in line with standards set for the rest of the population. Liaison and diversion services can help ensure that people of all ages with health and social care needs who enter the criminal justice system are identified and provided with the most appropriate interventions to reduce the likelihood of their reoffending. This is particularly important for offenders with mental health problems and those dependent on drugs and alcohol. They can also contribute to other goals of the criminal justice system, such as reduced reoffending. In addition, there is scope to ensure that offenders' health and wellbeing needs are met by improving the transition from custodial to community healthcare services.

Supporting the Armed Forces

4.17 The NHS Commissioning Board will be instrumental in discharging the Government's obligations under the Armed Forces Covenant[33] by working to ensure that the health needs of the Armed Forces community are met, including by promoting integration with social care where this would improve patient outcomes.

4.18 It can demonstrate this by, among other things, ensuring the effective transition from the Armed Forces to the NHS for injured personnel; ensuring that Armed Services personnel and their families experience the same levels of service from the NHS as they move around the country; by ensuring access to high quality prosthetic and

32 Singleton et al (1998), Psychiatric Morbidity among Prisoners in England and Wales, London: Office for National Statistics Ibid [8]. http://www.statistics.gov.uk/STATBASE/Product.asp?vlnk=10552

33 See http://www.mod.uk/DefenceInternet/AboutDefence/WhatWeDo/Personnel/Welfare/ArmedForcesCovenant/

mental health services for veterans; and by ensuring armed forces and their families have consistency of access to infertility services. The Board will be particularly well placed to address the needs of the Armed Forces since it is also charged with commissioning services, including specialist services, for it.

- **Objective 16: Contribute to the work of other public services where there is a role for the NHS to play in delivering improved outcomes. This includes, in particular:**
  - **ensuring that children and young people with special educational needs have access to the services identified in their agreed care plan;**
  - **continuing to improve safeguarding practice in the NHS;**
  - **contributing to multi-agency family support services for vulnerable and troubled families;**
  - **upholding the Government's obligations under the Armed Forces Covenant;**
  - **contributing to reducing violence, in particular by improving the way the NHS shares information about violent assaults;**
  - **developing better integrated healthcare services for offenders.**

Promoting growth, innovation and research

4.19 The NHS contributes to the growth of the economy: not only by addressing the health needs of the population, thereby enabling more of us to be economically active; but also through supporting the life sciences industry, by adopting and spreading new technologies; and through exporting innovation and expertise internationally.

4.20 The Board has an important contribution to make in this area through its leadership of the NHS commissioning system, and through the systems and processes that it establishes for commissioning health services. The NHS infrastructure for research and innovation is a national asset, which the Board has an important role in protecting and developing. The Board has a statutory duty to promote innovation and health research. Increasing patient participation in research will be an important component of this.

4.21 In an increasingly tight financial climate, innovation must become a core part of NHS business. While the NHS is recognised as a world leader in invention there is still plenty of scope for improving and spreading best practice. The Government's strategy for health innovation and life sciences sets out a comprehensive plan to

transform the UK health innovation and life sciences sectors, and the Department of Health has set out an agenda for spreading innovation throughout the NHS.[34]

4.22 Building on the NHS's strengths in research and innovation, it is now more important than ever to maximise the international potential of this work. The NHS, working in collaboration with UK Trade and Investment, seeks to work with commissioners and providers to build and grow the commercial value of the NHS's skills technologies, products and knowledge internationally. The Board will need to play a role in encouraging innovation within a system that continually scans for new ideas, and takes them through to widespread use.

- **Objective 17: Ensure that the new commissioning system promotes and supports participation by NHS organisations and NHS patients in research funded by both commercial and non-commercial organisations, to improve patient outcomes and to contribute to economic growth through the life science industries:**
  - **Ensure payment of treatment costs for NHS patients who are taking part in research funded by Government and Research Charity partner organisations; and**
  - **Promote access to clinically appropriate drugs and technologies recommended by NICE, in line with the NHS Constitution**

Consultation questions

11. Does the draft mandate properly reflect the role of the NHS in supporting broader social and economic objectives?

34 See "Innovation, Health and Wealth: Accelerating Adoption and Diffusion in the NHS", Department of Health, December 2011 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131784.pdf

5. Effective commissioning

5.1 The new system of commissioning created by the Health and Social Care Act gives front-line professionals greater power, accompanied by greater responsibility, to ensure the commissioning of safe high quality care and to decide how NHS resources are used. This will lead to more innovation, higher quality care and better value for money. Achieving better outcomes will therefore depend on establishing the new commissioning system successfully. The transition needs to be managed safely, without compromising service performance or finances, and in a way that secures the transformation that the Government's reforms are designed to bring about. It is important to reflect this in the objectives for the NHS Commissioning Board, especially in this first mandate.

Establishing the commissioning landscape

5.2 The Government's objectives for establishing the new clinical commissioning system were set out in the Secretary of State's letter of 20 April 2012 to the Chair of the NHS Commissioning Board Authority.[35]

5.3 This made clear that a priority for the NHS Commissioning Board, in line with its statutory duty about promoting autonomy, is to support the transfer of power, from national and regional organisations to CCGs, Health and Wellbeing Boards, local providers and patients.

5.4 A first step in this process of decentralisation is for the Board to authorise CCGs. CCGs will not be authorised to take on any part of the commissioning budget in their local area until they are ready and willing to do so. Therefore the role of the Board will be to engage and support emerging CCGs, to maximise the number that can be authorised fully, without conditions, by April 2013. For each of those authorised with conditions, there should be a clear timetable and path to full authorisation. All authorisation conditions will be kept under review and removed when appropriate.

5.5 CCGs will have the freedom to work with whoever they want in securing support for commissioning health services. The Government expects the Board to publish a procurement framework to enable CCGs to procure support from a wide range of providers. As statutory bodies, CCGs will be able to choose commissioning support from whatever organisations in whatever sectors are best able to meet their needs. CCGs will hold the money for commissioning support and there will be no top-slicing

35 See http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_133667

of their budgets for this purpose. In the first instance, as commissioning support is further developed, there is likely to be a need for central hosting of support organisations. The Board will not have a long-term role in providing or hosting commissioning support services. The Board will host "clinical senates" and "clinical networks" as sources of advice, but CCGs should be free to make their own arrangements collectively or individually.

5.6 The Government's aim is to move away from the top-down management of the NHS to a system where fully authorised CCGs will have, as the Future Forum put it, "assumed liberty"; within the common framework of a comprehensive health service set out in legislation. At the same time, while CCGs have considerable autonomy, they are accountable to the Board for managing public funds robustly, for meeting their statutory duties and – through the Commissioning Outcomes Framework to be developed by the Board – for the outcomes they achieve.

5.7 The Board will therefore need to operate a transparent system, based on clear principles, in which its approach to issues such as pooling financial risks, and interventions in the event of poor performance, distress and failure, is clearly set out for CCGs.

- **Objective 18: Transfer power to local organisations and enable the new commissioning system to flourish, so that:**
  - **CCGs are established across England by 1 April 2013;**
  - **as many CCGs as are willing and able are fully authorised by April 2013;**
  - **CCGs are in full control over where they source their commissioning support;**
  - **clinical networks and senates are highly-valued sources of advice and insight to commissioners;**
  - **there is a transparent, principle-based system for the Board's interactions with CCGs, including the effective management of poor performance and financial risk; and**
  - **there is effective partnership working between CCGs and Health and Wellbeing Boards.**

Improved incentives, and a fair playing field for providers

5.8 The Board and CCGs will only be able to drive better outcomes if they are working within a financial framework that promotes quality and value for money.

5.9 The Government is committed to a major expansion and development of the pricing systems for paying providers, so that money follows patients, supporting their

choices, and reflects quality, including patient experience, and not simply activity. Achieving this will be a key priority for the Board, working jointly with Monitor. The Board will need to work closely with Monitor, and other partners, including the Department, in the process of developing tariffs which promote better outcomes for patients.

5.10 Pricing must support a fair playing field between providers. Improved payment systems should not be undermined by non-tariff payments, loans or subsidies. It will be important for the Board to minimise the use of non-tariff payments and ensure that, wherever they are used, they are justified transparently.

5.11 Similarly, there should be incentives for commissioners, through a Quality Premium developed by the Board, which reward them for achieving high-quality outcomes within the resources available. Funding for the Quality Premium will come from within the overall administration costs limit set in directions for the NHS commissioning system.

- **Objective 19: Ensure that financial incentives for commissioners and providers support better outcomes and value for money; extend and improve NHS pricing systems so that money follows patients in a fair and transparent way that enables commissioners to secure improved outcomes.**

Redesigning services to ensure high quality care

5.12 One of the aims of the Government's reforms is to create more flexibility for NHS services to adapt and evolve, to respond to the choices of patients, meet new health challenges, take advantage of new technologies and medicines, and improve the quality of care.

5.13 CCGs (and the Board for the services that it commissions directly) have a central role in planning or supporting service changes, to make sure that their populations have access to high quality services.

5.14 Service redesign should be led by the clinicians who best know their patients' needs, often in the local CCG. The Board will sometimes have a more active role: leading work to redesign services that it commissions, or supporting groups of CCGs in handling complex or large-scale service changes.

5.15 In all cases, the clinical case for reconfiguration must be robust, and reconfiguration must offer clear benefits over alternative solutions – priority should be given to changes to services which improve outcomes whilst also maintaining access. Reconfiguration processes should respect the principle of a fair playing field, ensuring

that all potential providers have the opportunity to contribute to proposals for providing care to the local population.

- **Objective 20: Support changes in services that lead to improved outcomes for patients. Priority should be given to changes to services which improve outcomes whilst also maintaining access, and changes must meet the Secretary of State's four tests that there is**
  - **support for proposals from clinical commissioners;**
  - **strong public and patient engagement;**
  - **a clear clinical evidence base; and**
  - **consistency with current and prospective need for patient choice.**

The Board's own commissioning

5.16 The Board itself will be responsible for around £20 billion of direct commissioning, including primary care, specialised services for patients with rare or very rare conditions, health services for people in custody, and military healthcare. Having a single commissioner provides an opportunity to tackle variation and drive improvements in these services: to ensure they are of high quality, are responsive to patients, and provide value for money.

5.17 Although CCGs are not responsible for commissioning primary care, they will have an important role in supporting the Board to improve its quality, as will healthcare professionals working in dental, pharmacy and eye care services. The Board will need to consider how to harness their expertise and enthusiasm to secure continuous improvement in the quality of these services.

5.18 In the same way that the Board will hold CCGs to account for the services they commission, it is important that there are robust and transparent arrangements to provide assurance about the quality and value for money of the services that it commissions itself. The Department will use these to hold the Board to account.

- **Objective 21: As part of the work to improve healthcare outcomes, put in place arrangements to demonstrate transparently that the services commissioned by the Board are of high quality and represent value for money.**

Consultation questions

12. Should the mandate include objectives about how the Board implements reforms and establishes the new commissioning system?

6. Finance and financial management

6.1 The NHS budget is, and always has been, finite. At this time of great pressure on the public finances, it is particularly important that the NHS Commissioning Board delivers the objectives in the mandate, and its other functions, within its available resources. This will require good financial management and unprecedented efficiency savings, through the Quality Innovation Productivity and Prevention (QIPP) programme.[36] The Board will be accountable for ensuring delivery of QIPP savings in a way that supports the current Spending Review period and beyond. The Board will need to keep a focus on finance even while playing its role in implementing the Government's programme of reforms.

- **Objective 22: Ensure the delivery of efficiency (QIPP) savings in a sustainable manner, to maintain or improve quality in the current Spending Review period and beyond.**

6.2 The Board will need to share relevant financial information and assumptions with the Department of Health and other bodies in the healthcare system, to mitigate financial risks and maximise the resources that can be made available for front-line services. Like any public body, it will need to comply with government accounting and financial management rules, such as those derived from HM Treasury's guidance *Managing public money*.[37] The Framework Agreement between the Department and the Board, which is being developed, will set out fuller details.

6.3 The final mandate will set out the Board's revenue and capital limits for 2013/14. Further technical limits and provisions, including spending on administration, will be set out in the accompanying financial directions. The Board's cash allotment will be notified to the Board separately in writing.

Allocating the NHS commissioning budget

6.4 In future, the Board will be responsible for allocating the budget for commissioning NHS services, this will prevent any perception of political interference in the way that money is distributed between different parts of the country. The Government expects the principle of ensuring equal access for equal need to be at the heart of the Board's approach to allocating budgets. This process will also need to be transparent, and to

36 See http://www.dh.gov.uk/en/Healthcare/Qualityandproductivity/index.htm
37 Available at http://www.hm-treasury.gov.uk/psr_mpm_index.htm

ensure that changes in allocations do not result in the destabilising of local health economies.

6.5 While decisions about allocating funding to commissioners are for the Board to make, the Department is responsible for managing the overall NHS budget, and therefore will need to understand the Board's approach to allocations. The Board should share its approach with the Department as it is developed, and should involve the Department at key stages of the process.

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