The NHS Commissioning Board, a key body in the Government’s NHS reforms, began operating as a special health authority in October 2011 and is set to formally start work in April 2013. The board will:

- have responsibility for commissioning primary care services and certain specialist services
- have oversight of clinical commissioning groups (CCGs), including their funding
- host clinical senates and clinical networks to advise both the Board and CCGs on commissioning decisions.

The Department of Health released a draft mandate to the NHS Commissioning Board for consultation on 4 July 2012. The consultation runs until 26 September and stakeholders are invited to respond to 12 questions. Following consultation, the Government will publish a final mandate ready to come into force by April 2013.

We are very keen that feedback from our members and stakeholders helps inform our response to the consultation. If you would like to contribute to our response please contact Ash Vithaldas, policy manager in the first instance by emailing ash.vithaldas@nhsconfed.org or phoning 020 7074 3237.

This briefing summarises the draft mandate and consultation questions. Alongside the mandate there are four annexes:

A) NHS Outcomes Framework
B) Key measures for assessing progress against the 22 objectives in the mandate
C) The legal duties of the NHS Commissioning Board
D) Choice Framework - a guide to the choices that the public can expect to have over their NHS-funded care and treatment in England.

**Five overarching priorities**
The draft mandate has five overarching priorities, supported by 22 objectives:

- improving our health and our healthcare
- putting patients first
- the broader contribution of the NHS
- effective Commissioning
- finance and financial management.

**NHS Confederation reaction**
When the draft mandate was published on 4 July, we said it broadly ticks the main box in that it keeps things relatively simple and consistent. Unlike documents that have gone before it, the mandate does not seek to develop an ever growing ‘wish list’ of objectives. It rightly encourages commissioners to exercise their knowledge of the needs of their local communities to plan and deliver the best care. We are particularly encouraged to see such a strong focus on the importance of good mental as well as physical health. We will have to wait to see whether this can be put in to
practice, and ensure the NHS Commissioning Board avoids returning to the old style of command and control.

What is the mandate to the NHS Commissioning Board?
- The NHS Commissioning Board will oversee the way that over £80 billion of taxpayers’ money is spent on NHS services. The mandate will be the main formal accountability document setting objectives for the Board - not the NHS as a whole - and what the Government expects to be achieved within the money it is given.
- It differs to the NHS Constitution as it aims to set the Government’s ambitions for improving the NHS service in the future. Future mandates will evolve as objectives are achieved and new priorities emerge.
- Ministers will continue to be accountable overall for the health service as a whole.
- The mandate will be a multi-year document, but published and updated annually. It can only be changed mid-year in exceptional circumstances. The first mandate will come into force in April 2013 and will be valid until March 2015.
- The mandate establishes the Board’s cross cutting duties in a number of areas including:
  - 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 where appropriate services are provided in an integrated way.

The mandate also places a duty on the Board to form successful partnerships with a wide range of organisations within and beyond the NHS and to operate in a transparent manner.

Consultation questions
The draft consultation asks 12 questions. The first five relate to the mandate as a whole.

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<thead>
<tr>
<th>Consultation questions</th>
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<tbody>
<tr>
<td>1. Will the mandate drive a culture which puts patients at the heart of everything the NHS does?</td>
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<td>2. Do you agree with the overall approach to the draft mandate and the way the mandate is structured?</td>
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<td>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?</td>
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<td>4. What is the best way of assessing progress against the mandate, and how can other people or organisations best contribute to this?</td>
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<td>5. Do you have views now about how the mandate should develop in future years?</td>
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Improving our health and our healthcare

This section of the draft mandate looks at maintaining progress across the Outcomes Framework.

- **Objective 6 (objectives 1-5 are below):** 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. The mandate contains objectives for each of the five domains in the NHS Outcomes Framework. However, it does not single out specific clinical conditions or patient groups to avoid distorting clinical priorities. Objective 6 (objectives 1-5 are below) in the mandate reflects this approach and is supported by domain-level objectives which gives 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.

The draft mandate does not yet include the actual levels of ambition against the Outcomes Framework, this will be set out in the final mandate taking into account responses to the consultation and further analysis.

In the draft mandate the Government has set objectives for each of the five domains of the NHS Outcomes Framework.

Domain 1: preventing people from dying prematurely

- **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. This objective prioritises the role of the NHS in reducing the number of avoidable deaths, recognising the complimentary role of public health organisations and of individuals in improving their own health.

Domain 2: enhancing quality of life or people with long-term condition

- **Objective 2:** Increase the number of Quality Adjusted Life Years for people in England with long term conditions to X by 2015; X by 2018; and X by 2023. This objective captures how well the NHS is supporting people with long-term conditions, and their carers, to live as normal a life as possible.

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

- **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. This objective captures the importance of helping people, especially older people, to recover as quickly as possible from illness or injuries. The indicators in this domain focus on emergency admission to hospitals and how well health services work closely with social care.

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

- **Objective 4:** Increase the proportion of NHS patients in England who would rate their experience as 'good' (as additional X patients by 2015); ii) increase the proportion 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. This objective reflects the importance of providing a positive experience of care, including treating patients with dignity and respect. It contains a ‘friends and families’ test i.e. whether patients would be happy for their friends and family to be treated or cared for similarly.

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

- **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. This objective seeks to embed the principle of ‘do no harm’ in the NHS. Similarly to domain 4 it is about treating patients with dignity and respect. It also reflects the importance of continuing to reduce healthcare-acquired infections.
In addition to setting objectives for each of the five domains in the NHS Outcomes framework, the Government has included additional objectives in Improving Health and Healthcare. They include:

Reducing inequalities and promoting equality

- **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) through greater improvement in more disadvantaged communities.

These objectives place a central duty on the Board to have regard to the need to reduce inequalities both in access and outcomes in healthcare for people of all ages; and ensure equality is promoted, for example by complying with legislation about age discrimination in services, due to come into force in October 2012. Domain one will set out the Government’s expectation in narrowing the eight-year gap in life expectancy between men in the most and least deprived areas of England, and a six-year gap for women. There is not yet a sufficiently detailed understanding of the drivers of inequalities to set ambitions for the Board in relation to domains two to five but the Government intends to set such ambitions for future mandates.

Putting mental health on a par with physical health

- **Objective 9**: Develop a collaborative programme of action to achieve the ambition that mental health should be on a par with physical health. Each domain captures measures for those with mental health problems reflecting the equal importance of mental and physical health.

Developing the NHS Outcomes Framework

The Department of Health, working with the Board, will continue to develop and improve the NHS Outcomes Framework over the coming years.

The NHS Constitution and service performance standards

- **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. The Board will have a role in maintaining or improving performance on existing service standards, for example standards relating to maximum waiting times, single sex accommodation and ensuring that patients and carers are offered the rights that they are entitled to, and that commitments are honoured under the NHS Constitution – including the right to drugs and treatments that have been recommended by NICE.

Improving health and preventing illness

- **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. The Board’s role in embedding public health in NHS Commissioning will be set out in an agreement made under section 7A of the NHS Act, which will be published alongside the mandate. The agreement will detail the Board’s role in emergency preparedness and health protection, including a power to facilitate a co-ordinated response to an emergency and that CCGs and providers of NHS services are properly prepared for such events.
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?

Putting patients first

This section covers:

- making ‘no decision about me without me’ the norm, giving all patients and carers an active role in decisions about care and treatment
- the need for the Board to focus on patients’ experience of their care
- using patient feedback to ensure NHS commissioners identify poor performance.

Securing shared decision making

- **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
  - 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.

- The Board and CCGs will help to promote shared decision making in the services they commission empowering patients to have a genuine role in their care and treatment.
- Patient choice is to be included throughout the care pathway, not just in primary care but also among providers and when selecting a lead clinician.
- Choice is to be pursued where it is in patients’ interest and not as an end in its own right.
- Government will publish ‘Choice Frameworks’ for different public services, setting out when and how the public can make choices about the services they use. Annex D to the mandate summarises what choices patients can expect and their right to be offered a choice.
- Subject to current pilots the Government wants commissioners to offer personal health budgets where appropriate, including the option of direct payments, and joint budgets across health, social care and other services. From April 2014 this will include people receiving NHS Continuing Healthcare and for parents of children with special educational needs or disabilities.

Integrating Care around patients

- **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.

- The Board has a role to promote joint commissioning, supporting CCGs to work in partnership with other organisations to get the best possible outcomes.
- While shared local leadership will be essential, the Board has a duty under the Health and Social Care Act 2012 to promote integration in the way services are provided, where this will lead to better health outcomes and reduce inequalities.
Improving information

- **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.
  - The Government’s new information strategy, *The Power of Information*, provides the overall context for the Board’s work in this area.
  - Collaboration between the Department of Health and the Board will set national information standards; and will support integration and to implement electronic patient and user records.

Supporting carers

- **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
  - Working collaboratively with local authorities and carers’ organisations to enable the provision of a range of support, including respite care.

  - 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.

  **Consultation questions**

  8. Is this the right way for the mandate to support shared decision-making, integrated care and support for carers?
  9. Do you support the idea of publishing a ‘Choice Framework’ for patients alongside the mandate?

The broader role of the NHS

- The way the NHS works in partnership with other public services can have a major impact on achieving better social outcomes overall. This section says CCGs will have statutory duties to engage in health and wellbeing boards and other collaborative arrangements such as community safety partnerships.
- It also talks about the Board’s vital contribution to making the best use of partnership working and joint commissioning. And it says commissioners can do more to help identify those with complex needs such as victims of crime, or people dependent on drugs and alcohol especially in the following four areas.

Supporting children, young people and families

- The Board will play a key role in supporting children and families by commissioning the Healthy Child Programme from pregnancy to age five until 2015, when responsibility will move to local authorities.
- The Board will expand the Family Nurse Partnership programme to improve outcomes for the most vulnerable first time teenage mother and their babies.

Tackling crime and improving community safety

- 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.
Supporting the armed forces (and other groups)

- **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 people 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.

- The NHS Commissioning Board will be instrumental in discharging the Government’s obligations under the Armed Forces Covenant by working to ensure that the health needs of the Armed Forces community are met, including by promoting integration with social care.

Promoting growth, innovation and research

- **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
  - promote access to clinically appropriate drugs and technologies recommended by NICE, in lines with the NHS Constitution.

**Consultation questions**

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

Effective commissioning

Establishing the commissioning landscape is the subject of this section of the mandate.

- **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 transparent, principle-based system for the Board's interactions with CCGs, including the effective management of poor performance and financial risks
  - there is effective partnership working between CCGs and health and wellbeing boards.

- The 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.
- 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.

- The Government expects the Board to publish a procurement framework to enable CCGs to procure support from a wide range of providers.
- CCGs will hold money for commissioning support and there will be no top-slicing of their budgets for this purpose.
- 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.
- 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 ‘assumed liberty’.
- CCGs are accountable to the Board for managing public funds robustly, for meeting statutory duties and for the outcomes they achieve through the Commissioning Outcomes Framework.

**Improved incentives, and a fair playing field for providers**

- **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.

  - Working with Monitor, a key priority for the Board will be to expand and develop the pricing systems and tariffs for paying providers, so that money follows patients and promotes better outcomes for patients.
  - 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.
  - There will be incentives for commissioners, through a Quality Premium developed by the Board, which will reward them for achieving high-quality outcomes within resources available. Funding for the Quality Premium will come from within the overall administration costs limit set in directions for the NHS commissioning system.

**Redesigning services to ensure high quality care**

- **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 based
  - consistency with current and prospective need for patient choice

- CCGs (and the Board for the services 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.
- Service redesign should be led by clinicians, 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.
The Board’s own commissioning

- **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.
  - 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.
  - While CCGs are not responsible for commissioning primary care, the Board will need to harness their expertise and enthusiasm to secure continuous improvement in quality.

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<td>11. Should the mandate include objectives about how the Board implements reforms and establishes the new commissioning system?</td>
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**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
  - The Board will be accountable for ensuring delivery of the QIPP savings in a way that supports the current Spending Review period and beyond including during the Government’s programme of reforms.
  - The Framework Agreement between the Department of Health and the Board, which is being developed, will set out further details on the Board’s need to comply with accounting and financial management rules.

**Allocating the NHS Commissioning Budget**

- In future, the Board will be responsible for allocating the budget for commissioning NHS services; this will also prevent any perception of political interference in the way this is done.
- 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.
- While decisions about allocating funding to commissioners will rest with the Board, the Department of Health is responsible for the overall NHS budget and therefore the Board has a duty to share its approach at key stages.

**Help shape our response**

We are very keen that feedback from our members and stakeholders helps inform our response to the consultation. If you would like to contribute to our response please contact Ash Vithaldas, policy manager in the first instance by emailing ash.vithaldas@nhsconfed.org or phoning 020 7074 3237.

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