Consultation response

The King's Fund's response to the draft mandate for the National Health Service Commissioning Board consultation

26 September 2012

The King's Fund is a charity that seeks to understand how the health system in England can be improved. Using that insight, we help to shape policy, transform services and bring about behaviour change. Our work includes research, analysis, leadership development and service improvement. We also offer a wide range of resources to help everyone working in health to share knowledge, learning and ideas.

The King's Fund welcomes the development of the mandate to hold the NHS Commissioning Board to account for £80 billion public money. It is important that the mandate is well designed to ensure the Board can be effectively held accountable for its activities.

If the mandate is to serve a useful purpose, then the lessons of previous attempts to strengthen the accountability and performance of public services should be heeded. The most important are: the need to identify a small number of objectives and priorities that have NHS and public support, to ensure that these are expressed clearly, in ways that can be measured reliably and have external credibility, and that they include goals that are both stretching and realistic within a specified timescale. Our response describes the changes we believe are needed so that the mandate fulfils this purpose. Where possible we have made suggestions that we hope will be helpful in drafting future iterations of the mandate.

Key recommendations

- Be clear that the main purpose of the mandate is to hold the NHS Commissioning Board to account for improving outcomes, and focus the document on that.
- Move content that does not serve this purpose - such as expectations about ways of working between the Board and its key partners - into the framework agreement, memoranda of understanding or the annual business plan.
- Develop a narrative throughout the mandate that will communicate a vision for a better NHS.
- Give greater weight to the NHS Commissioning Board's direct commissioning responsibilities, and assess the feasibility of holding the Board to account for these responsibilities through the mandate.
- Develop stronger and more specific commitments on integrated care and the need to treat mental and physical health problems in a less fragmented way.
- Use a broader definition of shared decision-making and avoid equating this with choice of provider.

- Focus on the population rather than patients, paying greater attention to the NHS's contribution to public health

Recommendations for objectives 1-5 (relating to the Outcomes Framework)

- Simplify the methodology for setting levels of ambition, including by dropping the challenging task of trying to distinguish between NHS and non-NHS determinants.
- Drop the proposed use of QALYs (quality-adjusted life years) as a measure of aggregate performance and use simpler, more transparent and actionable performance measures.
- Set minimum levels of performance and more stretching levels of ambition for the overarching indicators in the Outcomes Framework.
- NICE (National Institute for Health and Clinical Excellence) and NHS Outcomes Framework Technical Advisory Group should continue to advise on the development of indicators, with the Advisory Group also having an advisory role in setting levels of ambition and assessing performance against them.

The purpose of the mandate

The draft mandate is a formal accountability document that sets objectives for the National Health Service Commissioning Board its principal purpose is to ensure that the Board is held to account for its use of the budget allocated to it.

Other arm's length bodies or non-departmental public bodies across government are held to account by a sponsoring Department through framework agreements that set out roles and responsibilities and lines of accountability. The plan is that the Department of Health will have framework agreements with each of its arm's length bodies including the NHS Commissioning Board. The Board will also have to agree an annual business plan with the Department, but this is likely to focus on how the Board will operate and what it will do. The ambition of this government is that the Board should be held to account for the outcomes it delivers rather than for processes, and the particular function of the mandate – distinct from the framework agreement or annual business plan – is to define what these outcomes should be and how the Board will be held accountable for delivering them.

What we welcome in the draft mandate

As the purpose of the mandate is to account for the outcomes the Board delivers, it makes sense that the draft is based substantially around the domains of the NHS Outcomes Framework. The NHS Outcomes Framework has been subject to extensive consultation and is now a widely accepted and understood framework for assessing future performance in the NHS. Moreover, other accountability mechanisms in development (eg, the Commissioning Outcomes Framework (COF)) are linked to this framework.

The inclusion of multi-year timeframes for measuring outcomes is positive, reflecting the long-term and multi-factorial nature of many outcomes.

We also welcome the prioritisation of integrated care and the desire to put mental health on a par with physical health. Fundamental change is needed in the model of care the NHS provides (Ham *et al* 2012). This will involve greater emphasis on integrated care in order to address the shifting burden of disease and the needs of people with multiple complex conditions, including mental health problems.

In these and other respects the progress made so far is encouraging. However, the current draft of the mandate needs considerable development in order to be fit for its central purpose. Our response describes the changes we believe are needed. Where possible we have made suggestions that we hope will be helpful in drafting future iterations of the mandate. The response is structured in four sections:

- Improving the NHS Commissioning Board's accountability through the mandate
- Defining the scope of the mandate
- Addressing specific weaknesses
- Using appropriate methodology to set the levels of ambition

1: Improving the NHS Commissioning Board's accountability through the mandate

Accountability typically refers to 'a relationship involving answerability, an obligation to report, to give an account of, actions and non-actions (Maybin *et al* 2011). Accountability requires there to be publicly available verifiable information to support the account and usually implies that there are consequences if the account holder is not satisfied that the account giver has fulfilled the objectives set or made effective use of the resources allocated (Maybin *et al* 2011).

If the mandate is to serve a useful purpose, then the lessons of previous attempts to strengthen the accountability and performance of public services should be heeded. The most important are: the need to identify a small number of objectives and priorities that have NHS and public support, to ensure that these are expressed clearly, in ways that can be measured reliably and have external credibility, and that they include goals that are both stretching and realistic within a specified timescale. The draft mandate as currently written does not meet these criteria.

First, there are too many wide-ranging objectives (22 in total). The absolute number is not a problem in itself but some of them are not specific enough (eg, Objective 22 'delivery of efficiency savings in a sustainable manner'), others overlap with those in the Board's statutory duties (Objective 10 'uphold…the rights and pledges for patients in the NHS Constitution'), and others would be more suited within the framework agreement and business plan as they are related to activities rather than performance (eg, Objectives 18 and 19 set out its responsibility to establish clinical commissioning groups and (with Monitor) set tariffs for NHS services). The Department needs to be clear what the key priorities are in relation to improving health, the outcomes of care that the population can expect, the experience of patients and reducing the incidence of harm, and reflect these in the objectives used.

Second, not all of the objectives appear to be measurable. Take for example objective 9 'develop a collaborative programme of action to achieve the ambition that mental health should be on a par with physical health'. Mental health should indeed be a priority for the Board, but this and other objectives will need further development if they are to create powerful drivers for the changes that are needed (see Section 3).

Third, some of the measures are very complex and will be opaque to both technical and non-technical audiences. Objectives 1-5 are set as summary, quantitative measures of the improvements to be made across each of the five domains of the Outcomes Framework. These summary measures are to be derived on the basis of the 60 indicators in the NHS outcomes framework (Department of Health 2011). However, the complex methodology for deriving these summary measures (described in technical annexes running to more than 650 pages) raises both conceptual and measurement issues (see Section 4).

Fourth, assessment of the Board's performance over time could be jeopardised by extensive annual revisions. The mandate, including the multi-year levels of ambition and the underpinning assumptions, will be revised annually. There is a risk that the levels of ambition

could be set too low for political reasons. If the levels of ambition are revised up or down by government, this will further politicise the process. It is conceivable that the levels will not be stretching for fear that the NHS will be seen to be failing. Frequent revisions could cause uncertainty and confusion in the NHS and, in the public arena, could look like retrospective adjustments to accommodate under-performance.

To avoid accusations that changes in levels of ambition are motivated by political expediency, we suggest that a committee of independent experts (NHS Outcomes Framework Technical Advisory Group) is tasked by the Department to recommend whether the levels of ambition are appropriately stretching, oversee annual progress on Outcome Framework indicators in the mandate, and advise the Secretary of State on whether or not performance goals are being met, and whether some goals need upward or downward revision.

Fifth, it is not clear how failure will be judged and what the consequences will be. The Board is legally obliged to 'seek to' meet the objectives set out in the mandate. How will performance expectations be set and assessed on the non-quantifiable elements of the mandate? Will a failure on some objectives be judged more critically than others? Will the Secretary of State formally warn the Board? What justifications and explanations for poor performance will be tolerated? Given the lack of measurability of many objectives, will any perceived performance issues actually stick? A fuller account of the process and approach to accountability needs to be set out alongside the mandate. It needs to explain how the Board will be held to account and what the consequences are for poor performance.

Sixth, in taking a transactional rather than transformative tone, the mandate fails to convey any sense of how patient and public experiences of health and care will be improved as a result of achieving the objectives set out. The mandate needs to set out what is important, and specify the areas where there is greatest room for improvement. This will support the Board to focus its efforts in order to achieve clear and stretching goals.

Key recommendations

- Be clear that the main purpose of the mandate is to hold the NHS Commissioning Board to account for improving outcomes, and focus the document on that.
- Develop a narrative throughout the mandate which will communicate a vision for a better NHS.
- NICE and NHS Outcomes Framework Technical Advisory Groupshould continue to advise on the development of indicators, with the Advisory Group also having an advisory role in setting levels of ambition and assessing performance against them.

2: Defining the scope of the mandate

Despite its name, the Board will be much more than a commissioning board. Aside from the core business of commissioning, it will be hosting clinical networks and senates, setting information standards and performing a wide range of other functions. However, the scope of the mandate should not be used to hold the Board accountable for the full range of its responsibilities. Expectations for non-core functions should be set out in the Board's framework agreement, the business plan or specific funding agreements with the Department.

The mandate contains a number of objectives which the Board will only be able to achieve by working collaboratively with other parts of the system. To some extent this is appropriate, and reflects the distributed nature of leadership in the reformed health system. However, the mandate should not describe specific ways in which the Board needs to work with other bodies

to discharge its functions. These expectations about ways of working should appear in both organisations' framework agreements and bilateral memoranda of understanding rather than being included in the mandate. For example, objective 14 (Improve the quality and availability of information about NHS services, with the goal of having comprehensive, transparent, and integrated information and IT, to drive improved care and better healthcare outcomes) would sit better in framework agreements and/or memoranda of understanding for the Information Centre and Board than in the mandate.

Since the Board will only be able to deliver on the expectations described in the mandate through its relationship with clinical commissioning groups, it is important that there is a good 'fit' between the mandate and commissioning outcomes framework (COF). Many of the proposed COF indicators should contribute to improvements in the NHS Outcomes Framework indicators, but for some indicators there is no a direct relationship between the two. It is, for example, possible that good clinical commissioning group performance on COF clinical indicators pertaining to long-term conditions like diabetes and stroke are not reflected in improved performance on the indicators used in the NHS outcomes framework and mandate. Further work will be needed to ensure alignment between these two levels of accountability and how they are measured.

It is ironic that the outcomes most directly under the control of the Board – those relating to primary care and highly specialised services commissioned directly by the Board – receive minimal coverage in the mandate. Performance in some of these areas will be picked up through the NHS Outcomes Framework, but the focus on these is limited. Under current proposals the accountability arrangements for the performance of services commissioned directly by the Board will be weaker and less specific than those commissioned by clinical commissioning groups. The Department should consider how it can use the mandate to hold the Board to account for its direct commissioning responsibilities more robustly, including in terms of outcomes.

Key recommendations

- Move content that does not serve the purpose of holding the Board to account for improving outcomes – such as expectations about ways of working between the Board and its key partners – into the framework agreement, memoranda of understanding or the annual business plan.
- Make sure there is a good 'fit' between the mandate and COF.
- Give greater weight to the Board's direct commissioning responsibilities, and assess the feasibility of holding the Board to account for these responsibilities through the mandate.

3: Addressing specific weaknesses

Integrated care

We strongly commend the inclusion of an objective relating to integration in the mandate. However, if the development of integrated care is to become a 'must do' for the NHS – as our work suggests it should – then the mandate will need to set requirements for the Board that are stronger and more specific than those included in the current draft.

We have previously argued that the best way to understand integrated care is from the perspective of patients and carers (Goodwin *et al* 2012), and the commitment to develop a patient-reported measure for future inclusion in Domain 5 of the NHS Outcomes Framework is welcome. While this measure is under development there is still a need to account for progress towards the delivery of integrated care.

The Board will need to play a critical role in supporting the development of integrated care through its direct commissioning functions, and the mandate should reflect this more fully. In particular, that its commissioning of general practice ensures that primary care can provide better co-ordinated care for patients with multi-morbidity, frail older people and those with complex needs (Goodwin *et al* 2012).

Finally, a key barrier to the development of integrated care is a lack of clarity among local commissioners regarding what is and what is not permitted under competition rules. The Board will need to ensure that clinical commissioning groups understand how these rules should be interpreted and ensure they do not inhibit integrated care. This expectation should be spelt out, if not in the mandate perhaps more appropriately in its framework agreement with Monitor.

Mental health

We also strongly commend the emphasis placed on mental health in the mandate and agree that this should be a priority for the Board. In particular, we support the inclusion of a specific objective relating to strengthening mental health care, given the scale of improvements needed in this area.

There is much the Board can do to drive quality improvement in mental health, and the mandate outlines some of the main challenges. However, the biggest challenge is not just to place mental health 'on a par' with physical health in the sense of attaining some form of equivalence, but to integrate mental health care more closely with other services. The opportunities to do so are considerable and include the possibility of reducing the £8 billion or more currently spent annually on long-term physical conditions as a result of poor mental health (Naylor *et al* 2012).

The expansion of IAPT (Improving Access to Psychological Therapies) services to include people with co-morbid long-term conditions should help with this, but will not be sufficient by itself. The proportion of people with long-term conditions who receive psychological support as a component of the package of support for their physical condition should be measured, and included in the Outcomes Framework measures for Domain 3.

The physical health of those with mental health problems should also be measured. The QOF now includes indicators relating to physical health checks for people with serious mental illness, with similar measures expected for dementia and depression. These could be candidates for inclusion in future iterations of the NHS Outcomes Framework and mandate.

A related and important issue is 'dual diagnosis'. Between a quarter and a half of people with severe mental health problems also use substances in a way that is problematic and can impede recovery from illness (Graham *et al* 2001; Weaver *et al* 2003). Under the new outcomes frameworks, substance misuse is a responsibility for the public health system but not the NHS. This risks further fragmenting the way that substance misuse and mental health problems are dealt with, and highlights the need to develop more cross-linkages between the different outcomes framework.

Shared decision-making

The conceptualisation of shared decision-making currently used in the mandate is flawed. Objective 12 and the measures supporting it are framed largely in terms of choice of provider and the use of personal health budgets. This is a highly skewed and limited interpretation of the opportunities that genuine shared decision-making presents.

We have previously defined shared decision-making as 'a process in which clinicians and patients work together to select tests, treatments, management or support packages, based on clinical evidence and the patient's informed preferences', supported by a range of tools and techniques including decision aids, risk communication and information-sharing (Coulter and Collins 2011). Decisions regarding all aspects of a patients care – not simply which provider

they attend – should be made in this way wherever possible. This would require significant cultural as well as procedural change.

To reflect this, objective 12 and the measures supporting it need to be reframed to give greater emphasis to the Board's role in monitoring the quality of shared decision-making within the services it commissions, building the kinds of consultation techniques and communication skills required to make shared decision-making a reality, and expanding the use of relevant decision-support tools. Ideally, a patient-reported measure of shared decision-making should be included in the Outcomes Framework and the mandate. This could be done in a number of ways, including by systematically measuring and reporting the proportion of 'preference misdiagnoses' made by professionals (Mulley *et al* 2012).

On the roll-out of any qualified provider markets, the Secretary of State has previously explained to GP leaders that 'the breadth and scope of competition in the NHS is something that you will determine, in the interests of your patients' (Lansley 2012). We would support this indication that clinical commissioning groups themselves are best placed to decide how and when to commission on an any qualified provider basis. Inclusion of specific expectations regarding the expansion of any qualified provider within the mandate runs counter to the principle of liberating the NHS from excessive top-down control. At the national level, Monitor as the economic regulator already has formal responsibility for overseeing the application of competition. The mandate (or the accompanying framework agreement) should simply state that the Board is responsible for producing guidance to help local commissioners make these decisions themselves.

Public health

The mandate focuses on patients rather than populations and takes a narrow view of the NHS's role in preventing illness and promoting public health. Insufficient recognition is given to the significant role the NHS can play in addressing the broader determinants of health, with the mandate being formulated in terms of patients rather than populations. The document lacks a systematic consideration of the interdependencies between the NHS and public health system.

The lack of ambition in this area is evident in a number of ways, for example:

- Objective 7 relates to providing 'an assessment of progress in narrowing inequalities for all domains of the NHS Outcomes Framework, and work towards a greater understanding of effective interventions to narrow health inequalities'. The first part of this objective needs to be much more ambitious if the policy momentum on reducing inequalities of the last decade is not to be lost. The second part is unnecessary since there is plenty of evidence about interventions to reduce health inequalities that the NHS can act on now.
- Objective 8 requires 'continuous improvement in reducing inequalities in life expectancy at birth… through greater improvement in more disadvantaged communities'. This is ambiguous, and could be interpreted to mean that widening inequalities are acceptable so long as the pace of widening slows.
- Other than this global indicator, there is little detail on how inequalities will be measured and progress on reducing them assessed.

Objective 11 requires the Board to demonstrate evidence of working in partnership with Public Health England and others, but there are no quantitative measures to accompany it. Following from our argument set out above, we recommend that the intention to measure partnership working be set out in the Memorandum of Understanding between the Board and Public Health England.

The Department also needs to revisit the opportunities for including public health and social care outcomes and indicators within the mandate/ NHS Outcomes Framework. We also encourage the Department to progress with their (separate) plans to produce a public-facing narrative that explains the alignment between the three outcomes frameworks.

Key recommendations

- Develop stronger and more specific commitments on integrated care and the need to treat mental and physical health problems in a less fragmented way.
- Take a broader definition of shared decision-making and emphasise the Board's responsibility to take a strategic lead on ensuring shared decision- making is widely practised among professionals and patients.
- Focus on the population rather than patients, paying greater attention to the NHS's contribution to public health.

4: Using appropriate methodology to set the levels of ambition for objectives 1-5

The basics of the methodology and underlying assumptions were published alongside the mandate rather than included in the main consultation document. The technical annexes describing the methodology run to almost 700 pages.

The methodology is complex, lacking in transparency, open to challenge, and susceptible to error. Modelling and other statistical techniques have their place, but are not a substitute for pragmatism and cannot provide answers where none or few exist. The Department needs to ensure the methodology can withstand detailed scrutiny, including from an international audience, and challenge from the NHS.

The methodology for creating levels of ambition requires several assumptions to be made for each of the 60 indicators, and in their conversion and aggregation to a common currency.

Assumptions will need to be made about what is and isn't an NHS determinant of the indicator trends. Even if it is possible to fully dissemble and define NHS vs non-NHS determinants for each indicator, is it possible to reliably measure their impacts separately in ways that carry credibility with the NHS? If performance departs from the projections, will it be possible to distinguish whether this is due to NHS under/over performance or extraneous determinants? Domains 1 and 2 in particular raise significant issues re distinguishing between NHS and non-NHS determinants and trends in them.

The methodology also entails other assumptions, for example about incremental improvement possible within existing resources through eg, uptake of best practice, reduced variations, improved effectiveness etc. But these are not constants. For example, evidence that financial constraints are leading to restrictions on cataract surgery could have progressively negative effects on QALYs for people needing surgery.

Converting different indicators into a common currency will require even further assumptions. Technically, this is not in itself a problem for Domain 1, as reductions in mortality rates for different conditions and/or ages are readily convertible into years of life. Domain 4 is also not problematic, as it will be derived directly from the patient and staff survey data. But the currency for Domains 2, 3 and 5 is QALYs and converting the hugely different indicators into QALYs entails many assumptions in areas where evidence is often weak or not available and, for many on the frontline, QALYs are not transparent or actionable. Most challenging of all are the patient safety indicators in Domain 5. The fragility of much safety data and the scale of assumptions made stretches credulity and virtually guarantees that goals for 'reducing QALYs lost to NHS patients through avoidable harm by X% by 2015' will need revision within the first year or two and make a mockery of the projected levels of ambition over 10 years.

A more transparent approach could be to set minimum levels of performance *and* stretching levels of ambition for each of the overarching indicators in the Outcomes Framework. Setting fixed minimum levels of performance and more stretching levels of indicators on the overarching indicators will support the Board to focus on what it has to deliver and within what parameters, and how it will be assessed on this.

Expected performance thresholds can be based on projections of current trends, as proposed, but without attempting some of the statistical estimations entailed in, for example, trying to distinguish between NHS and non-NHS determinants. In some cases, the performance goals may need to be defined arbitrarily, but this may be more defensible than statistical derivatives based on contested assumptions or weak evidence. The NHS and patients and the public are long-familiar with the reality of targets, and accept them as testing goals that public services must deliver on.

In summary, the methodology entails numerous, ambitious assumptions at several stages. Inaccuracies at any individual stage will multiply through successive stages, especially where data is based on surveys or is of poor or variable quality. QALYs are an abstract construct that will not be transparent, meaningful and actionable to many in the NHS.

Key recommendations

- Simplify the methodology for setting levels of ambition, including by dropping the challenging task of trying to distinguish between NHS and non-NHS determinants.
- Drop the proposed use of QALYs as a measure of aggregate performance and use simpler, more transparent and actionable performance measures.
- Set minimum levels of performance and more stretching levels of ambition for the overarching indicators in the Outcomes Framework.

References

Coulter A, Collins A (2011). *Making Shared Decision-making a Reality: No decision about me, without me*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/nhs_decisionmaking.html (accessed on 26 September 2012).

Department of Health (2012a). *Developing our NHS Care Objectives: a consultation on the draft mandate to the NHS Commissioning Board*. London: Department of Health.

Department of Health (2012b). *NHS Outcomes Framework: a technical annex about setting levels of ambition*. London: Department of Health.

Department of Health (2011). *NHS Outcomes Framework 2012-13*. London: Department of Health.

Dixon A, Ham C (2012). 'Setting objectives for the NHS Commissioning Board'. Editorial. *British Medical Journal* l, vol 345, e5893. Available at: www.bmj.com/content/345/bmj.e5893?ijkey=uzuOmhWAQApRNnk&keytype=ref (accessed on 26 September 2012).

Goodwin N, Smith J, Davies A, Perry C, Rosen R, Dixon A, Dixon J, Ham C (2012), *Integrated care for patients and populations: improving outcomes by working together. A report to the Department of Health and the NHS Future Forum* [online]. The King's Fund website. Available at: www.kingsfund.org.uk/publications/future_forum_report.html (accessed on 26 September 2012).

Graham H L, Maslin J, Copello, A, Birchwood M, Mueser K, McGovern D, Georgiou G |(2001). 'Drug and alcohol problems amongst individuals with severe mental health problems in an inner city area of the UK'. *Social Psychiatry and Psychiatric Epidemiology*, vol 36, no 9, pp 448–55.

Ham C, Dixon A, Brooke B (2012). *Transforming the Delivery of Health and Social Care: he case for fundamental change*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/case_for_change.html (accessed on 26 September 2012).

Lansley A (2012). 'Ambition for clinically led NHS'. Letter to CCGs [online]. Department of Health website. Available at: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_133423.pdf (accessed on 26 September 2012).

Maybin J, Addicott R, Dixon A, Storey J (2011). *Accountability in the NHS: Implications of the government's reform programme.* London: The King's Fund. Available at: www.kingsfund.org.uk/publications/nhs_accountability.html (accessed on 26 September 2012).

Mulley A, Trimble C, Elwyn G (2012). *Patient's Preferences Matter: Stop the silent diagnosis.* London: The King's Fund. Available at: www.kingsfund.org.uk/publications/patients_preferences.html (accessed on 27 September 2012).

Naylor C, Parsonage M, McDaid D, Knapp M, Fossey M, Galea A (2012). *Long-term Conditions and Mental Health: The cost of co-morbidities*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/mental_health_ltcs.html (accessed on 27 September 2012).

Weaver T, Madden P, Charles V, Stimson G, Renton A, Tyrer P, Barnes T, Bench C, Middleton H, Wright N, Paterson S, Shanadan W, Seivewright N, Ford C (2003). 'Comorbidity of substance misuse and mental illness in community mental health and substance misuse services'. *British Journal of Psychiatry*, vol 183, pp 304–13.