NHS Confederation response
September 2013

Introduction
The NHS Confederation is the only body to bring together the full range of organisations that make up the modern NHS to help improve the health of patients and the public. We are an independent membership organisation that represents all types of providers and commissioners of NHS services. We speak for the whole of the NHS on the issues that matter to all those involved in healthcare. We also reflect the diverse views of the different parts of the healthcare system.

We welcome this opportunity to engage with consultation on 'refreshing' the NHS mandate for 2014-15. Our response is informed by an online member survey and discussions with members from across the health system, as well as our previous response to the original 2013-15 mandate.

Summary of main points
It is essential that the mandate provides a high level and strategic framework for the system, and that changes between mandates are kept to a minimum, as we emphasised when the first version was being developed. The NHS needs a stable environment so that it can concentrate on the strategic challenges it must address in order to remain sustainable in the future. We need to develop and embed a new way of working, focused on improving patient and population outcomes over the long term rather than meeting short term, process-driven targets.

The NHS Confederation is therefore concerned and disappointed to see so many proposed revisions adding a significant amount of detail within a year of the first mandate.

To support a high level, strategic approach, we have developed a set of principles for the mandate. We urge the Department of Health to reflect these, and we will test future versions of the mandate against them. The mandate should:

- empower clinicians to lead, and patients to influence, commissioning
- be based on a manageable number of objectives which:
  - focus mainly on long term outcomes for patients and populations rather than measures of how services are delivered
  - encourage collective responsibility for patient outcomes rather than silo working - particularly the expected outcomes from integrated care
  - are easily measurable, specific and realistic to enable accountability across NHS England, commissioners, providers, patients and the public
  - can be implemented efficiently rather than imposing unnecessary or disproportionate cost and burden
  - align with the requirements on the other national bodies; and
  - are in language which is accessible to patients and the public.

1 We are currently undertaking a major piece of work looking at how we can cut bureaucracy in the NHS, and will publish a report on this soon.
• retain a focus on enabling, supporting and delivering effective commissioning and avoid diverting NHS England's efforts into areas that other organisations (whether local or national) are better placed to address

We also believe the Department of Health could do more to address four overarching strategic issues within the mandate and in related announcements:

• **Acknowledging funding pressures** by setting out the costs of the additional commitments and how these will be met. National leaders have a responsibility to be clear and honest with patients and the public regarding the affordability of healthcare developments.

• **Developing a whole system approach** reflecting the practical contributions of all parts of the system in addressing challenges. The refreshed mandate should also take the opportunity to emphasise and support the overall direction of travel towards more care being delivered outside hospitals.

• **Strengthening working relationships** between NHS England and CCGs and providers. This should include mechanisms to develop a relationship based on cooperation and co-production between CCGs and NHS England, and seeking feedback from providers on NHS England.

• **Bringing leaders across the whole system together** at local and regional level to find joint solutions where action is required across many boundaries, such as service reconfiguration across a whole local health economy. NHS England may potentially have a role to play in this, though we are clear that local commissioners and providers need to drive collaboration rather than asking NHS England to intervene.

The behaviours and culture generated will be just as important as the words written in the mandate. We have consistently argued for the empowerment of commissioners and providers to drive improvement and be accountable locally, rather than micromanagement from the centre. It is still too early to tell whether NHS England has been able to implement the mandate in the way we hoped, but this will be a critical issue for the future development of the mandate.

Our response also includes a range of practical feedback from members in relation to specific proposals to amend and add objectives, and the key recommendations from our separate response to the Vulnerable Older People's Plan. We highlight in particular that the Confederation welcomes the increased emphasis on putting mental health on a par with physical health.
Principles and themes for the mandate

The NHS faces enormous strategic challenges to remain sustainable in the future. It desperately needs a stable environment so that it can concentrate on these big issues. We were therefore pleased that the original 2013-15 mandate stated that the Government would 'strive to keep changes between mandates to the minimum necessary' and 'exercise discipline by not seeking to introduce new objectives for the Board between one mandate and the next'. When it was published, we said we would 'hold ministers to their word that they will not try to revise the mandate on an ad hoc piecemeal basis in response to the latest issue that hits the headlines'. We are therefore concerned and disappointed to see so many proposed revisions adding a significant amount of detail within a year of the first mandate.

In refreshing the mandate, the Government should reassert its original intention of supporting a new way of working: focusing on improving patient outcomes over the long-term rather than meeting short-term, process-driven targets. The numerous proposed additions risk diluting the focus on the objectives in the mandate and diverting attention from NHS England’s core role of enabling, supporting and delivering effective commissioning. We need to avoid replicating the old way of working which, by consulting annually on Operating Frameworks containing a wide range of new, detailed short term objectives for the NHS, did not support NHS leaders to plan for the long term.

Our members want a mandate which is high level and strategic, and supports a new way of working. We have developed in consultation with members three overall principles against which current and future versions of the mandate should be assessed. We urge the Department of Health to reflect these when further developing the mandate.

Principles for the mandate

The mandate should:

• empower clinicians to lead, and patients to influence, commissioning
• be based on a manageable number of objectives which:
  o focus mainly on long term outcomes for patients and populations rather than measures of how services are delivered
  o encourage collective responsibility for patient outcomes rather than silo working - particularly the expected outcomes from integrated care
  o are easily measurable, specific and realistic to enable accountability across NHS England, commissioners, providers, patients and the public
  o can be implemented efficiently rather than imposing unnecessary or disproportionate cost and burden
  o align with the requirements on the other national bodies; and
  o are in language which is accessible to patients and the public.
• retain a focus on enabling, supporting and delivering effective commissioning and avoid diverting NHS England's efforts into areas that other organisations (whether local or national) are better placed to address

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We are currently undertaking a major piece of work looking at how we can cut bureaucracy in the NHS, and will publish a report on this soon.
The behaviours and culture generated in the new NHS architecture will be just as important as the words written in the mandate. We have consistently argued for both DH and NHS England to avoid micromanagement and instead empower commissioners and providers to drive improvement and be accountable locally. We hope the mandate will support and enable NHS England to adopt a new way of working in place of the old 'command and control' style. However, as the current mandate only came into effect in April of this year, we feel it is still too early to tell whether NHS England has been able to implement it in the way we hoped. We will continue to seek feedback from our members on their experiences and feed this back to the DH and NHS England.

We also believe the Department of Health could do more to address the following over-arching issues, including through the revisions to the Mandate.

- **Funding.** NHS England's national policy director has expressed concern that the costs of the proposed additional commitments are not yet known. Given the pressures on funding within the NHS, we share this concern - particularly if a similar number of commitments is added each year. Members who responded to our online member survey, undertaken to inform our response to this consultation, unanimously agreed with this point.

A number of members also felt national leaders have a responsibility to be clear and honest with patients and the public regarding the affordability of healthcare developments. This should include being clear that not every new treatment will automatically be funded by the NHS.

- **Whole system approach.** References to provider improvement and action in the current mandate and the proposed refresh are very strongly focused on acute and primary care services. There is barely any mention of community services, yet a majority of mental health services, and an increasingly large proportion of physical health care services, are delivered in community settings. This risks preventing the NHS from efficiently achieving good outcomes for patients if it leads us to ignore alternative ways of providing care or to design the detail of policy primarily to work well in acute and/or primary care rather than considering how policy will work across the system as a whole, including different settings and different clinical models of care.

The proposals also do not fully reflect the consensus that in order to meet the needs of the growing number of older people with multiple long term conditions the system needs to deliver a significantly greater proportion of care outside hospitals. The refreshed mandate should take the opportunity to emphasise and support this overall direction of travel for the NHS.

- **Working with commissioners and providers.** We welcome NHS England seeking 360° feedback from CCGs on its work, as set out in the original mandate. This is something we made a case for when consulted on the original mandate; we hope that feedback is acted upon and continues in future. We would also like to see similar feedback gathered from providers in relation both to NHS England's role in managing the commissioning system and its role in directly commissioning services.
We have also in the past argued for the mandate to include mechanisms to develop a relationship based on cooperation and co-production between CCGs and NHS England and would have liked to see something on this in the refreshed mandate. The disquiet around the handling of the specialised commissioning budget is one example of such a relationship not yet being evident in all parts of the country, and may add to the case for addressing this.

We would like the Department of Health and NHS England to set out how they will demonstrate to commissioners, providers and the public the ways in which the mandate’s goals and ambitions are being met. It would be helpful if NHS England could be clear with CCGs, health and wellbeing boards and the public on where people should expect the same standards and where local discretion applies with performance checked against outcomes measures.

- **System leadership.** There is a need for leaders across the whole system to come together at local and regional level to find joint solutions where action is required across many boundaries, such as service reconfiguration across a whole local health economy. Such problems usually require solutions across a number of local authority (and therefore health and wellbeing board) boundaries. We have some concern that system wide strategic planning in relation to such challenges is not happening as much as it should. There does not seem to be any organisation or grouping that would facilitate development of a strategy for the provider landscape across a large area, including potentially rethinking how particular services are provided locally rather than simply relying on incremental change by individual organisations and persuasion by individual leaders. This kind of 'system leadership' could help prevent, rather than simply respond to, major problems across health economies.

It is important that leaders communicate system-wide problems, solutions and strategic plans in terms which focus on population needs as the starting point, with service provision based around people rather than the needs of individual provider sectors. Many of the practical solutions we have developed and put forward elsewhere, for example our recent briefing on urgent and emergency care\(^3\), start from this basis of how the health service together can best meet the population's needs.

More work is needed to develop clear solutions, but NHS England may potentially have a role to play. This role could focus on sharing good practice, setting expectations that organisations demonstrate partnership working, participation by local area teams in relevant discussions, and supporting leaders to balance their organisational and system wide responsibilities. There is arguably a question about what happens where a problem clearly exists and is not being tackled. However, we are clear that local commissioners and providers need to drive collaboration rather than asking NHS England to intervene.

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\(^3\) *Emergency care: an accident waiting to happen?* NHS Confederation, September 2013
http://www.nhsconfed.org/Publications/briefings/Pages/Emergency-care.aspx
Views on the vulnerable older people's plan (VOPP), and its reflection in the refreshed mandate

(Q8,9,10) We welcome the focus on improving care for vulnerable older people, and are submitting separately a more detailed response to 'Getting it right for vulnerable older people'; the key points from this are restated here.

Our main concern on the Department of Health's current proposal for a vulnerable older people's plan is that it should not just focus on primary care. Instead, a successful VOPP should include local government, social care, mental health, the acute sector, health and social care commissioners, community health and other Government departments (such as those with responsibility for housing and transport), in delivering a whole system solution that genuinely takes into account the diverse health and wellbeing needs of older people.

We also have a number of specific recommendations for NHS England and the Department of Health:

- Supporting the commissioning of dignified care for older people should be a key objective for NHS England, as set out in our report with Age UK and the Local Government Association, Delivering Dignity: securing dignity in care for older people in hospitals and care homes⁴.
- Incentives for primary care providers and other parts of the whole healthcare system should be aligned around a health and wellbeing agenda and more investment should be earmarked to make 24/7 community care a reality.
- There need to be more incentives, in the form of practical support, to encourage data sharing across health and social care.
- We must support the development of primary care services which recognise that older people may need a different programme of care geared towards their particular needs, as opposed to relying on demand-led care. Investment is needed in primary care to support the development of new models of service delivery that improve the health and wellbeing of vulnerable older people. A significant barrier to delivering excellent primary care to vulnerable older people lies in commissioners' current inability to frontload costs to invest in community and social care.
- It is crucial that the Department of Health defines what being 'accountable' would mean in practice, and what a 'named accountable clinician' would be accountable for, before deciding who would be best placed to carry out this role.

In reflecting the VOPP in the objectives of the mandate, we would reiterate the need to focus on outcomes rather than processes. The Department of Health and NHS England should avoid being overly prescriptive and instead allow local commissioners and providers the freedom to adopt solutions suitable to the needs of their local population. Our members are ready to help inform further policy development as the detail is decided.

⁴ http://www.nhsconfed.org/Publications/reports/Pages/Delivering-Dignity.aspx
Additional issues relating to specific proposed changes

We received practical feedback, reflected below, from members in relation to some specific proposals to amend and add objectives.

**Urgent care pressures**

(Q4) In setting an objective around strengthening A&E services it is vital to avoid too narrow a focus on A&E. Instead, it should reflect both the need for organisations across the whole system to play their part in reducing the pressures on urgent and emergency care, and the potential role of services other than A&E in providing urgent care. For example, rapid response services in the community provided by health and social care together have been piloted and shown to have an immediate impact on emergency admissions. Members tell us that further investment in primary *and* community care to make seven day care a reality would have the biggest impact on relieving the pressures in A&E.

The detailed objective should also reflect existing commitments to improve care for people in need of urgent help for an acute mental health situation or illness (a mental health crisis), such as the forthcoming Concordat for improving care for people who are in a mental health crisis.

**Putting mental health on a par with physical health**

The NHS Confederation strongly supports the commitment made by the Government to ‘put mental health on a par with physical health, and close the gap between people with mental health problems and the population as a whole’. We welcome the increased emphasis and proposals to revise the mandate to reflect this, though we restate our position that the overall package of changes to the mandate should avoid adding too many new details.

(Q5) It is right for the NHS to seek to increase the proportion of people with dementia who have a diagnosis, but we note concern that funding will need to be available to treat and care for the additional people diagnosed. (This relates to amending the objective on dementia to specify that by 2015 two-thirds of the estimated number of people with dementia in England should have a diagnosis, with appropriate post-diagnosis support.)

(Q6) We welcome the proposal to revise objectives to ensure that A&E departments have adequate Liaison Psychiatry services attached to them and for acute and emergency care for people in mental health crisis to be as accessible and high-quality as for physical health emergencies. This is important to support parity of esteem. Our Mental Health Network also emphasises that the mandate needs to be explicit that inter-agency cooperation between the police, ambulance and health and social care partners is required to ensure people in crisis get the mental health care they need. Action by the police and NHS commissioners is needed to tackle the inappropriate use of police custody as a ‘place of safety’\(^5\) and ensure that any person

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\(^5\) Recent reports indicate that police custody is frequently used as a place of safety, even though this should only be in exceptional circumstances. For example, HMIC, Her Majesty’s Inspectorate of Prisons, the Care Quality Commission. see also Healthcare Inspectorate Wales (2013) A Criminal Use of Police Cells? and Independent Commission into Mental Health and Policing Report (2013) London.
taken to a police station experiencing crisis is diverted to Liaison and Diversion services.

(Q7) We also welcome an explicit aim of improving access to mental health services; this should help move towards parity of esteem between mental and physical health services. However we caution that focusing solely on process measures such as waiting times would promote good practice but risk overlooking people's outcomes. We highlight that our Mental Health Network would welcome further opportunities to work with the Department of Health and NHS England to consider new access standards, including waiting times, for mental health services, including the financial implications of any such standards.

In seeking to promote parity between mental and physical health, there are two key areas in which the refreshed mandate could go further: long term conditions and premature mortality. Of the 15.4 million people living in England today with a long term condition, 30 per cent - nearly 5 million people nationwide - will also have a mental health problem\(^6\). The original 2013-15 mandate notes that people with physical health conditions often have mental health needs that go unrecognised, and in refreshing it the Department of Health should take the opportunity to be more explicit that the Government's vision for improved care for people with long term conditions includes support for co-morbid mental health conditions, building on previous commitments.

People with severe mental health problems are more likely to smoke and have higher rates of obesity and cardiovascular disease, amongst other physical health problems. In relation to the objective to avoid premature deaths (Q3), the revised mandate could helpfully make specific reference to targeting interventions for people with mental health problems and other high risk groups.

Finally, we note that stigma, judgement and discrimination, either real or perceived, can deter people seeking access to mental health services, as well as keeping people isolated and preventing people realising their potential. To help ensure that measures to improve people's access to mental health services deliver as much benefit as possible, and support the employment of more people with mental illness\(^7\), our Mental Health Network would welcome a restatement of the Government's commitment to working with the national Time to Change campaign which aims to reduce negative attitudes and behaviours to people with mental health problems. We also reiterate that local systems need freedoms to work out how best to achieve these objectives for their local populations.

**Integrated care**

(Q12) The phrase referring to an 'ambition that each area moves to a wholly integrated approach to health and care by 2018' (paragraph 44) is aspirational rather than meaningful. It would be better to state the main outcomes we should be looking to achieve through integration.

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\(^7\)Employment of people with mental illness is identified as an improvement area in relation to the Outcomes framework indicator on health related quality of life for people with long term conditions.
Children and young people
(Q13) We have long argued that improving children and young people’s health outcomes should be a priority for the NHS and related services, especially given the impact on people’s longer term health outcomes. (For example, it is acknowledged that half of all mental illness develops before the age of 14.8) Given the roles of other organisations, notably local government, in children and young people’s services, in drafting an objective for NHS England to improve support for children it will be important to be clear where NHS England is expected to use the levers it has and where it is expected to achieve progress through joint agreements with others.

‘Friends and family’ test
(Q14) In extending the ‘friends and family’ test to community and mental health services it will be important both to learn from the experience of implementing this in acute settings and to adapt the test to the different and varied circumstances and ways of working in the community and mental health sectors. For example, in community services patients may have an ongoing relationship and daily visits from the person asking the question, and a health visitor who involves child protection services may receive a very negative rating despite providing very high quality care and support. In mental health services, careful consideration would need to be given to how appropriate feedback might be sought from patients who are receiving compulsory care in restrictive settings. It would be helpful if the wording of the objective recognised the need to ensure the test is relevant to, and works appropriately in, different settings including by adapting it where required.

Improving patient safety
(Q15) Our Mental Health Network would be keen to work with NHS England and the Department of Health as the detail of revisions to the objective on patient safety develops. In particular, use of restraint has been a recent focus of attention for providers of mental health services. The Mental Health Network is strongly positioned to inform discussions and to promote best practice in the ways to reduce serious harm in the use of restraint.

Fair playing field
(Q16) We support the development of the fair playing field for providers, and the proposal to strengthen the objective on this. Choice is a fundamental part of healthcare delivery in 21st century Britain, as recognised in the 2013-15 mandate and guaranteed by the NHS constitution, and this requires a fair playing field. Our independent sector members are concerned that patient choice and any qualified provider are not being fully implemented at local level; it would therefore be helpful for the final version of the mandate to re-emphasise the importance of delivering the existing objective on patients’ rights to choice and ensuring that progress with this is systematically monitored.

Information technology and data sharing
(Q18) In relation to updating the technology objective to reflect the policy for the NHS to make more use of IT and become ‘paper light’ by 2018, our members expressed some scepticism about whether this might repeat past delivery problems with

updating the NHS’ IT systems. DH and NHS England will need to address this as the
detail of the policy is developed and communicated. Rather than focusing exclusively
on paperless systems, it will be important that this work also includes opportunities to
• remove a major barrier to integrated care by supporting and encouraging
organisations locally to work together to ensure their updated systems are better
able to share information across organisations' boundaries. In the future staff in a
wide range of settings will need to access information about a person’s treatment
and care package, sometimes urgently, so digitisation must look beyond
hospitals.
• use and build on existing infrastructure where possible, given ongoing funding
constraints
• recognise the growing desire of patients and the public to interact with health
services digitally. For example, one of our members estimates they currently
receive 30% of their health visitor referrals via facebook, having first set up their
facebook presence four months ago
• reflect the wishes of many patients to own their medical records

Recovering costs from overseas visitors
(Q21) In relation to requiring NHS England to ensure NHS organisations recover the
costs they incur from overseas visitors, some members favour recovering these
costs, with the important caveat that the costs of so doing should not exceed the
money recovered. One member cited the recent measure enabling border authorities
to prevent people with outstanding NHS debts from re-entering the UK as an
example of how central Government could help the NHS tackle this.

Conclusion
Finally, we reiterate our overall stance that any changes need to be designed to
keep the mandate high level and strategic, and to support a new way of working
across the NHS and its partners which focuses on long term outcomes for patients
and populations. To help achieve this, we urge the Department of Health to heed the
principles outlined by us in this submission when further developing the mandate.
We welcome the opportunity to feed in our members' views, and look forward to
working with the Department of Health, NHS England and others as the various
elements of policy detail develop further.

If you have any questions about this consultation response, please contact Kate
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