The Mandate

A mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015

November 2012

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Foreword

Now in its sixty-fifth year, the NHS remains as vital and as respected as ever.

Millions of us depend upon it every week, and through the dedication of thousands of professionals, we do so in confidence that it will be there for us, whatever our background or needs.

I am immensely proud of what the NHS has achieved, not only for the extraordinary things it does for us as individuals, but also for what it says about us as a nation.

This mandate – the first of its kind in the world – underlines my responsibility as Health Secretary to preserve and defend those principles to which we all remain indebted.

The most important of these is that the NHS remains comprehensive and universal, free at the point of delivery, and available to all based on clinical need. Under this Government, that will never change.

Yet the Mandate reflects a second responsibility – to ensure the NHS stays relevant and trusted in a rapidly changing world.

Never in its history has the NHS had to face such a profound shift in our needs and expectations.

An ageing population, rising costs of treatments, and a huge increase in the number of us with long-term, often multiple conditions are rewriting our relationship with health and care, all at a time of acute pressure on public finances.

These challenges go to the heart of the objectives I am setting the NHS Commissioning Board.

By offering health professionals more power and space, and by focusing on the things that people tell us matter most, we will make sure the NHS responds decisively and stays ahead of the game.

Similarly, whilst most people experience excellent care, nobody claims the NHS today is perfect.

I therefore want us to open every possible window into performance, so that we expose and prevent poor care, inspire the whole NHS to aim higher, and give everyone more confidence in the services they use.

Last century, the NHS set itself the highest ideals of compassion and dignity, carried by a commitment to the very best standards of treatment and support.

This mandate shows how we will honour that promise for the 21st century – and ensure our proudest creation continues to be our finest.

JEREMY HUNT
Secretary of State for Health

Introduction

The NHS belongs to the people. It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill, and when we cannot fully recover, to stay as well as we can to the end of our lives. It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of most basic human need, when care and compassion matter most. The NHS is founded on a set of common principles and values that bind together the communities and people it serves – patients and the public – and the staff who work for it.

The NHS Constitution

1. As a nation, we are proud of what the NHS has achieved and the values it stands for. But public expectations of good healthcare do not stand still. So on behalf of the people of England, patients and those who care for them, this first mandate to the NHS Commissioning Board sets out our ambitions for how the NHS needs to improve. It covers the period from April 2013 to the end of March 2015.

2. It is the Government's privilege to serve as guardian of the NHS and its founding values. We will safeguard, uphold and promote the NHS Constitution; and this is also required of the NHS Commissioning Board.

3. The NHS is there for everyone, irrespective of background. The Government will continue to promote the NHS as a comprehensive and universal service, free at the point of delivery and available to all based on clinical need, not ability to pay. We will increase health spending in real terms in each year of this Parliament. We will not introduce new patient charges.

4. The creation of an independent NHS Commissioning Board, and this mandate to the Board from the Government, mark a new model of leadership for the NHS in England, in which Ministers are more transparent about their objectives while giving local healthcare professionals independence over how to meet them.

5. The NHS budget is entrusted to the Board, which shares with the Secretary of State for Health the legal duty to promote a comprehensive health service. The Board oversees the delivery of NHS services, including continuous improvement of the quality of treatment and care, through healthcare professionals making decisions about services based on the needs of their communities. The Board is subject to a wide range of statutory duties, and is accountable to the Secretary of State and the public for how well it performs these.

6. This mandate plays a vital role in setting out the strategic direction for the Board and ensuring it is democratically accountable. It is the main basis of Ministerial instruction to the NHS, which must be operationally independent and clinically-led. Other than in exceptional circumstances, including a general election, it cannot be changed in the course of the year without the agreement of the Board. The Mandate is therefore intended to provide the NHS with much greater stability to plan ahead.

7. The Board is legally required to pursue the objectives in this document[1]. However it will only succeed through releasing the energy, ideas and enthusiasm of frontline staff and organisations. The importance of this principle is reflected in the legal duties on the Secretary of State and the NHS Commissioning Board as to promoting the autonomy of local clinical commissioners and others.

8. The scale of what we ask will take many years to achieve, but if the Board is successful, by March 2015 improvement across the NHS will be clear. By then, patients will see real and positive change in how they use health services, and how different organisations work together to support them.

9. The Government's ambition for excellent care is not just for those services or groups of patients mentioned in this document, but for everyone regardless of income, location, age, gender, ethnicity or any other characteristic. Yet across these groups there are still too many longstanding and unjustifiable inequalities in access to services, in the quality of care, and in health outcomes for patients. The NHS is a universal service for the people of England, and the NHS Commissioning Board is under specific legal duties in relation to tackling health inequalities and advancing equality. The Government will hold the Board to account for how well it discharges these duties.

10. The objectives in this mandate focus on those areas identified as being of greatest importance to people. They include transforming how well the NHS performs by:

- preventing ill-health, and providing better early diagnosis and treatment of conditions such as cancer and heart disease, so that more of us can enjoy the prospect of a long and healthy old age (*see section 1*);
- managing ongoing physical and mental health conditions such as dementia, diabetes and depression – so that we, our families and our carers can experience a better quality of life; and so that care feels much more joined up, right across GP surgeries, district nurses and midwives, care homes and hospitals (*see section 2*);
- helping us recover from episodes of ill health such as stroke or following injury (*see section 3*);

1 See section 13A(2) of the National Health Service Act 2006, as inserted by the Health and Social Care Act 2012

- making sure we experience better care, not just better treatment, so that we can expect to be treated with compassion, dignity and respect (*see section 4*);
- providing safe care – so that we are treated in a clean and safe environment and have a lower risk of the NHS giving us infections, blood clots or bed sores (*see section 5*).

11. These areas correspond to the five parts of the NHS Outcomes Framework, which are listed in this document and will be used to measure progress. The framework will be kept up to date to reflect changing public and professional priorities, and balanced to reduce distortion or perverse incentives from focusing inappropriately on some areas at the expense of others. In order to allow space for local innovation at the front line, both the Government and the NHS Commissioning Board will seek to ensure that local NHS organisations are held to account through outcome rather than process objectives. As one of its **objectives**, the Board will need to demonstrate progress against the five parts and all of the outcome indicators in the framework – including, where possible, by comparing our services and outcomes with the best in the world.

12. As part of this, the Government has identified the following priority areas where it is expecting particular progress to be made: (i) improving standards of care and not just treatment, especially for older people and at the end of people's lives; (ii) the diagnosis, treatment and care of people with dementia; (iii) supporting people with multiple long-term physical and mental health conditions, particularly by embracing opportunities created by technology, and delivering a service that values mental and physical health equally; (iv) preventing premature deaths from the biggest killers; (v) furthering economic growth, including supporting people with health conditions to remain in or find work. The Board is also expected to play a full role in supporting public service reform.

13. These priorities reflect the Government's absolute commitment to high quality healthcare for all, while highlighting the important additional role the NHS can play in supporting economic recovery.

14. The Mandate is not exhaustive. As part of the changes in the relationship between the Government and the NHS, the Board has agreed to play its full part in fulfilling pre-existing government commitments not specifically mentioned in the Mandate. For its part, the Government will exercise discipline by not seeking to introduce new objectives for the Board between one mandate and the next.

15. In all it does, whether in the Mandate or not, whether supporting local commissioners or commissioning services itself, the Commissioning Board is legally bound to pursue the goal of continuous improvement in the quality of health services.

1. Preventing people from dying prematurely

1.1 We want people to live longer, and with a better quality of life. Too many people die too soon from illnesses that can be prevented or treated. From cancer, liver and lung disease – and for babies and young children, England's rates of premature mortality are worse than those in many other European countries. There are also persistent inequalities in life expectancy and healthy life expectancy between communities and groups, which need to be urgently addressed by the NHS Commissioning Board.

1.2 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.

1.3 National and local government, the NHS Commissioning Board, Public Health England and others will all need to take action, with each organisation having the same goal. All will need to invest time now in developing strong partnerships, so that rapid progress can be made from April 2013.

1.4 Only after many years of sustained effort and innovation will this ambition be realised. Along the way, the NHS Commissioning Board's **objective** is to make significant progress:

- in supporting the earlier diagnosis of illness, particularly through appropriate use of primary care, and tackling risk factors such as high blood pressure and cholesterol. This includes working with Public Health England to support local government in the roll out of NHS Health Checks;
- in ensuring people have access to the right treatment when they need it, including drugs and treatments recommended by the National Institute for Health and Care Excellence (NICE), and services for children and adults with mental health problems;
- in reducing unjustified variation between hospitals in avoidable deaths, so that standards in all hospitals are closer to those of the best. The NHS should measure and publish outcome data for all major services by 2015, broken down by local clinical commissioning groups (CCGs) where patient numbers are adequate, as well as by those teams and organisations providing care. To support this, the Government will strengthen quality accounts, which all providers are legally required to publish to account for the quality of their services;

- in focusing the NHS on preventing illness, with staff using every contact they have with people as an opportunity to help people stay in good health – by not smoking, eating healthily, drinking less alcohol, and exercising more. As the country's largest employer, the NHS should also make an important contribution by promoting the mental and physical health and wellbeing of its own workforce.

Preventing people from dying prematurely: Key areas where progress will be expected *(Part one of the NHS Outcomes Framework)*
Overarching indicators
1a Potential Years of Life Lost (PYLL) from causes considered amenable to health care *(This is a measure of premature deaths that can be avoided through timely and effective healthcare.)* **i** Adults **ii** Children and young people
1b Life expectancy at 75, **i** males **ii** females
Improvement areas:
Reducing premature mortality from the major causes of death
1.1 Under 75 mortality rate from cardiovascular disease
1.2 Under 75 mortality rate from respiratory disease
1.3 Under 75 mortality rate from liver disease
1.4 Under 75 mortality from cancer **i** One- and **ii** Five-year survival from all cancers **iii** One- and **iv** Five-year survival from breast, lung and colorectal cancer
Reducing premature death in people with serious mental illness
1.5 Excess under 75 mortality rate in adults with serious mental illness
Reducing deaths in babies and young children
1.6.i Infant mortality
1.6.ii Neonatal mortality and stillbirths
1.6.iii Five-year survival from all cancers in children
Reducing premature death in people with learning disabilities
1.7 Excess under 60 mortality in adults with learning disabilities

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

2.1 We want to empower and support the increasing number of people living with long-term conditions. One in three people are living with at least one chronic condition, such as hypertension, diabetes or depression. By 2018 nearly three million people, mainly older people, will have three or more conditions all at once.

2.2 Too many people with ongoing health problems are treated as a collection of symptoms not a person. Simple things like getting a repeat prescription or making an appointment need to be much easier. People should expect the right support to help them manage their long-term conditions so that they do not end up in hospital needlessly or find that they can no longer work because of mental or physical illness. We need the NHS to do much better for people with long-term conditions or disabilities in the future. To stay relevant to our changing needs, different parts of the NHS have to work more effectively with each other and with other organisations, such as social services, to drive joined-up care.

2.3 To address these challenges, the NHS Commissioning Board's **objective** is to make measurable progress towards making the NHS among the best in Europe at supporting people with ongoing health problems to live healthily and independently, with much better control over the care they receive.

2.4 By 2013, the new 111 phoneline will be up and running for non-emergency care. By March 2015, we expect the Board to have made particular progress in four key areas: (i) involving people in their own care; (ii) the use of technology; (iii) better integration of services; and (iv) the diagnosis, treatment and care of those with dementia.

2.5 The NHS Commissioning Board's **objective** is to ensure the NHS becomes dramatically better at involving patients and their carers, and empowering them to manage and make decisions about their own care and treatment. For all the hours that most people spend with a doctor or nurse, they spend thousands more looking after themselves or a loved one. Achieving this objective would mean that by 2015:

- far more people will have developed the knowledge, skills and confidence to manage their own health, so they can live their lives to the full;
- everyone with long-term conditions, including people with mental health problems, will be offered a personalised care plan that reflects their preferences and agreed decisions;

- patients who could benefit will have the option to hold their own personal health budget, subject to the evaluation of the pilot programme, as a way to have even more control over their care;
- the five million carers looking after friends and family members will routinely have access to information and advice about the support available – including respite care.

2.6 In a digital age, it is crucial that the NHS not only operates at the limits of medical science, but also increasingly at the forefront of new technologies. The Board's **objective** is to achieve a significant increase in the use of technology to help people manage their health and care. In particular, the Government expects that by March 2015:

- everyone who wishes will be able to get online access to their own health records held by their GP. The Board should promote the implementation of electronic records in all health and care settings and should work with relevant organisations to set national information standards to support integration;
- clear plans will be in place to enable secure linking of these electronic health and care records wherever they are held, so there is as complete a record as possible of the care someone receives;
- clear plans will be in place for those records to be able to follow individuals, with their consent, to any part of the NHS or social care system;
- everyone will be able to book GP appointments and order repeat prescriptions online;
- everyone will be able to have secure electronic communication with their GP practice, with the option of e-consultations becoming much more widely available;
- significant progress will be made towards three million people with long-term conditions being able to benefit from telehealth and telecare by 2017; supporting them to manage and monitor their condition at home, and reducing the need for avoidable visits to their GP practice and hospital.

2.7 As a leader of the health system, the NHS Commissioning Board is uniquely placed to coordinate a major drive for better integration of care across different services, to enable local implementation at scale and with pace from April 2013.

2.8 The focus should be on what we are achieving for individuals rather than for organisations – in other words care which feels more joined-up to the users of services, with the aim of maintaining their health and wellbeing and preventing their

condition deteriorating, so far as is possible. We want to see improvements in the way that care:

- is coordinated around the needs, convenience and choices of patients, their carers and families – rather than the interests of organisations that provide care;
- centres on the person as a whole, rather than on specific conditions;
- ensures people experience smooth transitions between care settings and organisations, including between primary and secondary care, mental and physical health services, children's and adult services, and health and social care – thereby helping to reduce health inequalities;
- empowers service users so that they are better equipped to manage their own care, as far as they want and are able to.

2.9 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. The challenge is to tackle practical barriers that stop services working together effectively, and for national organisations to provide help and expertise where this will be needed, rather than to design and impose a blueprint. Local commissioners have the vital role of stimulating the development of innovative integrated provision – for example, across primary, secondary and social care, or for frail elderly patients. In responding to the barriers revealed by their work, further national action will be needed in a number of areas, including: better measurement of user experience of seamless care; better use of technology to share information; open and fair procurement practice; and new models of contracting and pricing which reward value-based, integrated care that keeps people as healthy and independent as possible.

2.10 Dementia is the illness most feared by people in England over the age of 55, yet in the past it has not received the attention it needs. This has inspired the Prime Minister's Challenge on Dementia, which was launched in March 2012. The Government's goal is that the diagnosis, treatment and care of people with dementia in England should be among the best in Europe.

2.11 The **objective** for the NHS Commissioning Board is to make measurable progress towards achieving this by March 2015, in particular ensuring timely diagnosis and the best available treatment for everyone who needs it, including support for their carers. 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.

2.12 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.

Enhancing quality of life for people with long-term conditions: Key areas where progress will be expected *(Part two of the NHS Outcomes Framework)*
Overarching indicator
2 Health related quality of life for people with long-term conditions
Improvement areas
Ensuring people feel supported to manage their condition
2.1 Proportion of people feeling supported to manage their condition
Improving functional ability in people with long-term conditions
2.2 Employment of people with long-term conditions
Reducing time spent hospital by people with long-term conditions
2.3.i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) *(Chronic ambulatory care sensitive conditions are those where the right treatment and support in the community can help prevent people needing to be admitted to hospital.)*
2.3.ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s
Enhancing quality of life for carers
2.4 Health-related quality of life for carers
Enhancing quality of life for people with mental illness
2.5 Employment of people with mental illness
Enhancing quality of life for people with dementia
2.6.i Estimated diagnosis rate for people with dementia
2.6.ii A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life

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

3.1 Every year, millions of people rely on the NHS to help them recover after an illness or rehabilitate after injury. It does so not only through effective treatment but also through ongoing help in recovering quickly and regaining independence – whether from a planned operation such as a hip or knee replacement, an injury from a fall or other accident, a respiratory infection in a young child, or a major emergency like a stroke. Helping people get back as quickly or as much as possible to their everyday lives is not something the NHS can achieve alone, but requires better partnership with patients, families and carers, social services and other agencies.

3.2 Many parts of the NHS are world-leading in helping people to recover from ill health or injury. Because standards are high overall, most people assume all NHS services are equally good. Yet there are huge and unwarranted differences in quality and results between services across the country – even between different teams in the same hospital, or GP practices in the same vicinity.

3.3 An **objective** for the NHS Commissioning Board is to shine a light on variation and unacceptable practice, to inspire and help people to learn from the best. We want a revolution in transparency – so that the NHS leads the world in the availability of information about the quality of services. This means:

- reporting results at the level of local councils, clinical commissioning groups, providers of care and consultant-led teams;
- the systematic development of clinical audit and patient-reported outcome and experience measures;
- real consideration of how to make it easy for patients and carers to give feedback on their care and see reviews by other people, so that timely, easy-to-review feedback on NHS services becomes the norm.

3.4 Better information may expose the need for change. For example, stroke services in London have recently been brought together to provide rapid access to highly specialised emergency treatment, significantly reducing mortality rates. Priority should be given to changes to services which improve outcomes whilst also maintaining access. Where local clinicians are proposing significant change to services, we want to see better informed local decision-making about services, in which the public are fully

consulted and involved. The NHS Commissioning Board's **objective** is to ensure that proposed changes meet four tests: (i) strong public and patient engagement; ii) consistency with current and prospective need for patient choice; iii) a clear clinical evidence base; and iv) support for proposals from clinical commissioners.

3.5 Treating mental and physical health conditions in a coordinated way, and with equal priority, is essential to supporting recovery. Yet people with mental health problems have worse outcomes for their physical healthcare, and those with physical conditions often have mental health needs that go unrecognised. The NHS Commissioning Board's **objective** is to put mental health on a par with physical health, and close the health gap between people with mental health problems and the population as a whole.

3.6 By March 2015, we expect measurable progress towards achieving true parity of esteem, where everyone who needs it has timely access to evidence-based services. 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. The Board 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%. The Board will work with stakeholders to ensure implementation is at all times in line with the best available evidence.

Helping people to recover from episodes of ill health or following injury: Key areas where progress will be expected *(Part three of the NHS Outcomes Framework)*
Overarching indicators
3a Emergency admissions for acute conditions that should not usually require hospital admission
3b Emergency readmissions within 30 days of discharge from hospital
Improvement areas
Improving outcomes from planned treatments
3.1 Total health gain as assessed by patients for elective procedures
3.1.i Hip **ii** Knee replacement **iii** Groin Hernia **iv** Varicose veins **v** Psychological therapies *(These indicators will measure the number of people accessing particular treatments and whether patients report that they are effective.)*
Preventing lower respiratory tract infections (LRTI) in children from becoming serious
3.2 Emergency admissions for children with lower respiratory tract infections (LRTI)

Helping people to recover from episodes of ill health or following injury: Key areas where progress will be expected *(Part three of the NHS Outcomes Framework)*
Improving recovery from injuries and trauma
3.3 Proportion of people who recover from major trauma
Improving recovery from stroke
3.4 Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months *(The Modified Rankin Scale is commonly used to measure the degree of disability or dependence following a stroke.)*
Improving recovery from fragility fractures
3.5 The proportion of patients with fragility fractures recovering to their previous levels of mobility/walking ability at **i** 30 days and **ii** 120 days
Helping older people to recover their independence after illness or injury
3.6.i Proportion of Older People (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
3.6.ii Proportion offered rehabilitation following discharge from acute or community hospital.

4. Ensuring that people have a positive experience of care

4.1 The NHS is not there just to offer excellent treatment and support. It is there to care for us. Quality of care is as important as quality of treatment, but the public are less confident about consistency in care provision than they are about treatment.

4.2 No one going in to hospital should have to worry about being left in pain, unable to eat or drink, or go to the toilet. And those who have relatives or friends who need support should have peace of mind that they will be treated with compassion, respect and dignity – whether at home or in residential care.

4.3 While most people receive excellent care, we have all been shocked by incidents of major failings in care. It is frequently those who are very old or vulnerable who bear the brunt – those with complex conditions, who are unlikely or unable to complain, and who in some instances no longer have friends or family members who can fight for them. As a society, as a health and care system, and as a Government, we all find such failings abhorrent and intolerable. The Government is clear that, where serious failures of care and treatment have occurred, managers in both the NHS and social care sector will be better held to account.

4.4 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.

4.5 Later in the autumn of 2012, the Government will issue a full and detailed response to the appalling abuse that was witnessed at Winterbourne View private hospital. The NHS Commissioning Board's **objective** is to ensure that CCGs work with local authorities to ensure that vulnerable people, particularly those with learning disabilities and autism, receive safe, appropriate, high quality care. The presumption should always be that services are local and that people remain in their communities; we expect to see a substantial reduction in reliance on inpatient care for these groups of people.

4.6 Our ambition stretches beyond ensuring that all parts of the health and care system will satisfy minimum standards of care. The NHS Commissioning Board's **objective** is to pursue the long-term aim of the NHS being recognised globally as having the highest standards of caring, particularly for older people and at the end of people's lives.

4.7 The quality of care is closely related to how well organisations engage, manage and support their own staff. The NHS Constitution includes important pledges to staff who provide NHS care, and the NHS Commissioning Board is required to promote the NHS Constitution in carrying out its functions. The Board also has a statutory duty as to promoting education and training, to support an effective system for its planning and delivery. The Board should support Health Education England in ensuring that the health workforce has the right values, skills and training to enable excellent care.

4.8 The Government also expects to see the Board make significant progress by March 2015 in two principal areas. The first **objective** is to make rapid progress in measuring and understanding how people really feel about the care they receive and taking action to address poor performance. The NHS staff survey provides important information about organisations' health, and it already asks whether staff would recommend their place of work to a family member or friend as a high-quality place to receive treatment and care (the 'friends and family test'). However, staff are only asked this question annually, and the Board should ensure that much more regular feedback on the 'friends and family test' becomes the norm.

4.9 Part of this objective is for the NHS Commissioning Board to introduce the 'friends and family' test for patients across the country: for all acute hospital inpatients and Accident and Emergency patients from April 2013; for women who have used maternity services from October 2013; and as rapidly as possible thereafter for all those using NHS services. Hospitals with good scores on the 'friends and family' test will be financially rewarded.

4.10 We want to boost professional and public pride in all the caring professions, and to empower patients to demand improvements where care is not as good as it could be. By 2015, a further part of this objective is to increase the proportion of people, across all areas of care, who rate their experience as excellent or very good.

4.11 The second **objective** for the Board, which will require joined-up care between the NHS and local authorities across health, education and social services, is to improve the standards of care and experience for women and families during pregnancy and in the early years for their children. As part of this, we want the Board to work with partner organisations to ensure that the NHS:

- offers women the greatest possible choice of providers;

- ensures every woman has a named midwife who is responsible for ensuring she has personalised, one-to-one care throughout pregnancy, childbirth and during the postnatal period, including additional support for those who have a maternal health concern;
- reduces the incidence and impact of postnatal depression through earlier diagnosis, and better intervention and support.

4.12 Our ambition is to help give children the best start in life, and promote their health and resilience as they grow up; and the Government's commitment to an additional 4,200 health visitors by 2015 will help to ensure this vital support for new families. We expect to see the NHS, working together with schools and children's social services, supporting and safeguarding vulnerable, looked-after and adopted children, through a more joined-up approach to addressing their needs. We welcome the Board's commitment to its full participation in local safeguarding arrangements for vulnerable children and adults. We will work with the NHS Commissioning Board, and Healthwatch England, to consider how best to ensure that the views of children, especially those with specific healthcare needs, are listened to.

4.13 One area where there is a particular need for improvement, working in partnership across different services, is in supporting children and young people with special educational needs or disabilities. The Board's **objective** is to ensure that they have access to the services identified in their agreed care plan, and that parents of children who could benefit have the option of a personal budget based on a single assessment across health, social care and education.

4.14 Timely access to services is a critical part of our experience of care. The NHS should be there for people when they need it; this means providing equally good care seven days of the week, not just Monday to Friday. More generally, over the last decade, the NHS has made enormous improvements in reducing waiting times for services. The people of England expect all parts of the NHS to comply with the rights, and fulfil the commitments set down in the NHS Constitution, including to maintain high levels of performance in access to care. The Board's **objective** is to uphold these rights and commitments, and where possible to improve the levels of performance in access to care.

4.15 Too often, access to services for people with mental health problems is more restricted and waiting times are longer than for other services, with no robust system of measurement in place even to quantify the scale of the problem. 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.

Ensuring that people have a positive experience of care: Key areas where progress will be expected *(Part four of the NHS Outcomes Framework)*
Overarching indicators
4a Patient experience of primary care **i** GP services **ii** GP out-of-hours services **iii** NHS Dental Services
4b Patient experience of hospital care
4c Friends and Family test
Improvement areas
Improving people's experience of outpatient care
4.1 Patient experience of outpatient services
Improving hospitals' responsiveness to personal needs
4.2 Responsiveness to in-patients' personal needs
Improving people's experience of accident and emergency services
4.3 Patient experience of A&E services
Improving access to primary care services
4.4 Access to **i** GP services and **ii** NHS dental services
Improving women and their families' experience of maternity services
4.5 Women's experience of maternity services
Improving the experience of care for people at the end of their lives
4.6 Bereaved carers' views on the quality of care in the last 3 months of life
Improving the experience of healthcare for people with mental illness
4.7 Patient experience of community mental health services
Improving children and young people's experience of healthcare
4.8 An indicator is under development
Improving people's experience of integrated care
4.9 An indicator is under development

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

5.1 As indicated in the NHS Constitution, patients should be able to expect to be treated in a safe and clean environment and to be protected from avoidable harm. In recent years the NHS has made progress in developing a culture of patient safety in the NHS, through the introduction of stronger clinical governance within organisations. But much remains to be done.

5.2 Improving patient safety involves many things: treating patients with dignity and respect; high quality nursing care; creating systems that prevent both error and harm; and creating a culture of learning from patient safety incidents, particularly events that should never happen, such as wrong site surgery, to prevent them from happening again.

5.3 The NHS Commissioning Board's **objective** is to continue to reduce avoidable harm and make measurable progress by 2015 to embed a culture of patient safety in the NHS including through improved reporting of incidents.

5.4 It is also important for the NHS to take action to identify those groups known to be at higher risk of suicide than the general population, such as people in the care of mental health services and criminal justice services. The Board will need to work with clinical commissioning groups to ensure that providers of mental health services take all reasonable steps to reduce the number of suicides and incidents of serious self-harm or harm to others, including effective crisis response.

Treating and caring for people in a safe environment and protecting them from avoidable harm: Key areas where progress will be expected *(Part five of the NHS Outcomes Framework)*
Overarching indicators
5a Patient safety incident reporting
5b Safety incidents resulting in severe harm or death
5c Hospital deaths attributable to problems in care
Improvement areas
Reducing the incidence of avoidable harm
5.1 Incidence of hospital-related venous thromboembolism (VTE)
5.2 Incidence of healthcare assosiated infection (HCAI) **i** Incidence of MRSA **ii** Incidence of C. difficile
5.3 Incidence of newly-acquired category 2, 3 and 4 pressure ulcers
5.4 Incidence of medication errors causing serious harm
Improving the safety of maternity services
5.5 Admission of full-term babies to neonatal care
Delivering safe care to children in acute settings
5.6 Incidence of harm to children due to 'failure to monitor'

6. Freeing the NHS to innovate

6.1 The Government and the NHS Commissioning Board are of one mind in recognising that the scale of the ambitions in this mandate cannot be achieved through a culture of command and control. Only by freeing up local organisations and professionals, and engaging the commitment of all staff to improve and innovate, can the NHS achieve the best health outcomes in the world. This mandate, together with new legal duties that relate to promoting autonomy, demands a new style of leadership from Ministers and from the Board which is about empowering individuals and organisations at the front line of the NHS. We welcome the Board's commitment to support improved outcomes, including by understanding and responding to the needs and preferences of patients and communities locally.

6.2 The Board's **objective** is to get the best health outcomes for patients by strengthening the local autonomy of clinical commissioning groups, health and wellbeing boards, and local providers of services. The Government will hold the Board to account for achieving this; and it will be supported by a process of comprehensive feedback for assessing the Board's performance.

6.3 The establishment of CCGs and health and wellbeing boards is a critical part of the process of decentralising power, as is the progression of NHS trusts through the pipeline to Foundation Trust status under the leadership of the NHS Trust Development Authority. 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.

6.4 The objectives in this mandate can only be realised through local empowerment. The Board's role in the new system will require it to consider how best to balance different ways of enabling local and national delivery. These may include:

- the power of its expertise and its professional leadership, working with partners such as the Royal Colleges;
- its ability to bring NHS organisations together across larger geographical areas, not as the manager of the system, but as its convener;

- its ability to work in partnership with local authorities and commissioners, particularly through health and wellbeing boards;
- its duties and capabilities for engaging and mobilising patients, professionals and communities in shaping local health services;
- its duties to promote research and innovation – the invention, diffusion and adoption of good practice;
- the transformative effect of information and transparency, enabling patients to make fully informed decisions, and encouraging competition between peers for better quality;
- its control over incentives such as improving the basis of payment by results, introducing the quality premium for CCGs, and the quality and outcomes framework in the GP contract;
- leading the continued drive for efficiency savings, while maintaining quality, through the Quality Innovation Productivity and Prevention (QIPP) programme;
- and by spreading better commissioning practice, including redesigning services, open procurement and contracting for outcomes, to ensure consistently high standards across all areas of commissioning.

6.5 To support the NHS to become more responsive and innovative, the NHS Commissioning Board's **objective** by 2015 is to have:

- fully embedded all patients' legal rights to make choices about their care, and extended choice in areas where no legal right yet exists. This includes offering the choice of any qualified provider in community and mental health services, in line with local circumstances. The Government will shortly publish a Choice Framework, following consultation, which will help patients understand the choices they can expect to have, and the Board is working further with Monitor on how choice can best be used to improve outcomes for patients;
- supported the creation of a fair playing field, so that care can be given by the best providers, whether from the public, independent or voluntary sector. This calls for the Board to lead major improvements in how the NHS undertakes procurement, so that it is more open and fair, and allows providers of all sizes and from all sectors to contribute, supporting innovation and the interests of patients;
- made significant improvements in extending and improving the system of prices paid to providers, so that it is transparent, and rewards people for doing the right thing.

6.6 The previous administration commissioned an independent evaluation of the impact of many of its policies on the NHS, and during 2013 the Department of Health will commission a similar evaluation programme.

7. The broader role of the NHS in society

7.1 The NHS is the biggest public service in the country, accounting for eight per cent of national income. It contributes to the growth of the economy: not only by addressing the health needs of the population, thereby enabling more people to be economically active; but also through supporting the life sciences industry, by adopting and spreading new technologies; and through exporting innovation and expertise internationally.

7.2 The NHS Commissioning Board's **objective** is to ensure that the new commissioning system promotes and supports participation by NHS organisations and NHS patients in research funded by both commercial and non-commercial organisations, most importantly to improve patient outcomes, but also to contribute to economic growth. This includes ensuring payment of treatment costs for NHS patients taking part in research funded by Government and Research Charity partner organisations.

7.3 The NHS and its public sector partners need to work together to help one another to achieve their objectives. This is a core part of what the NHS does and not an optional extra, whether it is working with local councils, schools, job centres, housing associations, universities, prisons, the police or criminal justice agencies such as Police and Crime Commissioners and Community Safety Partnerships. The NHS Commissioning Board's **objective** is to make partnership a success. This includes, in particular, demonstrating progress against the Government's priorities of:

- continuing to improve services for both disabled children and adults;
- continuing to improve safeguarding practice in the NHS;
- contributing to multi-agency family support services for vulnerable and troubled families;
- upholding the Government's obligations under the Armed Forces Covenant;
- contributing to reducing violence, in particular by improving the way the NHS shares information about violent assaults with partners, and supports victims of crime;
- improving services through the translation of scientific developments into benefits for patients;
- helping people experiencing ill health, whether mental or physical, to remain in or return to work, and avoid homelessness;

- developing better healthcare services for offenders and people in the criminal justice system which are integrated between custody and the community, including through development of liaison and diversion services;
- championing the Time to Change campaign to raise awareness of mental health issues and reduce stigma, including in the NHS workforce.

8. Finance

8.1 The NHS Commissioning Board's revenue budget for 2013–14 is £95,623 million (of which £1,843 million is for delivery of the section 7A agreement[2] with the Secretary of State) and its capital budget is £200 million[3]. At a time of great pressure on the public finances, it is vital to deliver this mandate within available resources, both in the current spending review period and beyond. Therefore, the Board's **objective** is to ensure good financial management and unprecedented improvements in value for money across the NHS, including ensuring the delivery of its contribution, and that of CCGs, to the QIPP programme. The Board will also need to comply with the financial directions made under the NHS Act 2006 and published alongside this mandate, which set out further technical limits, including spending on administration. Like any other public body it will be covered by all relevant government guidance on the management of public finances, which are summarised in the Framework Agreement between the Department of Health and the NHS Commissioning Board.

8.2 The Board will be responsible for allocating the budgets for commissioning NHS services. This will prevent any perception of political interference in the way that money is distributed between different parts of the country. The Government expects the principle of ensuring equal access for equal need to be at the heart of the Board's approach to allocating budgets. This process will also need to be transparent, and to ensure that changes in allocations do not result in the destabilising of local health economies.

2 The NHS Commissioning Board will be responsible for carrying out some specific public health functions on behalf of the Secretary of State for Health. These functions, and further details of the funding granted to support them, will be set out in an agreement made under section 7A of the NHS Act 2006.

3 See section 223D of the NHS Act 2006 (financial duties of the Board); the revenue and capital budgets are the amounts specified as the limits on total resource use under subsections (2) and (3).

9. Assessing progress and providing stability

9.1 The Government is formally setting the NHS Commissioning Board the objectives in this document under section 13A of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012[4]. We will assess annually the success of the Board against the progress it makes against this mandate, and in carrying out other legal duties and functions.

9.2 The NHS Commissioning Board will be directly commissioning NHS services provided by GPs, dentists, community pharmacists and community opticians; specialised care; health services for people in custody; and military health. This offers a great opportunity to improve standards and national consistency, for example in services for people with rare conditions. The Board has an important responsibility to drive improvements in the quality of primary care, reflecting the vital role that stronger primary care will play in supporting delivery of objectives across this mandate.

9.3 The Department will hold the Board to account for the quality of its direct commissioning, and how well it is working with clinical commissioners, health and wellbeing boards, and local healthcare professionals. An **objective** is to ensure that, whether NHS care is commissioned nationally by the Board or locally by clinical commissioning groups, the results – the quality and value of the services – should be measured and published in a similar way, including against the relevant areas of the NHS Outcomes Framework. Success will be measured not only by the average level of improvement but also by progress in reducing health inequalities and unjustified variation.

9.4 Every year, the Board must report on its progress, and the Government will publish an annual assessment of the Board's performance. To ensure that our assessment is fair, the Government will invite feedback from CCGs, local councils, patients and any other people and organisations that have a view. This will mean successes can be recognised, and areas for improvement can be acted on.

4 The Secretary of State also has power to use the Mandate to set any "requirements" that he thinks are necessary for the purpose of achieving the objectives; these must be backed up by regulations. This mandate does not include any requirements.

9.5 This mandate provides democratic legitimacy for the work of the Board. It will be updated annually and laid before Parliament. The Government will maintain constancy of purpose, and strive to keep changes between mandates to the minimum necessary. In this way the Mandate will help provide greater stability for the NHS to plan ahead, innovate and excel to bring the greatest benefit to all those who use it.

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Produced by Williams Lea for the Department of Health