

# Response to the draft mandate to the NHS Commissioning Board

---

## Key Points

- The government should resist the temptation to develop the mandate too far and too quickly. There is already a risk of confusion by an excess of objectives.
- In the short term, given the financial pressures facing the NHS and the immediate threats to the quality of services, it may be important to organise the mandate in an understandable way that clearly specifies the short-term priorities facing the NHS, as well as paving the way for longer-term clinically-led improvement, as intended
- Future development of the mandate should depend on extensive consultation (taking into account the experience of commissioners and others who are attempting to deliver on the mandate's objectives). It also needs to be led by the availability and robustness of underpinning datasets: objectives without clear measures of progress should be avoided.
- Related to this, the annual report on progress against the mandate needs to be a credible, non-partisan document that unflinchingly reports on both progress and failure. It is also essential that the NHS Commissioning Board (CB) makes technical annexes containing the underlying data, and the methodology behind any analyses, publicly available so that all claims about progress can be independently verified.
- The development of the mandate should take into account increasingly available datasets on the process and outcome of care, and international indicators (which would allow a better comparison of health and health care performance across the UK and internationally).

We support the government's determination to create a patient-centred culture in the NHS. However, the probability that the mandate will achieve this depends on how it will be used, both by the Secretary of State and Parliament (i.e. in the chain of upward accountability), and the NHS CB (in its role as performance manager of clinical commissioning groups, contract holder for primary care and commissioner of specialised services).

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

One of the objectives of the Health and Social Care Act was to 'liberate' the NHS, in other words loosen the grip of the centre on the day-to-day operations of the NHS. Historically, this grip has been exercised both by Ministers and the senior managers of the Department of Health, and dispersed through SHAs and other regional bodies. The CB was set up to distance the running of the NHS from Ministers. It may enable this shift, but does not guarantee it, especially since the accompanying mandate notes suggest that ministers will hold regular meetings with the CB. We would ask for clarification about whether this will be the only contact between Ministers and the CB. If there are other forms of contact, will they be similarly documented and their minutes put on public record?

The second component of grip has been exercised within the hierarchy of the NHS, from the centre downwards. At the moment, it is not clear how closely the CB and its regional outposts will attempt to control the actions and behaviours of local commissioners, and to what extent this control will involve the mandate. This uncertainty is partly a function of the implementation cycle: much effort is understandably being expended on authorising clinical commissioning groups to a tight timetable. Nevertheless, we would welcome more detail about how the mandate will be used and 'translated' into objectives for individual commissioning groups, how these will align with locally-generated commissioning plans and the rigour with which any mandate-derived objectives will be performance-managed.

It will also be important that the mission and purpose of other key organisations, such as Monitor and the CQC, are aligned with the CB and the mandate. Will these other key bodies have an equivalent explicit mandate like the NHS CB, that (a) is congruent with the objectives of the CB mandate, and (b) can be used to hold these other arms length bodies to public account?

### **Do you agree with the overall approach to the draft mandate and the way the mandate is structured?**

The categorisation of objectives into broad themes is logical: health outcomes, putting patients first, broader role of the NHS, effective commissioning and finance/financial management (although 'effective commissioning' should perhaps be re-titled 'implementation of commissioning', since health outcomes, better patient care and good financial management are all subsets of effective commissioning).

Our main observation is that the objectives are not all of the same scope or magnitude, and the rationale for this is not clear. What is the rationale, for example, for a separate objective for mental health, with very specific measures (e.g. use of care pathways, IAPT) but not for other disease groups?

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

We feel that there are too many objectives and it is not clear what respective weight they carry. This has the potential to cause confusion both for those commissioning services and for those who wish to hold the system to account.

### **Improving health**

The objectives (1 to 8) which relate to improved health outcomes are sound in intent. If successfully designed and implemented, they will represent an important step forward in measuring the impact of a modern health system. Nevertheless, we do not underestimate the complexity of calculating meaningful baselines and achievable targets: the science behind this is still under development.

The first three objectives (reducing avoidable mortality, QALYs for people with long-term conditions, QALYs from recovery from illness, injury) are therefore likely to be both experimental in the short run, which will place additional emphasis on the existing outcome/process measures (contained in the Outcomes Framework and NHS Constitution sections). In practice, this means that the system will still be reliant on disease-specific outcome measures and process measures such as waiting times. This will be compounded by the long timeframes attached to some of the measures of avoidable mortality or improvements in quality of life for people with chronic conditions, where it will take several years for any changes to register.

The debate about disease-specific objectives is a complex one: overall health improvement at a population level will come from tackling the major diseases that affect large numbers of people, and the mandate, if properly implemented, could be a tool for ensuring that the NHS finally deals with multiple morbidities, rather than pursuing separate disease silos. However, the NHS should not lose sight of the need to respond to rarer conditions that affect a minority of people, but have little impact on overall levels of health.

### **Prevention**

The proposed outcomes objectives relate to reducing premature mortality and improving the quality of the care given to people with chronic conditions. We believe that, in addition, the core objectives should also include an explicit focus on the prevention of chronic conditions; in other words, the prevention of premature morbidity. This will require much more upstream work by commissioners to tackle issues such as obesity and inactivity, as well as measurable outcomes that might involve disease-specific approaches, e.g. to halt and reverse the trend of type 2 diabetes prevalence.

Objectives of this kind would enable commissioners to concentrate public health and NHS prevention services on tackling the rise of long-term conditions such as diabetes, heart disease and other preventable conditions. The objective (11) that relates to prevention is weak and hard to monitor (that all health care professionals take all opportunities to support people to improve their health). It would be far more valuable for the CB, for example, to report on the nature and scale of proactive prevention activity (beyond QOF) being undertaken in primary care, local government, other community settings or in conjunction with secondary care.

### **Patient experience (Objective 4)**

It is clearly important to include a positive patient experience as an outcome measure of improved health. We would question whether the measures in objective 4 are overly skewed towards the acute hospital sector. How will progress in the patient experience of primary and community care be understood and measured? In addition, will these high-level indicators of overall progress give the CB sufficient confidence that particularly vulnerable patients – such as older people with dementia – are being treated with dignity and respect? There is also an urgent need to understand patients' experiences of care across care boundaries. The mandate's current focus on experience within individual institutions means that improvement efforts will remain contained within rather than across institutions.

### **Inequalities (Objectives 7 and 8)**

The inequalities objectives seem weak. It is not made clear why one specific dimension is singled out (life expectancy at birth). How ill health is distributed across the population and within sub-groups is as important as making progress at a population level as a whole. Overall improvements in health are likely, on current trends, to sharpen the gradient in the distribution of ill health and worsen inequalities. This will potentially be invisible to high-level outcomes measurement, which will show overall improvement. There are still significant gaps in the data to permit a thorough analysis of inequalities: we would recommend a mapping of the available data against the Outcomes Framework and other mandate objectives, with a view to some sort of separate report, similar perhaps to the annual disparities report in the US, compiled by the Agency for Healthcare Research and Quality.

### **Shared decision-making and choice (Objective 12)**

Although shared decision-making is stated as a clear objective, there does not seem to be any meaningful way of measuring whether this has taken place. Instead, most of the measurement relates to the offer of patient choice at different points in the system, which is also important but is not the same as shared decision-making. The draft choice framework that was published alongside the mandate is a useful distillation of the choice that will be on offer to patients. However, it is not clear how it will be monitored. The DH survey of patient choice of elective care has been discontinued: we would ask the CB (in conjunction with Monitor) what steps they are taking to see whether patients are routinely making choices and are able to access the information needed to support these choices.

### **Integrated care (Objective 13)**

The focus on this in the mandate is welcome, but the suggested measures of progress are vague, as with patient choice. As we mentioned above, this underlines the need to urgently develop a way of measuring patients' and carers' perspectives on how fragmented or integrated their care is.

### **Financial management (Objective 22)**

This seems under-developed. It is very important to report on the progress of QIPP, but commissioning in its wider sense is likely to be dominated by the financial backdrop. Will data be made available about the financial performance of individual clinical commissioning groups and will there be analysis of the relationship between clinical commissioning groups' financial performance and outcome/activity data?

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

The annual report on progress against the mandate needs to be a credible, non-partisan document that unflinchingly reports on both progress and failure. It is also essential that the NHS CB makes technical annexes containing the underlying data, and the methodology behind any analyses, publicly available so that all claims about progress can be independently verified.

We would also support the publication of all relevant underpinning data and reports against progress during the year. There is currently a dearth of regular information about the implementation of commissioning or progress against QIPP plans. A commitment to interim reporting would support the government's wider objectives for transparency in government.

We suggest that progress against the mandate should be assessed rigorously by Parliament, preferably in the Health Select Committee, alongside the annual CQC report. It is important that patient and community organisations have a role in assessing progress against the mandate, including Healthwatch (local and national), and health and wellbeing boards.

In addition, it will be important that there is some clarity about the relationship between the mandate and the NHS Constitution, which also has to report on whether or not it is being adhered to. The NHS Constitution is clearly intended to be a public-facing document. It is not clear whether the mandate is also intended to be similarly accessible (it is not in its current form), and yet it may well have a much more profound influence on the NHS.

For more information about Nuffield Trust,  
including details of our latest research and analysis,  
please visit [www.nuffieldtrust.org.uk](http://www.nuffieldtrust.org.uk)



Download further copies of this policy response  
from [www.nuffieldtrust.org.uk/publications](http://www.nuffieldtrust.org.uk/publications)



Subscribe to our newsletter:  
[www.nuffieldtrust.org.uk/newsletter](http://www.nuffieldtrust.org.uk/newsletter)



Follow us on Twitter: [Twitter.com/NuffieldTrust](https://twitter.com/NuffieldTrust)

---

---

Nuffield Trust is an authoritative  
and independent source of  
evidence-based research and  
policy analysis for improving  
health care in the UK

---

59 New Cavendish Street  
London W1G 7LP  
Telephone: 020 7631 8450  
Facsimile: 020 7631 8451  
Email: [info@nuffieldtrust.org.uk](mailto:info@nuffieldtrust.org.uk)



[www.nuffieldtrust.org.uk](http://www.nuffieldtrust.org.uk)

Published by the Nuffield Trust.  
© Nuffield Trust 2012. Not to be reproduced  
without permission.