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SCRUTINY BOARD (HEALTH AND WELL-BEING AND ADULT SOCIAL CARE)

Meeting to be held in Civic Hall, Leeds, LS1 1UR on Thursday, 28th November, 2013 at 10.00 am

(A pre-meeting will take place for ALL Members of the Board at 9.30 a.m.)

MEMBERSHIP

Councillors

G Hussain	-	Roundhay;
J Walker	-	Headingley;
C Fox	-	Adel and Wharfedale;
K Bruce	-	Rothwell;
J Illingworth (Chair)	-	Kirkstall;
S Varley	-	Morley South;
M Robinson	-	Harewood;
J Lewis	-	Kippax and Methley;
E Taylor	-	Chapel Allerton;
C Towler	-	Hyde Park and Woodhouse;
S Lay	-	Otley and Yeadon;

Please note: Certain or all items on this agenda may be recorded

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Produced on Recycled Paper

A G E N D A

Item No	Ward/Equal Opportunities	Item Not Open		Page No
1			**APPEALS AGAINST REFUSAL OF INSPECTION OF DOCUMENTS** To consider any appeals in accordance with Procedure Rule 25* of the Access to Information Procedure Rules (in the event of an Appeal the press and public will be excluded). (* In accordance with Procedure Rule 25, notice of an appeal must be received in writing by the Head of Governance Services at least 24 hours before the meeting).	
2			**EXEMPT INFORMATION - POSSIBLE EXCLUSION OF THE PRESS AND THE PUBLIC** 1 To highlight reports or appendices which officers have identified as containing exempt information, and where officers consider that the public interest in maintaining the exemption outweighs the public interest in disclosing the information, for the reasons outlined in the report. 2 To consider whether or not to accept the officers recommendation in respect of the above information. 3 If so, to formally pass the following resolution:- **RESOLVED –** That the press and public be excluded from the meeting during consideration of the following parts of the agenda designated as containing exempt information on the grounds that it is likely, in view of the nature of the business to be transacted or the nature of the proceedings, that if members of the press and public were present there would be disclosure to them of exempt information, as follows: **No exempt items have been identified on this agenda.**	

Item No	Ward/Equal Opportunities	Item Not Open		Page No
3			**LATE ITEMS** To identify items which have been admitted to the agenda by the Chair for consideration. (The special circumstances shall be specified in the minutes.)	
4			**DECLARATION OF DISCLOSABLE PECUNIARY INTERESTS** To disclose or draw attention to any disclosable pecuniary interests for the purposes of Section 31 of the Localism Act 2011 and paragraphs 13-16 of the Members' Code of Conduct.	
5			**APOLOGIES FOR ABSENCE AND NOTIFICATION OF SUBSTITUTES** To receive any apologies for absence and notification of substitutes.	
6			**MINUTES - 30 OCTOBER 2013** To confirm as a correct record, the minutes of the meeting held on 30 October 2013.	1 - 10
7			**FUNDAMENTAL REVIEW OF NHS ALLOCATIONS POLICY** To consider a report from the Head of Scrutiny and Member Development presenting a range of information associated with the Fundamental Review of NHS Allocations Policy.	11 - 18
8			**LEEDS HEALTH AND SOCIAL CARE TRANSFORMATION BOARD** To consider a report from the Head of Scrutiny and Member Development updating the Scrutiny Board on the work of the Leeds Health and Social Care Transformation Board, including details of its governance arrangements and main work streams. **(Report to follow)**	19 - 20

Item No	Ward/Equal Opportunities	Item Not Open		Page No
9			**NHS ENGLAND: CALL TO ACTION** To consider a report from the Head of Scrutiny and Member Development presenting a formal response from Leeds CCGs in relation to the NHS England publication ‘The NHS belongs to the people: a call to action’.	21 - 34
10			**GOVERNMENT MANDATE TO NHS ENGLAND: 2014-15 REFRESH** To consider a report from the Head of Scrutiny and Member Development presenting information in relation to the Government Mandate to NHS England 2014-15.	35 - 76
11			**WORK SCHEDULE** To consider the Board’s work schedule for the forthcoming municipal year.	77 - 90
12			**DATE AND TIME OF THE NEXT MEETING** Wednesday, 18 December 2013 at 10.00am (Pre-meeting for Board Members at 9.30am)	

SCRUTINY BOARD (HEALTH AND WELL-BEING AND ADULT SOCIAL CARE)

WEDNESDAY, 30TH OCTOBER, 2013

PRESENT: Councillor J Illingworth in the Chair

Councillors J Walker, C Fox, S Varley, J Lewis, E Taylor, C Towler, N Buckley, J Hardy and K Mitchell

45 Chair's Opening Remarks

The Chair opened the meeting and welcomed everyone in attendance.

The Chair reported that Mr David Johnson – the first Chief Executive of Leeds Teaching Hospitals NHS Trust when it was formed in April 1998 – had recently passed away. Members of the Board offered their condolences for Mr Johnson's family during this difficult time.

The Chair also commented on the recent meeting of NHS England's Task and Finish Group (associated with the new review of Congenital Heart Disease (CHD) services in England) – held the preceding day (29 October 2013) in London. The Chair reported he had:

- Attempted to attend the meeting, but had been refused entry on the basis that it was not a meeting open to the public.
- Spoken to a number of those in attendance to attend the meeting, following its conclusion.

The Chair went on to make the following points in relation the previous *Safe and Sustainable* Review of Children's Congenital Cardiac Services and the new CHD review:

- The need for evidence based medicine and decision-making;
- Transparency arrangements;
- Levels of Yorkshire and the Humber representation within NHS decision-making;
- Joint Health Overview and Scrutiny Committee (JHOSC) arrangements;
- The number of Freedom of Information requests associated with the Safe and Sustainable review.

46 Late Items

The following items were submitted and accepted as supplementary information for consideration during the meeting:

- Item 7 – Fundamental Review of Allocations Policy: Response on behalf of Leeds North CGG, Leeds South & East CCG and Leeds West CCG to NHS England (minute 51 refers);
- Item 11 – Care Quality Commission (CQC) hospital inspection programme: Intelligent Monitoring (minute 50 refers).

The above documents were not available at the time of the agenda despatch, but would be made available to the public on the Council's website. Copies of the papers were also made available at the meeting.

47 Declaration of Disclosable Pecuniary Interests

There were no disclosable pecuniary interests declared to the meeting.

48 Apologies for Absence and Notification of Substitutes

The following apologies for absence and substitute arrangements had been received and were reported to the Scrutiny Board.

- Apologies from Cllr G Hussain – Cllr J Hardy attending as a substitute.
- Apologies from Cllr K Bruce – Cllr K Mitchell attending as a substitute.
- Apologies from Cllr M Robinson – Cllr N Buckley attending as a substitute.
- Apologies from Cllr S Lay – no substitute member in attendance.

49 Minutes - 25 September 2013 (Ordinary and Call in Meetings)

RESOLVED –

That the minutes of the ordinary and call-in meeting held on 25 September 2013 be approved as a correct record.

50 Care Quality Commission (CQC) hospital inspection programme: Intelligent Monitoring

The Head of Scrutiny and Member Development submitted a report that outlined details of the Care Quality Commission (CQC) second phase of hospital inspections – due to commence in January 2014 – announced on 24 October 2013.

The report outlined that 19 NHS trusts have been identified/ selected for the second phase of inspections based on whether they scored highly using the CQC intelligent monitoring tool; are a foundation trust applicant that Monitor have requested CQC to inspect; or were previously investigated as part of the Keogh Mortality Review.

The CQC's second phase of hospital inspections would include Leeds Teaching Hospitals NHS Trust and would seek to answer the following questions:

- Are services safe?
- Are services caring?
- Are services effective?
- Are services well-led? and,
- Are services responsive to people's needs?

The first phase of inspections started in September 2013 and by December 2015, CQC will have inspected every NHS Trust in England.

The report also outlined that the CQC's intelligent monitoring tool utilises 150 different indicators covering a range of information, including patient and staff experience and statistical measures of performance, aimed at providing inspectors with a clear picture of the areas of care that need to be looked at in NHS acute trusts.

To help inform more detailed understanding, details of frequently asked questions (FAQs) relating to CQC's intelligent monitoring was appended to the report.

The following representatives were in attendance to help the Scrutiny Board consider the information presented:

- Rod Hamilton (Compliance Manager (Leeds) – Care Quality Commission)
- Julian Hartley (Chief Executive – Leeds Teaching Hospitals NHS Trust)
- Dr Bryan Gill (Medical Director (Quality and Governance) – Leeds Teaching Hospitals NHS Trust)
- Dr Bryan Power (Joint Medical Director (Quality and Performance) – Leeds West Clinical Commissioning Group)
- Diane Hampshire (Director of Quality and Nursing – Leeds West Clinical Commissioning Group)

In addressing the Scrutiny Board, the following points were made:

<u>CQC's Compliance Manager (Leeds)</u>

- The hospital review programme was being led by the newly appoint Chief Inspector of Hospitals, Professor Sir Mike Richards;
- The CQC was now operating under a different inspection regime, using a new methodology;
- The inspection programme would make use of larger teams and more specialist staff;
- The CQCs intelligent monitoring tool utilised indictors of risk;
- Hospitals inspections would see an assessment of risk factors.

<u>Leeds Teaching Hospitals NHS Trust (LTHT) – Chief Executive</u>

- Welcomed the early opportunity to address the Scrutiny Board, since formally starting as Chief Executive on 14 October 2013;

- The CQC's recent announcement was an assessment of risk and was not a judgement;
- There was an awareness of some historical areas for improvement/ under-performance;
- The inspection was likely to take place early in the New Year (2014) and there was a desire to be open and transparent with any CQC work.

A detailed discussion took place, during which a number of issues were raised, including:

- Assurances sought around the hospitals inspection programme being about improvement.
- Clarification around forming/ appointing the inspection team.
- Clarification around the levels of Health Care Acquired Infections (namely C-difficile) in recent years, which had seen a reduction of 73% over the past 5 years.
- The role of LTHT in promoting healthy lifestyles – including through the use of its estate.
- Serious education concerns expressed by the Deanery / General Medical Council (GMC).
- Recognition that healthcare provision is not a risk-free enterprise.
- The relationship between the outcome of the hospitals inspection programme and the Trust Development Authority's programme for aspiring NHS foundation trusts.
- Staffing levels/ challenges, providing direct patient care and the impact of implementing the 'Ward Healthcheck' and 'e-rostering' systems.

The Chair thanked those in attendance for their contribution to the discussion at the meeting and looked forward to their input at future Scrutiny Board meetings, where appropriate.

RESOLVED –

(a) To note the information presented and discussed at the meeting.
(b) Following the inspection of Leeds Teaching Hospitals NHS Trust, to formally consider the CQC's inspection report and any associated implications.

51 Fundamental review of NHS Allocations Policy

Following the previous meeting on 25 September 2013, the Head of Scrutiny and Member Development submitted a report that highlighted some of the issues highlighted and discussed with NHS England, and introduced a range of further information associated with NHS England's fundamental review of NHS allocations policy.

The information presented included:

- An overview of Leeds bid to become an 'integrated health and social care pioneer', including an update provided to the Health and Wellbeing Board at its meeting on 2 October 2013.

- An overview of the current financial landscape of the health and social care sector in Leeds – as presented to the Health and Wellbeing Board at its meeting on 2 October 2013.
- High level budget information from each of the three local Clinical Commissioning Groups (CCGs) – including details of the current / existing budgets and allocation across the main areas of commissioning.
- Leeds wide outcome benchmarking pack – produced by NHS England.

As agreed earlier in the meeting (minute 46 refers), a response on behalf of Leeds North CGG, Leeds South & East CCG and Leeds West CCG to NHS England was submitted and considered as supplementary information.

The following representatives were in attendance to help the Scrutiny Board consider the information presented:

- Cllr Lisa Mulherin (Executive Board Member for Health and Wellbeing – Leeds City Council)
- Nigel Gray (Chief Officer – Leeds North Clinical Commissioning Group)
- Dr Jason Broch (Clinical Chair – Leeds North Commissioning Group)
- Dr Bryan Power (Joint Medical Director (Quality and Performance) – Leeds West Clinical Commissioning Group)
- Mark Bradley (Chief Finance Officer – Leeds South and East Clinical Commissioning Group)
- Dennis Holmes (Deputy Director, Adult Social Services – Leeds City Council)
- Rob Kenyon (Chief Officer Health Partnerships – Leeds City Council)
- Dr Ian Cameron (Director of Public Health – Leeds City Council)

A brief introduction to the report was provided by the Principal Scrutiny Adviser, after which a number of specific points were highlighted by those in attendance, including the following:

Executive Board Member for Health and Wellbeing

- The potential loss of CCG funding in Leeds was £84M and across Yorkshire and the Humber it was around £400M;
- The huge challenges that such proposed changes in funding should not be underestimated;
- Concerns about the potential funding in Leeds had been raised by the Leader of the Council to the Chair of NHS England, Sir Malcolm Grant;
- It would appear that the 'deprivation factor' – previously present in funding allocations – had been removed from the new proposed funding formula;
- The proposed funding allocations would have a direct impact on achieving the aims and objectives of Leeds' Joint Health and Wellbeing Strategy;
- The overall funding was not clear, with proposed funding levels for NHS England's direct commissioning activity (primary care and specialist services) not being made available;

- Suggestions that Public Health funding could ‘fill the funding gap’ seemed disingenuous, given Leeds’ entire Public Health budget was less than 50% of the proposed £84M loss of CCG funding.

Chief Officer – Leeds North CCG

- It was important to recognise the current period of significant austerity across all public services, including the NHS;
- No decision on CCG funding allocations had yet been made;
- Leeds CCGs were working jointly in responding to the proposals;

Chief Finance Officer – Leeds South and East CCG

- Following the announcement in August 2013, there had been significant engagement between Leeds’ CCGs and NHS England regarding proposed funding allocations;
- Leeds’ CCG were unable to understand the detail of the proposed £84M reduction in CCG funding, but there were some significant factors that appeared to have a negative impact, including:
    - Loss of the 10% factor for deprivation;
    - Details of the 2011 census data compared with the population estimates used in funding formulas in recent years;
    - The sometime transient characteristics of some inner-city populations.
- Due to the small/ zero level of growth across NHS budgets, there appeared limited flexibility to deliver any changes in allocation other than through a very slow pace of change.
- All ‘core cities’ seem to be affected in similar ways if the proposed level allocations policy / formula is agreed and implemented. The core cities had therefore worked collaboratively in responding to NHS England’s proposals.

Through discussion with the Scrutiny Board the following points were also highlighted and discussed:

- The impact of any changes to NHS/ local CCG funding should be considered in the context of general reductions in public expenditure, in particular local authority budgets.
- The uncertainty around future budgets and funding levels served to undermine and hinder forward planning.
- The ‘integration transformation funding’ was not additional funding to the system, but would represent a reallocation of some of the available resource. Any allocation of integration transformation funding would also bring associated, additional responsibilities.
- Any shift in the structure of the workforce and changing skill requirements would take time.
- The potential financial impact on local NHS providers, in particular Leeds Teaching Hospitals NHS Trust.
- The transformation programme for health and social care locally (expressed through the pioneer bid) represents a significant challenge.

- CCGs had not had access to the full funding allocations model.
- CCGs continued to work together and had a risk sharing agreement to help provide some safeguards across the local system.

The Chair thanked those in attendance for their contribution to the meeting and subsequent discussion.

RESOLVED –

(a) To note the information presented and discussed at the meeting.
(b) To consider an update position at the next Scrutiny Board meeting, with a view to issuing a response to NHS England ahead of its Board meeting in December 2013.

52 NHS England: Call to Action

The Head of Scrutiny and Member Development submitted a report that outlined details of NHS England's Call to Action and advised the Scrutiny Board of the available information and actions taken by the Chair outside of the meeting cycle. The following information was appended to report:

- The NHS belongs to the people: A Call to Action;
- Letter from the Chair of the Scrutiny Board to the Director of NHS England's West Yorkshire Area Team (dated 16 October 2013);
- Letter from NHS England's Chief Executive to NHS Commissioners (10 October 2013).

The following representatives remained in attendance to contribute to the Scrutiny Board consideration of the information presented:

- Cllr Lisa Mulherin (Executive Board Member for Health and Wellbeing – Leeds City Council)
- Nigel Gray (Chief Officer – Leeds North Clinical Commissioning Group)
- Dr Jason Broch (Clinical Chair – Leeds North Commissioning Group)
- Dr Bryan Power (Joint Medical Director (Quality and Performance) – Leeds West Clinical Commissioning Group)
- Mark Bradley (Chief Finance Officer – Leeds South and East Clinical Commissioning Group)
- Dennis Holmes (Deputy Director, Adult Social Services – Leeds City Council)
- Rob Kenyon (Chief Officer Health Partnerships – Leeds City Council)
- Dr Ian Cameron (Director of Public Health – Leeds City Council)

Through discussion with the Scrutiny Board the following points were also highlighted and discussed:

- Local CCGs had a comprehensive engagement plan, details of which would be provided (as requested);

- The local response to the Call to Action included a response through the work undertaken through the Transformation Board:
    - Considering the 'Leeds Pound';
    - Developing a Health and Social Care Strategy;
    - Considering current commissioning strategies;
    - Role of competition and procurement.
- The integration transformation fund (ITF) and its associated implications was likely to impact on providers of acute care.
- Submissions to access the ITF would need to be finalised by mid-February 2014. The Scrutiny Board expressed an interest in considering proposals prior to final submission.
- The 'Call to Action' had implications for the quality improvement agenda, in addition to the financial landscape.
- NHS England's role in providing leadership around the 'Call to Action'.

The Chair thanked those in attendance for their contribution to the meeting and subsequent discussion.

RESOLVED –

(a) To note the information presented and discussed at the meeting.
(b) To consider further progress and developments associated with NHS England's 'Call to Action' at a future meeting.
(c) To consider proposals to access the integration transformation fund (ITF) prior to the final submission in February 2014.

Councillor E Taylor and Councillor J Walker left the meeting at 12:00noon, during consideration of this item.

53 Work Schedule

The Head of Scrutiny and Member Development submitted a report that outlined the on-going development of the Scrutiny Board's work schedule for 2013/14.

The report reminded the Scrutiny Board that, at its meeting on 21 June 2013, members had identified the following themes to form the broad direction of the its work programme for 2013/14:

- Narrowing the Gap;
- Service quality;
- Urgent and emergency care;
- Progress / implications associated with achieving NHS Foundation Trust status;
- Information flows/ data sharing

It was also highlighted that at its meeting on 31 July 2013, the Scrutiny Board also considered and agreed to undertake further work around the following requests for scrutiny:

- Men's health;

- Dermatology; and,
- Children's Epilepsy Surgery.

At its previous meeting (25 September 2013), the Board had agreed that its work schedule should have some initial focus on issues associated with the NHS allocation policy and should also focus its efforts on Narrowing the Gap and increasing Physical Activity.

The ongoing work to translate these issues into a more detailed work schedule was appended to the report.

RESOLVED –

(a) To note the information presented and discussed at the meeting.
(b) Subject to other issues highlighted during the meeting, the draft work schedule as presented be agreed.

Councillor J Hardy left the meeting at 12:10pm, during consideration of this item.

54 Date and Time of the Next Meeting

RESOLVED –

That, following further consultation with members of the Board, the date and time of the next meeting (due to be held in November) was to be confirmed.

(The meeting concluded at 12:25pm)

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Leeds
CITY COUNCIL

Agenda Item 7

Report author: Steven Courtney

Tel: 24 74707

Report of the Head of Scrutiny and Member Development

Report to Scrutiny Board (Health and Wellbeing and Adult Social Care)

Date: 28 November 2013

Subject: Fundamental review of NHS Allocations Policy

	Yes	No
Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: 10.4.3	☐ Yes	☒ No

Summary of main issues

1. At previous meetings, the Scrutiny Board has considered a range of information associated with the Fundamental Review of NHS Allocations Policy.

2. The purpose of this report is to provide additional information in this regard. The following information is appended to this report:

   - An update / briefing note provided by NHS England, through the West Yorkshire Area Team (Appendix 1);
   - Summary of the action points arising from the ‘core cities’ Chief Finance Officer’s meeting – 4 October 2013 (Appendix 2);
   - A briefing note from the Director of Public Health regarding the Public Health budget in Leeds (Appendix 3)

3. Appropriate representatives have been invited to attend the meeting to assist the Scrutiny Board in its deliberations. This will include a representative from local Clinical Commissioning Groups in Leeds to provide an update outlining recent local activity.

Recommendations

4. The Scrutiny Board (Health and Wellbeing and Adult Social Care) is asked to:
   - Consider the information presented and discussed at the meeting;
   - Determine any specific matters it would wish to highlight to NHS England; and
   - Identify any further details it wishes to consider ahead of formalising a response to NHS England.

Background documents[1]

5. None used.

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

NHS England

Briefing Note for the Leeds City Council's Scrutiny Board (Health and Wellbeing and Adult Social Care)

The decision on CCG allocations for 2014/15 and 2015/16 will be made at the NHS England Board meeting in December 2013. Engagement over the past 3-4 months has been undertaken to establish the best way forward. There are however three issues to consider in the allocations formula which have countervailing effects.

Firstly, the current CCG allocations are based on populations which are at least 3 or 4 years out of date and have had no pace of change applied in recent years causing a dislocation in the commissioning system.

Secondly, we have an aging population and age is a significant factor in determining the health needs of a local population.

Lastly, there needs to be proper weight given to deprivation and inequality as this is central to the mission of NHS England. When compared to the existing formula and taking account of age and population factors then there is generally more resources weighted to more deprived areas. Inequalities resulting in needs which are currently being met are captured in baselines and target allocation formulae but NHS England remain concerned that whilst the formula accurately predicts need as currently met, it does not capture unmet need. As a consequence, the Board will be considering proposals for introducing an unmet need adjustment to the CCG allocations formula.

The other factor in determining CCG allocations is the how fast we move from what we have currently got to whatever the formula states. This pace of change determines the amount of resources a particular CCG receives, based on the difference between the CCG’s target and baseline positions – its distance from target. NHS England is committed to fairness and accordingly the pace of change should be set at the maximum level possible with the risks fully identified and where necessary mitigated through a clear transparent transition plan. Other factors influencing pace of change are the:-

- Ability to invest and dis-invest from services whilst maintaining safe services and not reducing overall efficiency;
- Desire not to “yoyo” around allocations creating uncertainty;
- Impact of potential transition costs in investment / disinvestment; and
- Ability of local CCGs to address difficult issues when reducing proportionate funding in the wider context of the overall efficiency challenges.

NHS England

It should be highlighted that there is no readily available evidence identifying an appropriate pace of change or the maximum level of additional funding that any one area can realistically and efficiently invest in a year. In addition, due to limited growth funding for the NHS, the speed of any change will be quite measured and controlled. The recent allocation workshops have also looked at identifying practical experiences for controlled investment / disinvestment and the interdependencies of specialised services and primary care.

I hope this briefing note is helpful and gives you an understanding of the work we are carrying out in this area and of the commitment we have made to make the review a transparent and open process.

APPENDIX 2

NHS
Liverpool
Clinical Commissioning Group

CORE CITIES CHIEF FINANCE OFFICERS MEETING
FRIDAY 4 OCTOBER 2013 10AM – 1PM
(Sandwich lunch from 12 Noon - 1pm)
THE STUDIO – BIRMINGHAM
7 Cannon Street Birmingham B2 5EP

Summary Action Points (for approval)

DRAFT - FOR APPROVAL

Expected Attendees

Sam Higginson	NHS England - Director of Strategic Finance
Tom Jackson	NHS Liverpool CCG
Joanne Newton	NHS North, South and Central Manchester CCGs
Julia Newton	NHS Sheffield CCG
Terry Allen	NHS Nottingham CCG
Visseh Pejhan-Sykes	NHS Leeds West CCG
Philip Johns	NHS Birmingham Cross City CG
Mary Connor	NHS Bristol City CCG
Mark Bradley	NHS Leeds South and East CCG
Martin Wright	NHS Leeds North CCG

Apologies

Rob Robertson	NHS Northumberland CCG
Alison Thompson	NHS North Tyneside CCG
Joe Corrigan	NHS Newcastle North & East, West CGGs and Gateshead CCG

ITEM	Action
1. Sam Higginson	**Presentation**
SH updated the group on the emerging work and thinking for 2014/15 and 2015/16 allocations. Issues discussed included; funding objectives within the Mandate, principles for use of the £3.8bn Integration Transformation Fund, the global impact of local authority cuts on social care, metrics to address inequalities, population metrics, alignment of financial strategy with the emerging health inequalities strategy. Key decisions required are - how to allocate funding between different funding areas - how to allocate funds within each area - the pace of change In conclusion the views of the Core Cities Finance Group are; 1) the entirety of CCG allocations should encompass measures to address health inequalities	

NHS
Liverpool
Clinical Commissioning Group

2) the historic 10% quantum for health inequalities should be maintained. 3) use of SMR for under 75s should be considered 4) component parts of the formula eg population should be understood 5) given outstanding uncertainties regarding the case for change, the pace of change should be minimal. As specific actions, Joanne Newton will circulate the Manchester Public Health work to support the 10% quantum. The details of the next Commissioning Assembly subgroup will be circulated to CFOs, Tom Jackson will canvass expressions of interest and representation confirmed with Sam. Following Sam's departure the CFOs discussed the most appropriate way to formalise a core cities response to future allocations. It was agreed to forward the minutes of this meeting to Sam Higginson.	 **Joanne Newton** **TJ** **TJ/LH**

DRAFT - FOR APPROVAL

With the transfer of public health responsibilities from the NHS to Leeds City Council in April 2013 came a budget as a ring fenced Public Health Grant.

The Department of Health published in February 2012 and January 2013 details of the national funding allocations for public health activities. These allocations were for two years and for Leeds were £36.9m in 2013/14 and £40.5m in 2014/15. The Department of Health in its allocations to Leeds acknowledged that the funding by Leeds Primary Care Trust had been under "target". The 2013/14 allocation equated to £48 per head compared to a Department of Health target of £57 per head. The additional funding for 2014/15 therefore represents movement towards that target.

In 2013/14 ring fenced grant was intended to maintain the current level of services plus meet any national changes made by the Department of Health on Council responsibilities. At the time when Leeds City Council budget report for 2013/14 was presented to Full Council there was acknowledgement that were still uncertainties around precisely which functions are funded through the financial settlement.

In practice those uncertainties continue to the present, in particular around prescribing costs. There have also been additional cost pressures for example with the recent announcement in Parliament that the Warm Homes Healthy People Fund will not be available as in previous years but instead is incorporated within the ring fenced Public Health Grant.

For 2013/14 the majority of the £36.9m ring-fenced Public Health Grant is spent on commissioned services (£30m). The providers are Leeds Teaching Hospitals NHS Trust; Leeds Community Healthcare; Leeds & Yorkshire NHS Partnership Foundation Trust, Voluntary, Community & Faith Sector; General Practices, Pharmacists.

A further £1.5m has been spent in 2013/14 on funding current Local Authority Services that can be considered public health services.

The table below identifies the public health expenditure by selected specific Public Health areas.

In taking on its new responsibilities Leeds City Council has therefore inherited those public health services previously commissioned by Leeds Primary Care Trust. However, the government has only made a relatively small number of these services mandatory. These include sexual health services, NHS Health Check, the National Child Weight Management Programme, public health advice to Clinical Commissioning Groups and health protection assurance. Other services such as the school nursing service, drugs and alcohol services are now at the discretion of the Council.

Public Health expenditure by selected specific Public Health areas	
Adults	
Drug misuse	9.6m
Alcohol misuse	2.7m
Sexual health services	8.3m
Stop smoking services	1.0m
NHS Health Check	0.8m
Obesity services	0.6m
Children	
School nursing	2.3m
Healthy schools	0.4m
Obesity services	0.3m
Physical activity	0.2m
Drugs	0.6m
Alcohol	0.2m

The 2014/15 ring fenced grant will be £40.5m – an uplift of around £3.7m. Leeds City Council in its financial plan has already ear marked £2m of that uplift to fund current council services that relate to public health. At present the remainder is to be used to deal with the cost pressures that have arisen from the transfer of existing commissioned services.

The Department of Health is reviewing the Public Heath allocation formula. One change to the funding formula will arise from the introduction of "health premium". This was announced in the White Paper Equity & Excellence: Liberating the NHS July 2010 as a "new health premium" designed to promote action to improve population wide health and reduce health inequalities. In October 2013 an interim report has been produced for the Advisory Committee on Resource Allocation (ACRA) that sets out possible Public Health outcome indicators that could be used to reward performance with a mixture of nationally and locally chosen indicators. The interim report suggests a considerable amount of further work will be needed before the health premium is implemented.

In August 2013, NHS England published the implications for the three Leeds Clinical Commissioning Groups (CCG's) of implementation of a revised funding formula. This would result in a loss of £84m across the three Leeds CCG's. That loss dwarfs the total Public Health ring fenced grant for Leeds – which is anyway wholly committed. The ring fenced Public Health grant, tied as it is to council responsibilities cannot be seen as being able to compensate for the loss of any CCG funding. There would need to be a radical increase in Public Health funding to compensate for the potential loss of CCG funding. The findings from the Department of Health review of the Public Health allocations formula is awaited with interest.

Agenda Item 8

Leeds CITY COUNCIL

Report author: Steven Courtney

Tel: 24 74707

Report of the Head of Scrutiny and Member Development

Report to Scrutiny Board (Health and Wellbeing and Adult Social Care)

Date: 28 November 2013

Subject: Leeds Health and Social Care Transformation Board

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: 10.4.3	☐ Yes	☒ No

Summary of main issues

1. As part of the Scrutiny Board's consideration of the Fundamental Review of NHS Allocations Policy, it was suggested that the Scrutiny Board might usefully consider an update on the work of the Leeds Health and Social Care Transformation Board, including details of its governance arrangements and main work streams.

2. A report setting out the update is attached at Appendix 1.

3. Appropriate representatives have been invited to attend the meeting to assist the Scrutiny Board in its deliberations.

Recommendations

4. The Scrutiny Board (Health and Wellbeing and Adult Social Care) is asked to:
   - Consider the information presented and discussed at the meeting;
   - Determine any specific matters it would wish to highlight in its response to NHS England around its Fundamental Review of NHS Allocations Policy; and
   - Identify any matters that warrant further and/or more detailed scrutiny.

Background documents[1]

5. None used.

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

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Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 24 74707

Report of the Head of Scrutiny and Member Development

Report to Scrutiny Board (Health and Wellbeing and Adult Social Care)

Date: 28 November 2013

Subject: NHS England: Call to Action

	Yes	No
Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: 10.4.3	☐ Yes	☒ No

Summary of main issues

1. At its previous meeting, the Scrutiny Board considered a report that set out details of NHS England publication 'The NHS belongs to the people: a call to action – which had a stated aim of stimulating a national debate about the future shape of the NHS.

2. At that meeting, members considered a range of information, including:

   - The 'Call to Action' publication;
   - A report presented to the Leeds Health and Wellbeing Board considered a report on the 'Call to Action' presented by the Director of NHS England's West Yorkshire Area Team;
   - A copy of the Chair's letter to NHS England seeking confirmation of its 'Call to Action' activity locally; and,
   - A copy of a letter from the Chief Executive of NHS England to all NHS commissioners –which made specific reference to the 'Call to Action' workstreams.

3. At that meeting, the Scrutiny Board heard from local CCG representatives about local activity.

4. Since that time, a formal response from Leeds CCGs has been received. This is attached at Appendix 1. The following supplementary information was also provided:

   (a) How and in what format does the information gathered by CCGs get fed back to NHSE?
   The CCGs are using Enventure, an external agency to analyse the surveys and provide consistent and impartial feedback. We will be providing NHS E with city wide feedback, and feedback broken down to CCG level

(b) What timescales have NHSE asked CCGs to work to?
The Call to Action guide published by NHSE does not give any end date and the CCGs will continue to gather people's views to feed into their own planning processes.

(c) How is NHSE helping to facilitate / support discussions locally?
NHS E have agreed to attend a city wide event drop in that the CCGs have organised at Leeds City Museum on 27 November between 10.30am and 12.30pm and 1.30pm and 3.30pm.

(d) How does the annual planning cycle fit with the allocation announcement expected in December?
The CCGs undertake some draft planning based on assumptions made by the finance teams about what the final allocations might be. Once allocations have been announced the CCGs will work quickly to firm up their plans. They need to be in a position to submit final draft plans to the area team in February 2014

5. At the time of writing this report, no formal response from NHS England has been received. In addition, no further feedback has been provided from other organisations. However, it should be noted that in his report to the NHSE Board on 8 November 2013, the Chief Executive of NHS England made specific reference to the overall 'Call to Action' activity. A copy of the report is attached at Appendix 2.

Recommendations

6. The Scrutiny Board (Health and Wellbeing and Adult Social Care) is asked to consider the information presented and discussed at the meeting and determine what, if any, further action it wishes to take.

Background documents[1]

7. None used

.

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

On behalf of the Clinical Commissioning Groups in Leeds

Councillor John Illingworth
Chair, Scrutiny Board
(Health and Wellbeing and Adult Social Care)
3rd Floor (East)
Civic Hall
LEEDS LS1 1UR

5 November 2013

Sent by e-mail only

Dear Cllr Illingworth

NHS England – Call to Action

Thank you for your recent letter with regard to NHS England's Call to Action initiative, and your request for details about the clinical commissioning groups' in Leeds local engagement plans.

NHS Leeds North CCG, NHS Leeds South and East CCG and NHS Leeds West CCG are committed to engaging with local people to develop their plans. The CCGs review their plans annually to identify key priorities.

This year the CCGs have the additional responsibility to actively participate in the Call to Action which is intended to be a national, open and honest debate about the future of the NHS.

The Call to Action asks the public to give their views on four fundamental questions:

- How can we improve the quality of NHS care?
- How can we meet everyone's healthcare needs?
- How can we maintain financial sustainability?
- What must we do to build an excellent NHS now and for future generations?

In addition, GP practices will be contacted directly to support the national campaign, specifically relating to a Call for Action on general practice.

The CCGs in Leeds are playing an active role in encouraging local people to participate in the Call to Action and to feed their views and comments back into the national process. This is through signposting and awareness using local media, social networking, websites, internal and external bulletins and other local communication mechanisms, and active engagement through face-to-face events, online discussions, in public meetings and conversations with key stakeholders.

In addition to the Call to Action, CCGs in Leeds are entering the annual planning cycle and will involve patients, the public, political stakeholders and partner organisations in developing local priorities and action plans.

As with the rest of the UK, the NHS in Leeds is facing significant future challenges as a result of a rise in demand for services and increasing public expectations coupled with flat funding (adjusted for inflation) over the coming years. The CCGs recognise the need to engage with local people to provide a clear picture about the challenges facing the NHS. This will enable people to:

- acknowledge the NHS' limitations and in turn begin to refocus their expectations of what the NHS in Leeds can and cannot provide;
- understand the rationale for commissioning decisions and lend their support to future change;
- be more engaged in discussions and decisions about the NHS in the future; and
- empower people to realise their own personal responsibilities to their health and wellbeing and to their use of NHS services. The foundation for these responsibilities is included in the NHS Constitution.

The CCGs are engaging with people in a number of ways; at CCG-level, in local partnerships and at city-wide level. This will demonstrate a commitment to joined-up working, reducing duplication and using resources to effectively engage at very local community level.

At city-wide level there is mass communication to key networks using online, social networking (also at CCG level), general advertising in city-wide publications which promoting the national Call to Action and all CCG websites.

At CCG level there is a local delivery plan tailored to each CCG. This includes a review of existing patient experience information, communications and engagement activity based on the specific needs of local communities, bespoke activity to target protected groups, seldom heard groups, using community engagement and communication mechanisms, local media relations, and localised social networking activity.

Also at CCG level, Call to Action is integrated into existing engagement plans – for example by including the debate in pre-arranged meetings with area committee leaders, internal audiences and pre-existing patient groups.

The joint CCG activity will focus on the local CCG planning process but with engagement on Call to Action undertaken in conjunction with this. There is an open event for people in Leeds on 27 November to understand the context and challenges their local NHS operates in. Each CCG will then hold a 'break out session' to discuss their own key areas of focus with local people. CCGs will share the feedback to enable them to gain local insights with added value of insights from other CCG areas. Cross-referencing the feedback will provide city-wide and CCG-specific themes as well as identifying themes emerging from specific groups or communities.

The methods that we are using are:

- **Online questionnaire:** The CCGs in Leeds have developed an online survey which is now live. Questions have been developed under the four headings that are in Call to Action. They are very broad, but we have tried to encourage people to think about what they want to tell us. Because they are narrative responses they will be analysed externally so that they are as objective as possible. The online questionnaire is available directly from Survey Monkey as well as through the CCG websites. We are promoting this using a range of channels including CCG bulletins, partner bulletins, the media, social media, direct emails and through community engagement events.
- **Paper based questionnaire:** a paper-based version of the questionnaire is available to our community and voluntary sector partners and to Leeds Involving People who

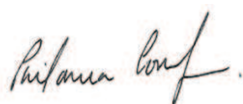
are attending events on behalf of the CCGs in Leeds. A limited number of copies are being printed in line with the sustainability policies of all CCGs in Leeds, however further copies can be made available upon request. CCG engagement staff have already been asking questions as part of their ongoing work developing their community networks.

- **CCG website:** a prominent link from the home page of the CCG's website is set up so that people can quickly access information and take part in the debate. The website includes a link to the online version of the survey as well as a number/email address so that people can request a hard copy if they wish to do so.
- **Social media:** we are using the CCGs' social media accounts to promote and encourage debate using the following #LeedsCallToAction. We are also encouraging partner organisations to use their own accounts to spread the word.
- **Meetings with elected members and MPs**: CCGs either have already held, or are arranging meetings with their local elected members to gather their views and talk about how we can work more closely together
- **Engagement events including a citywide event on 27 November:** we will either attend, or ask Leeds Involving People to attend a range of existing events and hold stalls/awareness sessions so that people can participate in Call to Action. We will round this off by organising our own citywide event that will be a mix of a structured session where those attending can answer the four wider questions before breaking off and speaking directly to commissioners from their relevant CCGs for more detailed questions. Our engagement activities will be a mix of attendance at events, focus groups and one to one interviews.
- **Staff engagement:** we are promoting Call to Action in the CCG's e-bulletin and also setting up a staff workshop (or workshops) so that staff can take part in the debate.
- **Media:** a press release was sent in early August and will be issued again to alert the media that the local survey is active. A further press release will be issued prior to the citywide engagement event on 27 November. We are also working with the Yorkshire Evening Post to look at the feasibility of setting up a live Twitter chat and we will look to offer similar opportunities to other local media outlets

We hope that this level of detail is helpful to demonstrate the approach that the CCGs in Leeds are taking to involve local people in both the national Call to Action and local planning, but if you require any further detail, please do not hesitate to contact Carolyn Walker, communications, NHS Leeds West CCG at carolyn.walker@nhs.net

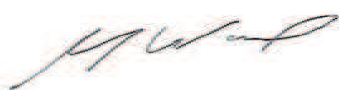
Yours sincerely

Philomena Corrigan



Chief Officer
NHS Leeds West CCG

Matt Ward



Chief Operating Officer
NHS Leeds South and East CCG

Nigel Gray

Chief Officer
NHS Leeds North CCG

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NHS England

Paper NHSE13101

BOARD PAPER - NHS ENGLAND

Title: Chief Executive's report

Clearance: Sir David Nicholson, Chief Executive

Purpose of paper:

- This report highlights a number of significant events that have taken place since the last meeting of the Board and are not covered elsewhere on the agenda. It also records urgent action taken since the last Board meeting.

Key issues and recommendations:

The two months since the last Board meeting have seen a great deal of progress and a number of significant developments. We have followed up the 'Call to Action' with a significant programme of work. We have held a successful annual meeting of the NHS Commissioning Assembly.

Actions required by Board Members:

- The Board is asked to note the report.

Chief Executive's report

Introduction

1. This report highlights a number of significant events that have taken place since the last meeting of the Board and are not covered elsewhere on the agenda. It also records urgent action taken since the last Board meeting.

The 'Call to Action'

2. To mark the 65th anniversary of the NHS in July, NHS England published 'The NHS Belongs to Us All: A Call to Action'. This document demonstrated why the health service must be transformed to survive. Since the launch of the Call to Action, NHS England has been working on two key strands that will take the challenges identified in a Call to Action into the strategic planning round for 2014/2015 – 2018/2019.

3. The first strand is creating the space for local debate and discussion. A key component of this is the primary care engagement strand. 'Improving general practice – A call to action' was launched in August and describes the case for change and our underlying objectives for general practice together with an evidence pack about current general practice and health needs. It also identifies a number of questions about how NHS England can best support these local changes. We have created an online survey to collect views and this is open until 10 November 2013. An accelerated learning event on this topic was held on 15 October 2013 to bring together colleagues from across NHS England alongside (clinical commissioning group) CCG clinical leaders and primary care stakeholders to input into the emerging workstream groups that are developing elements of the strategic framework for commissioning primary care.

4. We expect to publish a call to action for community pharmacy in November 2013 and we are also developing similar frameworks to stimulate debate about our strategic approach to primary care dental services which will be published during winter.

5. The second key strand has been to develop a series of 'thought leadership' products. These thought leadership products will be released in time to influence the development of the strategic plans due to be submitted in summer 2014. The first in the series will focus on prevention and early diagnosis, based on research and case studies, together with contributions from the first national Call to Action event held in Birmingham on 7 October. The second event in the series will be an 'NHS Futures Summit'. This is being delivered in partnership with Monitor and the NHS Trust Development Authority. The summit will bring together national leaders and thinkers to consider how the provider sector will need to change in response to shifts in commissioning intentions driven by the Call to Action and wider NHS Strategy programme.

6. In addition, NHS England is developing a product called 'Any Town CCG'. This is report based on quantitative and qualitative modelling that demonstrates for three types of typical CCG what the challenges and opportunities could look like. This

report will describe a selection of interventions that would make a contribution to meeting the challenges of improving health outcomes whilst living within our financial means.

NHS Commissioning Assembly

7. Our success as NHS commissioners in improving outcomes for patients is determined to a large extent by the relationships which are formed between CCGs and NHS England at a national and local level. By working together there is greater opportunity for improving the quality and commissioning outcomes for patients.

8. The NHS Commissioning Assembly was established in Autumn 2012, as the community of leaders for NHS commissioning - the 'one team' which will deliver better outcomes for patients. It comprises the clinical leader from every CCG in England and NHS England Directors (area team, support centre and national clinical directors).

9. The NHS Commissioning Assembly aims to:

- create shared leadership at national and local level across all clinical commissioners, fostering the sense of 'one team' with joint responsibility for ensuring that clinically-led commissioning develops and flourishes;
- be the infrastructure through which CCGs and NHS England can co-produce national strategy and direction;
- be the mechanism through which commissioners can agree principles, build consensus and have a common voice on key issues;
- be a learning network through which leaders of NHS England and CCGs can develop commissioning to be the best it can be; and
- connect the leaders of the clinical commissioning system at a national level.

10. The NHS Commissioning Assembly has an established programme of work to deliver its ambitions, with members contributing via themed working groups, digital members networking and an annual event.

11. In its first year the NHS Commissioning Assembly has played a key role in in the commissioning system. The NHS Commissioning Assembly membership have influenced key policy and strategy development, such as Call to Action, provided views on hot topics, such as NHS 111 and produced practical help to support all commissioners, including the 'Transforming Participation' Guide, a review of how we can improve the ability of NHS England and CCGs to commission for the same population, the directory of CCG development support ; a quality tool to support commissioners in identifying intervention which can contribute to reducing premature mortality .

12. Members of the NHS Commissioning Assembly came together for the 2013 annual event in late September to review progress to date, consider the key issues and themes we must work on together if we are to have the biggest impact on outcomes for patients and agree action for the future.

13. The event is a key point in the calendar to give assembly members a voice and influence. Immediate impact has included:

- inclusion of quantifiable ambitions for each NHS Outcome Framework domain in our future focus;
- earlier indication of the approach to planning in 2014/2015 and beyond (David Nicholson letter 10/10/13)
- feedback to the CEO recruitment process on hot issues, and
- increase in shared learning and networking via the new NHS Commissioning Assembly website, launched at the event.

14. Over the longer term the commissioning assembly work programme will incorporate the output of the four key themes discussed on the day; patients and the public; improving quality; service transformation and major service change, and ways of working in shared commissioning . Each has tangible deliverables aligned to the aims of the Assembly.

15. The NHS Commissioning Assembly Annual Report will be produced in Winter 2013/2014.

NHS England Mandate refresh

16. Productive discussions have taken place with the Secretary of State and Department of Health officials over the autumn regarding the Mandate for NHS England for 2014/2015. We anticipate that the Department of Health will publish the refreshed Mandate on 8 November. Professor Sir Malcolm Grant intends to write to the Secretary of State following the publication of the Mandate to set out commitments to improving outcomes for patients and some of our specific priorities for achieving them.

Medical revalidation

17. Following a successful Health Gateway Review, the role of Senior Responsible Owner for revalidation will pass from the Department of Health to NHS England. Dr Mike Bewick, Deputy Medical Director, with responsibility for medical revalidation will take on the role from 24 October 2013 and will chair the England Revalidation Implementation Board (ERIB) to oversee the implementation and standardisation of revalidation across some 160,000 doctors employed by around 700 designated bodies in England.

18. The annual report (2012/2013) on the implementation of medical revalidation was published on 25 October (http://www.revalidationsupport.nhs.uk/news_media.php). Whilst progress remains broadly on track in primary care, the report highlights an unacceptably low medical appraisal rate in secondary care. On the basis of this report, concern has been raised about the commitment of boards to the implementation of the necessary systems and processes. Sir Bruce Keogh has subsequently written to all responsible officers of acute sector NHS hospital trusts and foundation trusts.

19. The General Medical Council, the Care Quality Commission and Monitor will also be writing to Chairs, Chief Executives and Responsible Officers of all UK designated bodies drawing their attention to their statutory responsibilities to ensure that doctors are up to date and fit to practise, setting out an expectation that the frequency and quality of medical appraisals will be monitored and reported.

Urgent actions taken since the last meeting of the Board

20. I would like to report two urgent actions taken since the last meeting.

- Approval of a letter of commissioner support for the Phase 1 PFI Redevelopment of the Royal National Orthopaedic Hospital, Stanmore.
- Children and Young People's Improving Access to Psychological Therapies: approval of MOU with HEE North Central and East London.

21. Further details of both urgent actions are contained in annex A.

Sir David Nicholson
Chief Executive
October 2013

NHS England

Annex A: NHS England urgent action

Name of urgent action	Lead National Director(s)	Overview	Details	Board members approved	Date to be reported to Board
Royal National Orthopaedic Hospital	Barbara Hakin/Paul Baumann	Approval of a letter of commissioner support for the Phase 1 PFI Redevelopment of the Royal National Orthopaedic Hospital, Stanmore.	Business case reviewed by the Finance and Investment committee at its meeting on the 2nd of September. NHS England's function in relation to this business case is to confirm support for the income assumption and the Trust's long term financial model. This is not a commitment to any payment or guaranteed income levels and such this decision does not have a financial consequence for NHS England. Urgent decision agreed for the Chief Financial Officer to issue to the Trust a letter to confirm commissioner support.	Finance and Investment Committee members including Paul Baumann, Bill McCarthy, Moira Gibb and Ed Smith	8 November 2013
Children and Young People's Improving Access to Psychological Therapies programme MOU	Sir Bruce Keogh	Approval of MOU with HEE North Central and East London	The CYP IAPT Programme arranged for HEE NCEL to commission all training from pre-existing providers previously commissioned by SHAs for the academic year starting November 2013 HEE NCEL required a signed MOU and PO in place before issuing Service Level Agreements to all providers. The MOU required Board approval	Professor Sir Malcolm Grant (Chair) Ed Smith (Non-executive Director) Lord Victor Adewale (Non-Executive Director)	8 November 2013

Name of urgent action	Lead National Director(s)	Overview	Details	Board members approved	Date to be reported to Board
			Finalisation of MOU precluded Board review at September Meeting It was agreed to proceed with the MOU.		

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Leeds
CITY COUNCIL

Report author: Steven Courtney
Tel: 24 74707

Report of the Head of Scrutiny and Member Development

Report to Scrutiny Board (Health and Wellbeing and Adult Social Care)

Date: 28 November 2013

Subject: Government Mandate to NHS England: 2014-15 Refresh

	Yes	No
Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐	☒
Are there implications for equality and diversity and cohesion and integration?	☐	☒
Is the decision eligible for Call-In?	☐	☒
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: 10.4.3	☐	☒

Summary of main issues

1. On 9 November 2013, the Government published is Mandate to NHS England, setting out its priorities for 2014/15.

2. Copies of the NHS Mandate, a summary/ explanation of the mandate alongside NHS England's response are appended to this report for consideration.

Recommendations

3. The Scrutiny Board (Health and Wellbeing and Adult Social Care) is asked to consider the information presented and identify any further details that may be required at a future meeting.

Background documents[1]

4. None used.

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

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Department of Health

The Mandate

A mandate from the Government to NHS England: April 2014 to March 2015

November 2013

The Mandate

A mandate from the Government to NHS England: April 2014 to March 2015

Presented to Parliament pursuant to Section 13A(1) of the National Health Service Act 2006

Contents

Foreword 3

Introduction 4

1. Preventing people from dying prematurely 8

2. Enhancing quality of life for people with long-term conditions 10

3. Helping people to recover from episodes of ill health or following injury 14

4. Ensuring that people have a positive experience of care 17

5. Treating and caring for people in a safe environment and protecting them from avoidable harm 21

6. Freeing the NHS to innovate 23

7. The broader role of the NHS in society 25

8. Finance 27

9. Assessing progress and providing stability 28

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Foreword

Since 1948, our NHS has been there whenever we have needed it. We have world-class doctors, nurses and other professionals who take on huge challenges with great ability, determination and courage to provide the best possible care and treatment.

However, the challenges which faced the NHS over the years have changed significantly compared with today. This means we now need to look at how we can ensure that long into the future, the NHS will be here, providing high quality, compassionate and joined-up care.

One of the biggest challenges facing the NHS today is an ageing population. People over 75 make up around 30 per cent of emergency hospital admissions, and because they can be the most vulnerable, this can be distressing for them and their families. It also puts undue strain on A&E and hospitals. And already one quarter of the population is living with a long-term condition, which may require extra attention because their needs are complex.

This is why this updated Mandate reflects the Government's priority to transform the way the NHS provides care for older people and those with complex needs – from a system which is largely reactive, responding when something goes wrong to a proactive service, which is centred around the needs of each individual patient.

To achieve this, we have set our ambition for GPs to be responsible for coordinating this patient-centred care, with mental health conditions being treated with the same importance as physical health, by making sure to involve patients and their carers in any decision about their treatment and care plans.

And above all, patients should expect to be cared for with dignity, compassion and respect.

Over the past year, we have had to confront tragedies and major failings in care at Mid Staffordshire, Morecambe Bay and Winterbourne View. In his report on Mid Staffordshire, Robert Francis QC said we need a 'real change in culture of all who work in the NHS – from top to bottom of the system – putting the patient first'.

The NHS must focus on compassionate care, where patients are put first. I have profound admiration for NHS and social care staff who have already started this culture shift. This mandate now challenges the NHS to build on all the great work it has already done to put patients at the heart of everything it does in order to be recognised globally as having the highest standards of care.

I am immensely proud of the NHS, its ability to face up to adversity and its ability to innovate and evolve. As Health Secretary, I will continue to challenge the NHS to transform how it cares, both in practice and in value. This will ensure that long into the future, the NHS will be here for us all.

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 mandate to NHS England[1] sets out our ambitions for how the NHS needs to improve. This Mandate covers the period from April 2014 to the end of March 2015 and carries forward all the existing objectives in the first Mandate to NHS England.[2]

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 NHS England.

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 England, and their mandate 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 NHS England, which shares with the Secretary of State for Health the legal duty to promote a comprehensive health service. NHS England 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. NHS England 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.

[1] Legally known as the National Health Service Commissioning Board

[2] https://www.gov.uk/government/publications/the-nhs-mandate

6. This mandate plays a vital role in setting out the strategic direction for NHS England 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 NHS England. The Mandate is therefore intended to provide the NHS with much greater stability to plan ahead.

7. NHS England is legally required to pursue the objectives in this document.[3] 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 NHS England 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 NHS England 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 NHS England is under specific legal duties in relation to tackling health inequalities and advancing equality. The Government will hold NHS England 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);
    - 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).

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

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 NHS England will seek to ensure that local NHS organisations are held to account through outcome rather than process objectives. As one of its **objectives**, NHS England 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. In this Mandate, we are challenging NHS England to make greater progress towards transforming patient care and safety and in tackling the growing pressures and demand on NHS services. Significant improvements are expected by:

    - taking forward the relevant actions set out in the further response to the Robert Francis QC public inquiry into the lessons from Mid Staffordshire NHS Foundation Trust;
    - taking forward the actions set out in the vulnerable older people's plan which will set out the Government's ambition for improved health for the whole population, starting with the most elderly and vulnerable in society; and
    - taking forward actions to deliver a service that values mental and physical health equally.

13. These build on the following priority areas where the Government 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;

    iv. preventing premature deaths from the biggest killers;

    v. furthering economic growth, including supporting people with health conditions to remain in or find work. NHS England is also expected to play a full role in supporting public service reform.

14. 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.

15. The Mandate is not exhaustive. As part of the changes in the relationship between the Government and the NHS, NHS England 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 NHS England between one mandate and the next.
16. In all it does, whether in the Mandate or not, whether supporting local commissioners or commissioning services itself, NHS England 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 NHS England.

1.2 Our ambition is for England to become one of the most successful countries in Europe at preventing premature deaths, and our **objective** for NHS England, working with CCGs, is to develop their contribution to the new system-wide ambition of avoiding an additional 30,000 premature deaths per year by 2020.

1.3 National and local government, NHS England, 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.

1.4 Only after many years of sustained effort and innovation will this ambition be realised. Along the way, NHS England'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 (taking account of the Pharmaceutical Price Regulation Scheme agreement), 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 a learning disability
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, NHS England'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 There are increasing pressures on the health and care service in England, which will become increasingly difficult to meet without the successful transformation of the way the health and care services provide for the population. This must be particularly true for those who are the oldest and most vulnerable. This requires primary care, especially general practice, to proactively support patients who are most at risk; keep them out of hospital wherever possible and; help people to live well and maintain their independence. Care for vulnerable older people cannot be provided through general practice alone, so we are asking NHS England to explore how better integrated out of hospital care can improve care for this group, and the wider population. As part of this objective, NHS England should take forward the actions and the ambitions of the vulnerable older people's plan (which is subject to agreement on affordability with NHS England), with rapid progress to be made from April 2014.

2.5 In 2013, the new 111 phoneline was introduced for non-emergency care. By March 2015, we expect NHS England 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.

2.6 NHS England'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 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.

2.7 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. NHS England'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. NHS England 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.

2.8 As a leader of the health system, NHS England 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.

2.9 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.

2.10 In taking forward this **objective**, we are asking NHS England to work with local Government and other key partners to take forward their commitments in Integrated Care and Support: Our Shared Commitment.[4] This includes supporting the integration pioneers who are exploring different approaches to providing better care and breaking down the barriers that prevent transformational change happening at scale and pace. 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.

2.11 To support the ambition that each area moves to a wholly integrated approach to health and care by 2018, the Government has created the health and social care Integration Transformation Fund.[5] For 2015/16, this fund will make available £3.8bn to support health and care services to work more closely together. This will improve outcomes for people and deliver better value for money. NHS England needs to deliver the best possible foundation for the Fund's implementation, working in partnership with local authorities and local health and wellbeing boards.

2.12 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

[4] https://www.gov.uk/government/publications/integrated-care

[5] http://www.england.nhs.uk/2013/10/18/ccgs-issue-44-181013/#itf

is that the diagnosis, treatment and care of people with dementia in England should be among the best in Europe.

2.13 The **objective** for NHS England 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.

2.14 NHS England have agreed a national ambition for diagnosis rates that by 2015 two-thirds of the estimated number of people with dementia in England should have a diagnosis, with appropriate post-diagnosis support. Better dementia diagnosis will improve the lives of people with the condition and give them, their carers and professionals the confidence that they are getting the care and treatment they need. NHS England 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 in 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 NHS England 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 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. NHS England'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. NHS England'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. Recent reports have highlighted a particular challenge around mental health crisis intervention. Only by working with key partners, including the police, can we ensure that people with mental health problems get the care they need in the most appropriate setting. To bring about the transformational change necessary, we expect NHS England to make rapid progress, working with CCGs and other commissioners, to help deliver on our shared goal to have crisis services that, for an individual, are at all times as accessible, responsive and high quality as other health emergency services. This includes ensuring there are adequate liaison psychiatry services. We expect every community to have plans to ensure no one in crisis will be turned away, based on the principles set out in the soon to be published Mental Health Crisis Care Concordat.

3.7 This will also 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. NHS England 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%. They will also begin planning for country wide service transformation of children and young people's IAPT. NHS England will work with stakeholders to ensure implementation is at all times in line with the best available evidence.

3.8 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. The Department of Health and NHS England are committed to ending this and believe that implementing new access and/or waiting time standards is vital in order to have true parity of esteem. We expect NHS England to work with the Department of Health and other stakeholders to develop a range of costed options in order to implement these standards starting from April 2015, with a phased approach depending on affordability.

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)
Improving recovery from injuries and trauma
3.3 Survival 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 The Government's response to the Francis Inquiry will seek to ensure that the commissioning, delivery, monitoring and regulation of healthcare brings about a transformational change that focuses on achieving reliably safe and high quality care, that puts patients at its heart and where compassionate care and patient experience are as important as clinical outcomes. NHS England's **objective** is to take forward the actions they have agreed in this response, working closely with its partners to achieve change with significant progress expected in 2014/15.

4.5 The Government has now issued a full and detailed response to the appalling abuse that was witnessed at Winterbourne View private hospital. NHS England'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. This includes NHS England taking forward those actions which they signed up to in the final report and concordat.[6] 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.

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[6] Winterbourne View Review Concordat: Programme of Action – Published December 2012
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127312/Concordat.pdf.pdf
Transforming care: A national response to Winterbourne View Hospital. Department of Health: Final Report
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127310/final-report.pdf

4.6 Our ambition stretches beyond ensuring that all parts of the health and care system will satisfy minimum standards of care. NHS England'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 NHS England is required to promote the NHS Constitution in carrying out its functions. NHS England also has a statutory duty as to promoting education and training, to support an effective system for its planning and delivery. They 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 NHS England 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 NHS England should ensure that much more regular feedback on the 'friends and family test' becomes the norm.

4.9 Part of this objective is for NHS England 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; general practice and community and mental health services by the end of December 2014; and the rest of NHS funded services by the end of March 2015. 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 NHS England, 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 NHS England to work with partner organisations to ensure that the NHS:

- takes forward the pledges they signed up to in Better health outcomes for children and young people: Our pledge,[7] to improve the physical and mental health outcomes for all children and young people;
- offers women the greatest possible choice of providers;

[7] https://www.gov.uk/government/publications/national-pledge-to-improve-children-s-health-and-reduce-child-deaths

- 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 NHS England's commitment to its full participation in local safeguarding arrangements for vulnerable children and adults. We will work with NHS England, 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. NHS England'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. NHS England's **objective** is to uphold these rights and commitments, and where possible to improve the levels of performance in access to care.

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 Children and young people's experience of outpatient services
Improving people's experience of integrated care
4.9 People's experience of integrated care

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, as highlighted by the Berwick Review on patient safety.[8]

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 NHS England'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. NHS England 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.

8 https://www.gov.uk/government/publications/berwick-review-into-patient-safety

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 Deaths from venous thromboembolism (VTE) related events
5.2 Incidence of healthcare associated infection (HCAI) **i** Incidence of MRSA **ii** Incidence of C. difficile
5.3 Proportion of patients with 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 NHS England 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 NHS England which is about empowering individuals and organisations at the front line of the NHS. We welcome NHS England's commitment to support improved outcomes, including by understanding and responding to the needs and preferences of patients and communities locally.

6.2 NHS England'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 NHS England to account for achieving this; and it will be supported by a process of comprehensive feedback for assessing their 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. Following the CCG authorisation process, NHS England has a vital role in ensuring that CCGs meet any conditions placed on them and assuring themselves of compliance with those terms.

6.4 The objectives in this mandate can only be realised through local empowerment. NHS England'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, NHS England'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 has published a Choice Framework,[9] following consultation, to help patients understand the choices they can expect to have, and NHS England is working further with Monitor on how choice can best be used to improve outcomes for patients;
- working with Monitor to support the creation of a fair playing field,[10] so that care can be given by the best providers, whether from the public, independent or voluntary sector. This calls for NHS England 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. Similarly, this Government is commissioning an evaluation to assess the extent to which our vision and underlying policies of the 2012 Health and Social Care Act have been implemented, and what their effects have been. The Health Reforms Evaluation Programme is a long term project that will start in summer 2014 and complete by summer 2017.

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9 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216981/2012-13-Choice-Framework.pdf

10 http://www.monitor-nhsft.gov.uk/fpfr

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, via the Strategy for UK Life Sciences;[11] by adopting and spreading new technologies; and through exporting innovation and expertise internationally. NHS England is committed to delivering the recommendations in the Innovation, Health and Wealth Report[12] to improve outcomes for individuals, carers and families.

7.2. NHS England'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. NHS England'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;

11 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/32457/11-1429-strategy-for-uk-life-sciences.pdf

12 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213204/Creating-Change-IHW-One-Year-On-FINAL.pdf

- 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 NHS England's revenue budget for 2014/15 is £97,952 million (of which £1,929 million is for delivery of the section 7A agreement with the Secretary of State) and its capital budget is £320 million.[13, 14] The indicative revenue budget for 2015/16 is £99,909 million and its indicative capital budget is £220 million. 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, NHS's England'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. It is in this context that the Government is committed to ensuring the development of a fair and transparent identification and payment system for overseas visitors and migrants accessing the NHS. We will, therefore, continue to work with providers and NHS England to identify cost-effective ways of maximising the recovery of costs incurred through the treatment of chargeable patients (as to be defined by the forthcoming legislation). NHS England 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 NHS England.

8.2 NHS England is 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 NHS England'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.

[13] 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).

[14] NHS England is 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, are set out in an agreement made under section 7A of the NHS Act 2006 which can be found at: https://www.gov.uk/government/publications/public-health-commissioning-in-the-nhs-from-2013

9. Assessing progress and providing stability

9.1 The Government is formally setting NHS England 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.[15] We will assess annually the success of NHS England against the progress it makes against this mandate, and in carrying out other legal duties and functions.

9.2 NHS England directly commissions 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. NHS England has an important responsibility to drive improvements in the quality of primary care, reflecting the vital role that stronger primary care plays in supporting delivery of the objectives across this mandate.

9.3 The Department of Health will hold NHS England 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 NHS England 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, NHS England must report on its progress, and the Government will publish an annual assessment of NHS England'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.

9.5 This mandate provides democratic legitimacy for the work of NHS England. 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.

[15] 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.

Department
of Health

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Department of Health

The Mandate explained

NHS England is the independent organisation now responsible for managing the budget and the day to day workings of the NHS. It supports clinical commissioning groups – local groups of GPs and other health professionals who now buy most NHS services – to improve patient care.

To make sure the taxpayer has a say in how this money is spent, the Government provides direction and ambitions for the NHS through a document called 'the Mandate'.

By listening to the needs of patients, carers and families, NHS England is responsible for deciding the best way to achieve these ambitions, working across the health and social care system.

The Mandate is published every year to make sure it is up-to-date, but it also sets long term ambitions to make sure the NHS is always there and always improving. NHS England must try to achieve these ambitions and the Secretary of State for Health will hold them to account for improving care for people.

Ambitions for the NHS

By March 2015, the Government expects NHS England to make improvements in the quality of care it offers. They should:

1. Help people live well for longer
2. Manage ongoing physical and mental health conditions
3. Help people to recover from episodes of ill health or following injury
4. Make sure people experience better care
5. Provide safe care
6. Free the NHS to innovate;
7. Support the NHS to play a broader role in society;
8. Make better use of resources.

'The Mandate - at a glance' provides a summary of what the Mandate should mean for patients and the public.

You can find the current version of the Mandate and additional documents at https://www.gov.uk/government/publications/nhs-mandate-2014-to-2015 or get in touch at: mandate-team@dh.gsi.gov.uk

The Mandate 2014/15 at a glance

The Government wants NHS England to:

1. Help people to live well for longer

NHS England should play its part in the ambition to save an additional 30,000 lives per year by 2020 by:

- helping ensure patients receive an early diagnosis to prevent people developing more serious conditions;
- working to give people the right treatment when they need it;
- making sure all hospitals are as good as the best hospitals;
- supporting NHS staff to make every contact with patients an opportunity to help people stay in good health.

2. Manage ongoing physical and mental health conditions

The NHS should be amongst the best in Europe at supporting people with long term health conditions so that people can experience a better quality of life. NHS England should:

- involve people in their own care and treatment to ensure vulnerable people receive safe, appropriate, high quality care;
- make better use of technology so patients can, for example, order prescriptions online;
- work to improve care across different services;
- improve diagnosis, treatment and care for people with dementia.

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

NHS England should shine a light on variation in care and unacceptable practice in the NHS, share best practice and improve services. They should:

- Improve transparency by publishing more data and involve local people in decision-making;
- put mental health on a par with physical health, close the current health gap and support people who fall into crisis;
- work on developing access and waiting time standards for all mental health services for a rolling implementation beginning in April 2015.

4. Make sure people experience better care

Patients should experience better care, not just better treatment, particularly older people and those at the end of their lives. NHS England should:

- measure how people feel about their care by asking if you would recommend a service to your friends or family;
- improve the standards of care and experience for women during pregnancy;
- support children and young people with specific health and care needs;
- provide good quality care seven days of the week;
- implement the lessons learnt from the Mid-Staffordshire and Winterbourne View scandals.

5. Provide safe care

NHS England should continue to reduce the number of incidents of avoidable harm and embed a culture of patient safety through improved reporting of incidents. They should also take action to identify those groups known to be at a high risk of suicide.

6. Free the NHS to innovate

NHS England must get the best health outcomes for patients by:

- strengthening local autonomy;
- promoting innovation in the NHS;
- controlling financial incentives to drive up the quality of NHS services;
- lead the continued drive for efficiency savings
- ensure there is a fair playing field for providers of NHS care.

7. Support the NHS to play a broader role in society

NHS England should promote and support participation by NHS organisations and patients in research, to improve outcomes and contribute to economic growth. They should also make partnership working with local councils, the police, job centres, housing associations and others a success to improve care for all.

8. Making better use of resources

NHS England will be given £98 billion in 2014/15 to achieve the objectives in the Mandate. They must ensure good financial management of this money.

NHS England

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12 November 2013

Dear Jeremy

Government Mandate to NHS England: 2014-15 Refresh

We welcome the refreshed mandate to NHS England for 2014-15. This reinforces the firm foundations established by the current mandate and on which we have built a strong partnership with the Department of Health to act together in the best interests of patients and the public. We look forward to building on this to secure the significant improvements in health outcomes we all want to see.

One of the objectives of the Government's health reforms was to release the power of clinical leadership at all levels within the NHS and to distance the Government from its day to day operational management. The mandate establishes the Government's strategic objectives for the NHS, retaining a clear focus on outcomes rather than inputs and processes, and empowering commissioners to think creatively about how local populations are best served.

The new healthcare commissioning system has only been in place for seven months, yet real progress has been already made. Commissioners are making full use of the newly conferred flexibility to respond to local need, especially for older people with long-term conditions. Many are developing tailored schemes to identify and treat undiagnosed illnesses, working directly in partnership with local authorities to ensure health and social care services are organised around patient needs.

That such progress should have been made in so short a time under circumstances of unprecedented difficulty following a reform process of exceptional complexity is testament to the skill, experience and dedication of everyone working across the NHS.

Our responsibility is to continue to support the commissioning system to make the most of the freedom that the mandate allows for the benefit of patients. In particular we are:

- **prioritising patients in everything we do**: this requires commitment to transparency of information so patients can play an active part in decisions regarding their own healthcare, and the public in decisions about the kind of NHS services they use. We are actively listening to patients and citizens and engaging them on issues that are important. For example, through our Call to Action we will have open and honest debate about the future shape of the NHS to meet rising demand. We are also seeking patient feedback on their experience of services via the Friends and Family Test. And we are creating a

new Citizens Assembly – a national network that will help design services and hold them to account;

- **empowering clinical leadership**: for example through the creation of the NHS Commissioning Assembly, set up to create shared leadership nationally and locally;

- **supporting our commissioners**: through excellent and affordable commissioning support services, both in strengthening NHS Commissioning Support Units but also developing the market to include voluntary and private sector providers;

- **promoting transparency and openness**: for example for the first time we are publishing consultant level clinical outcomes data for ten surgical specialties that will help further drive up quality and help patients make informed decisions; and

- **putting innovation at the heart of the NHS**: for example we have established 15 new Academic Health Science Networks to bring together NHS service users and providers with academic institutes and industry. Through collaboration and shared goals these networks will 'hot house' innovation to ensure it can spread quickly and successfully throughout the NHS.

We are fully committed to delivering the outcomes specified in the mandate. In particular we share the Government's ambition of putting mental health on a par with physical health. Our vision is for a real change in attitude towards mental health and the way services are delivered so people experience a holistic approach to their care. This will be driven forward by our **Parity of Esteem** programme and is an essential part of our approach to tackling health inequalities. Our **Urgent and Emergency Care Review** covers mental health, and we are committed to continuing to work with the Department in the development of the mental health crisis concordat. As part of our parity programme, we are committed to the development of costed options for access / waiting time standards for consideration to implement as part of the discussions for next year's mandate.

We are supportive of the strategic direction of Vulnerable Older People's Plan. Joint working is continuing between the Department of Health and NHS England on the details and to ensure alignment with NHS England's emergent long term strategy. In particular:

- As Robert Francis QC stressed in his report on Mid Staffordshire NHS Foundation Trust, a robust and well-functioning system of accountability in the NHS is a critical condition for creating a culture of safe, compassionate care. This needs to include strengthening the accountability that individual clinicians have for their patients' care.

- When patients are in hospital, it is important that they have a consultant who is responsible for overseeing their care. We are committed to ensuring a parallel system with GPs for out-of-hospital care. We wish to ensure at the earliest possible opportunity that vulnerable older patients have a named, accountable GP and to extend this approach thereafter to other patients with long term conditions or complex health needs.

- The ability to take full accountability for a patient's care will depend upon being able to ensure that the full range of primary and community services are tailored to meet the individual patient's needs and are provided in an integrated fashion based around the patient's agreed care plan. We are working through how to strengthen the authority and influence of accountable GPs in relation to these wider services.

We will continue to work closely with the Department of Health as the Vulnerable Older People's Plan is finalised. We need to ensure that the proposals remain outcomes focused, allow sufficient local flexibility for how they are delivered, and are affordable. Where the additional requirements included in the mandate refresh require additional investment, their implementation will be dependent upon the funding being made available.

Our ambitions for patients are not constrained by the mandate: NHS England is a dynamic new organisation and we are working above and beyond the mandate, across a wide range of areas and demonstrating significant progress and benefit.

- **Our radical 7-day service review** is looking at how we can offer a much more patient focussed service offering high quality care seven days a week that will help transform patient outcomes.

- **The new flexibility is empowering clinical commissioning groups (CCGs) to meet local need in different ways**: some have used clinical leadership to develop schemes to identify and treat undiagnosed conditions for those with the worst health outcomes. Others are putting in place structures with health and wellbeing board partners for integrated commissioning to ensure that services are organised around patient needs.

- **Outcomes**: as part of the next NHS planning round we will support local commissioners to develop ambitions for all five domains of the outcomes framework that reflect local need and are owned across health and wellbeing board partners. This will allow us for the first time to define a national level ambition of improvement for all five domains of the outcomes framework.

- **Evidence**: we will provide CCGs with a range of evidence based tools and resources to support commissioning for improved outcomes as well as working with providers delivering specialised services to ensure for the first time we have a set of national, consistent services standards.

- **Harnessing technology**: we will continue to embrace the opportunities created by technology, particularly to enhance the lives of those with long term conditions. We have made significant progress already, and have plans in place for further improvement:

    - our **Patient Online Programme** will support general practice to use technology to transform the service offer of the NHS, and empower patients and citizens to take greater control and make more informed choices about their care; and

    - **Paperless NHS** includes the E-referrals programme and a re-launch of Choose and Book which will make electronic referrals widely and

easily available to patients and their health professionals for all secondary care services by 2015.

- **Transparency and patient voice**: these are key to transforming customer service in health and care: patients, professionals and citizens need far better information about local services in order to provide meaningful feedback that in turn will help ensure they have the services they need and deserve. We will drive forward the work we have already started to develop a modern data service for the NHS and social care to improve the quality, efficiency, equity, and experience of care for all:

    - Our **Friends and Family Test** will be extended to cover GP practices, community and mental health services.

    - We will extend our programme of **publishing consultant level data** for ten specialties into non-surgical specialties.

    - Later this year new information about the **quality of care** provided by GP practice and associated health outcomes will be made available both as open data and also through public facing channels.

    - In **social care**, transparency measures relating to things such as pressure sores or drug errors for about 10,000 care homes collected by the NHS Choices website will be made available as open data in the summer of 2014.

    - Newly developed **Patient Centred Outcome Measurement (PCOM)** tools will provide new insights into how well services for people with 20 different rare and complex conditions are meeting the needs of their patients. These measures will expand the evidence base for the effectiveness of treatments, therapies and interventions and have the potential to really improve the quality of patient care.

- **Genomics:** whole genome sequencing has the potential to revolutionise cancer treatment, advance personalised medicine, and improve early diagnosis of rare diseases. We are working with the newly established Genomics England Limited to support the development of an approach to help accelerate the delivery of the Prime Minister's ambition for whole genome sequencing in this exciting and hugely important area of health. The NHS has a central role in this programme, for example, the use of data to support the programme and the clinical leadership that supports patient confidence in the programme.

Conclusion

We are all working within a new system where commissioning functions are devolved and where responsibility is shared across a number of bodies. We look forward to continuing to work closely with you to ensure that the system delivers on the Government's objectives for the new model, as specified in the refreshed mandate,

and in ensuring best value for patients and taxpayers for every pound invested in the NHS and ensuring that the NHS delivers continuing improvements in outcomes for all patients.

Yours sincerely

Sir Malcolm Grant
Chair
NHS England

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Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 24 74707

Report of Head of Scrutiny and Member Development

Report to Scrutiny Board (Health and Well-being and Adult Social Care)

Date: 28 November 2013

Subject: Work Schedule – November 2013

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

1 Purpose of this report

1.1 The purpose of this report is to consider the Scrutiny Board's work schedule for the remainder of the municipal year, 2013/14.

2 Main issues

2.1 At its meeting on 21 June 2013, a number of potential topics/ work programme areas were highlighted and discussed as potential matters for the work programme. At that meeting the Scrutiny Board (Health and Wellbeing and Adult Social Care) identified the following themes to form the broad direction of the its work programme for 2013/14:

- Narrowing the Gap;
- Service quality;
- Urgent and emergency care;
- Progress / implications associated with achieving NHS Foundation Trust status;
- Information flows/ data sharing

2.2 At its meeting on 31 July 2013, the Scrutiny Board was presented with and discussed matters relating to:

- Progress / implications associated with achieving NHS Foundation Trust status;
- Urgent and emergency care;

2.3 At that meeting, the Scrutiny Board also considered and agreed to undertake further work around the following requests for scrutiny:

- Men’s health;
- Dermatology; and,
- Children’s Epilepsy Surgery.

2.4 At its meetings on 25 September 2013, the Scrutiny Board considered details relating to NHS England’s (draft) NHS Funding Allocations Policy and Leeds’ Better Lives Programme – specifically related to the future provision of residential care and day services for older people.

2.5 Work undertaken to translate the above areas into a planned and more detailed work schedule is presented at Appendix 1. Further refinement is likely to be necessary as the work programme develops – specifically taking into account comments from the Scrutiny Board.

2.6 It should be noted that given the range of issues being considered by the Scrutiny Board, it will be necessary to hold a number of working groups looking at specific issues/ matters.

Narrowing the Gap

2.7 As reported above, at its meeting on 21 June 2013 the Scrutiny Board identified ‘Narrowing the Gap’ as a specific theme for its 2013/14 work programme. The draft work schedule (attached at Appendix 1) identifies three potential meeting dates (February, March and April 2014) to consider matters associated with this particular theme. As agreed at the Scrutiny Board meeting in October 2013, it is intended to incorporate any specific matters/ issues associated with ‘men’s health’ relevant to the matters under consideration at these meetings.

2.8 However, as yet, the precise focus of the ‘narrowing the gap’ discussions is yet to be agreed/ defined. One suggestion could be to identify no more than 3 priority areas from the JHWS (attached at Appendix 2) and consider specific progress in relation to one area per session: Alternatively, the Scrutiny Board consider different elements of a single priority area over three sessions.

2.9 It is also worth noting that an independent peer review around the Council’s approach to reducing the impact of smoking across the City is likely to take place in early 2014. Subject to the timing of the peer review and any associated report, the Scrutiny Board might consider using one of the meeting sessions to review progress against the tobacco action plan, the previous Scrutiny Board recommendations (detailed in its report, May 2012) and the outcome of the scheduled peer review.

2.10 The Scrutiny Board is specifically asked to consider this in more detail and agree the focus of its work in relation to ‘narrowing the gap’.

Health Service Developments Working Group

2.11 As previously report, the Health Service Developments Working Group met on 6 September 2013, where consideration was given to a number of matters, including:

- Inpatient maternity and neonatal services reconfiguration review – update
- Individual Funding Requests (IFR)

2.12 Notes of the meeting are being finalised and will be presented to a future meeting.

2.13 It should also be noted that revised terms of reference for the working group need to completed and reported to a future meeting of the Scrutiny Board, along with confirmation of future meeting dates for the remainder of the municipal year.

Dermatology Working Group

2.14 At its meeting on 31 July 2013, the Scrutiny Board agreed to undertake further work associated with a request for scrutiny from the Leeds Dermatology Patient's Panel.

2.15 A working group meeting is scheduled for 20 November 2013 to discuss proposed changes to the middle-grade medical rotas at Leeds Teaching Hospitals NHS Trust (LTHT) with members of the LDPP and Trust representatives. A report on the outcome of that meeting will be presented to a future Board meeting and a verbal update will be provided on 28 November 2013 if required.

3 Recommendations

3.1 Members are asked to consider and comment on the details in this report and;

3.1.1 Identify and agree the focus of its work in relation to 'narrowing the gap'

3.1.2 Agree or amend the draft work schedule presented at Appendix 2.

4. Background papers[1]

4.1 None used

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

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Scrutiny Board (Health and wellbeing and Adult Social) Work Schedule for 2013/2014 Municipal Year

	Schedule of meetings/visits during 2013/14		
Area of review	**June 2013**	**July 2013**	**August 2013**
Narrowing the Gap			
Service quality			
Urgent and emergency care		• Introductory report to the Board	
Aspiring NHS Foundation Trusts in Leeds		• Report to the Board. Contributions from: • NHS Trust Development Authority • LTHT • Leeds Community Healthcare • Leeds CCGs	
Information flows/ data sharing			
Request for Scrutiny – Dermatology		• Request for Scrutiny	
Request for Scrutiny – Men's Health		• Request for Scrutiny	
Request for Scrutiny – Children's epilepsy surgery		• Request for Scrutiny	
Other	• Health and Wellbeing of people living in Hyde Park and the need for local Schools and Community to access Sports and Leisure Facilities		
Call-in			
Briefings	• Best Council Plan 2013-17 • 2011 Census – comparing results across Leeds		
Budget & Policy Framework Plans			
Recommendation Tracking			

Scrutiny Board (Health and wellbeing and Adult Social) Work Schedule for 2013/2014 Municipal Year

	Schedule of meetings/visits during 2013/14		
Area of review	**June 2013**	**July 2013**	**August 2013**
Performance Monitoring	• 2012/13 Q4 Performance Report		
Budget			

Scrutiny Board (Health and wellbeing and Adult Social) Work Schedule for 2013/2014 Municipal Year

	Schedule of meetings/visits during 2013/14		
Area of review	**September 2013**	**October 2013**	**November 2013**
Narrowing the Gap			
Service quality			
Urgent and emergency care			
Aspiring NHS Foundation Trusts in Leeds			
Information flows/ data sharing			
Request for Scrutiny – Dermatology			• Report to a working group meeting – 20 November 2013.
Request for Scrutiny – Men's Health			
Request for Scrutiny – Children's epilepsy surgery			
Fundamental Review of NHS Allocations Policy	• Introductory report to the Board	• Report to the Board presenting a range of input/ information, including: • Funding of health & social care in Leeds • Integration Pioneers update	• Further report to the Board presenting a range of information. • Report to the Board presenting an update on the work of Leeds Health and Social Care Transformation Board

Scrutiny Board (Health and wellbeing and Adult Social) Work Schedule for 2013/2014 Municipal Year

	Schedule of meetings/visits during 2013/14		
Area of review	**September 2013**	**October 2013**	**November 2013**
Other	• Request for Scrutiny – Better Lives for People of Leeds: The Future of Day Care Services for Older People • Health Service Developments Working Group	• Report to the Board presenting details associated with the CQC's hospital inspection programme.	• Health Service Developments Working Group **– *not held*** • Report to the Board presenting an update on NHSE's Call to Action • Report to the Board presenting details of NICE consultation • Report to the Board presenting details associated with the Woodlands GP surgery, Chapeltown (TBC)
Call-in	• Better Lives for People of Leeds: The Future of Residential Services for Older People		
Briefings		• NHS England – Call to Action	• Report to the Board presenting the NHS Mandate & NHSE response
Budget & Policy Framework Plans			
Recommendation Tracking			
Performance Monitoring			
Budget			

Scrutiny Board (Health and wellbeing and Adult Social) Work Schedule for 2013/2014 Municipal Year

	Schedule of meetings/visits during 2013/14		
Area of review	**December 2013**	**January 2014**	**February 2014**
Narrowing the Gap			• Report to the Board (specific area to be determined)
Service quality	• Report to the Board on the Better Lives Programme • Quality Accounts working group (date to be confirmed)	• Quality Accounts working group (date to be confirmed)	• Report to the Board on the work of the Leeds Adult Safeguarding Board • Quality Accounts working group (date to be confirmed)
Urgent and emergency care	• Report to the Board including: • Update on the national review • Update from the Leeds Urgent Care Board • Update on additional A&E funding		
Aspiring NHS Foundation Trusts in Leeds		• Update report to the Board.	
Information flows/ data sharing			
Request for Scrutiny – Dermatology		• Report on the outcome of the working group held 20 November 2013	
Request for Scrutiny – Men's Health			• Incorporate into 'Narrowing the Gap' considerations
Request for Scrutiny – Children's epilepsy surgery		• Report to the Board	
Fundamental Review of NHS Allocations Policy		• Report to the Board on outcome of NHS England Funding Allocation Decision & implications of NHS England Planning Guidance	

Scrutiny Board (Health and wellbeing and Adult Social) Work Schedule for 2013/2014 Municipal Year

	Schedule of meetings/visits during 2013/14		
Area of review	**December 2013**	**January 2014**	**February 2014**
Other	• Report to the Board on Chief Medical Officer report 2013 • DPH Annual Report 2013 • Update report to the Board on NHSE's Call to Action	• Health Service Developments Working Group (date to be confirmed)	• Report to the Board on the outcome of the CQC's inspection of LTHT (timing subject to confirmation)
Call-in			
Briefings			
Budget & Policy Framework Plans			
Recommendation Tracking			
Performance Monitoring			
Budget	• Budget proposals presented to Executive Board (TBC)	• Budget proposals presented to Executive Board (TBC)	

Scrutiny Board (Health and wellbeing and Adult Social) Work Schedule for 2013/2014 Municipal Year

	Schedule of meetings/visits during 2013/14		
Area of review	**March 2014**	**April 2014**	**May 2014**
Narrowing the Gap	• Report to the Board (specific area to be determined)	• Report to the Board (specific area to be determined)	
Service quality	• Update report to the Board on the Better Lives Programme – implementation of Executive Board decision around older people's residential care homes and day services • Workshop on Leeds response to Francis and Winterbourne View reports (TBC) • Quality Accounts working group (date to be confirmed)		
Urgent and emergency care		• Report to the Board including: • Update on the national review • Update from the Leeds Urgent Care Board • Review of Winter Plan arrangements	
Aspiring NHS Foundation Trusts in Leeds		• Update report to the Board.	
Information flows/ data sharing			
Request for Scrutiny – Dermatology			• Progress report to a working group meeting – date to be confirmed
Request for Scrutiny – Men's Health	• Incorporate into 'Narrowing the Gap' considerations	• Incorporate into 'Narrowing the Gap' considerations	
Request for Scrutiny – Children's epilepsy surgery			
Fundamental Review of NHS Allocations Policy			

Scrutiny Board (Health and wellbeing and Adult Social) Work Schedule for 2013/2014 Municipal Year

	Schedule of meetings/visits during 2013/14		
Area of review	**March 2014**	**April 2014**	**May 2014**
Other	• Health Service Developments Working Group (date to be confirmed)	• Review of Partnership Working – Leeds Health and Wellbeing Board	• Health Service Developments Working Group (date to be confirmed)
Call-in			
Briefings			
Budget & Policy Framework Plans			
Recommendation Tracking			
Performance Monitoring			
Budget			

Leeds Joint Health and Wellbeing Strategy 2013-2015

Vision for health & wellbeing: Leeds will be a healthy and caring city for all ages

Principle in all outcomes: People who are the poorest, will improve their health the fastest

Indicator: Reduce the differences in life expectancy between communities

Outcomes	Priorities	Indicators
People will live longer and have healthier lives	1. Support more people to choose healthy lifestyles 2. Ensure everyone will have the best start in life 3. Ensure people have equitable access to screening and prevention services to reduce premature mortality	1. Percentage of adults over 18 that smoke 2. Rate of alcohol related admissions to hospital 3. Infant mortality rate 4. Excess weight in 10-11 year olds 5. Rate of early death (under 75s) from cancer. 6. Rate of early death (under 75s) from cardiovascular disease
People will live full, active and independent lives	4. Increase the number of people supported to live safely in their own home 5. Ensure more people recover from ill health 6. Ensure more people cope better with their conditions	7. Rate of hospital admissions for care that could have been provided in the community 8. Permanent admissions to residential and nursing care homes, per 1,000 population 9. Proportion of people (65 and over) still at home 91 days after discharge into rehabilitation 10. Proportion of people feeling supported to manage their condition
People's quality of life will be improved by access to quality services	7. Improve people's mental health & wellbeing 8. Ensure people have equitable access to services 9. Ensure people have a positive experience of their care	11. The number of people who recover following use of psychological therapy 12. Improvement in access to GP primary care services 13. People's level of satisfaction with quality of services 14. Carer reported quality of life
People will be involved in decisions made about them	10. Ensure that people have a voice and influence in decision making 11. Increase the number of people that have more choice and control over their health and social care services	15. The proportion of people who report feeling involved in decisions about their care 16. Proportion of people using NHS and social care who receive self-directed support
People will live in healthy and sustainable communities	12. Maximise health improvement through action on housing 13. Increase advice and support to minimise debt and maximise people's income 14. Increase the number of people achieving their potential through education and lifelong learning 15. Support more people back into work and healthy employment	17. The number of properties achieving the decency standard 18. Number of households in fuel poverty 19. Amount of benefits gained for eligible families that would otherwise be unclaimed 20. The percentage of children gaining 5 good GCSEs including maths & English 21. Proportion of adults with learning disabilities in employment 22. Proportion of adults in contact with secondary mental health services in employment

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