Department of Health

The Government's response to the consultation on the draft mandate to the NHS Commissioning Board

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The Government's response to the consultation on the draft mandate to the NHS Commissioning Board

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Introduction

1. Under the Health and Social Care Act 2012, the Government must set objectives for the delivery of NHS care by the NHS Commissioning Board in a 'mandate'. The Mandate is a multi-year document setting rolling objectives, but refreshed annually following consultation.

2. On 4th July 2012 the Government launched *Our NHS care draft objectives: a draft mandate to the NHS Commissioning Board*, to help decide our approach for the first ever mandate. The consultation ran for 12 weeks, in line with the Government Code of Practice, and closed on the 26th September 2012.

3. This document summarises the main findings and conclusions from the consultation and explains the approach the Government took to developing the final mandate.

1. The consultation

Who contributed and how?

1.1 During the consultation, we were able to reach out to a broad audience in a range of ways:

- We had a series of discussions with stakeholders from the health and care community, ranging from small meetings to larger-scale events;
- we encouraged organisations to hold discussions with their members to inform their own response;
- we received 212 consultation responses in the form of letters, email responses and feedback via the website;
- over 24,000 unique page views of the mandate website http://mandate.dh.gov.uk/; and
- 80 people responded to an online survey which we set up to poll what people thought about the objectives.

1.2 A breakdown of the organisations that responded can be found at annex A. Responses were also received from people who use health and care services, carers, NHS staff and the wider health and care workforce. We analysed all the feedback we received: website comments, the feedback forms, letters submitted and summaries of events and formal consultation responses.

1.3 We would like to thank those who took the time to contribute. It enabled us to hear many different perspectives and views and the feedback helped shape the approach we took to the final mandate.

2. Summary of responses and key changes

What we heard

2.1 The consultation revealed overwhelming support for developing the mandate as a robust mechanism for holding the NHS Commissioning Board to account for the money it spends and the outcomes it achieves. Organisations such as Alliance Boots recognised that "*accountability is a critical aspect of the mandate*" whilst the Royal College of Nursing felt that "*the document will have a fundamental role in shaping the relationship and system of accountability between the Secretary of State for Health and the NHS Commissioning Board. The Board will take on a large range of statutory duties and the Mandate will need to be very carefully crafted to ensure that it captures the wide range of NHS Commissioning Board responsibilities and can practically offer a system to monitor its performance across these different areas*."

2.2 Most respondents were extremely supportive of taking an outcomes based approach, and of the Government's commitment to put patients, carers and the public at the heart of the NHS. However, people also felt that the draft mandate failed to meet the scale of our ambitions. We heard that the mandate lacked the vision required to tackle the big challenges facing the NHS, and to bring about the changes needed.

Key changes

2.3 In developing the final mandate, we have made a number of significant changes to reflect what we have heard through the consultation. There are four main changes.

2.4 The **first** change is to make clear the Government's **vision and long-term agenda** in transforming the NHS to **improve outcomes**. The 2020Health.org expressed concern "*that it [the draft mandate] does not set out the Secretary of State's vision for the NHS... This document should be a catalyst for change leading to improvements for patients in the NHS*." Many organisations told us that the mandate should set the overall direction and overarching goals for the NHS, based on a core set of priorities. In response and to bring the NHS in line with the best, the Government wants to see the greatest rate of progress for:

i. improving standards of care, not just treatment, especially for older people and at the end of people's lives;

ii. improving the diagnosis, treatment and care of those with dementia;

iii. supporting people with long term physical and mental health conditions to live fulfilling and independent lives;

iv. preventing premature deaths from the five biggest killers; and

v. furthering economic growth, including supporting people with health conditions to remain in or find work.

2.5 The **second** change is to restructure the document around the domains of the **NHS Outcomes Framework** and **embed the objectives** under the **relevant domain**. The majority of respondents were clear that basing the mandate around the NHS Outcomes Framework will provide a consistent and coherent approach to improving outcomes. For example, NICE said "*that the mandate should be structured in a more coherent way. We recommend that the list of objectives should be translated into a model that shows how objectives …. connect to each other and contribute in combination to the mandate's pre-eminent, NHS outcomes framework related objectives. Such an approach would help with communication about the mandate within the NHS and beyond*."

2.6 The **third** is to place a **stronger focus** on **outcomes** and set **stretching ambitions** to be among the **best in Europe** based on what people told us was important. Our original proposal to set quantified levels of ambition defined in life years or quality-adjusted life years (QALYs) was criticised by some as too complex. We have listened and we think comparing England with other European countries, in relation to key priority areas, would be a more effective way to express the scale of our ambition and inspire the NHS to be the best. The Royal College of Anaesthetists suggested "*a comparison tool with other health systems in Europe may be helpful and stretch the ambition further to place the UK nearer the top of the performance table*."

2.7 The **fourth** change is to **simplify** and **shorten** the mandate to make it more **accessible**. We agree with the majority of organisations who felt that Government priorities should be communicated clearly through the mandate to the public so that Government, the NHS Commissioning Board, local commissioners and providers can be held to account accordingly. The Trade Union side of the Social Partnership Forum also felt that it was "*important that NHS patients, users and members of staff have a clear understanding of the NHS Commissioning Board's role in delivering the Government's vision on health care and an explanation of how the Board will be held to account*."

2.8 The following section provides a more detailed analysis of the consultation responses based on the consultation questions. These have been grouped into the following themes:

i. Our approach to the mandate (Q1 – Q3)

ii. Assessing progress (Q4 – Q5)

iii. Improving our health and healthcare (Q6 – Q8)

iv. Putting patients first (Q9 – Q10)

v. The broader contribution of the NHS (Q11)

vi. Effective commissioning (Q12)

3. Our approach to the mandate (Q1 – Q3)

Q1. Will the mandate drive a culture which puts patients at the heart of everything the NHS does?

Q2. Do you agree with the overall approach to the draft mandate and the way the mandate is structured?

Q3. Are the objectives right? Could they be simplified and/or reduced in number; are there objectives missing? Do they reflect the over-arching goals of NHS commissioning?

Overall approach and structure

3.1 There was overwhelming support for using the mandate to transform outcomes and put people, carers and families at the heart of the NHS. We heard that the mandate was an important means to drive this change. Monitor suggested it could be a "*powerful and transformative document*" to inspire and challenge the NHS. However, the prevailing view was that the draft lacked a sense of priorities and was too technocratic, long and transactional in tone to realise this ambition. A coalition of Mental Health charities said that "*the mandate, though well intentioned, is a complex and technical looking document*". Similarly, whilst welcoming the draft mandate, Prostate Cancer UK were "*concerned at the length of the draft mandate. We believe that the current draft is not as succinct a document as we had originally hoped which we fear will serve to dilute its effectiveness*." We have therefore refocused the final mandate to set a clear direction with stretching goals.

3.2 In shortening the final mandate, we recognised that there is a tension around the level of detail required for accountability purposes. Some respondees wanted the mandate to include more detailed and target driven objectives. The final mandate therefore seeks to strike the right balance between a visionary and succinct document, but also including the detail required to assess progress and hold the NHS Commissioning Board to account for achieving the objectives.

Strengthening the mandate

3.3 In revising the mandate, we have sought to embrace the opportunities, which the consultation identified. These included:

- Setting clear expectations for the NHS, articulating the outcomes it should achieve but without being prescriptive about how it should be done. The NHS Commissioning Board Authority suggested that "*by setting the objectives at this more ambitious level, the Government will challenge the NHS commissioning system to account for progress against each objective in its widest sense, and avoid inadvertently narrowing their focus*."
- Embedding the principle of local autonomy and innovation, and empowering patients, service users and carers. NHS Clinical Commissioners viewed the mandate as "*a welcome first start and in broad keeping with the Government's principles for devolution in the NHS, it supports CCG autonomy in relation to commissioning, emphasising that clinicians and patients are at the heart of decision making*."
- Setting the tone for, and encouraging the right behaviours and culture across the health and care system. The Health Foundation "*believe it is essential that the mandate makes explicit this change in mindset, culture and behaviour, and systems in which services aim to minimise harm and support patients and clinicians to work in partnership*."
- Setting a longer term agenda and providing stability for the NHS to plan ahead and innovate. Turning Point were clear that the mandate "*needs to remain clear and resolute in its purpose to provide the stability that is needed by the system*."
- Focusing and driving forward an outcomes based approach and placing greater emphasis on putting patients, carers and families at the heart of the NHS. The Royal College of Surgeons "*support the mandate being based around the NHS Outcomes Framework, which allows the NHS to retain a single focus on the way in which quality and outcomes for patients are measured and improved*."
- Transforming the way that NHS priorities are set, organisations are held to account and performance is monitored and assessed. As NICE pointed out "*the mandate is a new type of accountability mechanism for a new NHS governance arrangement*."
- Promoting the values and principles of the NHS Constitution. The Royal College of Nursing suggested that the mandate "*when taken together with the NHS Constitution it is likely to have a significant impact on the culture and practice of the NHS a whole*."

3.4 Whilst many saw the potential of the mandate, a consistent theme through many responses was the feeling that the mandate, in isolation, will not bring about the culture and behaviour change needed. Other factors, such as strong leadership and partnership working at all levels, were identified as being particularly important in driving the necessary behaviour change. The Government agrees and as the final mandate makes clear, real and lasting change can only be achieved in partnership – between Government, the NHS, local councils, commissioners, providers, the voluntary sector, staff, patients and carers.

4. Assessing progress (Q4 – Q5)

Q4. *What is the best way of assessing progress against the mandate, and how can other people or organisations best contribute to this?*

Q5. *Do you have views now about how the mandate should develop in future years?*

Refreshing the mandate

4.1 The majority of respondents welcomed the fact that the mandate will be refreshed every year. For example, the NHS Partners Network felt that "*it is sensible and encouraging to see that the mandate will be revised each year to ensure that it remains up to date*." The Patients' Association also felt that the mandate "*should develop to meet the challenges that it will face in the future. For example, with an ageing population, the priorities of the NHS may need to change to meet that challenge*." This will ensure that the mandate evolves to remain relevant and reflect the most important priorities to meet these challenges.

4.2 However, organisations were also clear that the mandate should set a long term agenda, to allow for appropriate and sustainable planning to deliver improved outcomes. Commissioners should have the confidence to invest in longer term solutions, prevention and new models of care. This was felt to be particularly important if the NHS is to achieve efficiency savings in a sustainable way. Revisions to the mandate should be kept to a minimum and respondents felt strongly that it should not be undermined by short term-ism and political whim. We agree with this approach; the mandate is a multi-year document setting rolling objectives from April 2013 to March 2015. NHS Clinical Commissioners welcome this, as it will "*create[s] stability and continuity for the Board and CCGs respectively*." The mandate can only be changed in year by agreement, after a general election or in exceptional circumstances, and any changes would need to be explained to Parliament.

4.3 The responses revealed strong support for focusing on outcomes, structured around the NHS Outcomes Framework to measure progress. The final mandate does this, and in certain areas we have included interim objectives and milestones as markers of progress. This responds to suggestions such as from the King's Fund who argued that it is important to be able to account for progress against an objective, even if a formal success measure (for example on integrated care) has not yet been developed. This also reflects the long term and complex nature of measuring outcomes, which may take several years to achieve. The BMA recognised that "*there is often a significant time lag between any intervention and a resulting measurable outcome*." Focusing on outcomes presents a new and radical approach for the NHS but we are

only at the start of this journey – a point that was widely acknowledged. It will take time to develop outcome success measures and the necessary reporting cycles to assess performance, and future mandates will reflect these improvements.

Measuring success

4.4 A key change, in response to what we heard, was to avoid setting quantified levels of ambition for improvement against the five domains of the NHS Outcomes Framework. Whilst the consultation revealed strong support for the principle of focusing on outcomes, there was criticism from some that setting quantified levels of ambition for objectives 1 to 5 was too complex. The King's Fund summarised the methodology as being too "*complex, lacking in transparency, open to challenge, and susceptible to error*." Others expressed concern that the quantified levels of ambition could be translated into top-down targets. In addition, the online survey of the objectives revealed that respondents found the concept of QALYs in this context hard to understand.

4.5 As a result, we have tried to set a clearer vision of the scale of improvement we want to see: for example by setting overarching goals and stretching ambitions to be among the best in Europe for key priority areas. We think that comparisons with other countries are an effective and readily understandable way to inspire and challenge the NHS to be the best. However, the structure and objectives of the final mandate ensure we retain a close link to the NHS Outcomes Framework as the main way of measuring progress.

Transparency and accountability

4.6 Many responses stressed the importance of transparency and that progress against the objectives should be made public. We agree; the Health and Social Care Act 2012 makes clear that the NHS Commissioning Board must publish a business plan each year, saying how it intends to carry out its functions and deliver the objectives in the mandate. The NHS Commissioning Board must also publish a report on its progress against the objectives at the end of each year and the Secretary of State will then will publish an annual assessment of the NHS Commissioning Board's performance. As part of this process, we will hold the NHS Commissioning Board to account for all its duties and responsibilities, which include its duty in relation to tackling inequalities. This was considered particularly important by a large number of organisations and we have therefore reflected this in the final mandate.

4.7 The responses showed overwhelming support for incorporating comprehensive feedback into the annual assessment process. The NHS Alliance suggested that "*the annual report of the NHSCB and the Secretary of State's response will be a key element of this, but a more rounded approach based on 360 degree feedback should*

be developed. This would take into account views from CCGs, take account of local authority overview and scrutiny functions, and be informed by both local and national Healthwatch." We welcome this suggestion and the mandate invites feedback from clinical commissioning groups, local councils, Healthwatch, NHS staff and any other people and organisations that have a view. We want to ensure this is a fair and transparent process so that successes can be recognised and celebrated, and poor performance and areas for improvement addressed in a timely way.

4.8 Some organisations felt that draft mandate lacked the necessary detail to hold the NHS Commissioning Board to account for its own direct commissioning, particularly for specialised commissioning for rarer conditions but also for primary care. Respondents told us that where services are commissioned by the NHS Commissioning Board, the results (quality and value for money) should be explicitly assessed in as rigorous a way as for services commissioned by CCGs. For example, the Specialised Healthcare Alliance argued that "*the draft mandate might usefully note that the Board will be assessed not only on its contribution to broader social and economic objectives through its oversight of CCGs, but also through its direct commissioning functions*." We agree with this and have amended the mandate to reflect this.

Tackling poor performance

4.9 Many respondees did not feel it was sufficiently clear what action will be taken if the NHS Commissioning Board or CCGs do not make sufficient progress. For example, the BMA were "*concerned that the mandate does not describe how, in practice, the Secretary of State would hold the Board to account and support the Board if it appeared likely that it would fail to meet the objectives*."

4.10 The mandate is one part of a wider cycle of accountability for the NHS Commissioning Board. In addition to the formal annual assessment process, there will be an ongoing sponsorship relationship between the Department and the NHS Commissioning Board, which will be described in the framework agreement. Where performance falls short, there are actions that the Secretary of State and the Department of Health can take. Ministers could, for example, ask the NHS Commissioning Board to report publicly on what action has been taken, or ask the Chair to write a letter setting out a plan for improvement.

5. Improving our health and healthcare (Q6 – Q8)

Q6. Do you agree that the mandate should be based around the NHS Outcomes Framework, and therefore avoid setting separate objectives for individual clinical conditions?

Q7. Is this the right way to set objectives for improving outcomes and tackling inequalities?

Q8. How could this approach develop in future mandates?

Focusing on outcomes

5.1 In general, most respondents supported basing the mandate on the NHS Outcomes Framework and avoiding setting separate objectives for individual clinical conditions. Some respondents suggested that the mandate should include references to particular conditions. However, overall we heard that the mandate should focus on the issues that affect all those who use health services. Examples of such issues include; the lack of coordination of services and care planning and insufficient focus on prevention. Some felt that focusing on individual clinical conditions could undermine this, such as Age UK who commented "*we do not believe these would be addressed and in fact could be compounded by focusing on single conditions*."

5.2 However, responses on the whole recognised this is a difficult issue. We share the Nuffield Trust's view that "*the debate about disease specific objectives is a complex one*". A large number of responses showed support for including in the mandate separate objectives for individual clinical conditions where there was deemed to be a particular problem or where improvement is hard to secure. The Royal College of Midwives advised "*that there ought to be some flexibility in how individual objectives are determined in order to acknowledge instances where particular services or conditions require urgent attention*."

Dementia

5.3 Similarly, Cancer Research UK said that "*whilst we understand that the first iteration of the mandate has not singled out any clinical conditions we do not think that this should be ruled out in future mandates. For example, the Board may need to focus on a particular urgent health problem or focus on an area that has seen little*

improvement." Having reflected on this, dementia has been highlighted by the Government as an area in which significant progress is required.

5.4 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. One in four people in NHS hospital beds has Alzheimer's disease or another type of dementia – but only 42% of people with dementia have a diagnosis. We believe dementia care needs to be improved nationwide, so that more people are diagnosed early and supported to stay independent and in good health for longer.

5.5 As with other complex diseases, people with dementia often need a wide range of NHS, care and support services. We think that greater integration across health and social care, as well as working collectively with the wider local government and the voluntary sector, can make a difference and overcome a number of challenges to improve care and support for people with dementia, their families and carers. Improving the quality of dementia care will therefore be a powerful litmus test of how well the NHS can join up services around the needs of the individual.

'No health without mental health'

5.6 Some organisations did argue that the focus on mental health was another example of Government singling out an individual clinical condition for particular attention. However, the majority of respondents felt that this should be a priority for the NHS Commissioning Board given the scale of improvements needed in this area. We heard that too often access to mental health services is more restricted, waiting times are longer than for other services and those with mental health problems have worse outcomes for their physical healthcare. Parity of esteem between mental and physical health was debated extensively in the House of Lords during the passage of the Health and Social Care Act 2012.

5.7 The Government feels strongly that good care means understanding people's health needs, both mental and physical. They should not be seen in isolation from each other – people's health and mental health go hand in hand. This is reflected in the Government's mental health strategy 'No health without mental health' (Feb 2011). We also agree with those such as the King's Fund who felt that a key test will be "*not just to place mental health 'on a par' with physical health in the sense of attaining some form of equivalence, but to integrate mental health care more closely with other service*s." We have sought to strengthen the focus on mental health throughout the final mandate.

Tackling inequalities

5.8 We heard that the scope of the draft mandate in tackling inequalities was too confined to the domains of the NHS outcomes framework and that the mandate should be bolder about its expectations. Many respondees felt that the NHS Commissioning Board's role extended to tackling inequalities more widely and that it should contribute to the work of other public services where there is a role for the NHS to play in delivering improved outcomes. To address these concerns, the mandate makes clear that across the entirety of the NHS Commissioning Board's work, it has specific legal duties in relation to tackling health inequalities and advancing equality. We did not feel that the mandate should specify which particular groups or inequalities to focus on. This should be determined locally through health and wellbeing boards and local priority setting. Instead, the mandate makes clear that tackling inequalities should be a principle underpinning everything it does.

A mandate for everyone

5.9 Some responses were concerned that the mandate overly focused on adults at the expense of children and young people. The National Children's Bureau said that "*it must be made clear that all relevant outcomes described in the NHS Outcomes Framework should be improved for people of all ages regardless of the current technical limitations of the specific indicator measures*." We want to stress that the mandate applies as much to children and young people, as to older people, equality groups, and adults of working age. We have refreshed the NHS Outcomes Framework and strengthened the emphasis on children, for example, including a separate children's indicator as part of the overarching indicator 1a for Domain 1 (preventing people from dying prematurely). This emphasis is also reflected in the final mandate.

5.10 Furthermore, the mandate sets out our expectation for ensuring mothers, children and families should be given the best start in life. Similarly, the Government agrees with those responses that the NHS has a crucial role in supporting people at the end of their life. We acknowledge that this was not adequately reflected in the draft and have amended the final mandate to make this clear.

Prevention and early intervention

5.11 There was a strong feeling amongst respondees that there should be greater focus on prevention and early intervention. We agree with the consultant who commented that healthcare should be viewed "*as a continuum through from public health and health prevention …right through to supportive and end of life care when an illness can no longer be treated effectively*". We recognise the important role the NHS can play in preventing illness and promoting wellbeing and this is reflected in the mandate as an objective to embed the role of prevention in improving our health and healthcare.

6. Putting patients first (Q9 – Q10)

Q9. Is this the right way for the mandate to support shared decision-making, integrated care and support for carers?

Q10. Do you support the idea of publishing a "Choice Framework" for patients alongside the mandate?

Patient choice and patient involvement

6.1 The consultation revealed broad support for the underpinning principle of 'putting patients first' and creating a more patient centred NHS. However, there were mixed views about the extent to which the mandate will achieve this. Many felt that the success of this ambition will require a step change in behaviour by frontline professionals in putting the experience of the user first. National Voices suggested that the NHS Commissioning Board should "*put patient involvement at the heart of its vision, strategy and business plans*" to demonstrate this leadership.

6.2 The majority of respondents highlighted that involving patients and carers in their treatment and care, as much as they want to be, is a powerful driver for improving patient experience. However, they did not feel that the draft mandate adequately reflected this. Many respondents were critical that the separate elements of 'choice' and 'patient involvement' had been conflated in the draft mandate and accompanying draft choice framework. Many people felt that it focused too much on choice of provider and where people might prefer to receive their care. Some organisations felt strongly that this does not constitute shared decision making and that meaningful 'patient involvement' requires people to be supported and involved in decisions about their care and treatment as well as being offered choice. We heard that without appropriate information and support, patients, their carers and families would not be in a position to make informed choices, or be truly involved in making decisions about their care. Some even argued that without adequate support, there was the potential to increase health inequalities. The majority of responses felt that the mandate should emphasise the important role that information and technology can play in supporting people. The forthcoming response to the 'No decision about me, without me' consultation will consider these issues in more depth.

6.3 We agree with the Health Foundation that the mandate needs to "*aspire to create an NHS in which people have the skills, knowledge and confidence to play a greater role in their own healthcare by sharing in decisions about the management of their care and treatment and by being supported to adopt healthy lifestyles.*" The final mandate includes a specific objective for the NHS to make significant improvements

in involving patients and carers, and empowering them to manage and make decisions about their own care and treatment. We have set expectations for achieving this objective in the mandate; for example, by 2015 everyone with a long term condition, including those with mental health problems, will be offered a personalised care plan that reflects their preferences. This includes expectations that the NHS Commissioning Board should drive improvements in the availability of information about the quality of services and make it easier for patients and carers to give feedback on their care.

6.4 There was support from respondents for including 'patient experience' as an outcome measure of improved health, but some felt that too much emphasis was placed on the acute hospital sector, suggesting that there needs to be a measure relating to primary and community care. The NHS Commissioning Board has specific objectives to make rapid progress in measuring and understanding patient experience and using this to act on poor performance. Part of this will be to introduce the 'Friends and Family Test' for patients in a staged approach nationwide, starting with acute and Accident & Emergency services before extending to cover all NHS services. Some respondents were critical of the test. The Picker Institute were sceptical and "*maintains that the 'friends and family test' based on near-real time data collected by provider organisations would be unreliable as a national indicator*." However, they did acknowledge that it "*may prove useful as an agent of change at local level, particularly if used as a part of a conversation to elicit more detailed qualitative feedback that can be used to develop and evaluate quality improvement initiatives*."

6.5 Others were more positive and felt that the ability for patients, service users and their families to comment on their experience would be an important way to improve services and ensure people are treated with dignity and respect. The Government agrees and we feel such a test is the right approach, particularly as it enables vulnerable groups, whose voices are more likely to go unnoticed, to be heard. The test will become an overarching indicator in domain four of the NHS Outcomes Framework.

Integrated care

6.6 There was strong support for making integrated care a priority in the mandate. NHS Wiltshire welcomed this "*recognition within the mandate …. especially the importance of greater co ordination of care for patients with complex needs and long term conditions*." However, many felt that the draft outcome measures were too process based. The Nuffield Trust rightly commented that current patient experience measures focus on individual institutions, which will not capture the breadth of the patient's experience of care. The Government's commitment to develop an indicator to measure 'improving people's experience of integrated care' for future inclusion in Domain 4 of the NHS Outcomes Framework was widely

welcomed. We recognise the importance of integrated care and the role of the NHS working with CCGs, local authorities and other partners to achieve better outcomes. The final mandate asks the NHS Commissioning Board to lead a major drive to enable better integration of care, focusing on outcomes and enabling local implementation. We also recognise that providers play an equally important role, as it is the provision of services, not commissioning, that individuals experience directly. We expect local commissioners to work together and demonstrate leadership by stimulating the development of innovative provision of integrated care.

Carers

6.7 The inclusion of carers within the mandate received strong support. Carers UK "*warmly welcomes the inclusion of this particular objective believing that it firmly embeds the important notion in the NHS that action must be taken for carers to ensure that they have the information and advice to care for themselves as well as the person for whom they care. It is an important and valuable step forward for carers*." The Government recognises the vital contribution carers of all ages make and that more is needed to help identify and support carers. The final mandate seeks to give carers prominence.

7. The broader contribution of the NHS (Q11)

Q11. Does the draft mandate properly reflect the role of the NHS in supporting broader social and economic objectives?

Partnership working and supporting growth

7.1 There was broad support amongst respondees for encouraging the NHS to contribute to the wider community and play a greater role in tackling inequalities and the wider determinants of health. Many people reflected that their local NHS does not always fully engage in issues affecting their local community such as reducing crime and tackling problem families. The majority of responses supported the idea of partnership working outlined in the draft mandate. For example, The Royal College of General Practitioners felt the mandate "*goes some way to place the NHS in its wider social and economic context – especially in so much as it recognises the role of the wider determinants of health inequality, and the possibilities of integrated working to advance whole population outcomes*." However, some were concerned that no detail was given of how it would work in practice or be measured.

7.2 Many respondents criticised the supporting list as "haphazard", expressing concern that some areas had been left out and stating that the list did not sufficiently reflect the broader role of the NHS, for example, its contribution to sustainable development. In the final mandate, we have not attempted to list every area where the NHS can contribute but have emphasised those priority areas where Government feels most progress is needed.

7.3 We also heard much support for emphasising the contribution that the NHS, and organisations providing NHS-funded care, can make to economic growth. Supporting and promoting research, the adoption of new technology and innovation and spreading best practice were identified as important areas where the NHS Commissioning Board can play a key role. Parkinson's UK advised "*embedding research and innovation as part of the new NHS, in order to ensure high quality care is of upmost importance*." Many responses also pointed to the impact that economic growth, employment and financial well being have on health outcomes. The mandate continues to emphasise this importance and includes objectives to contribute to economic growth and to do more to improve access and break down the barriers to research.

8. Effective commissioning (Q12)

Q12. Should the mandate include objectives about how the Board implements reforms and establishes the new commissioning system?

Modernising the NHS

8.1 Some responses felt that including an objective for the NHS Commissioning Board to establish an effective commissioning system would dilute the focus on outcomes. However, the BMA suggested that "*including in the first mandate some clear expectations around how the NHS Commissioning Board should implement the reforms, seems sensible*." We agree with the Royal College of Surgeons that "*the Board are central to the establishment of the new commissioning system and governance arrangements so should have a specific objective against which progress can be measured*." The mandate makes clear the NHS Commissioning Board's role in ensuring a safe transition to the new system.

8.2 Many responses emphasised the importance of using the mandate to set the tone for and embed local leadership and autonomy. This view, supported by a wide range of Mental Health charities, was that the mandate should "*reflect the Board's role in leading by example.*" The National Association of Primary Care argued that "*the NCB should be judged on how successful it is in promoting the autonomy of CCGS*." The mandate, together with new legal duties that relate to promoting autonomy, demands a new approach from Ministers and the NHS Commissioning Board to empower individuals, organisations and frontline professionals. The Government has a clear vision to liberate the NHS from top down control. Only by freeing up local organisations and professionals can they pursue excellence as set out in the mandate. We have sought to reflect this in the final mandate by setting a clear objective to achieve the best outcomes by strengthening the local autonomy and capability of CCGs, health and wellbeing boards, and local providers of services. The mandate also makes clear the principles, which should underpin implementation particularly the values and principles of the NHS Constitution.

Communities matter

8.3 We heard that it was important that the objectives should be overarching so that they could be considered in a local context and be informed by local priorities. The City of York Council summed this up in their response, "*it is essential the voice of the public is heard at a local level in order that the NHS can be shaped 'bottom up' as well as being moulded 'top down*"'. The Patients' Association also made the point that "*it may be that there are specific issues and challenges in certain parts of the*

country that do not exist elsewhere for examples the demographics of Kent and Barnet show a rapidly ageing population yet in Tyneside there is a growing younger population. The NHS Commissioning Board should work with its local branches to ensure that it is able to tackle specific health inequality issues in each area." We agree and local commissioners should work through health and wellbeing boards and with their local communities to determine how to achieve the objectives. The objectives are not for the NHS Commissioning Board to impose on CCGs but to be achieved through local empowerment.

8.4 Many responses highlighted the need for a greater emphasis on the involvement of patients, service users and the public in the planning and commissioning of local health and care services. Respondents such as the NHS Alliance felt that the mandate should make clear that the NHS Commissioning Board and CCGs should involve patients, carers and local communities on service planning and design. The mandate highlights the NHS Commissioning Board's duties and capabilities for engaging and mobilising patients, professionals and communities in local commissioning – this is essential to the operation of a modern NHS.

8.5 Some organisations thought the objective should be more ambitious on commissioning for a changing system and encouraging new models of service delivery. We agree with this sentiment. An objective of the NHS Commissioning Board is to support the NHS to be more responsive and innovative, for example, by embedding choice and encouraging a fair playing field which encourages high quality providers from the public, independent or voluntary sector to flourish and respond to people's needs and what they want to achieve.

Conclusion

9.1 We are very grateful to all those who responded to the consultation on the draft mandate to the NHS Commissioning Board. We particularly welcome, and are encouraged by, the level of constructive engagement and the broad mix of contributions.

9.2 The wide-ranging perspectives revealed through the consultation have been extremely helpful in illustrating some of the challenges raised in preparing the first mandate to the NHS Commissioning Board. The views and suggestions we received have directly helped to shape the approach to the final mandate.

9.3 Taking forward the Government's vision and the objectives set out in the mandate to transform outcomes and put people, carers and families at the heart of the NHS, will require a real shift in the way that we approach health and healthcare. The Government, the NHS, local councils, patients, carers, providers, voluntary organisations and communities along with leaders at every level, from chief executives to nurses and health and care workers, have shared responsibility for making this a reality.

9.4 We want to continue to work closely with our partners, stakeholders and patients and we would welcome your feedback on the NHS Commissioning Board's performance as part of the annual assessment process.

Annex A – List of organisations (excludes public respondees, peers and MPs)

Specialised Healthcare Alliance
NHS Sustainability Unit
Isle of White NHS PCT
Boehringer Ingelheim
NHS Kirklees
HM Inspectorate of Prisons
Greater Manchester Police
NHS Kent & Medway
The Royal College of Ophthalmologists
English Community Care Association
Healthwatch-UK
NHS Wiltshire
Cardiff Community Safety Partnership and Cardiff University Health Board
Breast Cancer Care
NHS Midlands and East
NHS South of England
Royal College of Anaesthetists
Probation Chiefs Association
Carers UK (Newham) branch
Nottinghamshire Healthcare NHS Trust
Independent Advisory Panel on Deaths in Custody
Oxfordshire Local Involvement Network
BMJ Group
The Association for Perioperative Practice
Gateshead Local Involvement Network
Easton Planning
Teenage Cancer Trust
The Health Foundation
Chelsea and Westminster Hospital NHS Foundation Trust
Climate and Health Council
SOLACE
Picker Institute Europe
North Somerset Council
Aspire
The Faculty of Pain Medicine
National Voices
Royal Pharmaceutical Society
The Royal College of Radiologists
Shire Pharmaceuticals Ltd
Cancer Research UK
PSNC
Novo Nordisk Ltd
MENCAP and The Challenging Behaviour Foundation
Monitor
British In Vitro Diagnostics Association (BIVDA)
NHS Alliance PPI Steering Group
NAT (National AIDS Trust)
NHS Bristol
Deafblind UK
The Neurological Alliance
NHS Clinical Commissioners
Disability Rights UK
NHS Commissioning Board Authority
Royal College of Nursing

South East Coast Ambulance Service NHS Foundation Trust

Foundation Trust Network

College of Optometrists and Optical Confederation (joint response)

NHS Confederation

Alzheimer's Society

Centre for Public Scrutiny

NHS South of England

Child Accident Prevention Trust

Medtronic

Forest Heath District Council

Patient Governance

Chief Nursing Officer Black and Minority Ethnic Advisory Forum

National Institute for Health and Clinical Excellence (NICE)

Academy of Medical Royal Colleges

Pfizer

Stonewall

MS Society

Royal College of Midwives (RCM)

Marie Curie Cancer Care

Tuke Institute

Pharmacy voice

Macmillan Cancer Support

Kidney Alliance

Action against Medical Accidents (AvMA)

Age UK

National Osteoporosis Society

Wellcome Trust

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NHS Alliance

Spatial Planning and Health Group

The National Autistic Society

Academy of Medical Sciences

Royal College of Physicians of Edinburgh

Young Minds

Salford City Council

Hampshire County Council Adult Services

NHS Bournemouth & Poole

City of York Council

TB Alert

Genzyme Theraputics Ltd

Royal College of Obstetricians and Gynaecologists

Staffordshire County Council

Somerset Partnership NHS Foundation Trust

East of England Regional Academic Public Health Forum

Carer Support Wiltshire

British Association of Dermatologists

The Nuffield Trust

NIHR Clinical Research Network

Luton Borough Council/NHS Luton

NHS Bristol

National Rheumatoid Society

Lundbeck Ltd

Association of Surgeons of GB and ireland

The Faculty of Intensive Care Medicine

National End of Life Care Programme (NEoLCP)

Men's Health Forum

Concord Medical Centre and University of Bristol

NHS Partners Network

Crossroads Care Bury

Association of the Bristish Pharmaceutical Industry (ABPI)

Coloplast

Urology Trade Association

Prostate Cancer UK

The Carers' Resource
Sanofi
Greater Manchester Public Health Network
The Parliamentary & Health Service Ombudsman
Bury Council Adult Care Services
Carers UK
Asthma UK
Specialised Services Patient and Public Engagement Steering Group
Local Government Association and ADASS
UNISON
CLIC Sargent
Motor Neurone Disease Association
Hepatitis C Trust
British Medical Association
Advisory Group for National Specialised Services
Children and Young People's Mental Health Coalition
Royal National Institute of Blind People
Action on Hearing loss
British Dental Association
Bliss
FPA and Brook
Royal Town Planning Institute
Dignity in Dying
Royal College of Surgeons
Help the Hospices
Turning Point
St Mungo's
The King's Fund
National Children's Bureau
Essex County Council
Parkinson's UK
Trade Union Side of the Social Partnership Forum
Revolving Doors Agency
Association of Medical Research Charities
Coalition of Mental Health Charities
Standing Commission on Carers
Healthwatch England
Breast Cancer Campaign
Royal Collage of General Practitioners
Arthritis Research UK
NACRO
Carers Trust
The Patients Association
The British Geriatrics Society
The Whittington Hospital NHS Trust
Genetic Alliance UK
The National Council for Palliative Care
Faculty of Public Health
Sefton Recovery Group Network
Care Quality Commission (CQC)
Royal Collage of Paediatrics and Child Health
The Lesbian and Gay Foundation
ACEVO
Guild of Healthcare Pharmacists
UK Partnership Forum
NHS East Midlands
Royal Collage of Speech and Language Therapists
Alliance Boots
MENCAP
NHS Midlands and East Learning Disabilities leads group
Coalition of health and social care voluntary sector organisations
Cheshire East Council and Cheshire East Shadow health and wellbeing board
National Association of Primary Care

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