The British Medical Association (BMA) is an independent trade union and voluntary professional association which represents doctors and medical students from all branches of medicine all over the UK. With a membership of over 149,000 worldwide, we promote the medical and allied sciences, seek to maintain the honour and interests of the medical profession and promote the achievement of high quality healthcare.

We are concerned that the current draft mandate does not provide a clear vision for the NHS and does not adequately communicate the role of the NHS Commissioning Board. It is unclear who the intended audience for the mandate is and how it will be used to hold the Board to account.

The mandate should provide a high-level strategic vision for the NHS that is clearly communicated to all staff working within the NHS.

This consultation response does not intend to provide detailed feedback on individual objectives; rather our aim is to put forward our view on the aim of the mandate and the approach to this first draft mandate.

1. **The overall approach to the draft mandate**

   The BMA believes the role of the mandate should be to set a clear strategic direction for the NHS and the NHS Commissioning Board. The mandate should be a high level document that imparts the values and priorities for the NHS at a strategic level. This is a significant departure from the previous communication between the Government and the NHS, which was a relationship of direct performance management detailed through a system of targets. While the past approach improved areas of NHS performance, the disadvantage was a tendency to produce unintended consequences, which arose as a result of focusing efforts on meeting targets.

   Any potential benefit in the new approach will only be realised if the NHS Commissioning Board is given legitimate authority to exercise its own judgement in achieving the strategic aspirations set by the Secretary of State. Therefore, the mandate should set out what the Board should achieve, and allow the Board flexibility to decide how to deliver results against these expectations.

   The BMA supports the inclusion of transitional objectives that include practical instructions to the Board within the first mandate and potentially future early mandates. This is important in order to communicate to staff involved what the objectives are for the Board in initiating its own functions. However, once this is in place it will make sense for the mandate to become a more strategic document.

   The BMA is particularly supportive of the concept of a long-term strategy for NHS achievement. Stability of objectives over time is essential to allow policies the greatest chance of success. Allowing the Board the autonomy to establish policies and processes that will achieve long-standing goals set by the Government is key to the success of this new approach.

2. **Driving a culture which puts patients at the heart of the NHS**

   In its current form, the aim of the mandate and its intended audience is unclear. The BMA sees NHS staff as the key stakeholder and audience for the document. If the intention is to drive a culture which puts patients at the heart of everything the NHS does, the mandate should communicate this to staff working in the NHS. It should focus on the core principles of the NHS, and disseminate this in a way in which all NHS staff can relate.

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1 For example, Dr Colin-Thomé’s 2009 report on the independent review of failures in emergency services at Mid Staffordshire NHS Foundation Trust concluded that focusing efforts on meeting targets diverted attention away from ensuring the quality of services.
The mandate should define the role of the NHS Commissioning Board and make its expectations clear to all organisations in the NHS. Keeping the objectives strategic will ensure the mandate is accessible to a wide audience.

The mandate is not the only mechanism for holding the Board to account. However, we believe that the legal duties set out in the Health and Social Care Act, and expectations set out in the framework agreement, should be reflected in the mandate so that NHS staff can have a clear picture of the role of the Board and how it is held to account.

Similarly, the mandate should be linked, where appropriate, to the NHS Constitution. The Constitution is mentioned in the current draft, but only in relation to the rights for patients. We believe the mandate should also refer to workforce issues and the rights of staff if it is to drive a shift in culture and behaviour.

3. Measuring progress against the mandate

As it stands, the draft mandate includes a large number of objectives that range from broad aspirations to detailed performance management. We believe the mandate should have fewer, more strategic objectives. In this way the mandate would focus on accountability of the Board rather than performance management by removing detail that undermines the autonomy of the Board.

In order to hold the Board to account, the mandate should distinguish between wider aspirations for the NHS and measurable outcomes that the Board can directly influence. There should be clear distinction in the way these different aspirations are reported.

The Health and Social Care Act imposes a number of duties on the NHS Commissioning Board: to promote autonomy, innovation, integration, address inequalities, and to have regard to NICE quality standards as set out in Annex C. Although we agree that these duties should be reflected in the mandate, they can not easily be measured. The Board should report on its attempts to uphold these principles, through a range of indicators including feedback from all relevant stakeholders, in particular, staff.

For example, while the Board cannot ensure innovation, it may be able to promote innovation, and ensure that it does not stifle innovation, through its commissioning activities and leadership. When examining progress against such wider aspirations, assessing the Board should include evaluating the Board’s performance with input from all relevant stakeholders, including NHS staff and service users.

Where specific measures are used these must be meaningful. For example, for objectives the Board can influence directly, such as in its commissioning for rare conditions, a useful approach would be to focus on the SMART (Specific, Measurable, Attainable, Relevant, Timely) concept. Such measures should be within the direct influence of the NHS Commissioning Board.

It is essential that any new objectives used are evidence based. The mandate should not use untested outcome measures. The indicators chosen should be proven to be sensitive and reliable in measuring outcomes against the objectives. This relies on suitable data collection and analysis. Therefore, a wholesale shift to a new outcomes approach, without first testing the performance assessment methods, holds potential risks. Furthermore, if there are changes in routine data collection, the relative performance of the new system will be difficult to measure. Care must also be taken in setting the levels of ambition. This requires robust benchmark data at the outset, and suitable expertise to set appropriate levels of achievement expected.

In order to measure progress against the mandate it is essential to consider the timeframe for expected outcomes. There is often a significant time lag between any intervention and a resulting measurable outcome. The mandate should be realistic about the time allowed to achieve objectives. All outcome measures should use indicators with suitable timeframes attached. This will also aid decisions to support the Board or intervene where it is likely to fail to meet objectives.
4. Holding the NHS Commissioning Board to account
The BMA supports transparent reporting mechanisms for the mandate. We understand that the mandate will be revised annually and the Board will make public its plans and report annually on its achievements against the mandate. However, we are concerned that the mandate does not describe how, in practice, the Secretary of State would hold the Board to account and support the Board if it appeared likely that it would fail to meet the objectives. For the mandate to be effective it should set out transparent accountability mechanisms, which should include stakeholder engagement. These mechanisms to ensure or support progress of the Board against the mandate should be established and made known to all appropriate stakeholders in order to support the Board’s progress and to hold it to account.

5. Specific comments on the draft mandate
   a. Improving our health and our healthcare
      A key duty of the NHS Commissioning Board is to ameliorate health inequalities. However, the theme ‘Improving our health and our healthcare’ does little to emphasise prevention and addressing health inequalities. Furthermore, aspects of the proposals, such as the introduction of a quality premium could serve to widen health inequalities. This section could be strengthened to emphasise the role of the NHS Commissioning Board in tackling health inequalities.

   b. Putting patients first
      The BMA’s main concern with the detail of the draft mandate is the emphasis placed on the choice agenda. Not only is this a concern where the issue of choice is conflated with shared decision making, but it appears to be the focus in parts of the document at the expense of other aims, such as integration. Specifically, objective 12 conflates the issues of shared decision making and extending choice. These separate policy objectives should not be confused.

      We believe that integrating care pathways to improve the quality and efficiency of healthcare should be the focus of improvements through commissioning rather than focusing on choice of provider and competition amongst healthcare providers.

      The choice framework sets out the choices that patients should expect. This is not problematic in principle in terms of making clear to patients and the public what choices are available to them. However, the draft framework includes references to schemes, which are still in the pilot stage. The choice framework should only reflect the options currently available to patients. We are also concerned that objective 12 proposes to extend personal health budgets, which is an initiative still in pilot stage. We hope that the final mandate and any related documents would only include initiatives that have completed pilot phases and subsequently been recommended on evaluation.

   c. The broader role of the NHS
      The BMA supports the recognition of the broader role of the NHS. Section four of the draft mandate discusses this role, but includes a very specific selection of narrow objectives. This approach risks not truly capturing the broader role of the NHS.

      The NHS Commissioning Board has an important role in supporting wider social and economic objectives. We believe that better integration of services within the wider health and social care and public health system should be the focus of this section. In the mandate, this should be reflected in the Board’s partnership working with other agencies across sectors, for example, in its involvement with strategic planning and relationships with local authorities. We also welcome the inclusion of research in this section. The Board should promote research centres and the development of research capacity within providers through its leadership and commissioning roles.

      It will be difficult to attribute some of the outcomes required by the mandate. Many of the high level objectives set are influenced by wider societal factors beyond the control of the NHS. The mandate should focus on objectives that can be directly influenced by the NHS Commissioning Board.
d. Effective commissioning

It is important that the transition to the new system is achieved as seamlessly as possible. Therefore, including in the first mandate some clear expectations around how the Board should implement the reforms, seems sensible. In particular, we welcome the clear outline of timescales for the transfer of power to local organisations including Clinical Commissioning Groups (CCGs) Board’s.

We would like to see this section promote consistency of approach to commissioning and embed evidence based clinical decision making in success measures, for example measuring true clinical involvement in commissioning. We also believe that this section should make clear the Board’s role in its direct commissioning and the expectations attached to this function.

The BMA has significant concerns about the introduction of a ‘quality reward’. This has the potential to widen health inequalities as CCGs commissioning for deprived populations, with higher health needs, could find it harder to achieve any award available. As it will be top-sliced from an overall commissioning budget, which includes CCGs budgets, these CCGs will be deprived of the vital funding they need at the beginning of the financial year when they start to look at what improvements they can make.