



Department  
of Health

# The Government's response to the consultation on refreshing the Mandate to NHS England: April 2014 to March 2015

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# Introduction

1. Under the National Health Service Act 2006, as amended by the Health and Social Care Act 2012, the Secretary of State must publish a mandate every year to ensure that NHS England's objectives remain up to date and relevant, following consultation.
2. On 5th July 2013, the Government launched the consultation *Refreshing the Mandate to NHS England: April 2014 – March 2015*.<sup>1</sup> The consultation ran for 12 weeks and closed on 27th September 2013.
3. This document summarises the main findings and themes from the consultation; explains the approach taken; and outlines the final changes the Government made to the Mandate.
4. In parallel to the consultation, we engaged widely over the summer on the detail of the vulnerable older people's plan. A comprehensive summary of the feedback received through the engagement on the vulnerable older people's plan has been included in this document. It also takes account of the responses to the consultation questions (Q8 – Q10) which are relevant to the plan.

## The consultation

5. Over the course of the consultation, we received 225 consultation responses in the form of letters, email responses and feedback. Of these, 65 were specifically

on the proposals for the vulnerable older people's plan. We also held events and detailed discussions with a broad range of organisations and service users as part of the engagement on the vulnerable older people's plan.

6. We had over 7,218 unique page views of the Mandate section on the Gov.uk website: [www.gov.uk/government/consultations/refreshing-the-nhs-mandate](http://www.gov.uk/government/consultations/refreshing-the-nhs-mandate).

The dedicated webpage on the vulnerable older people's plan received 33,680 unique views: <http://betterhealthandcare.readandcomment.com/>.

7. We would like to thank those who took the time to contribute. We would also like to thank NHS England and Healthwatch England as our statutory consultation partners for their close and constructive engagement throughout the consultation period. A breakdown of the organisations that provided responses to the consultation and the engagement on the vulnerable older people's plan can be found in Annex A.

8. Responses were also received from people who use health and care services, NHS staff and the wider health and care workforce. We analysed all the feedback we received which helped shape the refresh of the Mandate.

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<sup>1</sup> [www.gov.uk/government/consultations/refreshing-the-nhs-mandate](http://www.gov.uk/government/consultations/refreshing-the-nhs-mandate)

## Summary of the feedback

9. In refreshing the Mandate, we took a number of actions to reflect what we have heard through the consultation.
10. The **first** was to rationalise the volume of changes introduced in the Mandate. A broad range of organisations felt strongly that the Government should seek to minimise the number of new changes so soon into a two year Mandate. For example, the NHS Confederation argued that *“the numerous proposed additions risk diluting the focus on the objectives in the Mandate.”* Whilst it is important that the Government is able to set out and consult on stretching ambitions, we recognise the importance of providing focus and clarity on the priorities for NHS England. We have therefore avoided overloading the Mandate and kept changes to an essential minimum, based on priorities which are stretching but realistic. A limited number of policy updates have been made to reflect the work being taken forward by NHS England. As a result, a number of the consultation proposals, whilst important, have not been reflected in the final version of the Mandate. This is particularly the case where proposals were deemed to be sufficiently covered by the existing objectives or better pursued through the accountability and assurance process with NHS England.
11. The **second** was to ensure that the Mandate was refreshed in a way that ensures stability and builds on the progress being made. Some viewed the consultation proposals as presenting significant change from the first Mandate, in that *“there appears to be a significant change from last year’s mandate to this year, suggesting a rewrite rather than refresh of what was a two year mandate”* – Sunderland CCG. The core aim of the Mandate is to provide constancy of purpose and direction. We recognise that the

Government cannot do this if the Mandate is radically changed from one year to the next. We have therefore carried out this refresh by updating the existing Mandate document rather than producing a new document.

12. The **third** was to strengthen the focus on outcomes and to avoid being overly prescriptive. Whilst some organisations felt that the consultation proposals lacked detail, many organisations felt that the proposals were taking an increasingly prescriptive and process driven approach, and moved away from the outcomes focus of the existing Mandate. The King’s Fund made the point *“at present, a number of the proposed updates stray into the territory of specifying how NHS England and other bodies are expected to deliver outcomes.”* In making the changes, we have sought to strike the right balance in providing strong leadership by Government whilst not crowding out local innovation, creativity and leadership.

## Key changes to the Mandate

13. To help understand where changes have been made to the first Mandate, they are set out by chapter in Annex B. The changes can be grouped into the following:

- Introduction of new system wide priorities to transform care:
  - The vulnerable older people's plan as a means for improving the health of the whole population and to provide excellent care for older people;
  - The addition of one new objective in relation to the system wide response to the Francis Inquiry recommendations to transform patient care; and
  - Taking forward actions to deliver a service that values mental and physical health equally.
- Setting out further ambitions on a limited number of areas to improve patient care:
  - Reducing avoidable premature mortality;
  - Supporting people with dementia;
  - Improving patient experience (Friends and Family test); and
  - Making better use of resources.

- Updates to reflect the work being taking forward by NHS England:
  - The shared commitment being taken forward to improve integrated care and the creation of the Integrated Transformation Fund, announced as part of the Spending Round 2013;
  - Addressing the failings witnessed at Winterbourne View private hospital;
  - Working with Monitor to support a fair playing field for providers;
  - Improving outcomes for children and young people; and
  - To support innovation to improve patient care.

14. The refreshed Mandate also sets NHS England's capital and revenue budget for 2014/15.

## Themes from the consultation

### Refreshing the Mandate (Q1 – Q2)

Q1. *What views do you have on the proposed approach to refreshing the Mandate?*

Q2. *What views do you have on assessing NHS England's progress to date against the objectives?*

#### Refreshing the Mandate

15. The majority of responses welcomed the open and transparent approach of consulting on the proposed changes to the Mandate: *"It is an open and transparent method of inclusion in an NHS that affects the population of England"* – Healthwatch and Public Involvement Association (HAPIA). Respondents welcomed the principle of reviewing the Mandate in consultation with stakeholders.

16. There was broad support for providing stability and focus by carrying forward the existing Mandate objectives. Asthma UK made the point *"this will be vital if progress is actually to be made in these areas."* Whilst many respondents agreed that the Mandate objectives and expectations should be refreshed to remain relevant and fit for purpose, some organisations felt strongly that the Mandate should not be updated one year into a two-year Mandate. On the whole, responses were in favour of refreshing the Mandate annually but urged caution against too much change. It was suggested that changes should be carefully considered as well as broad agreement that the Mandate should reflect emerging key system wide priorities, such as the response to the Francis

Inquiry, improving mental health services and the vulnerable older people's plan: *"It is right that the national requirements on the NHS are updated to reflect changing need and priorities although this does need to be balanced against appearing to respond to the many operational pressures the NHS experiences."* – Sheffield CCG. The Government agrees with the point made by the Foundation Trust Network (FTN) that the Mandate should drive future direction taking a system wide approach *"to ensure the Mandate remains a forward looking driver of strategic priorities rather than simply a document which 'catches up' with the existing policy context and sets increasingly detailed targets."*

17. We heard from many respondents that the consultation document, on the whole, was too prescriptive in tone and moved away from the high level and strategic outcomes approach set out in the existing Mandate. The NHS Clinical Commissioners commented that it *"contains well intentioned ambitions, but the language and tone of the document presents these ambitions as centrally prescribed processes and measurable targets for commissioners."* We acknowledge the points made that a balance should be struck between the Government setting out clear objectives and expectations, and going on to identify how these should be delivered. This informed our approach when updating the Mandate for 2014/15.

18. Some organisations, particularly local commissioners and CCGs, felt that some

of the proposals risked crowding out local autonomy and innovation. There was a strong sense that the Mandate should retain a strategic focus so that there is sufficient scope for NHS England and CCGs to take forward the objectives in a way that respects local circumstances and makes sense locally. However, there were some respondents who felt strongly that Government should take a more prescriptive approach in directing NHS England to achieve progress on the issues important to them. Whilst the Government agrees that progress is needed across the Mandate objectives, we also agree with the point that *“strengthening the autonomy of local organisations and frontline professionals to improve and innovate will be key to achieving health and care outcomes”* – Gateshead Council.

19. A number of responses felt that particular groups were under and/or insufficiently represented. Many respondents offered views and recommendations that were specific to the interests of the people and organisations they represent. In contrast, there were organisations who *“believe that the Mandate is very ‘disease’ and ‘pathway’ specific. It is therefore not ‘patient centred’.”* – BAPEN. We recognise there will always be a tension in striking the right balance on including specific groups and people and supporting the principle that the Mandate objectives focus on improving care and services for everyone who uses the NHS.

20. The volume and nature of the proposed changes was a particular concern for many respondents: *“NHS England, and Clinical Commissioning Groups, are in their early stages of implementation. It would, therefore, be inappropriate to make major changes to the Mandate at this stage and could impede the effectiveness and efficiency of these organisations”* – Urology User Group Coalition. There was concern that introducing too many changes and new objectives risked

creating a long list of competing priorities, diminishing the direction and focus for NHS England. In refreshing the Mandate, we have taken on board the point *“that this variability in the proposed changes may result in a lack of clarity about what is to be prioritised by NHS England”* – Nuffield Trust. The Government agrees with National Voices in that *“the NHS is more likely to achieve success in meeting the big strategic challenges if the Mandate is subject to significant revision towards the end of its life, allowing stability during its operational lifetime.”*

21. We also heard that simply asking the NHS to do more than it can manage is not a sustainable position. Questions were raised about whether new commitments introduced would require additional resources. The overriding concern was that the Mandate must be affordable within available finances.

22. In setting the Mandate and NHS England’s budget, we have worked closely with NHS England to understand any additional cost implications and to ensure that the Mandate continues to be affordable within their allocation. The Government recognises that this is a time of significant pressure on public finances and the NHS (as detailed at Spending Round 2013 and in NHS England’s call to action).<sup>2</sup> This was a key consideration in rationalising the volume of changes and ensuring that the objectives are stretching but realistic for NHS England to deliver.

### Assessing progress

23. The opportunity to comment on NHS England’s progress was widely welcomed. The general feeling was that it was too early to meaningfully comment and that NHS England has not been given sufficient time to demonstrate progress. Age UK made the point that NHS England and the new system need to bed in: *“NHS England should have*

<sup>2</sup> [www.england.nhs.uk/2013/07/11/call-to-action/](http://www.england.nhs.uk/2013/07/11/call-to-action/)

*the time and stability to oversee meaningful change in how care and support is planned, delivered and improved upon."*

24. Many organisations placed high importance on regular evaluation and reporting that is open and transparent: *"It is essential policy to regularly review, evaluate and identify areas for development, change or analysis of performances."* – Individual. This should cover both CCG performance and direct commissioning by NHS England. However, the point was made that *"expectations of progress being made in the first year of the new system should be realistic. The scale of the changes to the NHS means that it will take time for roles and responsibilities to become clear before real improvements can be seen"* – Cancer Research UK. Incorporating feedback from patients and families into the assurance process was considered an important aspect and we take the point made by Healthwatch England not to be overly *"reliant solely on information gathered by the NHS."* Assessing progress should be based on measureable outcomes, although this was thought to be easier for some objectives than others.

25. A number of organisations asked for clarity on how the Department of Health will hold NHS England to account against progress, particularly in reducing health inequalities. The Government has developed a robust assurance and accountability process to hold NHS England to account for delivery against the objectives. There are a number of in-year checks in addition to the end of year reports produced by NHS England and the Department of Health respectively on their progress towards achieving the objectives in the Mandate. The Secretary of State holds accountability meetings every two months with the NHS England Chair, alongside monthly senior departmental sponsorship meetings. The Government acknowledges the importance

of transparency and making information available to improve public confidence. The Association of Medical Research Charities (AMRC) made the point that *"it is important for NHS England to demonstrate that it is making progress to inspire the confidence of patients and the public as it establishes its central role in the NHS."*

26. To support openness, the Government intends to publish progress updates including annual assessments, which are easily understandable and accessible.

### **Helping people live well for longer (Q3)**

Q3. *What views do you have on the proposal to help people live well for longer?*

27. The majority of respondents were supportive of the ambition to reduce excess deaths and tackle avoidable premature mortality. To help achieve this goal, a popular suggestion was that there should be greater focus on and investment in prevention, early intervention and early diagnosis. The point was also made that individuals themselves have a role in taking greater responsibility for their own health: *"There needs to be a greater emphasis on the personal responsibility of patients and the public to ensure that they live healthy lifestyles, and not merely on the role of the NHS as a 'safety net'."* – Somerset Partnership NHS Foundation Trust. In many cases, this requires individuals to be provided with the information in order to self-manage long-term conditions, or everyday healthy lifestyles. It also means making every contact count with health care professionals. There were numerous and varied suggestions of the factors, diseases, conditions and health inequalities which contribute to avoidable premature mortality. We also heard that reducing excess deaths across all age groups, in adults, children and young people is important. Some organisations felt that timely access to the right treatments and



medicines including those approved by NICE would help in achieving this objective.

**28.** Many respondents highlighted the collaborative nature of achieving this goal as many of the contributory factors fall outside the control and influence of the NHS. Tackling the wider determinants of health will require strong partnership working with Public Health England, local Government and other key partners at local and national level. In this context, we heard from several respondents that allocating a part of the new ambition was potentially confusing and counterproductive. The Richmond Group expressed concerns over holding NHS England to account for only a third of the system wide ambition of avoiding an additional 30,000 premature deaths per year by 2020, because it would “*promote a siloed approach.*” We also note the cautionary point by Healthwatch Bucks who were “*against the development of an excessive number of targets, particularly those that measure process and outputs rather than focusing on outcomes.*”

**29.** The objective has been updated to reflect the system wide approach that is needed to achieve the overall ambition. We have removed the 10,000 figure to avoid potential fragmentation and unintended consequences. As every community is different, the Government recognises the value and benefits of the contribution being informed through a bottom-up approach by NHS England and CCGs. This supports local autonomy and provides CCGs with the opportunity to work with local partners in their communities along with health professionals and Health and Wellbeing Boards to define their contribution based on local priorities. We have also reflected the need for NHS England to take account of the Pharmaceutical Price Regulation Scheme agreement given the important role which medicines can play in keeping people healthy.

### **Managing ongoing physical and mental health conditions (Q4 – Q5)**

*Q4. What views do you have on using the refreshed Mandate to reflect the plans to strengthen A&E services?*

*Q5. What views do you have on the proposal to reflect NHS England’s ambition to diagnose and support two-thirds of the estimated number of people with dementia in England?*

#### **A&E services**

**30.** In general, most respondents supported the short term planning to manage pressures on A&E services for this winter. However, there was a strong feeling that short-term measures would not address the underlying issues and demands which are placing unsustainable pressures on A&E services. For example, the Neurological Alliance made the point that “*increasing pressure on A&E services is often the consequence of failings in the rest of the health and social care system. Whilst we recognise that A&E services must be supported to ensure in the short term that they are capable of meeting demand, it is vital that the Mandate takes a long term view.*” Respondents suggested strengthening primary care and out-of-hospital services and building capacity in other parts of the health and care system was vital.

**31.** The Government agrees that focusing on strengthening A&E services alone detracts from the need to build the capacity of services to reduce the pressures on urgent and emergency care. We have therefore considered the issue as part of developing the vulnerable older people’s plan to transform health services. NHS England are also carrying out an Urgent and Emergency Care Review which will help shape the future of urgent and emergency care services. This long-term review will ensure long-term

changes are delivered to sustain urgent and emergency care in the NHS.

### **Dementia**

**32.** The consultation revealed broad support for tackling the growing problem of dementia and the Government agrees with those who feel people with dementia can be better supported. Whilst many respondents considered the diagnosis level as stretching, some felt that it could be more ambitious due to the variation which exists. *“The RCN view is that this proposal does not go far enough. Diagnosis rates are currently about 44% across the UK on average but some regions are as high as 75%.”* The Government agrees that NHS England has an important role in holding CCGs to account for unacceptable variation in diagnosis.

**33.** Although many respondents welcomed the focus on diagnosis, the overwhelming majority felt that early detection and diagnosis will be ineffective on its own without better post diagnosis care and support. University Hospitals Birmingham NHS Foundation Trust made the point that *“the focus now needs to move beyond the assessment, diagnosis and referral of people with dementia to ensuring they are treated and supported in the community to reduce admissions to secondary care.”* Many organisations felt that more investment in community services will be needed to cope with demand and support people to live in their own homes and communities.

**34.** Support for carers and families was considered as particularly important to help them cope with the demands of their role. The Carers Resource made the point that *“we very much welcome the drive to identify and support people with dementia however this must be coupled with the appropriate provision of support for their carers during/ following diagnosis.”*

**35.** The Government takes the view that better diagnosis will help more people get the right post-diagnosis support and, given the scale of the challenge, we have therefore updated the objective in the refreshed Mandate. Local commissioners should work together to ensure that adequate services are commissioned to support people with dementia and their carers to live well in the community. Better community support for people with dementia should reduce unnecessary hospital admissions and can delay the need for institutional care.

### **Helping people recover from episodes of ill health or following injury (Q6 – Q7)**

*Q6. What views do you have on updating the Mandate to make it a priority for NHS England to focus on mental health crisis intervention as part of putting mental health on a par with physical health?*

*Q7. What views do you have on the proposals to ask NHS England to take forward action around new access and / or waiting time standards for mental health services and IAPT services?*

### **Mental health**

**36.** The consultation demonstrated strong support for greater focus on improving mental health services. Putting mental health on a par with physical health was viewed as critical to improving outcomes across many of the Mandate objectives. One respondent who provided views to Beat's response thought that *“if the public felt that the NHS could, and would, treat – and cure – mental health problems as easily and readily as they address physical illness, many more people would come forward to access treatment.”* Despite the focus in the existing Mandate, there was a general feeling that mental health services remain the 'poor' relation to physical health services.

**37.** Most respondents agreed that crisis services were inadequate and a priority for improvement: *“I would urge a rethink about how crisis services are delivered, with the views of users central to this process”* – student social worker. We heard that significant variation across England in accessing crisis care/services exists. The Royal College of Psychiatrists highlighted that *“recent research conducted by Mind has uncovered: ten-fold variations between English mental health trusts in terms of access to crisis care services.”* There were particular concerns over long waiting times and insufficient capacity to ensure people can access crisis services when they need them. A consequence is that people experiencing a mental health crisis can often end up in an inappropriate setting such as a police cell. The lack of adequate liaison psychiatric services was considered to be an important contributory factor in preventing prompt access to mental health support.

**38.** Many organisations felt that to achieve the level of improvement needed, it would require further investment in mental health services. The point was also made that existing resources could also be better spent, for example, through better partnership working. It was noted that several agencies need to be involved when a person suffers a crisis, including social care, the NHS, the police and the ambulance service. Better inter-agency co-operation will avoid duplication of efforts and ensure existing resources can be spent in a more effective way. The point was also made that time, money and resources could be saved by treating people early rather than intervening later when their condition becomes more severe.

**39.** The broader point was made that significant improvements are needed in all mental health services, not just crisis care, and the importance of taking a life course

approach to support good mental health. Mental health services should be available to, and support people of all ages, including children and young people. The point was often made that children and young people’s mental health services lagged behind that of adults: *“evidence suggests that mental health services for children and young people are regarded as an add-on rather than a mainstream service in their own right and currently lag behind the status of adult mental health”* – National Children’s Bureau and Council for Disabled Children.

**40.** Concerns were raised that focusing on improvements around crisis intervention will lead to resources being reallocated away from supporting prevention and early intervention: *“Whilst we acknowledge major challenges in responding better to mental health crises, we are keen to ensure much earlier preventive approaches which can avert crises and enable patients to remain in their families, employment and communities wherever possible”* – Standing Commission on Carers. The point was made that better early intervention and community services would help reduce emergency admissions to crisis services: *“Whilst we welcome the renewed focus on putting mental health on a par with physical health, it is important that this Mandate refresh should focus on all aspects of mental health services and not just at the point of crisis. Providing people with diabetes, for example, with timely access to treatment for psychological conditions, including depression, has been shown to improve glycaemic control, as well as reduce both psychological distress and the cost of healthcare”* – Diabetes UK. Improving Access to Psychological Therapy (IAPT) services were considered particularly important in supporting people to lead a fulfilling life and stay in or gain employment. It gives them the opportunity to contribute to society and the economy. It was also considered important

that people should be offered a choice of NICE-recommended psychological therapies and not just rely on cognitive behavioural therapy.

41. There was broad support for the proposal concerning access and waiting time standards: *"It is an example of the lack of parity that there are acceptable times within which physical health conditions have to be addressed but not for mental health. We would welcome work between NHSE [NHS England] and the Department of Health to consider ways of speeding up access and making it more equitable for those currently under represented. Routes into treatment must also be considered, for example people from BME communities who often access mental health services via emergency or crisis pathways"* – Turning Point.

42. The point was made that improving access is not an end in itself but a means to improving outcomes. Some respondents expressed concern about setting new targets: *"We would welcome a new waiting time standard, but we do have some concerns. For instance, the current 18 weeks waiting times target can act as a perverse incentive and result in young people being quickly given an initial assessment and then going on a longer internal waiting list. This focus on waiting lists can reduce the quality of care as services are concentrating on getting children and young people through the door quickly and stopping the waiting time clock, rather than ensuring that they are accessing the help and support they need. Any new standard should ensure that there are no such perverse incentives and that the emphasis is on the quality of care"* – YoungMinds.

43. Given the urgency and importance which respondents attached to the issue of mental health and crisis services, the refreshed Mandate increases the momentum

on NHS England to make progress. This includes developing options for new access and/or waiting times for mental health services, including IAPT services. We feel that this is a significant step in the right direction to realise the Government's ambitions to transform mental health services.

### **Making sure people experience better care (Q11 – Q14)**

Q11. *What views do you have on updating the Mandate to reflect the Francis inquiry and the review of Winterbourne View Hospital?*

Q12. *What views do you have on updating the objective to reflect NHS England's role in supporting person centred and coordinated care?*

Q13. *What views do you have on updating the existing objective to reflect the pledges in Better health outcomes for children and young people?*

Q14. *What views do you have on updating the existing objective to reflect the challenge for NHS England to introduce the 'friends and family test' to general practice and community and mental health services by the end of December 2014 and the rest of NHS funded services by the end of March 2015?*

### **Francis Inquiry and Winterbourne View Hospital Review**

44. There was overwhelming support for reflecting the actions being taken forward as a result of the Mid Staffordshire NHS Foundation Trust Public Inquiry and Winterbourne View Hospital Review, but in a high level and strategic way. The Health Foundation made the point that *"the very purpose of conducting reviews into failings of care is to uncover the causes for those failings, and to take action to minimise the same failings reoccurring either in the same organisation or elsewhere."* Understandably, many organisations wanted further detail on

the Government's system wide response to the Mid Staffordshire NHS Foundation Trust Public Inquiry.

45. Comments on these proposals focused primarily on the culture change needed to transform care. Legislation and regulation were acknowledged as important levers but they will not in themselves bring about the necessary behaviour change. The Government agrees with the Nuffield Trust who noted that "*without some clear expectations of demonstrating changed behaviour, there is a risk that the calls for genuinely patient-centred care become hollow statements of purpose.*" The Government recognises that change must come from within and across the NHS as a whole. Behaviour and culture change will not stem solely from direction through a Government document but must be owned and driven by organisations and frontline professionals themselves. "*The behaviours and culture generated will be just as important as the words written in the Mandate*" – NHS Confederation.

46. A key theme was the importance of creating an open and supportive environment within the NHS, which is conducive to learning from mistakes and poor practice: "*To promote and encourage healthy open cultures it is imperative that a constructive and supportive rather than blame culture is in place*" – Pharmaceutical Services Negotiating Committee. Individuals, carers and families as well as staff should be able to speak out when they see bad practice without fear of reprisal. Staff and leaders at all levels in the NHS and across the health and care system have an important role in encouraging and supporting this openness. Many respondents suggested that the NHS should become better at listening to patients, carers and families; others suggested a stronger emphasis on compassion in recruitment and

appraisals to foster the right attitudes and values within an organisation.

47. The refreshed Mandate reflects the actions being taken forward by NHS England in the final report and Concordat<sup>3</sup> that were developed in response to the Winterbourne View Review to improve the safety of vulnerable groups. We have also introduced a new objective for NHS England to take forward the actions in response to the Mid Staffordshire NHS Foundation Trust Public Inquiry to transform patient care. The underpinning detail will be set out in the system wide response which will be published shortly.

#### **Integrated care**

48. The proposal to update the current objective to reflect *Integrated Care and Support: Our Shared Commitment* and the Integration Transformation Fund (ITF) was widely supported. Integrated care was viewed by respondents as a priority for improving patient care but that significant progress was needed. Macmillan Cancer Support made the point that it would require "*removing the policy and organisational barriers within health and social care services, to enable this ambition.*" Some organisations asked for clarity as to how progress on integrated care will be measured.

49. The ITF was welcomed as an opportunity to encourage joint working between local organisations and incentivise cooperation between local commissioners, and between commissioners and providers.

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<sup>3</sup> Winterbourne View Review Concordat: Programme of Action – Published December 2012 [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/127312/Concordat.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127312/Concordat.pdf) and Transforming care: A national response to Winterbourne View Hospital. Department of Health: Final Report [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/127310/final-report.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127310/final-report.pdf)

The Local Government Association said that they thought the “*Integration Transformation Fund (ITF) announced in the spending round for 2015/16 will be crucial in driving forward integration*”. Many organisations considered it important that clinical commissioning groups (CCGs) and NHS England fully engage with local authorities and partners, particularly health and wellbeing boards, in the development of local plans. Some respondents wanted further clarity on how the ITF will work – further information can be found on NHS England’s website.<sup>4</sup> The full mechanics of the ITF are currently still being developed and more detail will be made available in the planning guidance from NHS England at the end of the year.

**50.** Whilst supportive of the aim, there was also a cautionary tone. There was a strong feeling that the focus should be on outcomes and not organisations. Concerns were raised that integration plans would concentrate on systems and processes rather than people. The Government agrees with the point that the measure of success must be based on outcomes, not simply whether organisations have worked together. The Government agrees that integration is a means to an end, not an end in itself and that the ITF is not the solution but a “*process mechanism to help achieve those outcomes*” – National Voices.

**51.** Many organisations were keen to emphasise that person-centred care applies to all patients, service users and age groups. The role of patients, carers and families was considered important, but often overlooked, in designing coordinated and holistic care packages to meet individual needs. Continuity of care was identified as important, for example, for women throughout pregnancy and at key transitions points such as into adulthood. We heard that care should

be responsive to different needs, for example, “*LGB&T people often feel that clinicians do not treat them as a whole person and do not understand their needs in relation to their sexual orientation and/or gender identity, meaning they are not given the correct care or signposted to appropriate specialist services.*” – National LGB&T Partnership.

**52.** The Government attaches great importance to integrated care and the refreshed Mandate has been updated to reflect the commitments NHS England are taking forward. With respect to how progress on integrated care will be measured, the Government has commissioned independent research to develop a national measure of people’s experience of integrated care. A progress update has been included in the NHS and adult social care outcome framework documents published alongside the Mandate. The ambition is to include an indicator of people’s experience of integrated care in the NHS, adult social care and the public health outcomes framework.

### **Better health outcomes for children and young people**

**53.** The majority of responses were supportive of updating the objective to reflect the pledges in *Better health outcomes for children and young people*.<sup>5</sup> The Royal College of Paediatrics and Child Health felt that “*by reflecting the Pledge in the Mandate the Department of Health can take the significant step of embedding these priorities throughout the NHS.*” Many organisations questioned how NHS England would take forward and implement the pledges as well as demonstrate progress. The Children and Young People’s Forum along with other organisations representing children wanted

<sup>4</sup> [www.england.nhs.uk/2013/10/18/ccgs-issue-44-181013/#itf](http://www.england.nhs.uk/2013/10/18/ccgs-issue-44-181013/#itf).

<sup>5</sup> [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/207391/better\\_health\\_outcomes\\_children\\_young\\_people\\_pledge.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/207391/better_health_outcomes_children_young_people_pledge.pdf)

the Department of Health to go further and require NHS England to undertake a number of actions including setting out a framework for implementation. However, we felt such an approach would be overly prescriptive and contrary to the points made about strengthening the autonomy of NHS England and CCGs. It is for NHS England to determine how best to achieve the objective working closely with partners. The Government will hold NHS England to account for the progress they make in achieving this.

**54.** A key theme from the responses was the importance of preventative and early intervention along with support for families. Better integrated services are needed that provide support for children and young people as they move from childhood through to adulthood. Another theme was the importance of a system wide approach, with partnership working required at the national level between NHS England, Public Health England and key partners but also at a local level. Together for Short Lives made the point that NHS England should “*demonstrate that they are engaging with children and young people and other England-wide health bodies, such as Public Health England, Healthwatch England and Health Education England, in order to ensure a coordinated strategic approach.*”

**55.** We also heard from several organisations that improving mental health outcomes for children and young people is as important as improving physical outcomes. The Government agrees that good mental health begins with mothers during pregnancy and throughout childhood. The point was also regularly made that children and young people should be listened to and involved in their own care.

**56.** In the Mandate we have reflected the pledges in *Better health outcomes for children and young people: Our pledge*.

We expect NHS England to set out further detail on how they intend to take forward the pledges when they update their business plan to reflect the Mandate for 2014/15.

### **Friends and Family test (FFT)**

**57.** The responses revealed broad support for the principle of capturing patient experience to improve services. However, on the use of FFT, the responses took a more balanced view. There were organisations who took the view that FFT can be a useful mechanism and that it should be rolled out and the feedback acted upon: “*We must also hold organisations accountable to negative F&F findings. The loop must be closed*” – University Hospitals of Leicester NHS Trust.

**58.** There were organisations that were more cautious and felt that FFT should be considered and evaluated further before faster roll out. There was also caution about how feedback may not always be indicative of the quality of care experienced: “*There are considerable doubts as to how useful the Friends and Family test is as a measure of quality*” – Lincolnshire West Clinical Commissioning Group. Some felt that patients resonate with some measures of patient satisfaction more than others, such as appointment waiting times and hospital environment. However, such measures are not standardised; can be influenced by sample size; and cannot always be directly linked with outcomes or the quality of the service received.

**59.** Some organisations questioned the approach altogether. Concerns centred around its usefulness including the robustness of the methodology and quality of data particularly for comparative purposes between services and organisations. The point was made that “*the friends and family test, taken alone, may be too limited to give complete information about the reasons*

*behind poor patient experience” – British Lung Foundation.*

**60.** In rolling out the test, respondents felt strongly that the test should not become a bureaucratic burden and that it should be adapted to different settings and ways in which care is delivered. Furthermore, it should be made accessible for all groups, for example, those who are hard to reach, those with mental health problems and people with learning disabilities. Mencap *“welcome[d] the concept of the friends and family test as we strongly believe that for services to improve, they [NHS England] need to take on board the comments, both positive and negative... However, we would strongly urge the addition of a commitment to make the test accessible to all, reflected in making alternative versions of the test available to meet people’s communication needs.”* It was stated that feedback should also be sought from children and young people using services, although some felt that FFT may not be the most effective way to elicit a response from children. The point was also made that carers and families were not invited for views.

**61.** Whilst the Government acknowledges the concerns raised, we welcome the fact that organisations, on the whole, were supportive of the intention. The Government feels strongly that patients should shape and evaluate services to help tackle poor performance, enable choice and drive continual improvement. We recognise that *“the ‘friends and family test’ is one way of collecting data on patient experience, but should not be viewed as the only meaningful method for gathering this information”* – Breakthrough Breast Cancer. Domain 4 of the NHS Outcomes Framework specifically focuses on ensuring people have a positive experience of care and is made up of a broad range of indicators.

**62.** FFT should be accessible to all and supported with other indicators of quality that enable in-depth analysis of patient experience. However, the Government feels that the test, although a simple survey, offers a method of service evaluation that provides rapid and valuable information, which is published regularly. Providers are already finding this regular feedback useful in driving service improvements.

**63.** The Government therefore supports greater momentum behind the roll-out of FFT and this has been reflected in the Mandate. We will continue to work with NHS England during roll-out to explore ways to capture and use patient feedback and experience to improve care.

### **Providing safe care (Q15)**

*Q15. What views do you have on these proposals to improve patient safety?*

#### **Patient safety**

**64.** In line with the findings of the Berwick Review, continuous improvements in patient safety were viewed as a priority by the majority of respondents. We also heard that improving patient safety applies to all care settings, for example, community services. This was considered particularly important if the emphasis is on greater care being provided out in the community, particularly in people’s own homes.

**65.** In line with responses to Q11, it was widely felt that organisational culture and staff behaviour needs to change towards complaints, and in encouraging an environment of learning rather than blame: *“Learning from complaints is key to the development of any organisation. People should feel confident about making a genuine complaint about their health care, but we recognise that the culture of the organisations and the professions needs to change to ensure that complaints are not received*



*negatively*” – Health Scrutiny Committee for Lincolnshire County Council. This includes promoting a learning culture amongst staff and professionals through constant feedback. Many organisations questioned whether current complaints processes would support a culture of learning and feedback: *“We believe that creating a culture of zero harm will depend on staff feeling able to speak freely about poor care. The objective must be a health service in which any concerns would be raised and addressed at an early stage, and to promote the message that raising concerns is not only acceptable but a positive thing – because it enables services to be improved”* – British Medical Association.

**66.** It was recognised that changing behaviours to create the right environment to promote safe and high quality care would be challenging. It will also require a system wide response. Strong leadership at all levels within organisations and across the health and care system was considered essential. There were wide-ranging suggestions on how to improve patient safety and foster the right culture which included more outcomes indicators, protocols, procedures, regular monitoring and greater information sharing of patient information across organisational boundaries. Increased reporting in the number of incidents and transparency were often raised as suggestions for building a culture of patient safety. However, greater candour in reporting needs to strike the right balance with reducing bureaucracy.

**67.** The Government’s response to the Berwick Review and Francis related reviews will be included as part of the system wide response to the Mid Staffordshire NHS Foundation Trust Public Inquiry which will be published shortly.

**68.** In terms of reflecting the Caldicott Information Governance Review in the Mandate, respondents were generally

supportive. Whilst many supported e-patient records to support better integrated care, appropriate safeguards and consent were considered necessary to protect patient confidentiality. Attitudes around data sharing were considered to be a particular challenge. NHS England has demonstrated their support for the principles in the review. In rationalising the changes introduced into the Mandate, we have not included this, but we expect NHS England, as a system leader, to demonstrate leadership on this issue.

### **Transforming services (Q16 – Q19)**

*Q16: What views do you have on the proposal to update the Mandate for NHS England to work with Monitor towards a fair playing field for providers?*

*Q17: What views do you have on the proposal for Government to provide additional leadership on delivery of agreed Government pre-existing commitments?*

*Q18: What views do you have on the proposal to update the objective to challenge NHS England to support the NHS to go digital by 2018?*

*Q19: What views do you have on the proposal to be more explicit on the expectation around reporting?*

### **Fair Playing Field Review**

**69.** Responses to this proposal were mixed. Some respondents supported the principle of competition as a means to improve the quality of care for patients. However, others expressed concern that competition could lead to fragmentation in the delivery of care by acting as a barrier to collaboration between care providers and preventing integrated service models from developing: *“The ambulance service believes that competition should be embraced where it can contribute to greater quality, innovation or value for money. However, care needs to be*

*taken that it does not threaten cooperation, coordination, integration and comprehensive cover” – Association of Ambulance Chief Executives.*

**70.** The Government agrees that competition should focus on quality and improving services for patients – including through the greater integration of services. The focus on creating a fair playing field is to help ensure existing competition in the NHS works well in the best interests of patients, not in the promotion of competition as an end in itself. In publishing the Fair Playing Field Review the Government welcomed Monitor's recognition – in line with its legal duties to enable the better integration of services – that the creation of a fairer system must contribute to the delivery of more integrated care. The Government agrees with the Richmond Group who articulated the point that *“the focus of creating a fair playing field for providers should be ultimately the achievement of person-centred, coordinated care that achieves the best outcomes possible, and the Government should be careful not to mandate action that will unintentionally disrupt existing local commissioning arrangements that are helping to meet this objective.”*

**71.** In refreshing the Mandate, we have updated the objective to reflect the work being taken forward by Monitor and NHS England to support a fair playing field for the benefit of patients.

### **Additional leadership**

**72.** Responses were generally supportive of the role which Government can play in providing leadership and direction. However, many organisations felt that the proposal was unclear and that the picture had become complicated between additional leadership from the Government and devolving responsibility, autonomy and accountability to NHS England and CCGs. The Women's

Institute in Holt, Norfolk was *“not sure that the Government which in one sense appears to be devolving the resources and management of the NHS to local bodies should at the same time be providing additional leadership (reads – like 'big brother').”*

**73.** The Government acknowledges these concerns and we have taken the decision not to update the Mandate in line with this proposal. The pre-existing Government commitments are reflected in the current Mandate (paragraph 15). We recognise the Government has to demonstrate leadership by promoting and strengthening the autonomy of organisations, clinicians and other frontline professionals to deliver. The Government will hold NHS England to account for delivery of these commitments through the accountability process.

### **Going digital**

**74.** The majority of organisations were supportive of exploiting the benefits of technology in the NHS to deliver high quality care; improve self-management of people's health and care needs; reduce waste; and save money by reducing the need for costly health interventions. The Hearing Loss and Deafness Alliance emphasised the opportunities it offers for people with sensory loss to participate in health interventions and avoid social isolation: *“people with hearing loss would greatly benefit from the availability of a variety of methods to book appointments, including online booking, and from greater use of technology to aid communication.”* Many organisations recognised the potential of digital patient records as a means to share and transfer information across organisations and care settings. This would support integrated care, particularly where people require a range of services. However, many respondents emphasised the need for consistency in format of digital patient records, and that a patient should be able to access their own records.

75. However, many respondents stressed the importance that *“we must remain aware that many older people with long term conditions are less likely to have access to or be literate in IT. Therefore provision must be made for these groups of people”* – Arthritis and Musculoskeletal Alliance. An unintended consequence of digitalisation is the potential for excluding people, for example older people and vulnerable groups who are less likely to access and utilise digital services. Groups should not be marginalised. The Women's Health and Equality Consortium were concerned *“that a move to a digital system could focus on less interaction with clinical staff. A combination of digital and personal interaction has consistently been a message from patient and community groups in their positive experiences of health and social care.”* The responses also revealed scepticism of large scale IT projects with a cautionary point around problems with the delivery of IT systems in the past and that lessons should be learnt.

76. In rationalising the volume of changes we have not updated the current objective around the use of technology. Our ambition remains, but the Government recognises that the current objective better articulates the outcomes and aims the Government is seeking to achieve through better use of technology. NHS England is expected to set out further progress on taking this forward in due course.

### **Transparency and reporting**

77. Transparency was viewed as an important means to improve patient safety as demonstrated by the Berwick Review.<sup>6</sup> We heard that good information is the basis for good and effective decision making. The Government agrees with the point that reporting should not create a blame culture

but one of improvement and a means to learn from the best. The Royal College of Surgeons felt that *“the recent publication of individual surgeons outcomes data for nine surgical specialties was a landmark moment in the history of the NHS. We believe the move will drive forward improvements in care and enable patients to understand far more about the nature of a surgeons work and their recovery after an operation ... We therefore strongly encourage the Government, NHS England, other royal colleges and medical specialties to look at how this initiative can be expanded to cover national audit data and outcomes data for all of medicine.”* A large number of organisations were supportive of extending reporting to cover a wide range of disciplines, settings and services. In doing so, the point was made that greater reporting should not become an administrative burden and at the expense of time spent on patient care.

78. However, some organisations expressed concern, particularly over the quality of data and how accessible it will be to external audiences. *“Data quality issues need to be addressed prior to any reporting/publication”* – NHS Bolton CCG. We heard from respondents that it is also important to understand why the variation has occurred, as it may not be due to poor practice but random variation. The variation should therefore clearly be explained when reported.

79. In rationalising the volume of changes in the Mandate, this objective has not been updated. We consider that the current objective is sufficiently clear on our ambitions. The Government agrees with those who were supportive of greater transparency in outcomes and we welcome the progress NHS England are making on this front. We expect NHS England to set out further detail on how they will strengthen reporting and drive up standards including how variation will be accounted for.

<sup>6</sup> [www.gov.uk/government/publications/berwick-review-into-patient-safety](http://www.gov.uk/government/publications/berwick-review-into-patient-safety)

## Supporting economic recovery and making better use of resources (Q20 – Q21)

Q20. *What views do you have on the proposals to update the objective in asking NHS England to support the recovery of the economy where they can make an important contribution?*

Q21. *What views do you have on the proposals to make better use of resources?*

### Supporting economic recovery

80. There was broad recognition of the important contribution the NHS makes in supporting the economic recovery. Coventry City Council highlighted the *“Marmot evidence [which] also describes the causal relationship between employment and improved health and wellbeing.”* The Government believes a healthy population (physically and mentally) will improve economic growth and productivity. However, many rightly pointed out that the contribution is much broader than NHS England, whilst some felt that the NHS's contribution was sufficiently captured by the current Mandate.

81. A strong theme as a means to support growth, but also outcomes, was through greater innovation and research: *“Carers UK agrees that the NHS has a significant role to play in promoting economic growth through innovation. Our recent report into the potential for telecare and telehealth to support carers shows the huge potential for innovation and technology in the health and care sector.”* NHS England is leading a programme of work to deliver the recommendations in the Innovation, Health and Wealth Report<sup>7</sup> to improve patient care which has been reflected in the Mandate.

82. With respect to genomics, there was support for the opportunities and potential which genomics technology offers. Some organisations on the other hand raised concerns over genome sequencing, particularly the unintended consequences. Unison were concerned that *“where this and the creation of a DNA database for England are concerned, there are too many issues that have not been adequately addressed around patient consent and confidentiality for such a programme to be safely carried out.”* We recognise the concerns raised, but the Government agrees with those who view genomics technology as an opportunity to transform the treatment and management of rare conditions and infectious diseases. We will continue to work with Genomics England Ltd and NHS England to address concerns and issues including patient consent and confidentiality.

83. In rationalising the volume of changes and in recognition that Genomics England Ltd are leading this work, we have not reflected this proposal in the refreshed Mandate. We welcome though NHS England's commitment to working with the Department of Health and Genomics England Ltd to support the programme and we expect significant progress in 2014/15.

### Making better use of resources

84. There was broad support for making best use of resources, particularly so that money is better spent on patient care. We heard that this should not result in short termism and unnecessary cost cutting: *“the imaging department in my local hospital has been transformed and waiting times slashed by better use of resources. There is a danger of better use of resources being misinterpreted as saving money rather than leading to long-term savings and better outcomes”* – Individual. There were numerous and wide-ranging suggestions on how to make better use of resources, for example;

<sup>7</sup> [www.gov.uk/government/publications/creating-change-innovation-health-and-wealth-one-year-on](http://www.gov.uk/government/publications/creating-change-innovation-health-and-wealth-one-year-on)

investing in preventative services; better procurement practices; reducing bureaucracy and reporting burdens; and more effective use and prescribing of medicines. The NHS working with key partners to invest in and drive better integration of care across different services was a particularly strong theme. The Government welcomes the helpful suggestions that were made. It is important that NHS England and all system partners should ensure the best use of public resources to fund high quality care.

**85.** In rationalising the volume of changes, the Government feels that making best use of resources and tackling economic crime including fraud is sufficiently covered by the current Mandate objectives. Rather than be overly prescriptive in the Mandate on how the objectives should be met, we think the best approach is for the Government to set the expected outcome and for NHS England to work out the best way to achieve them. The Government will hold NHS England to account for the results they achieve through the formal accountability process.

### **Recovering costs incurred from overseas visitors**

**86.** On the proposal to recover the costs incurred from overseas visitors where appropriate, views were mixed. Some respondents were supportive, particularly in the context of making best use of taxpayers' money, whilst others expressed reservations. Others felt strongly that it should not deter people from seeking help or stigmatise people. As this proposal was subject to a separate consultation and the fact that the Government will publish a separate summary in response, this document does not go into further detail here.

**87.** However, recently published independent research<sup>8</sup> has shed further light on the scale and potential costs incurred by the NHS on patients who are not, under current rules, eligible for free care. The Government will therefore continue to work with NHS England and providers to work through the issues raised, and to identify cost-effective ways of maximising the recovery of costs incurred through the treatment of chargeable patients. This has been reflected in the refreshed Mandate.

### **Vulnerable older people's plan (output from the engagement and Q8-10)**

*Q8. What views do you have on the ambitions and expectations for the vulnerable older people's plan?*

*Q9. What views do you have on how we should achieve our ambitions on the vulnerable older people's plan, particularly on how to strengthen primary care?*

*Q10. How should the ambitions for vulnerable older people be reflected in the refreshed Mandate?*

**88.** The consultation revealed overwhelming support for improving the care and the experience of care for older people and their carers. This information will supplement feedback received through a variety of other engagement exercises in order to develop the plan in the best way possible.

**89.** The following findings, divided by key categories, reflect the views expressed through the Mandate refresh consultation and are consistent with broader views expressed throughout the range of engagement exercises.

<sup>8</sup> [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/251908/Qualitative\\_Assessment\\_of\\_Visitor\\_Migrant\\_use\\_of\\_the\\_NHS\\_in\\_England\\_-\\_Observations\\_from\\_the\\_front-line\\_-\\_FULL\\_REPORT.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/251908/Qualitative_Assessment_of_Visitor_Migrant_use_of_the_NHS_in_England_-_Observations_from_the_front-line_-_FULL_REPORT.pdf)

90. In the Mandate, we have set the direction for NHS England in taking forward our ambitions for improved health for the whole population, starting with the most elderly and vulnerable in society. The detail of the plan, which has been informed by what we have heard, will be published later this year.

### Named clinician

91. The concept of assigning a named clinician to provide continuity of care was very positively received, with respondents providing several case studies of GPs and community matrons already playing a similar role. A broad range of options were suggested for the professional that would be best-suited as named clinician, including GPs, community matrons, geriatricians and specialist geriatric nurses.

92. The distinction was made between who would have overall accountability and who would perform the care coordinator role. The named clinician was seen by many as a more extended role than care coordinators, to whom many patients already have access. However, further clarification of the responsibilities of the role was requested.

93. There was also support for GPs taking on overall accountability for patients, working as part of multi-disciplinary teams. However, respondents felt that for GPs providing this accountability would have an impact on workloads. *“The work needs resources. We are seeing truly decreasing funding with no inflationary uplift for our expenses so that actual pay is decreasing”* – individual. Discussions involving NHS Alliance reinforced the issue of workloads for GPs. They called for an ‘uncluttering’ of general practice to allow the time to focus on new priorities.

94. Some suggested that for GPs to take on this responsibility a restructuring of priorities is required. The Royal College of General Practitioners suggests that we

need to *“shift more investment into general practice so that GPs have greater capacity – including more time – to develop anticipatory care systems and processes”* and *“ensure that GPs receive the right training to have a better understanding of the needs of their practice population, which will inform capacity and workforce planning, as well as improve service quality.”*

### Staying healthy for longer

95. Early diagnosis and preventative care models are not being properly utilised despite their proven effectiveness according to the consultation. Respondents suggested that carrying out opportunistic cancer screenings, amongst other precautions, could have long-term benefits.

96. Exploring different ways of incentivising GPs could have benefits in terms of the way that people are involved in their own healthcare. This could lead to a reduction in hospital admissions over time and allow people to take care in to their own hands in a more meaningful way. Similarly, some say that health education should be more prominent, again promoting opportunities for patients to be in control of their own care.

97. Several good examples were provided of risk stratification and preventative care which will be taken in to account when considering implementation of the plan: *“Bolton’s ‘Staying Well’ project which is testing the feasibility of an approach to systematically identify people at high risk of future care need and supporting them to stay happy, healthy and independent for longer”* – Bolton Council.

98. The role of carers was a major feature of many responses. Several respondents called for more services to support carers in their day-to-day lives. Suggestions included setting up support groups, adding home carer information to medical records so that they can be updated on any emergencies,

providing carers with time to recuperate from their responsibilities, facilitating training sessions and ensuring better integration with (and advertisement of) third sector organisations.

### Improving access

**99.** The broader engagement showed mixed views on accessing services through technology. Some supported the advancement however others cautioned against it as they felt that older people would not be inclined to embrace technology based access: *“Further work is required on the impact of technologies, particularly on access. Whilst video technologies offer new possibilities, it is important that the impact is properly evaluated. There is a risk that such technologies could alienate rather than improve access for some vulnerable older people who are more likely to have sensory or cognitive impairments and complex conditions, which make video consultation less appropriate”* – British Medical Association.

**100.** The Foundation Trust Network were one of many organisations that saw the developments of technology within primary care as a beneficial process: *“We also welcome the development of new technologies to improve patient care, accessibility and interactive services between patients and professionals alongside NHS England’s recent announcement of £1 billion investment into IT in the NHS and the announcement of the Integrated Transformation Fund to fund integrated care initiatives.”*

**101.** Respondents suggested a range of barriers that we may face. These include the cost of introducing new technology, the problems associated with constant advancements within technology and the lack of ability/familiarity that will exist amongst service users.

### Out-of-hours care

**102.** A consistent approach to out-of-hours care was called for, in order to raise the profile and trust levels of the services available. GPs were seen to have a key role in this, although community pharmacists and mental health carers were also mentioned. There were several comments that pharmacists are currently under-utilised. *“Out of hours pharmacies are often too few and far for frail patients to get to and very often it is not clear where the out of hours pharmacy is located in their area. Pharmacists can also play an important role in advising the patient on the medication they take and supporting the GP in their treatment plan of the patient”* – Royal College of Anaesthetists.

**103.** Discussions of information sharing crossed over to out-of-hours care, with the general consensus being that paramedics, 111 staff, community pharmacists and other out-of-hours carers should have digital access to patient records. The National Association of Primary Care specifically expressed interest in the sharing of GP records in order to improve out-of-hours care.

**104.** Respondents were keen to see GPs involved in the provision of out-of-hours care. Some respondents reported hearing dissatisfied reviews of the current system. Several suggested that a more integral role for GPs would rectify these issues and ensure a high quality service.

**105.** A strong link between out-of-hours care and the named clinician was also a desirable proposal. *“Whoever is designated as the named clinician for a service user would also have a role to play in ensuring he/she has access to appropriate out-of hours (OOHs) care as required. There is also a role for the local system collectively to ensure that OOHs care arrangements across the piece are fit for purpose and link in with ‘In-Hours’ services, including urgent care as appropriate”* – Gateshead Council.

### Choice and control

**106.** Respondents felt that the biggest issue facing improving patient choice and control was a lack of information about the options available to them, including options involving the voluntary sector. Access was highlighted as another barrier that people felt needed improvement. Respondents felt that having a named clinician to advise upon options would benefit people in terms of promoting choice and control.

**107.** St Oswald's Hospice provided an example of enabling a greater range of patient choice in the form of the 'Deciding Right' initiative: *"Deciding right identifies the triggers for making care decisions in advance, complying with both current national legislation and the latest national guidelines. At its core is the principle of shared decision making to ensure that care decisions are centred on the individual and minimise the likelihood of unnecessary or unwanted treatment."*

**108.** Sense, an organisation representing the interests of deaf and blind people, informed us that any new technology introduced must be designed with accessibility in mind: *"Any technology used must be accessible to those with a hearing and a sight impairment, and any courses that are provided to up skill older people to use these technologies must also be accessible."*

### Joining up services

**109.** A range of organisations called for better access to patient information, including allowing pharmacists, paramedics and out-of-hours providers to access and edit records. Some expressed concern over privacy and misuse of information.

**110.** More joined up working is needed between health and social care services. Problems with such integration are referred to repeatedly as the cause of low quality of care and economic waste: *"The lack of*

*interface of electronic care records (where they exist) between health and social care is a significant issue. Incentives are needed for local authority-funded providers to invest in electronic care documentation. Social care has been left out of the whole drive towards adoption of electronic care/health records and data/document exchange standards"* – BUPA. It was also noted that in the short term, any reformation would require up-front funds before savings are realised.

**111.** Two main barriers are noted here that are often considered to be linked: The culture of organisations and the different ways organisations are funded. Several respondents called specifically for a single source of funding in order to promote true integration: *"To promote integrated working between health and social care, (and primary and secondary care) shared funding is essential. This would help in removing the perception that admission to an acute hospital bed is the solution when a crisis in care occurs. Improved integration, coordination, and access to services within the community would also reduce the likelihood of such an episode occurring unless related to a genuine medical illness"* – British Geriatrics Society.

### Definition

**112.** Discussions involving the definition of 'vulnerable older people' recurred across the range of engagement exercises. Participants suggested that it is not appropriate to define the target group of vulnerable older people by their age, as many older people are far from vulnerable, whilst there are many vulnerable people that are not old. Identifying the cohort at a local level was seen as an important step to ensuring that the right care went to the right people.

**113.** Our attention has also been drawn to the needs of other groups besides the elderly, including those with sensory deprivation, a



learning disability, and/or a mental health condition. We envisage that the lessons we will learn whilst focusing on the current cohort will be invaluable tools for improving care for other groups in the future.

### Other topics

**114.** Several additional topics arose during the consultation. Housing was a frequent topic with related suggestions including proactively addressing housing issues for elderly individuals and working with housing organisations to reach the heart of communities: *“Housing organisations are well placed as partners for local Clinical Commissioning Groups as many have well developed community services and networks of residents and tenants associations which can provide a route for health professionals to connect with local communities – for targeting public health messages, and for identifying households and people where additional health and support may be needed”* – Chartered Institute of Housing.

**115.** Nursing homes were also discussed as a cost effective way of providing care to those that would otherwise spend long periods of time in hospital, although improved access and discharge procedures would be necessary to facilitate this.

**116.** Convalescent homes were mentioned on several occasions as a bridge between home-based care and hospital admission. It was also suggested that care homes should have better resources and training to ensure that residents aren't admitted to hospital unless completely necessary.

## Conclusion

**117.** We are very grateful to all those who responded to the consultation on refreshing the Mandate to NHS England for April 2014 – March 2015. The wide-ranging perspectives revealed through the consultation highlighted some of the difficulties the Government faces in setting new direction for NHS England in the face of emerging challenges, whilst providing stability and constancy of purpose. The Government can also do more to make future mandates more public facing in response to the challenge from Healthwatch England *“to produce a Mandate that is accessible to users of health and care services.”*

**118.** The Government will continue to work with NHS England, Healthwatch England, key system partners, stakeholders as well as people and carers who use services to make sure we get this balance right, and to ensure we are focusing on the things that matter most to people.

## Annex A – List of organisations only (excludes individual and public respondents, peers and MPs)

121 Care & Mobility Ltd.	British Geriatrics Society
5 Boroughs Partnership NHS Foundation Trust	British Heart Foundation
Age UK	British Lung Foundation
Albert House Nursing Home	British Medical Association
Alzheimer's Society	British Psychological Society
American Pharmaceuticals Group	British Society for Rheumatology
Anchor	British Specialist Nutrition Association
Arthritis and Musculoskeletal Alliance	BSHAA and NCHA
Arthritis Research UK	Bupa
Association for Palliative Medicine	Calderdale and Huddersfield NHS Trust
Association of Ambulance Chief Executives	Cancer Research UK
Association of British Pharmaceutical Industry	Carers Trust
Association of Medical Research Charities	Carers UK
Asthma UK	CARES
AstraZeneca	Centre for Mental Health
Audiology Online	Cerner
BAPEN	Chartered Institute of Housing
Bath, Gloucestershire, Swindon and Wiltshire Area Team – Directors of Nursing	Chartered Society of Physiotherapy
Beat	Chartered Society of Physiotherapy and AGILE
Bliss	Children & Young People's Health Outcomes Forum
Boehringer Ingelheim	Children and Young People's Health Policy Influencing Group
Bolton Public Health Department	Church of England
Breakthrough Breast Cancer	Civil Service Pensioner's Alliance
Breast Cancer Campaign	Clean Air in London
Brighter Futures Transport	Coloplast
British Academy of Childhood Disability	Coventry City Council
British Association for Counselling and Psychotherapy	Diabetes UK
British Dental Association	East Anglia Area Team

Festival Housing	National Housing Federation
Foundation Trust Network	National LGBT Partnership and the Lesbian and Gay Foundation
Gateshead Council	National Osteoporosis Society
General Medical Council	National Pharmacy Association
GeneWatch UK	National Policing Portfolio for Mental Health and Disability
Gilead	National Rheumatoid Arthritis Society
HAPIA	National Voices
Health Education England	Neurological Alliance
Health Foundation	Newham Council
Health Scrutiny Committee for Lincolnshire	NHS Bolton CCG
Health Visitor Taskforce	NHS Clinical Commissioners
Healthwatch Bucks	NHS Confederation
Healthwatch England	NHS Bradford City CCG and NHS Bradford District CCG
Hearing Loss and Deafness Alliance	NHS Dudley CCG
Help the Hospices	NHS Durham Dales, Easington and Sedgefield CCG
Housing Learning and Improvement Network	NHS Leeds North CCG
Janssen	NHS Lincolnshire West CCG
Lancashire Care NHS Foundation Trust	NHS Greenwich CCG
Lavender Support Services	NHS Quest Network
Leeds City Council	NHS Rotherham CCG
Local Government Association and ADASS	NHS Sheffield CCG
Local Government Association	NHS Tower Hamlets CCG
Londonwide LMCs	NHS West London CCG and Mental Health Programme Board for North West London
Macmillan Cancer Support	Norfolk and Suffolk NHS Foundation Trust
Marie Curie Cancer Care	North Staffs Users Group
Medical Protection Society	North West London Hospitals NHS Trust
Mencap	Nottinghamshire County Council
Mental Health Foundation	Novo Nordisk
Merck Serono Ltd.	Nuffield Trust
Mid Staffordshire NHS Foundation Trust	Optical Confederation
Milton Keynes Wheelchair Users Group	Pancreatic Cancer UK
Mind	Patient Governance
Monitor	Pfizer
My Ageing Parent	
Namaste Care	
National Children's Bureau and Council for Disabled Children	
National Council for Palliative Care	

Pharmaceutical Services Negotiating Committee  
Pharmacy Voice  
PHG Foundation  
PMRGCAuk  
Prison Reform Trust  
Prostate Cancer UK  
PSP Association  
Public Health England  
Radiotherapy Board  
Rarer Cancers Foundation  
Relationships Alliance  
Rethink Mental Illness  
Royal Berkshire Hospital Foundation Trust  
Royal College of Anaesthetists  
Royal College of General Practitioners  
Royal College of Midwives  
Royal College of Nursing  
Royal College of Obstetricians and Gynaecologists  
Royal College of Paediatrics and Child Health  
Royal College of Physicians  
Royal College of Physicians of Edinburgh  
Royal College of Psychiatrists  
Royal College of Radiologists  
Royal College of Surgeons  
Royal College of Surgeons of Edinburgh  
Royal Pharmaceutical Society  
SCA Hygiene Products UK Ltd  
Sense  
Signature  
Society of Chiropodists and Podiatrists  
Somerset Partnership NHS Foundation Trust  
South Essex Partnership Trust  
South Northants Homes  
Specialised Healthcare Alliance  
St. Oswald's Hospice  
Staffordshire County Council  
Standing Commission on Carers  
Stepping Hill Hospital  
Stockton Council  
Stroke Association  
Student Minds  
Sue Ryder  
Sussex Air Quality Partnership  
Target Ovarian Cancer  
Teenage Cancer Trust  
Tees Esk and Wear Valleys NHS Foundation Trust  
The Carer's Resource  
The King's Fund  
The National Autistic Society  
Together for Short Lives  
Trafford Council  
Turning Point  
UK Council for Psychotherapy  
UK Faculty of Public Health  
UNISON  
University Hospitals Birmingham NHS Foundation Trust  
University Hospitals Bristol  
University Hospitals of Leicester NHS Trust  
Urology Trade Association  
Urology User Group Coalition  
Vegan Society  
Weight Watchers  
Westcott Care Advisory Services  
Women's Health and Equality Consortium  
Women's Institute Holt Norfolk  
Worcestershire Health and Care Trust  
YoungMinds

# Annex B – Changes made to the Mandate by Chapter

## Chapter

Note: All references to “the NHS Commissioning Board” or “the Board” have been replaced with “NHS England” throughout the document.

### Foreword

New Foreword

### Introduction

Paragraph 1, new footnote inserted – 1.

Paragraph 1 – New final sentence “This Mandate covers the period from April 2014 to the end of March 2015 and carries forward all the existing objectives in the Mandate to NHS England<sup>2</sup>” replacing “It covers the period from April 2013 to the end of March 2015”.

New footnote inserted – 2.

Paragraph 4 – Replaced “this” with “their” and removed words “to the Board” before “from the Government”.

Paragraph 7 – Revised footnote number, 1 to 3.

Paragraph 12 – New paragraph inserted:

In this Mandate, we are challenging NHS England to make greater progress towards transforming patient care and safety and in tackling the growing pressures and demand on NHS services. Significant improvements are expected by:

- taking forward the relevant actions set out in the further response to the

Robert Francis QC public inquiry into the lessons from Mid Staffordshire NHS Foundation Trust;

taking forward the actions set out in the vulnerable older people’s plan which will set out the Government’s ambition for improved health for the whole population, starting with the most elderly and vulnerable in society.

All subsequent paragraph numbers changed from 13 onwards.

Paragraph 13 – Replaced opening words “As part of this, the Government has identified the following priority areas where it” with “These build on the following priority areas where the Government”.

Paragraph 13, iii – Removed words “and delivering a service that values mental and physical health equally”.

Paragraph 15, second sentence – Removed word “has” between “England” (formerly Board) and “agreed”.

### Preventing people from dying prematurely

Paragraph 1.2 – Inserted revised paragraph text:

Our ambition is for England to become one of the most successful countries in Europe at preventing premature deaths, and our **objective** for NHS England, working with CCGs, is to develop their contribution to the new system-wide

ambition of avoiding an additional 30,000 premature deaths per year by 2020.

Replacing the following:

About 20,000 lives a year would be saved if our mortality rates were reduced to the level of the best in Europe. We are under a moral imperative to act, so that more of us, our families, friends and neighbours, may enjoy the prospect of an independent and active old age. Our ambition is for England to become one of the most successful countries in Europe at preventing premature deaths, and our **objective** for the NHS Commissioning Board is to make measurable progress towards this outcome by 2016.

Paragraph 1.3 – Removed words “from April 2013”.

Paragraph 1.4, second bullet – Removed word “(NICE)” and inserted words “(taking account of the Pharmaceutical Price Regulation Scheme agreement)”

## Enhancing quality of life for people with long-term conditions

Paragraph 2.4 – New paragraph inserted:

There are increasing pressures on the health and care service in England, which will become increasingly difficult to meet without the successful transformation of the way the health and care services provide for the population. This must be particularly true for those who are the oldest and most vulnerable. This requires primary care, especially general practice, to proactively support patients who are most at risk; keep them out of hospital wherever possible and; help people to live well and maintain their independence. Care for vulnerable older people cannot be provided through general practice alone, so we are asking NHS England

to explore how better integrated out of hospital care can improve care for this group, and the wider population. As part of this objective, NHS England should take forward the actions and the ambitions of the vulnerable older people's plan (which is subject to agreement on affordability with NHS England), with rapid progress to be made from April 2014.

All subsequent paragraphs numbers changed from 2.5 onwards.

Paragraph 2.5 – Revised first sentence – “By 2013, the new 111 phoneline will be up and running” replaced with “In 2013, the new 111 phoneline was introduced”.

Paragraph 2.6 – Third bullet, removed words “subject to the evaluation of the pilot programme”.

Paragraph 2.10 – Inserted two new sentences at start of paragraph and new footnote added – 4:

In taking forward this **objective**, we are asking NHS England to work with local Government and other key partners to take forward their commitments in Integrated Care and Support: Our Shared Commitment.<sup>4</sup> This includes supporting the integration pioneers who are exploring different approaches to providing better care and breaking down the barriers that prevent transformational change happening at scale and pace.

Replacing the following:

In taking forward this **objective**, we are asking the Board to drive and coordinate engagement with local councils, CCGs and providers; and at national level, to work with the Department of Health, Monitor, Health Education England, Public Health England, and the Local Government Association, as well as other organisations that want to contribute.

Paragraph 2.11 – New paragraph inserted:

To support the ambition that each area moves to a wholly integrated approach to health and care by 2018, the Government has created the health and social care Integration Transformation Fund.<sup>5</sup> For 2015/16, this fund will make available £3.8bn to support health and care services to work more closely together. This will improve outcomes for people and deliver better value for money. NHS England needs to deliver the best possible foundation for the Fund's implementation, working in partnership with local authorities and local health and wellbeing boards.

New footnote added – 5. All subsequent paragraph numbers changed from 2.12 onwards.

Paragraph 2.13 – Removed following sentence from end of paragraph:

We want the Board to work with CCGs, driving significant improvements in diagnosis of dementia, and capturing this in a national ambition for diagnosis rates built up from local plans.

Paragraph 2.14 – Inserted revised text:

NHS England have agreed a national ambition for diagnosis rates that by 2015 two-thirds of the estimated number of people with dementia in England should have a diagnosis, with appropriate post-diagnosis support. Better dementia diagnosis will improve the lives of people with the condition and give them, their carers and professionals the confidence that they are getting the care and treatment they need. NHS England should work with CCGs to support local proposals for making the best treatment available across the country.

Replacing the following:

The NHS Commissioning Board will publish the expected level of diagnosis across the country through to March 2015. And because people with dementia, their carers and professionals rightly need to feel confident that a diagnosis of dementia will improve the lives of people with the disease, the Board should work with CCGs to support local proposals for making the best treatment available across the country

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

Paragraph 3.4, second sentence – Removed word “recently” between “have” and “been”.

Paragraph 3.6 – Revised paragraph with same first sentence, and rest of text moved to new paragraph 3.7. Inserted following new text:

Recent reports have highlighted a particular challenge around mental health crisis intervention. Only by working with key partners, including the police, can we ensure that people with mental health problems get the care they need in the most appropriate setting. To bring about the transformational change necessary, we expect NHS England to make rapid progress, working with CCGs and other commissioners, to help deliver on our shared goal to have crisis services that, for an individual, are at all times as accessible, responsive and high quality as other health emergency services. This includes ensuring there are adequate liaison psychiatry services. We expect every community to have plans to ensure no one in crisis will be turned away, based on the principles set out in the soon to be published Mental Health Crisis Care Concordat.

Paragraph 3.7 – New paragraph inserted, containing remaining text removed from paragraph 3.6:

This will involve extending and ensuring more open access to the Improving Access to Psychological Therapies (IAPT) programme, in particular for children and young people, and for those out of work. NHS England has agreed to play its full part in delivering the commitments that at least 15% of adults with relevant disorders will have timely access to services, with a recovery rate of 50%. NHS England will work with stakeholders to ensure implementation is at all times in line with the best available evidence.

Paragraph 3.7, first sentence – added word “also” between “will” and “involve”.

Paragraph 3.7, new third sentence added:

They will also begin planning for country wide service transformation of children and young people's IAPT.

Paragraph 3.8 – Paragraph 4.15 moved to 3.8, first sentence kept the same and following text inserted:

The Department of Health and NHS England are committed to ending this and believe that implementing new access and/or waiting time standards is vital in order to have true parity of esteem. We expect NHS England to work with the Department of Health and other stakeholders to develop a range of costed options in order to implement these standards starting from April 2015, with a phased approach depending on affordability.

Replacing the following:

As part of its objective to put mental health on a par with physical health, we expect the Board to be able to comprehensively identify levels of access to, and waiting times for, mental health

services. We want the Board to work with CCGs to address unacceptable delays and significantly improve access and waiting times for all mental health services, including IAPT. We will also work with the Board to consider new access standards, including waiting times, for mental health services, including the financial implications of any such standards.

Change to NHS Outcomes Framework table:

Indicator 3.3 changed from “Proportion of people who recover from major trauma” to “Survival from major trauma”

## Ensuring that people have a positive experience of care

Paragraph 4.4 – Inserted revised paragraph:

The Government's response to the Francis Inquiry will seek to ensure that the commissioning, delivery, monitoring and regulation of healthcare brings about a transformational change that focuses on achieving reliably safe and high quality care, that puts patients at its heart and where compassionate care and patient experience are as important as clinical outcomes. NHS England's **objective** is to take forward the actions they have agreed in this response, working closely with its partners to achieve change with significant progress expected in 2014/15.

Replacing the following:

In the early months of 2013, Robert Francis QC will publish the report of his independent Public Inquiry into the lessons from Mid-Staffordshire NHS Foundation Trust. Working in partnership with national agencies, including the Care Quality Commission and Healthwatch England, Monitor, the professional regulators and Royal Colleges, the



NHS Commissioning Board and Health Education England, the Government will bring about a response that is comprehensive, effective and lasting. It will be important to ensure there is a credible, robust and independent inspection regime across the entire health and care system.

Paragraph 4.5, first sentence – Replaced “Later in the autumn of 2012, the Government will issue” with “The Government has now issued”.

Paragraph 4.5, third sentence – New sentence added: “This includes NHS England taking forward those actions which they signed up to in the final report and concordat.<sup>6</sup>” New footnote added – 6.

Paragraph 4.9 – Replaced “and as rapidly as possible thereafter for all those using NHS services” with “general practice and community and mental health services by the end of December 2014; and the rest of NHS funded services by the end of March 2015”.

Paragraph 4.11, first bullet – Inserted additional bullet point:

- takes forward the pledges they signed up to in Better health outcomes for children and young people: Our pledge<sup>7</sup>, to improve the physical and mental health outcomes for all children and young people;

New footnote inserted – 7.

Paragraph 4.15 – Revised and paragraph moved to 3.8.

Changes to NHS Outcomes Framework table:

Indicator 4.8 – changed from “An indicator is under development” to “Children and young people’s experience of outpatient services”.

Indicator 4.9 – changed from “An indicator is under development” to “People’s experience of integrated care”.

## Treating and caring for people in a safe environment and protecting them from avoidable harm

Paragraph 5.1, final sentence – inserted new words “, as highlighted by Berwick review on patient safety.<sup>8</sup>” New footnote inserted – 8.

Changes to NHS Outcomes Framework table:

Indicator 5.1 changed from “Incidence of hospital-related venous thromboembolism (VTE)” to “Deaths from venous thromboembolism (VTE) related events”.

Indicator 5.3 changed from “Incidence of newly-acquired category 2, 3 and 4 pressure ulcers” to “Proportion of patients with category 2, 3 and 4 pressure ulcers”.

## Freeing the NHS to innovate

Paragraph 6.3 – Inserted new second sentence:

Following the CCG authorisation process, NHS England has a vital role in ensuring that CCGs meet any conditions placed on them and assuring themselves of compliance with those terms.

Replacing the following:

The Board has a vital role in completing the safe transition to a system of fully authorised CCGs. By engaging and supporting emerging CCGs, the Board can ensure that as many CCGs as are willing and able can be authorised fully, without conditions, by April 2013. For each of those authorised with conditions, the Board intends to set out a clear timetable and path to full authorisation. CCGs will be in full control over where they source their commissioning support. A sign of the Board’s success will be that it sets out and operates a transparent

system for intervention in CCGs where this is needed.

Paragraph 6.5, first bullet, third sentence – Removed words “will shortly publish”, replaced with “has published”. Removed words “which will”, replaced with “to”, between “consultation” and “help”. New footnote inserted – 9.

Paragraph 6.5, second bullet, first sentence – Removed word “supported”, replaced with “working with Monitor to support”. New footnote inserted – 10.

Paragraph 6.6, Removed words “and during 2013 the Department of Health will commission a similar evaluation programme” from end of existing sentence and inserted two new sentences:

Similarly, this Government is commissioning an evaluation to assess the extent to which our vision and underlying policies of the 2012 Health and Social Care Act have been implemented, and what their effects have been. The Health Reforms Evaluation Programme is a long term project that will start in summer 2014 and complete by summer 2017.

## The broader role of the NHS in society

Paragraph 7.1, second sentence, addition of new words: “via the Strategy for UK Life Sciences;<sup>11</sup>” New footnote inserted – 11.

Paragraph 7.1 – Addition of new final sentence: “NHS England is committed to delivering the recommendations in the Innovation, Health and Wealth Report to improve outcomes for individuals, carers and families<sup>12</sup>.” New footnote inserted – 12.

## Finance

Paragraph 8.1, inserted two new sentences:

NHS England's revenue budget for 2014/15 is £97,952 million (of which £1,929 million is for delivery of the section 7A agreement with the Secretary of State) and its capital budget is £320 million.<sup>13,14</sup> The indicative revenue budget for 2015/16 is £99,909 million and its indicative capital budget is £220 million.

Replacing the following:

The NHS Commissioning Board's revenue budget for 2013–14 is £95,873 million (of which £1,843 million is for delivery of the section 7A agreement<sup>2</sup> with the Secretary of State) and its capital budget is £200 million<sup>3</sup>.

Footnote numbers 3 and 4 revised to 13 and 14.

Existing footnote number 2 removed.

Footnote 14, first sentence – Replaced “will be” with “is”.

Footnote 14, second sentence – Replaced “will be” with “are”. Added “which can be found at: <https://www.gov.uk/government/publications/public-health-commissioning-in-the-nhs-from-2013>” to end of sentence.

Paragraph 8.1, Inserted two new sentences:

It is in this context that the Government is committed to ensuring the development of a fair and transparent identification and payment system for overseas visitors and migrants accessing the NHS. We will, therefore, continue to work with NHS England to identify cost-effective ways of maximising the recovery of costs incurred through the treatment of chargeable patients (as to be defined by the forthcoming legislation).

## Assessing progress and providing stability

Paragraph 9.1 – Revised footnote number, 5 to 15.

Paragraph 9.2, first sentence – Removed words “will be” before “directly”, replaced “commissioning” with “commissions”.

Paragraph 9.2, final sentence – Replaced words “will play” with “plays” and added “the” before “objectives”.

Paragraph 9.3, first sentence – Added words “of Health” after “Department”.



Department  
of Health