Developing our NHS care objectives

A consultation on the draft mandate to the NHS Commissioning Board

DH INFORMATION READER BOX

Policy HR/Workforce Management Planning/Performance	Clinical Commissioner Development Provider Development Improvement and Efficiency	Estates IM & T Finance Social Care/Partnership Working
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Circulation list		
Description	This document explains and seeks comments on the approach we have taken to developing a draft mandate to the NHS Commissioning Board. This consultation document is published alongside a draft of the first mandate with four annexes, including a draft 'choice framework' illustrating the Government's intended approach to explaining the choices that will be available for people using NHS services in England	
Cross reference	Our NHS care objectives: A draft mandate to the NHS Commissioning Board; Our NHS care objectives: A draft mandate to the NHS Commissioning Board, Annexes; Our NHS care objectives: A draft mandate to the NHS Commissioning Board – Coordinating document for the Impact Assessments and Equality Analysis	
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Foreword from the Secretary of State

The Health and Social Care Act, which has recently passed through Parliament, reaffirms the principles of the NHS as a comprehensive health service for everyone, based on clinical need not people's ability to pay.

The Act creates the legislation to support this Government's vision for improving the NHS, in order to:

- put patients and carers at the heart of the health service;
- focus the NHS on improving outcomes and what matters most to patients – high-quality care; and
- hand power to local professionals, and make NHS services more directly accountable to patients and communities.

We now want to work with patients, staff and our partners – including national health charities, think tanks and professional organisations – to put the changes into practice and make them a success.

In line with the new requirements in the Act, we are now consulting on our proposals for the Government's first mandate to the NHS Commissioning Board, and we have published a draft mandate. In future, the mandate will be the main way for the Government to say what it expects the NHS commissioning system to achieve with the money it is given. This is the first time that any government has been required by law to consult on its objectives for the NHS, and brings an unprecedented degree of transparency.

This document explains the approach we have taken to developing the mandate, and tells you how you can get involved and have your say.

Andrew Lansley CBE
Secretary of State for Health

Executive summary

The mandate

The new NHS Commissioning Board[1] will oversee the way that over £80 billion of taxpayers' money is spent to secure NHS services for the people of England.

Under the Health and Social Care Act 2012, the Government must set objectives for the Board in a "mandate", which must be updated every year, following consultation. In order to provide stability for the NHS, the mandate can only be changed mid-year in limited circumstances.

The mandate is one of the most important ways for the Government to set objectives for the Board, but it is just one part of a broader relationship through which the Secretary of State will hold the Board to account for its performance. Ministers will continue to be accountable overall for the health service as a whole.

We have now published:

- a **draft of the first mandate**, informed by what we have heard through previous consultations, debates in Parliament and discussions with stakeholders;
- a draft "**choice framework**", illustrating the Government's intended approach to explaining the choices that will be available for people using NHS services in England; and
- **this consultation document**, which explains the approach we have taken to developing the mandate.

Following consultation, we will publish a final mandate in the autumn, ready to come into force from April 2013.

Meanwhile, we are also publishing the Secretary of State's first report on the effect of the NHS Constitution. The Constitution and the mandate both set out what is expected of the NHS, but they have distinct roles:

- The mandate is a formal accountability document setting objectives for the Board. It is primarily about the Government's ambitions for improving NHS services *in future*. Future mandates will evolve as objectives are achieved and new priorities emerge.

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[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.

- By contrast, the NHS Constitution is an enduring document, which sets out the principles and values of the NHS and the rights and responsibilities of patients and staff. It describes what everyone can expect from the NHS *now*, and it is about the NHS as a whole – patients, public and staff – not just commissioners.

The structure of the draft mandate

The draft mandate includes objectives under five headings:

1. **Improving our health and our healthcare**: this sets objectives for improving outcomes and reducing inequalities under the NHS Outcomes Framework, rather than setting objectives for individual clinical conditions. It sets ambitions for:

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

2. **Putting patients first:** this sets objectives to extend shared decision-making and choice, improve information, make services more integrated around the needs of individuals, and improve the support the NHS gives to carers.

3. **The broader contribution of the NHS:** this sets objectives about how the NHS can work better with other public services, and how it can contribute to economic growth, including through its support for research and innovation.

4. **Effective commissioning:** this sets objectives about getting the full benefits from the new system of commissioning, while at the same time managing the transition in a way that safeguards service performance and finances.

5. **Finance and financial management:** this will set the Board's resources and expectations of increased efficiency.

Setting ambitions for improving high-level outcomes rather than focusing on processes or individual clinical conditions has many advantages. It focuses attention on the outcomes that really matter: saving and improving lives, reducing harm and enhancing patients' experience. It gives more freedom to local commissioners to decide how best to improve quality and outcomes in the light of the needs of their populations. And it recognises that, as more people are living with multiple long-term conditions, it is more important to take a holistic approach, looking at quality of life and quality of care as a whole, rather than focusing primarily on the treatment of specific clinical conditions.

However, as Chapter 3 explains, this is a radical shift in approach from the past, and the detailed approach we take will evolve as information about outcomes improves and our methodology develops.

Have your say

We would welcome your views on the objectives in the draft mandate, and on the consultation questions set out there (these are also listed below in Chapter 6). You can find out more and respond to this consultation at: http://mandate.dh.gov.uk. You can contact us via: mandate-team@dh.gsi.gov.uk. Please respond by 26 September.

1. The mandate in context

The Government's NHS reforms

1.1 From April 2013 **clinical commissioning groups** (CCGs) will become responsible for commissioning most healthcare – planning, buying and monitoring services to meet the needs of their local communities. Within CCGs, GPs and other healthcare professionals will be empowered to use their clinical insight and local knowledge to make decisions about NHS services.

1.2 A new national organisation – the **NHS Commissioning Board** – will support CCGs to commission high-quality care for their patients. The Board will also commission some healthcare services directly. The Department of Health will allocate funding to the Board, and set objectives for it in a "mandate".

1.3 CCGs and the Board will commission services from a range of **providers**, offering greater choice to patients. In turn, providers will be regulated on a consistent basis: by the **Care Quality Commission**, as now, to ensure safety and quality; and by **Monitor**, which will focus on promoting value for money in the provision of services, for example by regulating prices and taking action against anti-competitive behaviour that harms the interests of patients.

1.4 **Health Education England** will provide national leadership for professional education, training, and workforce development, to ensure that the health workforce has the right skills, behaviours and training, and is available in the right numbers, to support the delivery of excellent healthcare and health improvement.

1.5 Meanwhile, new **Health and Wellbeing Boards**, based in local authorities, will bring together NHS commissioners with local government, helping to join up the commissioning of NHS, public health, social care and other local services.

1.6 To strengthen the voice of patients and the public, **HealthWatch England** will be a new independent consumer champion, as a statutory committee within the Care Quality Commission. **Local HealthWatch** organisations will provide advice and information about access to local care services and choices available to patients, and a stronger voice for patients on the local Health and Wellbeing Board.

1.7 The Health and Social Care Act makes clear that, as now, **Ministers** will be accountable overall for the health service. The Department of Health will provide strategic direction and stewardship, and will hold all of the national bodies to account for their performance, to ensure that the different parts of the system work properly.

1.8 The final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, chaired by Robert Francis QC, is due to be published in the autumn. While many of the themes and objectives in the draft mandate address the issues that emerged from the previous inquiry, it will be for future mandates to reflect any specific recommendations from the final report relating to the new commissioning system.

The mandate

1.9 The mandate will be at the heart of the accountability relationship between the Board and the Department of Health. The Act says that the Secretary of State must publish a mandate setting objectives for the Board, and any supporting requirements, as well as the funding available to the Board. The Board must seek to achieve the objectives and must comply with any requirements.[2]

1.10 The mandate will be:

- a multi-year document, but published annually to ensure it remains up to date. The first mandate will come into force from April 2013, when the Board takes on its full powers;
- based on public consultation and consultation with the Board;
- fixed for the entire year: it can only be changed mid-year by agreement with the Board, or in exceptional circumstances, which Ministers would have to explain to Parliament (it could also be changed after a general election);
- an accountability mechanism for the Board, not for the NHS as a whole. For example, it would not deal with the way that providers are regulated, since this is the responsibility of Monitor and CQC, which have their own, distinct legal responsibilities.

Other requirements on the NHS Commissioning Board

1.11 The mandate will be the document that sets the Government's ambitions for the Board. But it will not be the only influence on the Board, nor will it cover everything that the Board will do. As explained in Chapter 4, the mandate forms part of a broader cycle of accountability.

1.12 Like other arm's-length bodies, the Board will also be bound by:

a) legal requirements

- The **Health and Social Care Act** sets out the Board's core functions, and gives the Board a number of cross-cutting duties, including duties about reducing

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[2] The Secretary of State considers that at this stage it is not necessary to impose any requirements in relation to any of the objectives.

inequalities, seeking continuous improvement in quality and promoting the NHS Constitution.

- **Regulations** made under the Act will set more detailed legal requirements including, for example, regulations defining exactly what services the Board should commission. "Standing rules" regulations will set legal requirements on the way the Board and CCGs commission services, and will be used to ensure that rights for patients in the NHS Constitution continue, such as the right for patients to access services within maximum waiting times. They will also be used to maintain existing policies, such as the eligibility rules for NHS continuing healthcare.[3]

b) standard government accountability procedures

- As with other arm's-length bodies across government, there will be a **framework agreement** outlining how the Board and the Department of Health will work together. For example, this will include details about financial management and financial reporting, and will describe how the Board will help the Department to respond to questions from Parliament.
- The Department will make a limited number of **financial directions** under the Act to set technical controls on the Board's spending, to ensure it is managed in line with Treasury requirements.

1.13 In addition, there are some public health services which in future will be the legal responsibility of the Secretary of State, but which the Board will commission on the Department's behalf. The details will be set out in a formal **"section 7A" agreement** under the Act, which will be published alongside the final mandate. The services it will cover include immunisation and screening programmes, public health services for young children and for people in custody, and the commissioning of sexual assault referral centres and of child health information systems.

1.14 The mandate is designed as a specific accountability mechanism for the Board, to recognise the scale of the Board's responsibilities and the size of the budget it will oversee. But there is no need for the mandate to duplicate requirements that are made elsewhere.

1.15 Some people have asked how the mandate relates to the NHS Constitution. The key distinction is that the NHS Constitution is about the entire NHS – public, patients and staff – and captures the essence of what people can expect from the NHS *now*. The mandate is a formal accountability document for the Board (therefore, for example, it says relatively little about staff, because the vast majority of staff in the NHS are

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[3] 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.

employed by providers of healthcare services), and deals mainly with the Government's ambitions for improving the NHS *in future*. While the Constitution is an enduring document, the mandate will evolve over time, as objectives are achieved and new priorities emerge.

1.16 We have asked the NHS Future Forum to consider how the NHS Constitution can be strengthened and reinforced for the future. The Forum plans to engage on potential changes over the summer. In light of its advice, we will launch a public consultation on any changes to the Constitution later this year.

2. Our approach to the mandate

2.1 The draft mandate we have published draws on an extensive process of consultation, listening and engagement. For example:

- We have already held full consultations on many of the elements within the draft mandate, including the NHS Outcomes Framework and our plans for extending shared decision-making and patient choice.
- We have had many informal discussions about developing the mandate with stakeholders and representative bodies, and drawn on feedback and recommendations from the work of the NHS Future Forum.
- The mandate was debated extensively in Parliament during the passage of the Health and Social Care Bill.
- We have worked very closely with the NHS Commissioning Board Authority (the preparatory body for the Commissioning Board).

2.2 Because this is the first mandate, and the start of a new system of commissioning, there has been much debate about high-level questions such as: how detailed the mandate should be; whether it should include objectives about the way the Board implements reforms as well as about the ultimate purpose of those reforms; and how to assess the Board's progress against the mandate.

2.3 However, some common themes have emerged. We have heard many people support the ideas that the mandate should be:

- based primarily around **outcomes** and the NHS Outcomes Framework – while at the same time recognising that the Board must be clearly accountable and that there are other important objectives that the Government will want to set;
- **aligned** with other parts of the NHS, and promoting an integrated approach with social care, public health and other public services;
- **affordable**, recognising the sustained financial challenge facing the NHS over the coming years; and
- **focused** on a core set of priorities, in line with the principle of promoting front-line autonomy, to ensure that commissioners have the headroom and flexibility to respond to local needs. Extending ambition in one area can only come at the expense of ambition in other areas. Many people have highlighted the risk that the mandate could turn into a long "shopping list" unless the Government is restrained in selecting its priorities.

2.4 We have reflected these points in the draft mandate.

2.5 Another point where we heard much agreement was that it would be helpful for the Government to consult on a draft version of the mandate, rather than simply on principles or high-level proposals. Many people said that, in order to avoid the consultation becoming abstract or theoretical, it would be easier to engage properly if they had seen an actual document. This is why we have published a draft mandate as the basis for consultation and discussion.

Structure of the draft mandate

2.6 The draft mandate is divided into five core sections:

- **Improving our health and our healthcare**. This section explains how we intend to set ambitions for improving healthcare outcomes and reducing inequalities, while upholding core performance standards such as on waiting times. It also includes an objective for strengthening the priority given by the NHS to preventing illness and supporting people to improve their health.
- **Putting patients first**. A core part of improving the quality of care, especially for the rising numbers of people living with long-term conditions, is to empower patients, families and carers, and support them to manage their health better. This section sets objectives to extend shared decision-making and choice, improve information, make services more integrated around the needs of individuals, and improve the support the NHS gives to carers. We have also published a draft "choice framework" alongside the draft mandate, explaining where and how patients can expect to be able to make choices.
- **The broader role of the NHS**. This section emphasises that the NHS is in a unique position to work with other public services to help achieve broader social and economic objectives. The NHS can, by working well with its partners, go beyond the traditional boundaries of the healthcare system, such as in providing support for children with special educational needs and disabilities, or helping to reduce reoffending. The draft mandate highlights some areas where partnership working between services is particularly important or needs to be improved. This section also includes an objective about the role of NHS commissioners in supporting research and contributing to economic growth through the life sciences industry.
- **Effective commissioning**. This section sets a small number of objectives about the way that the Board introduces the new commissioning system: to help achieve the full benefits of clinically-led commissioning, while at the same time managing the transition in a way that safeguards service performance and finances. There is a specific objective for the Board to be able to account transparently for the quality and value of the services that it commissions directly.

- **Finance and financial management**. This section will set the Board's budget (the figures are not included in this draft mandate but will be published in the final version). It also includes some principles for the Board to allocate resources in a fair and transparent way, and sets the Board an objective to make efficiency savings. However, most of the detailed financial requirements on the Board will be set out elsewhere – in particular in the framework agreement.

2.7 Because setting outcome-based objectives is a radically new approach for the NHS, the next chapter of this document gives some more background on this, and we have published a technical annex on the NHS Outcomes Framework with more detail. But we have not included a section-by-section commentary on the other parts of the draft mandate; instead, we have included some consultation questions in the draft mandate itself (these are listed in Chapter 6 below). We would welcome your views on these questions and on our approach to developing the mandate generally.

3. Setting outcome-based objectives

3.1 The core purpose of the mandate, and of the NHS Commissioning Board itself, is to help improve people's health and the outcomes of healthcare. The main way we propose to do that through the mandate is by setting objectives for improvement against the NHS Outcomes Framework.

The NHS Outcomes Framework

3.2 The NHS Outcomes Framework is a set of national outcomes goals and supporting indicators which patients, the public and Parliament will be able to use to judge the overall progress of the NHS, and which the Department of Health will be able to use in holding the Board to account.

3.3 The Framework, which has already been subject to extensive consultation, is structured around five "domains", capturing the NHS's role in reducing premature deaths, enhancing quality of life, helping people to recover from ill-health and injury, providing a good experience of care, and providing a safe care environment. The domains were chosen to reflect the three elements of good quality care: effectiveness, patient experience and safety.

Domain 1	**Preventing people from dying prematurely**	**Effectiveness**
Domain 2	**Enhancing quality of life for people with long term conditions**	
Domain 3	**Helping people to recover from episodes of ill health or following injury**	
Domain 4	**Ensuring people have a positive experience of care**	**Patient experience**
Domain 5	**Treating and caring for people in a safe environment and protecting them from avoidable harm**	**Safety**

3.4 Twelve overarching indicators cover the broad aims of these five domains, and 60 indicators in total capture the breadth of NHS activity. The NHS Outcomes Framework sits alongside similar frameworks for public health and adult social care. The distinct frameworks reflect the different delivery systems and accountability models for the NHS, public health and adult social care. But the frameworks are aligned and contain shared indicators to drive collaboration and integration.

Outcome-based objectives

3.5 The draft mandate sets an objective for the Board to ensure continuous improvement across all of the 60 indicators in the NHS Outcomes Framework. This is in line with the Board's legal duty about continuously improving the quality of care. But we do not propose to set specific objectives for individual indicators, or for particular clinical conditions or groups.

3.6 Instead, our intention is to set the Board a stretching ambition to improve against each of the five domains as a whole, based on an aggregate measure of performance for each domain. To reflect the fact that there can be a time-lag in changing outcomes, we plan to set ambitions to achieve within two, five and ten years.

3.7 We think there are several advantages of setting objectives at domain level:

- This focuses attention, in a transparent way, on the **ultimate outcomes of care** that matter to patients and professionals: saving and improving lives, enhancing patients' experience, and reducing harm.
- It provides a "**balanced scorecard**", which gives commissioners freedom to decide how to improve quality and outcomes in ways that are most important for their local populations. Setting prescriptive objectives for individual indicators would reduce local autonomy and risk distorting clinical priorities.
- The biggest healthcare challenge of the future is the rise in the number of people living with long-term conditions. Increasingly, many people have complex needs, with more than one condition at once. Therefore it is better for the mandate to take a **holistic approach** that looks at quality of life and quality of care as a whole, rather than focusing primarily on the treatment of individual clinical conditions.

3.8 As the draft mandate makes clear, there are specific areas of NHS care, such as care for people with cancer, where the Government has already set out ambitions for improvement. Many of these are reflected in the NHS Outcomes Framework, and we intend that they will be captured in the outcomes objectives we set the Board. There is no doubt that these areas will be priorities for the Board and for CCGs. However, we want the mandate to focus on the Board's performance as a whole, across the range of healthcare services.

Setting levels of ambition

3.9 A separate technical annex on the NHS Outcomes Framework describes the detailed methodology for constructing the levels of ambition. In summary, we are looking to create levels of ambition that take into account recent and likely future trends in outcomes (where these are known), and which set an additional challenge to the Board, which is achievable within the current resources available to the NHS.

3.10 More data on outcomes will become available during the consultation period. As the technical annex explains, we currently have a partial assessment of what could be included in a level of ambition for each domain. Our aim is therefore to develop the levels of ambition over the summer before they are published in the final mandate, so that they are as comprehensive as possible. The draft mandate includes suggestions of how these objectives might be phrased. The technical annex includes examples of what these levels of ambition may contain, and invites views.

3.11 We think it is right to use outcomes as the basis for assessing the performance of the health service. But we recognise that this approach is a significant shift from the past, and we are still at the early stages of a journey. It is likely that the ambitions included in the final mandate will still include some gaps – because of lack of evidence or measures. The Department of Health and the Board will need to work together over the coming years to develop and improve the NHS Outcomes Framework and the information and indicators that support it, and we have established an advisory group (the Outcomes Framework Technical Advisory Group – OFTAG) to provide expert input. Views expressed during this consultation will be particularly helpful in informing this longer term work.

3.12 We want the mandate to set a clear sense of direction and challenge to the Board. But some of the detail of the ambitions, especially the 10-year ambitions, is likely to be refined and updated in future mandates in the light of experience and improving information.

Reducing inequalities

3.13 A particular area where there is a need for further work is in measuring outcomes for different groups of people, to assess the impact on equality and inequalities.

3.14 The Health and Social Care Act has, for the first time, created legal duties about tackling inequalities in access to services and the outcomes of healthcare – in line with the Government's aim of improving the health of the poorest fastest. Legal duties about reducing health inequalities build on the existing duties of all public bodies in relation to promoting equality. The focus on localism and clinical leadership within the new NHS commissioning system, together with the creation of local Health and Wellbeing Boards, will produce new opportunities to address health inequalities in every area across the country, by focusing on disadvantaged groups which experience poor health outcomes, including those who are vulnerable or socially excluded.

3.15 Our approach to the NHS Outcomes Framework supports this: by highlighting data across a wide range of indicators, it will shine a light on areas that need to be tackled and expose unjustified variations in outcomes.

3.16 The draft mandate includes a specific objective to reduce inequalities in domain 1 of the NHS Outcomes Framework (preventing people from dying prematurely), where there is sufficient evidence to be able to set a level of ambition. To add more focus on inequalities in the other domains, the draft mandate includes a general objective for the Board to assess and seek to reduce inequalities while achieving the overall outcome objective. Our aim is that, as information and evidence improves and the methodology develops, this will provide a basis for setting more targeted goals in future mandates.

4. Assessing progress

4.1 The mandate is a formal mechanism for the Government to hold the NHS Commissioning Board to account for its performance, on behalf of patients and taxpayers. It is important to be able to judge clearly how well the Board has performed. Therefore, we have published an annex to the draft mandate (Annex B) describing for each objective how we intend to assess the Board's progress. In some cases, there is an obvious measure of performance to use. But for many objectives, there is no existing indicator, and we will be asking the Board to develop and provide evidence of what has been achieved.

4.2 In line with our commitment to transparency, the Government will be interested in evidence that can be objectively measured and, wherever appropriate, independently reported.

The accountability cycle

4.3 The mandate is one part of a wider cycle of accountability for the Board. The Health and Social Care Act makes clear that:

- The Board must publish a **business plan** each year, saying how it intends to carry out its functions and deliver the objectives and requirements in the mandate.
- The Secretary of State must **keep the Board's performance under review**, including how it is performing against the mandate.
- The Board must publish a **report** at the end of each year saying how it has performed.
- The Secretary of State must then publish an **assessment** of the Board's performance.

4.4 Besides these formal requirements, there will be an ongoing sponsorship relationship between the Department of Health and the Board, which will be described in the framework agreement. In particular, the Secretary of State will hold formal accountability meetings with the Chair of the Board, normally every two months, and the minutes of these meetings will be published. These meetings will be an opportunity for Ministers to discuss progress or raise any emerging priorities or concerns. If there were particular concerns about performance, Ministers could, for example, ask the Board to report publicly on what action had been taken, or ask the Chair to write a letter setting out a plan for improvement.

4.5 The Department of Health intends to carry out assessments of all its arm's-length bodies, looking not only at how they have carried out their functions, but also to give assurance about their "organisational health": the strength of their governance and their relationships with other bodies. In the same way as for other arm's-length bodies, we intend to use a range of hard and soft evidence to assess the Board's performance, including feedback from stakeholders such as patients, commissioners, GPs and other clinicians, as part of a balanced scorecard approach. We would be interested in your views about the best way of achieving this.

5. The consultation process

5.1 This consultation will run from 4th July to 26th September 2012.

5.2 You can find out more and respond to this consultation at: http://mandate.dh.gov.uk. You can contact us via: mandate-team@dh.gsi.gov.uk.

Criteria for consultation

5.3 This consultation follows the 'Government Code of Practice', in particular we aim to:

- formally consult at a stage where there is scope to influence the policy outcome;
- consult for at least 12 weeks with consideration given to longer timescales where feasible and sensible;
- be clear about the consultation's process in the consultation documents, what is being proposed, the scope to influence and the expected costs and benefits of the proposals;
- ensure the consultation exercise is designed to be accessible to, and clearly targeted at, those people it is intended to reach;
- keep the burden of consultation to a minimum to ensure consultations are effective and to obtain consultees' 'buy-in' to the process;
- analyse responses carefully and give clear feedback to participants following the consultation; and
- ensure officials running consultations are guided in how to run an effective consultation exercise and share what they learn from the experience.

5.4 The full text of the code of practice is on the Better Regulation website at:

http://www.bis.gov.uk/policies/bre/consultation-guidance/subscribers-to-code-of-practice

Comments on the consultation process itself

5.5 If you have concerns or comments which you would like to make relating specifically to the consultation process itself please contact:

Consultations Coordinator
Department of Health
3E48, Quarry House
Leeds
LS2 7UE
e-mail consultations.co-ordinator@dh.gsi.gov.uk

Please do not send consultation responses to this address.

Confidentiality of information

5.6 We manage the information you provide in response to this consultation in accordance with the Department of Health's Information Charter at http://www.dh.gov.uk/en/FreedomOfInformation/DH_088010.

5.7 Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

5.8 If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

5.9 The Department will process your personal data in accordance with the DPA and, in most circumstances, this will mean that your personal data will not be disclosed to third parties.

Summary of the consultation

5.10 A summary of the response to this consultation will be made available before or alongside any further action, such as laying legislation before Parliament, and will be placed on the Consultations website at http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/index.htm

6. Consultation questions

Our approach to the mandate

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?

Assessing progress

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?

Improving our health and our healthcare

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?

Putting patients first

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?

Our NHS care objectives

A draft mandate to the NHS Commissioning Board

Annexes

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Circulation list		
Description	Annexes to the first draft mandate for consultation. The consultation comprises a draft mandate, together with four annexes, including a draft 'choice framework', and a consultation document explaining the approach we have taken to developing the mandate.	
Cross reference	Our NHS care objectives: A draft mandate to the NHS Commissioning Board; Developing our NHS care objectives: A consultation on the draft mandate to the NHS Commissioning Board – Coordinating document for the Impact Assessments and Equality Analysis.	
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Timing	Views and comments are invited by 26th September 2012	
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For recipient's use		

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One framework
defining how the NHS will be accountable for outcomes
Five domains
articulating the responsibilities of the NHS
Twelve overarching indicators
covering the broad aims of each domain
Twenty-seven improvement areas
looking in more detail at key areas within each domain
Sixty indicators in total
measuring overarching and improvement area outcomes

The NHS Outcomes Framework 2012/13
at a glance

**Shared responsibility with the public health system and Public Health England and local authorities - subject to final publication of the Public Health Outcomes Framework.*

*** A complementary indicator is included in the Adult Social Care Outcomes Framework*

****Indicator replicated in the Adult Social Care Outcomes Framework*

Indicators in italics are placeholders, pending development or identification of a suitable indicator.

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- 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.
- Objective 2: Increase the number of Quality Adjusted Life Years[1] for people in England with long term conditions to X by 2015; X by 2018; and X by 2023.
- 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.
- 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[2] 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.
- 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.
- 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.

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[1] This is subject to establishing meaningful data and a baseline. The patient aspect of the "friends and family test" currently 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.

[2] 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.

- 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[3]) through greater improvement in more disadvantaged communities.

Key measures for assessing progress

- Evidence that all objectives are being met. Baselines are set out in the technical annex.
- Evidence of progress towards the outcomes which the NHS Outcomes Framework indicators track, as well as improvements of the indicators themselves.
- In relation to objective 4:
  - Collection of standardised data across all acute inpatient wards and A&E services from April 2013.
  - Publication of available data at ward and A&E level (as well as aggregated to Trust level) from April 2013, in a way that is meaningful to the public and informs choice and accountability.
  - Ensuring that local feedback data, including data from the friends and family test, is acted upon to improve services and root out poor care.
  - Development of a robust and meaningful national measure for use beginning in April 2014, with improvements against a baseline established from 2013-14 performance.
  - Measurable improvements in national performance from April 2014.
- In relation to objective 6, the technical annex sets out the baselines against which progress will be assessed for the indicators in the framework, and expectations of performance for indicators which are currently declining or flat.
- In relation to objective 8, the technical annex sets out the baseline against which progress will be assessed.

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[3] 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.

Objective 9

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

Key measures for assessing progress

- Improving Access to Psychological Therapies (IAPT): Of those completing treatment it is expected that at least 50% will recover.
- Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period – 95%.
- Evidence that commissioning plans for mental health are proportionate to assessed local needs.
- Agreed timetable for development of national quality and outcome measures for mental health services.

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 below.

Key measures for assessing progress

- Demonstrate that performance on the rights and pledges for patients in the NHS Constitution that are not specifically mentioned below are being upheld and where possible that performance has improved.
- Demonstrate that performance is being upheld and where possible improved on the following service performance standards:

Referral to treatment (RTT) waiting times for non-urgent consultant-led treatment	Admitted patients to start treatment within a maximum of 18 weeks from referral – 90% Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95% Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92%
Diagnostic test waiting times	Patients waiting for a diagnostic test should have been waiting no more than 6 weeks from referral – 99%

A&E waits	Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department – 95%
Cancer waits – 2 week wait	Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93% Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93%
Cancer waits – 31 days	Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94%
Cancer waits – 62 days	Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set
Category A ambulance calls	Category A calls resulting in an emergency response arriving within 8 minutes – 75% (standard to be met for both Red 1 and Red 2 calls separately) Category A calls resulting in an ambulance arriving at the scene within 19 minutes – 95%
Mixed Sex Accommodation Breaches	Minimise breaches

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.

Key measures for assessing progress

- Evidence of the development of a programme of action by April 2014, working in partnership with professional bodies, Health Education England, and Public Health England.
- Evidence that delivery of that programme is underway by April 2014.

Chapter 3: Putting patients first

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.

Key measures for assessing progress

- Evidence of the Board's role in:
  - commissioning that supports people to be involved in decisions about their care and treatment;
  - demonstrating that patients are as involved as they want to be in decisions about their care and treatment;
  - delivering and enforcing with immediate effect the rights to make choices about healthcare as set out in the NHS Constitution and associated documents;
  - continuing the extension of the Any Qualified Provider (AQP) policy in community and mental health services where this is in the interests of patients and aligns with local priorities. The 2012-13 NHS Operating Framework asked Primary Care Trusts (PCTs) to ensure that at least three services are delivered through AQP, and we expect phased implementation of AQP to continue where appropriate;

- extending choice in primary care (choice of GP practice), subject to the outcome of pilots; in secondary care (choice of named consultant led team or for secondary mental health services, choice of the team led by a specific professional); and in maternity care wherever possible;
- extending personal health budgets more widely to anyone who might benefit, especially those with long-term health needs, informed by evidence from the pilots;
- ensuring that personal health budgets are available for anyone eligible for NHS Continuing Healthcare, and to children with special education needs or disabilities, from April 2014;
- 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 will wait, for more than 18 weeks after referral to start consultant-led treatment for a non-urgent condition;
- ensuring that patients are aware of the choices available to them; and
- ensuring that, where appropriate, personalised care plans are available to all patients with long-term conditions and that they are developed and agreed with a named professional.

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.

Key measures for assessing progress

- Evidence that:
  - the Board has provided leadership and practical support for CCGs on commissioning integrated services;
  - the Board has prioritised investment in social care services which support the health system;
  - system levers and incentives, such as contracts and currencies, have been developed with a view to enabling integration;
  - the Board has effectively engaged with service users, local and national partners, including local government, in determining packages of care that are patient-centred;
  - patients report more integrated care – to be measured by a new indicator in the NHS Outcomes Framework; and

  - commissioners are jointly commissioning health and social care services with local authorities (using pooled budgets where appropriate) for key populations requiring integrated approaches; and, if not, can demonstrate that they have fully and properly explored the potential benefits of doing so.
- We will also look at the symptoms of fragmented care, including delayed discharge, inappropriate admissions, and missed appointments. For example, we will look specifically at unnecessary time spent in hospital by people with dementia.

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.

Key measures for assessing progress

- Evidence of:
  - easy and quick access where appropriate to patient records, for patients and professionals (including social care professionals);
  - increased use of technology to improve care and make health services easier to interact with (e.g. the ability for people to book appointments online);
  - fast and efficient transfers of information through different healthcare settings (and sharing of information between health and social care), supported by use of information standards;
  - improved breadth and quality of information (available at the level of clinical teams) about the quality and outcomes of services, including Patient Reported Outcome Measures (PROMs) and clinical audit (collected efficiently and effectively); and
  - comprehensive information on health services and health, including support for people using information at a local level.

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.

Key measures for assessing progress

- Evidence that carers:
  - are increasingly identified by health professionals and treated as expert partners in care;
  - have access to information, advice and support to enable them to care effectively and to look after their own health and well-being; and
  - are supported to have a life of their own alongside caring, in particular through breaks for carers.

Chapter 4: The broader role of the NHS

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; and
  - developing better integrated healthcare services for offenders.

Key measures for assessing progress

- Evidence that children and young people with Special Educational Needs or disabilities have access to healthcare services (including through use of personal health budgets where appropriate) identified in care packages which have been jointly developed and agreed between the NHS, the local authority and the school.
- Evidence of continued improvement in safeguarding practice in the NHS, and the maintenance of appropriate and clear responsibilities for safeguarding children, young people and vulnerable adults throughout the system.
- Evidence that the NHS is working with troubled families coordinators and other relevant agencies to contribute to the delivery of the troubled families programme.
- Evidence that the Board is upholding the obligations under the Armed Forces Covenant, in particular by ensuring no disadvantage to the Armed Forces, their families and veterans in accessing health services (particularly infertility services) when they move locations; and ensuring priority treatment (subject to the clinical needs of others) for veterans requiring treatment for service related conditions.
- Evidence of greater integration of healthcare services between custody and community for offenders.
- Evidence that commissioners make a contribution to reducing violence, in particular by ensuring that hospitals share anonymous, aggregated assault data with Community Safety Partnerships.

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.

Key measures for assessing progress

- Evidence that the treatment costs for patients who are taking part in research in the NHS are paid by the Board when it commissions services.
- Evidence that the Board has used its systems and processes to ensure that treatment costs for patients who are taking part in research in the NHS are paid by CCGs when they commission services.
- Evidence that patient recruitment to research in the NHS has increased.
- Evidence that performance of the NHS in initiating and delivering clinical research to time and target has increased.
- Develop and publish an innovation scorecard to track compliance with NICE Technology Appraisals.

Chapter 5: Effective commissioning

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.

Key measures for assessing progress

- Evidence of progress towards all the components of the objective, for example evidence from surveys of CCGs.

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.

Key measures for assessing progress

- Evidence that financial incentives for commissioners and providers support better outcomes and value for money.
- Evidence of progress in extending and improving NHS pricing systems as above, including an ambitious work plan to be agreed between Monitor and the Board for developing NHS pricing.

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.

Key measures for assessing progress

- Evidence of the Board's role in supporting appropriate service redesigns that lead to improved outcomes and meet the Secretary of State's four tests.

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.

Key measures for assessing progress

- Evidence of arrangements as set out in the objective.

Chapter 6: Finance and financial management

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.

Key measures for assessing progress

- Evidence that the objective has been met.

Annex C: The legal duties of the NHS Commissioning Board

The Board's accountability for meeting its legal duties

1. This document summarises the legal duties of the National Health Service Commissioning Board, as set out in the Health and Social Care Act 2012 ("the Act").[1]

2. The Secretary of State and Parliament will hold the Board to account for meeting its legal duties, as well as for its performance against the mandate. The Board must seek to achieve the objectives in the mandate, and comply with any requirements it contains (which must be backed by regulations).

The Board's overarching legal duties and functions

3. The Act makes clear that the Board has an overarching responsibility for promoting a comprehensive health service, concurrently with the Secretary of State (except to the extent that the Board's duty does not cover the Secretary of State's public health functions). The Board must promote a comprehensive health service designed to secure improvements in the physical and mental health of the people of England and in the prevention, diagnosis and treatment of physical and mental illness. Health services must be free of charge, except where charges are provided for by law.

4. In order to discharge the Board's duty under the Act to promote a comprehensive health service, the Act gives the Board the function of arranging for the provision of services for the purpose of the health service in England. The Act also gives the Board specified functions in relation to clinical commissioning groups (CCGs) – functions which the Board must exercise in such a way as to secure that services are provided in accordance with the provisions of the Act.

5. The Board has a number of general duties in exercising its functions:

   - A duty to have regard to the NHS Constitution; 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 the NHS Constitution among patients, staff and members of the public.

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[1] The Act amends the National Health Service Act 2006, inserting the provisions which establish the Board and confer its legal duties and powers. See sections 9 and 23, and Schedule A1, of the Act, available at http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted

- A duty to exercise its functions effectively, efficiently, and economically.
- A duty about securing continuous improvement in the quality of health services.
- A duty about promoting autonomy.
- A duty about reducing inequalities, both in the ability of patients to access health services and in the outcomes to be achieved for patients by health services. This builds on the existing legal duties of all public bodies in relation to promoting equality, under the Equality Act 2010.
- A duty to promote the involvement of patients, their carers and representatives in decisions relating to their care or treatment.
- A duty to act with a view to enabling patients to make choices about aspects of health services provided to them.
- A duty to take appropriate advice from people with professional expertise in public health.
- A duty to promote innovation.
- A duty to promote research on health service related matters, and the use in the health service of evidence obtained through research.
- A duty to have regard to the need to promote eduction and training, so as to assist with the Secretary of State's duty to ensure that there is an effective system for the planning and delivery of education and training.
- A duty to exercise its functions with a view to securing that health services are provided in an integrated way where this would improve the quality of those services, or reduce inequalities.
- A duty to take into account the impact of commissioning decisions on services for people who live in an area of Wales or Scotland that is near the border with England.
- A duty to avoid exercising its functions for the purpose of causing a variation in the proportion of services provided by any particular type of provider, such as those in the private (or public) sector.
- A duty to involve the public – for example by consulting them or providing them with information – in plans for commissioning or changing services.
- A duty to establish and operate systems for collecting and analysing information relating to the safety of services provided by the health services.

6. The Board also has a number of specific duties that relate to particular functions; these are summarised below.

Establishing and holding to account clinical commissioning groups

7. The Board's duties include:

    - Ensuring that each provider of primary medical services is a member of a CCG; and ensuring a comprehensive system of CCGs is in place, so that the areas of CCGs taken together cover the whole of England and do not coincide or overlap.
    - Authorising GCGs, granting applications from any prospective CCG that can satisfy the Board of certain matters including concerning its constitution, the area it will cover, the ability of the applicant to discharge its functions, and appropriate governance arrangements.
    - Holding CCGs to account. For example the Board must allocate funding to CCGs; publish guidance for CCGs; and conduct a performance assessment of each CCG every year. It also has powers to intervene where a CCG is failing, has failed, or is at significant risk of failing, to perform its functions.

The Board's direct commissioning of services

8. The Act gives the Secretary of State the power to make regulations requiring the Board to directly commission certain specified services, including prescribed types of dental services, services for members of the armed forces or their families, services for people in prison and other prescribed custodial settings, and such other services as may be prescribed (which it is intended will include specialised services).[2]
The intention is to lay regulations using this power in October.

9. The Act also gives the Secretary of State the power to make directions as to the exercise of any functions relating to arrangements for the provision of primary care services and high security psychiatric services.

10. The Act allows the Secretary of State to agree with the Board that it will commission certain public health services on the Secretary of State's behalf.

Partnership working and cooperation with other bodies

11. As part of a set of reciprocal duties for all arm's-length bodies, the Board has a duty to cooperate with Monitor, the Care Quality Commission, NICE, the Health and Social Care Information Centre and special health authorities, in the exercise of its functions.

12. In particular, the Act provides for the Board to work jointly with Monitor to agree the system of prices for paying providers of NHS services.

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[2] See section 15 of the Act

13. The Board has duties about:

- working with the Department of Health;
- contributing to the work of Health and Wellbeing Boards, as well as other statutory local partnerships of which it is a member;
- working with agencies and organisations outside the NHS in order to improve health and wellbeing and to achieve more efficient and integrated delivery of services; and
- meeting safeguarding duties for children and vulnerable groups.

Emergencies

14. The Board and CCGs have duties to ensure they are properly prepared for emergencies which might affect them. The Board also has duties to take steps to secure that CCGs and providers of NHS services are prepared for emergencies. The Secretary of State may direct the Board to exercise some of his functions relating to emergencies.

Financial duties

15. The Board's duties will include managing overall expenditure on commissioning and on administration within budget, and producing annual accounts that include the consolidated accounts of every CCG.

Annex D: Choice Framework

This is a draft document, published as an illustration to accompany the Government's consultation on the mandate to the NHS Commissioning Board. The document illustrates the Government's intended approach to explaining the choices that will be available for people receiving NHS services as part of the health service in England. For information about the current legal rights to make choices about your healthcare, please see the NHS Constitution. The choices set out here are in many cases subject to ongoing consultation and/or the outcome of pilot studies. As such they may be liable to change.

This is a guide to the choices that you can expect to have over your NHS-funded care and treatment in England. It explains:

- the choices you can expect to be offered about your care and treatment;
- when you can expect to be offered choices about your healthcare;
- where to get more information to help you make informed decisions; and
- how to make a complaint when you are not offered a choice.

The tables that follow explain your choices in the following areas:

Table 1. Choosing a provider for elective secondary care.

Table 2. Choosing your GP practice.

Table 3. Choosing a provider for some community and mental health services.

Table 4. Requesting an alternative provider for consultant-led treatment for a non-urgent condition.

Table 5. Choosing a team led by a named professional when you are referred to secondary care (e.g. a hospital) for non-urgent care as an outpatient.

Table 6. Choosing maternity services.

Table 7. Choosing your diagnostic test provider.

Table 8. Choosing to participate in research.

Table 9. Choosing a personal health budget.

Table 10. Choosing to be treated in another European Economic Area country.

The Government wants to help people make informed choices about the publicly funded services they use. Choice Frameworks will be published to set out and raise awareness of the choices available in publicly funded services, and how to raise a complaint if you are unhappy with the choice of services available.

Choice Frameworks will also be available for the following publicly funded services:

- Early years childcare
- Schools
- Social Housing

1. Choosing a provider for elective secondary care	
a. What choices are available?	You have the right to choose any provider in England for your first outpatient appointment with a consultant or a member of the consultant's team for most acute elective (non-urgent) care. This is a legal right, and is set out in the NHS Constitution. From April 2013, subject to consultation and legislation, you could have the legal right to choose a named, consultant-led team for your first outpatient appointment in secondary care where that is clinically appropriate. From April 2013, subject to consultation and legislation, you could also have the legal right to choose any named consultant-led or professional-led team within your secondary mental health service provider.
b. When is choice not available?	You can only choose a provider that is considered to be clinically appropriate given your condition. And you do not have the legal right to choose your provider if you are referred to: • Services for which it is particularly important to be diagnosed and treated quickly, including: – accident and emergency services; – cancer services for which there is a two-week maximum waiting time; and – services provided at Rapid Access Chest Pain Clinics for which there is a two-week maximum waiting time. • maternity services; • acute secondary care mental health services; or • any other services where it is necessary to provide urgent care. Where services are excluded from the legal right to choose, this does not necessarily mean that you will not be offered an opportunity to make a choice. For example, you can expect to be able to make choices over maternity services as described below (table 6).

	You do not have this right if you are prisoner, a serving member of the Armed Forces, or if you have been detained under the Mental Health Act 1983.
c. Who is responsible for giving me choice?	Your GP, dentist or optometrist must offer you a choice of any provider when referring you to your first consultant-led outpatient appointment. If they do not, your Primary Care Trust (from April 2013, your clinical commissioning group or the NHS Commissioning Board) must make arrangements to ensure that you have a choice. See: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_093004
d. Where can I find information to support my choice?	Please see: • NHS Choices: www.nhs.uk • Care Quality Commission: www.cqc.org.uk
e. What organisations can I approach for support in making decisions?	You have the right to information to help you make a choice. Primary Care Trusts (from April 2013, clinical commissioning groups) are required to publicise and promote awareness of information to help you make choices.
f. How do I complain if the choices outlined in section (a) are not available?	You can complain to your local Primary Care Trust. If the complaint is upheld, the Primary Care Trust is required to make sure that you are offered a choice. Primary Care Trusts (and from April 2013, clinical commissioning groups and the NHS Commissioning Board) have a duty to publish their procedures for complaints relating to these choices. If your Primary Care Trust is unable to resolve the complaint to your satisfaction, you have the right to refer the complaint to the independent Health Service Ombudsman. www.ombudsman.org.uk Subject to the introduction of secondary legislation, from April 2013 this right to make choices could be enforceable by the independent regulator Monitor, making other forms of redress available.

2. Choosing your GP practice	
a. What choices are available?	You have a right to choose which GP practice you register with. You have the right to express a preference for using a particular doctor within your registered GP practice, and for the practice to try to comply. These are legal rights, and are set out in the NHS Constitution.
b. When is choice not available?	A GP practice should accept you unless it has reasonable, non-discriminatory grounds for not doing so, for instance because you live outside its catchment area or because the practice has gained approval to close its list. Pilots are currently underway testing the best way of enabling people to choose from the widest possible range of GP practices. Under the pilots, GP practices may register patients from outside their normal catchment areas, whilst not having to provide home visits for them.
c. Who is responsible for giving me choice?	You will need to contact the GP practice with which you wish to register. If you are having difficulty registering with a GP practice, contact your Primary Care Trust (from 1 April 2013, the NHS Commissioning Board).
d. Where can I find information to support my choice?	Please see: • NHS Choices: www.nhs.uk • Care Quality Commission: www.cqc.org.uk
e. What organisations can I approach for support in making decisions?	Your Primary Care Trust (from April 2013, the NHS Commissioning Board) will provide information to help you make decisions.
f. How do I complain if the choices outlined in section (a) are not available?	If a GP practice does not accept you (without good reason), you can complain to your Primary Care Trust (from April 2013, the NHS Commissioning Board). If your Primary Care Trust is unable to resolve the complaint to your satisfaction, you have the right to refer the complaint to the independent Health Service Ombudsman. www.ombudsman.org.uk

3.	Choosing a provider for some community and mental health services
a. What choices are available?	Where commissioners have chosen to commission a service using an 'Any Qualified Provider' approach, you can expect to choose between a range of providers for that service. Choice of provider is being extended for some community and mental health services, where it is in patients' interests. Services which could be included are: physiotherapy, adult hearing services, psychological therapies or podiatry services. The services for which there will be choice of provider will differ from area to area depending on local commissioners' decisions. This is not a legal right, but an area in which you can expect to be able to share in decisions about your care and treatment. From April 2013, you can expect to be able to choose from any qualified provider for a wider range of community and mental health services. It will be for CCGs to decide where it is in patients' interests to use an 'any qualified provider' approach to offer greater choice of provider. As such, the services where this choice is available will vary across the country, reflecting local priorities. These are not legal rights.
b. When is choice not available?	In 2012/13, commissioners have selected at least three community and mental health services identified as local priorities for giving patients greater choice of who provides their care. Choice of provider may not be available for other services. From April 2013, it will be for clinical commissioning groups to decide where to commission services using an 'any qualified provider' approach to offer greater choice of providers. It is expected that the range of services for which choice of provider is available will increase over time.
c. Who is responsible for giving me choice?	You should contact your Primary Care Trust (or from April 2013, your clinical commissioning group) to identify for which local services there will be a choice of who provides your care. If you are referred to one of these services you should discuss the choices available with your GP (or the other health professional who made the referral).

d. Where can I find information to support my choice?	You can find out what choices are offered in your area by contacting your Primary Care Trust or viewing the 'any qualified provider' map: www.nhs.uk/aqpmap. Please also see: • NHS Choices: www.nhs.uk • Care Quality Commission: www.cqc.org.uk
e. What organisations can I approach for support in making decisions?	Your Primary Care Trust (from April 2013, your clinical commissioning group) will provide information to help you make decisions.
f. How do I complain if the choices outlined in section (a) are not available?	You should raise the matter (in writing or by speaking to them) with your practitioner, e.g. your nurse or doctor, or with your Primary Care Trust (or clinical commissioning group or the NHS Commissioning Board, from April 2013) but not to both. Your complaint should be resolved within 12 months. For assistance with your complaint, contact the Patient Advice and Liaison Service available in all hospitals or the Independent Complaints Advocacy Service. If your Primary Care Trust is unable to resolve the complaint to your satisfaction, you have the right to refer the complaint to the independent Health Service Ombudsman. www.ombudsman.org.uk

4.	Requesting an alternative provider for consultant-led treatment for a non-urgent condition
a. What choices are available?	You have the right to request a range of alternative providers if you either have waited or will wait for more than 18 weeks after referral to start your consultant-led treatment for a non-urgent condition. You also have the right to request an alternative provider if you will be waiting to be seen by a cancer specialist for more than two weeks since an urgent referral from your GP, where cancer is suspected. In response to your request, your Primary Care Trust (from April 2013, your clinical commissioning group or the NHS Commissioning Board) must investigate offering you a range of alternative providers that would be able to see or treat you more quickly. These are legal rights, and are set out in the NHS Constitution. From April 2013, subject to the outcome of pilots during 2012/13, you can expect to be able to choose from a range of alternative providers if you either have waited or will wait for more than 18 weeks after referral to start your consultant-led treatment for a non-urgent condition.
b. When is choice not available?	The right to request an alternative provider if you have waited for more than 18 weeks to start consultant-led treatment does not include non-medical consultant-led mental health services or maternity services. These rights will not apply if: • you choose to wait longer; • delaying the start of your treatment is in your best clinical interests, for example where smoking cessation or weight management is likely to improve the outcome of the treatment; • it is clinically appropriate for you to wait longer; • you fail to attend appointments which you had chosen from a set of reasonable options;

	• you are placed on the national transplant list; • you are referred for maternity services; • you refuse treatment; or • your treatment is no longer necessary.
c. Who is responsible for giving me choice?	To request an alternative provider you can contact either the organisation providing your treatment (e.g. your hospital) and/or the organisation commissioning your treatment (e.g. your Primary Care Trust, or from April 2013, your clinical commissioning group or the NHS Commissioning Board). They must take all reasonable steps to offer you a range of alternative providers that would be able to see or treat you more quickly.
d. Where can I find information to support my choice?	Please see: • NHS Choices: www.nhs.uk • Care Quality Commission: www.cqc.org.uk
e. What organisations can I approach for support in making decisions?	Primary Care Trusts (from April 2013, clinical commissioning groups and/or the NHS Commissioning Board) must establish a service for providing advice or assistance to patients whose treatment will be delayed beyond 18 weeks and to publicise that service.
f. How do I complain if the choices outlined in section (a) are not available?	You can complain to your local Primary Care Trust. If the complaint is upheld, the Primary Care Trust is required to take all reasonable steps to offer you a range of alternative providers that would be able to see or treat you more quickly. If your Primary Care Trust is unable to resolve the complaint to your satisfaction, you have the right to refer the complaint to the independent Health Service Ombudsman. www.ombudsman.org.uk

5. Choosing a team led by a named professional when you are referred to secondary care (e.g. a hospital) for non-urgent care as an outpatient	
a. What choices are available?	You can expect to choose a named, consultant-led team for your first outpatient appointment in secondary care. (see: www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_130425) This is not currently a legal right, although may become a legal right, subject to consultation and legislation. Subject to consultation, from April 2013, you could also be entitled to choose a specific professionally-led team when referred for a first outpatient appointment for secondary care mental health services.
b. When is choice not available?	Your choice must be clinically appropriate given the nature of your referral. For example, the provider you choose must offer the service that you require.
c. Who is responsible for giving me choice?	You should contact your Primary Care Trust (or from April 2013, your clinical commissioning group) to discuss the choices available.
d. Where can I find information to support my choice?	Providers are required to publish information about their services so that people can use this to make informed choices about their healthcare. Services listed on Choose and Book should name the responsible consultant or professional to allow you to choose a specific team. New consultant profiles have been launched on www.nhs.uk. These new profiles provide consultants with an opportunity to publish details about themselves and their areas of specialty. Please also see: • NHS Choices: www.nhs.uk • Care Quality Commission: www.cqc.org.uk • www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_130450.pdf
e. What organisations can I approach for support in making decisions?	There should be a discussion between the referrer and the patient about where and when the patient wants to be seen. This includes discussion of whether the patient wishes to be referred to a particular named consultant-led team.

f. How do I complain if the choices outlined in section (a) are not available?	Choice of named consultant-led team applies where patients have a legal right to choose their healthcare provider (table 1, above). If you do not feel you have been offered a choice of provider you may complain, as set out above. If you have been offered a choice of provider but not of named consultant-led team then you should raise the matter (in writing or by speaking to them) with your practitioner, e.g. your nurse or doctor, or with your Primary Care Trust (or clinical commissioning group or the NHS Commissioning Board, from April 2013) but not to both. Your complaint should be resolved within 12 months. For assistance with your complaint, contact the Patient Advice and Liaison Service available in all hospitals or the Independent Complaints Advocacy Service. If your Primary Care Trust is unable to resolve the complaint to your satisfaction, you have the right to refer the complaint to the independent Health Service Ombudsman. www.ombudsman.org.uk

6. Choosing maternity services	
a. What choices are available?	You can expect to have the option of going to your GP for a referral to a midwifery service, or going directly to a midwifery service without a referral from your GP. Depending on your circumstances, you can expect to be able to choose to receive antenatal care either from a midwife-only service or from a team of maternity health professionals including midwives and obstetricians. For some women, team care will be the safest option. Depending on your circumstances, you can expect to be able to choose between the following options for where you give birth: birth supported by a midwife at home; birth supported by a midwife in a local midwifery facility such as a designated local midwifery unit or birth centre; birth supported by a maternity team in a hospital. You will be able to choose any available hospital in England. After going home, you will have a choice of how and where to access postnatal care. This will be provided either at home or in a community setting, such as a Sure Start Children's Centre. Depending on where you live, you may have other choices about your maternity care. Contact your local Primary Care Trust (from April 2013, your clinical commissioning group) for information. These are not legal rights.
b. When is choice not available?	In making a decision about where to give birth, you will need to understand that your choice will affect the choice of pain relief available. For example, epidural anaesthesia will only be available in hospitals where there is a 24-hour obstetric anaesthetic service.
c. Who is responsible for giving me choice?	Your midwife will be able to tell you about the choices available locally. Alternatively, you can contact your Primary Care Trust (or from April 2013, your clinical commissioning group) to discuss the choices available.

d. Where can I find information to support my choice?	Please see: • your midwife • NHS Choices: www.nhs.uk • Care Quality Commission: www.cqc.org.uk • The Birthplace in England Research Programme: www.npeu.ox.ac.uk/birthplace • Information Service for Parents:www.nhs.uk/InformationServiceForParents/pages/home.aspx
e. What organisations can I approach for support in making decisions?	Your midwife will be able to give you information, advice and support so that you can make an informed decision. There are a number of charitable and voluntary organisations who are able to support you in your decision making. These include the National Childcare Trust, Birth Choice UK and Association for Improvements in the Maternity Services (AIMS).
f. How do I complain if the choices outlined in section (a) are not available?	Speak to your midwife or the Head of Midwifery in the first instance. You can also raise the matter with your Primary Care Trust (or clinical commissioning group or the NHS Commissioning Board, from April 2013). Your complaint should be resolved within 12 months. For assistance with your complaint, contact the Patient Advice and Liaison Service available in all hospitals or the Independent Complaints Advocacy Service. If your Primary Care Trust is unable to resolve the complaint to your satisfaction, you have the right to refer the complaint to the independent Health Service Ombudsman. www.ombudsman.org.uk

7.	Choosing your diagnostic test provider
a. What choices are available?	You have a legal right to choose from any secondary care provider in England when referred for a diagnostic test undertaken as a consultant-led first outpatient appointment. From April 2013, you can expect to have a choice of diagnostic test provider when referred by your GP for some of the more common diagnostic tests. Subject to consultation and legislation, this could become a legal right in time.
b. When is choice not available?	Choice of diagnostic test provider will only be available where clinically appropriate and safe. It will not be possible to choose who provides diagnostic tests offered as part of admitted or inpatient care or when tests are needed urgently.
c. Who is responsible for giving me choice?	You should contact your Primary Care Trust (or from April 2013, your clinical commissioning group) to discuss the choices available. For example, some Primary Care Trusts may be offering choice of any qualified provider for diagnostics such as Magnetic Resonance Imaging (MRI) and non-obstetric ultrasound. The choices available to you will be listed on the Choose and Book system.
d. Where can I find information to support my choice?	The Choose and Book system will show some information about the appointments listed. Please also see: • NHS Choices: www.nhs.uk • Care Quality Commission: www.cqc.org.uk
e. What organisations can I approach for support in making decisions?	There should be a discussion between the referrer and the patient about where and when the patient wants to be seen. You can contact your Primary Care Trust (or from April 2013 your clinical commissioning group) to discuss the choices available.

f. How do I complain if the choices outlined in section (a) are not available?	You should raise the matter (in writing or by speaking to them) with your practitioner, e.g. your nurse or doctor, or with your Primary Care Trust (or clinical commissioning group or the NHS Commissioning Board, from April 2013) but not to both. Your complaint should be resolved within 12 months. For assistance with your complaint, contact the Patient Advice and Liaison Service available in all hospitals or the Independent Complaints Advocacy Service. Diagnostic tests undertaken as part of a consultant led first outpatient appointment fall under choice of provider (table 1, above), and you should refer to that section if you wish to make a complaint in these circumstances. If your Primary Care Trust is unable to resolve the complaint to your satisfaction, you have the right to refer the complaint to the independent Health Service Ombudsman. www.ombudsman.org.uk

8.	**Choosing to participate in research.**
a. What choices are available?	You can expect to be offered the opportunity to participate in ethically approved research which is relevant to you, and will be free to choose whether you wish to do so. This is not a legal right.
b. When is choice not available?	If there is currently no research being conducted which is relevant to you, or if you do not meet the criteria for inclusion in a particular research study.
c. Who is responsible for giving me choice?	You should discuss with the clinical team (e.g. the hospital doctor, GP, nurse etc) that is providing your care.
d. Where can I find information to support my choice?	Information to help you decide about participating in research: www.nhs.uk/Conditions/Clinical-trials/Pages/Gettinginvolvedinresearch.aspx www.healthtalkonline.org/medical_research/clinical_trials www.crncc.nihr.ac.uk/ppi/ppi_involve The UK Clinical Trials Gateway provides information about clinical trials that are currently taking place: www.ukctg.nihr.ac.uk/aboutclinical.aspx http://public.ukcrn.org.uk/search/ http://apps.who.int/trialsearch/ You can get mobile phone access to the UK Clinical Trials Gateway via the iTunes and Android stores. Search for "clinical trials" to find the applications for iphone, ipad, android phone and tablet computers.
e. What organisations can I approach for support in making decisions?	The organisations whose websites are listed in section (d) above can help support you in deciding about participating in research. From April 2013, clinical commissioning groups will be required to promote patients' recruitment to and participation in research.

f. How do I complain if the choices outlined in section (a) are not available?	You should raise the matter (in writing or by speaking to them) with your practitioner, e.g. your nurse or doctor, or with your Primary Care Trust (or clinical commissioning group or the NHS Commissioning Board, from April 2013) but not to both. Your complaint should be resolved within 12 months. For assistance with your complaint, contact the Patient Advice and Liaison Service available in all hospitals or the Independent Complaints Advocacy Service. If your Primary Care Trust is unable to resolve the complaint to your satisfaction, you have the right to refer the complaint to the independent Health Service Ombudsman. www.ombudsman.org.uk

9.	**Choosing a personal health budget**
a. What choices are available?	Personal health budgets are currently being piloted. Subject to the evaluation, clinical commissioning groups across the country will be able to offer them to patients on a voluntary basis. Subject to affirmative resolution and secondary legislation, this will include the use of direct payments by summer 2013. It is the Government's aim to introduce a legal right to a personal health budget for people who would benefit from them, informed by the evaluation. Subject to the evaluation, people in receipt of NHS Continuing Healthcare and children with special educational needs or disabilities will be the first to have this right, by April 2014. This would be a legal right, set out in the NHS Constitution.
b. When is choice not available?	We do not believe personal health budgets will be right for all NHS services a person may receive. For example, they would not be appropriate for acute or emergency care or for GP services. The evaluation will help inform the decision on what NHS funded care can be included in a personal health budget. The evaluation will also help inform the decision on who should be eligible for a personal health budget. Currently the only people excluded from holding a direct payment are people subject to court-ordered drug rehabilitation requirements.
c. Who is responsible for giving me choice?	You should contact your Primary Care Trust (or from April 2013, your clinical commissioning group) to discuss having a personal health budget.
d. Where can I find information to support my choice?	Please see: • NHS Choices: www.nhs.uk • Personal health budget learning network www.dh.gov.uk/personalhealthbudgets
e. What organisations can I approach for support in making decisions?	Contact your Primary Care Trust (or from April 2013, your clinical commissioning group) to discuss having a personal health budget.

f. How do I complain if the choices outlined in section (a) are not available?	You should raise the matter (in writing or by speaking to them) with your practitioner, e.g. your nurse or doctor, or with your Primary Care Trust (or clinical commissioning group or the NHS Commissioning Board, from April 2013) but not to both. Your complaint should be resolved within 12 months. For assistance with your complaint, contact the Patient Advice and Liaison Service available in all hospitals or the Independent Complaints Advocacy Service. If your Primary Care Trust is unable to resolve the complaint to your satisfaction, you have the right to refer the complaint to the independent Health Service Ombudsman. www.ombudsman.org.uk

10. Choosing to be treated in another European Economic Area country	
a. What choices are available?	You have the right to choose, subject to certain conditions, to receive treatment which is normally available to you on the NHS in other countries within the European Economic Area (EEA).[1] This is a legal right set out in EU law. Subject to the legislative process, this will be set out in UK secondary legislation. Subject to consultation, this will also be set out in the NHS Constitution. Under a new EU Directive on patients' rights in cross-border healthcare, you have the right to access any healthcare service in another Member State that is the same as or equivalent to a service that would have been provided to you in the circumstances of your case. This means that **your treatment must be one that is available through the NHS.** You then have a right to claim reimbursement up to the amount the treatment would have cost under the NHS – or the actual amount, if this is lower. This means that you will normally have to pay for the full cost of your treatment upfront (though other arrangements may be available via your Primary Care Trust – or from April 2013, your clinical commissioning group or the NHS Commissioning Board). The Directive covers treatment provided in state-run hospitals and services provided by private clinics and clinicians.
b. When is choice not available?	The Directive does not cover: • social care; • access to and allocation of organs (for transplantation); or • public vaccination programmes against infectious diseases In some cases, prior authorisation may be required before you access treatment in another EEA country. This will enable you to confirm that you are entitled to the treatment requested, as well as the level of reimbursement that will apply.

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[1] The member states of the European union, plus Iceland, Liechtenstein and Norway.

	The process of prior authorisation will also ensure that you are aware of all of the possible treatment options within the NHS, which may be more convenient to you than going abroad. If you are unable to access treatment on the NHS without undue delay in your particular case, you must be granted authorisation.
c. Who is responsible for giving me choice?	If you wish to have your treatment in another EEA country, your GP, dentist or local commissioner must outline the choices that are available to you.
d. Where can I find information to support my choice?	Please see: • NHS Choices: www.nhs.uk • From 2013, you will be able to refer to the NHS Commissioning Board and National Contact Point websites.
e. What organisations can I approach for support in making decisions?	Contact your Primary Care Trust (or from April 2013, your clinical commissioning group or the NHS Commissioning Board) to discuss the choices available.
f. How do I complain if the choices outlined in section (a) are not available?	You can complain to your local Primary Care Trust (from April 2013 your clinical commissioning group or the NHS Commissioning Board). If the complaint is upheld, the Primary Care Trust is required to make sure that you are offered a choice. Primary Care Trusts (and from April 1st 2013, clinical commissioning groups and the NHS Commissioning Board) have a duty to publish their procedures for complaints relating to these choices. If your Primary Care Trust is unable to resolve the complaint to your satisfaction, you have the right to refer the complaint to the independent Health Service Ombudsman. www.ombudsman.org.uk

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Department of Health

Our NHS care objectives

A draft mandate to the NHS Commissioning Board

DH INFORMATION READER BOX

Policy HR/Workforce Management Planning/Performance	Clinical Commissioner Development Provider Development Improvement and Efficiency	Estates IM & T Finance Social Care/Partnership Working
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Contact details	The Mandate Development Team Room 602 Richmond House London SW1A 2NS mandate-team@dh.gsi.gov.uk	
For recipient's use		

DH Department of Health

Our NHS care objectives

A draft mandate to the NHS Commissioning Board

Contents

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

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[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

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[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.

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[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

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[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

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[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.**

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[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

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[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

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[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.

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[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

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[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.

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[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.

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[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

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[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?

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[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.

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[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.

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[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

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[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?

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[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

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[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

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[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.

Department of Health

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Produced by Williams Lea for the Department of Health

The broader contribution of the NHS

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

Effective commissioning

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

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