Developing our NHS care objectives

A consultation on the draft mandate to the NHS Commissioning Board

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Foreword from the Secretary of State

The Health and Social Care Act, which has recently passed through Parliament, reaffirms the principles of the NHS as a comprehensive health service for everyone, based on clinical need not people's ability to pay.

The Act creates the legislation to support this Government's vision for improving the NHS, in order to:

- put patients and carers at the heart of the health service;
- focus the NHS on improving outcomes and what matters most to patients – high-quality care; and
- hand power to local professionals, and make NHS services more directly accountable to patients and communities.

We now want to work with patients, staff and our partners – including national health charities, think tanks and professional organisations – to put the changes into practice and make them a success.

In line with the new requirements in the Act, we are now consulting on our proposals for the Government's first mandate to the NHS Commissioning Board, and we have published a draft mandate. In future, the mandate will be the main way for the Government to say what it expects the NHS commissioning system to achieve with the money it is given. This is the first time that any government has been required by law to consult on its objectives for the NHS, and brings an unprecedented degree of transparency.

This document explains the approach we have taken to developing the mandate, and tells you how you can get involved and have your say.

Andrew Lansley CBE
Secretary of State for Health

Executive summary

The mandate

The new NHS Commissioning Board[1] will oversee the way that over £80 billion of taxpayers' money is spent to secure NHS services for the people of England.

Under the Health and Social Care Act 2012, the Government must set objectives for the Board in a "mandate", which must be updated every year, following consultation. In order to provide stability for the NHS, the mandate can only be changed mid-year in limited circumstances.

The mandate is one of the most important ways for the Government to set objectives for the Board, but it is just one part of a broader relationship through which the Secretary of State will hold the Board to account for its performance. Ministers will continue to be accountable overall for the health service as a whole.

We have now published:

- a **draft of the first mandate**, informed by what we have heard through previous consultations, debates in Parliament and discussions with stakeholders;
- a draft "**choice framework**", illustrating the Government's intended approach to explaining the choices that will be available for people using NHS services in England; and
- **this consultation document**, which explains the approach we have taken to developing the mandate.

Following consultation, we will publish a final mandate in the autumn, ready to come into force from April 2013.

Meanwhile, we are also publishing the Secretary of State's first report on the effect of the NHS Constitution. The Constitution and the mandate both set out what is expected of the NHS, but they have distinct roles:

- The mandate is a formal accountability document setting objectives for the Board. It is primarily about the Government's ambitions for improving NHS services *in future*. Future mandates will evolve as objectives are achieved and new priorities emerge.

1 The NHS Commissioning Board will be established on 1 October 2012. The NHS Commissioning Board Authority, a Special Health Authority set up to prepare for the establishment of the Board, is being abolished at the same time as the Board is created.

- By contrast, the NHS Constitution is an enduring document, which sets out the principles and values of the NHS and the rights and responsibilities of patients and staff. It describes what everyone can expect from the NHS *now*, and it is about the NHS as a whole – patients, public and staff – not just commissioners.

The structure of the draft mandate

The draft mandate includes objectives under five headings:

1. **Improving our health and our healthcare**: this sets objectives for improving outcomes and reducing inequalities under the NHS Outcomes Framework, rather than setting objectives for individual clinical conditions. It sets ambitions for:

    - preventing people from dying prematurely;
    - enhancing quality of life for people with long-term conditions;
    - helping people to recover from episodes of ill-health or following injury;
    - ensuring that people have a positive experience of care; and
    - treating and caring for people in a safe environment and protecting them from avoidable harm.

2. **Putting patients first:** this sets objectives to extend shared decision-making and choice, improve information, make services more integrated around the needs of individuals, and improve the support the NHS gives to carers.

3. **The broader contribution of the NHS:** this sets objectives about how the NHS can work better with other public services, and how it can contribute to economic growth, including through its support for research and innovation.

4. **Effective commissioning:** this sets objectives about getting the full benefits from the new system of commissioning, while at the same time managing the transition in a way that safeguards service performance and finances.

5. **Finance and financial management:** this will set the Board's resources and expectations of increased efficiency.

Setting ambitions for improving high-level outcomes rather than focusing on processes or individual clinical conditions has many advantages. It focuses attention on the outcomes that really matter: saving and improving lives, reducing harm and enhancing patients' experience. It gives more freedom to local commissioners to decide how best to improve quality and outcomes in the light of the needs of their populations. And it recognises that, as more people are living with multiple long-term conditions, it is more important to take a holistic

approach, looking at quality of life and quality of care as a whole, rather than focusing primarily on the treatment of specific clinical conditions.

However, as Chapter 3 explains, this is a radical shift in approach from the past, and the detailed approach we take will evolve as information about outcomes improves and our methodology develops.

Have your say

We would welcome your views on the objectives in the draft mandate, and on the consultation questions set out there (these are also listed below in Chapter 6). You can find out more and respond to this consultation at: http://mandate.dh.gov.uk. You can contact us via: mandate-team@dh.gsi.gov.uk. Please respond by 26 September.

1. The mandate in context

The Government's NHS reforms

1.1 From April 2013 **clinical commissioning groups** (CCGs) will become responsible for commissioning most healthcare – planning, buying and monitoring services to meet the needs of their local communities. Within CCGs, GPs and other healthcare professionals will be empowered to use their clinical insight and local knowledge to make decisions about NHS services.

1.2 A new national organisation – the **NHS Commissioning Board** – will support CCGs to commission high-quality care for their patients. The Board will also commission some healthcare services directly. The Department of Health will allocate funding to the Board, and set objectives for it in a "mandate".

1.3 CCGs and the Board will commission services from a range of **providers**, offering greater choice to patients. In turn, providers will be regulated on a consistent basis: by the **Care Quality Commission**, as now, to ensure safety and quality; and by **Monitor**, which will focus on promoting value for money in the provision of services, for example by regulating prices and taking action against anti-competitive behaviour that harms the interests of patients.

1.4 **Health Education England** will provide national leadership for professional education, training, and workforce development, to ensure that the health workforce has the right skills, behaviours and training, and is available in the right numbers, to support the delivery of excellent healthcare and health improvement.

1.5 Meanwhile, new **Health and Wellbeing Boards**, based in local authorities, will bring together NHS commissioners with local government, helping to join up the commissioning of NHS, public health, social care and other local services.

1.6 To strengthen the voice of patients and the public, **HealthWatch England** will be a new independent consumer champion, as a statutory committee within the Care Quality Commission. **Local HealthWatch** organisations will provide advice and information about access to local care services and choices available to patients, and a stronger voice for patients on the local Health and Wellbeing Board.

1.7 The Health and Social Care Act makes clear that, as now, **Ministers** will be accountable overall for the health service. The Department of Health will provide strategic direction and stewardship, and will hold all of the national bodies to account for their performance, to ensure that the different parts of the system work properly.

1.8 The final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, chaired by Robert Francis QC, is due to be published in the autumn. While many of the themes and objectives in the draft mandate address the issues that emerged from the previous inquiry, it will be for future mandates to reflect any specific recommendations from the final report relating to the new commissioning system.

The mandate

1.9 The mandate will be at the heart of the accountability relationship between the Board and the Department of Health. The Act says that the Secretary of State must publish a mandate setting objectives for the Board, and any supporting requirements, as well as the funding available to the Board. The Board must seek to achieve the objectives and must comply with any requirements.[2]

1.10 The mandate will be:

- a multi-year document, but published annually to ensure it remains up to date. The first mandate will come into force from April 2013, when the Board takes on its full powers;
- based on public consultation and consultation with the Board;
- fixed for the entire year: it can only be changed mid-year by agreement with the Board, or in exceptional circumstances, which Ministers would have to explain to Parliament (it could also be changed after a general election);
- an accountability mechanism for the Board, not for the NHS as a whole. For example, it would not deal with the way that providers are regulated, since this is the responsibility of Monitor and CQC, which have their own, distinct legal responsibilities.

Other requirements on the NHS Commissioning Board

1.11 The mandate will be the document that sets the Government's ambitions for the Board. But it will not be the only influence on the Board, nor will it cover everything that the Board will do. As explained in Chapter 4, the mandate forms part of a broader cycle of accountability.

1.12 Like other arm's-length bodies, the Board will also be bound by:

a) legal requirements

- The **Health and Social Care Act** sets out the Board's core functions, and gives the Board a number of cross-cutting duties, including duties about reducing

2 The Secretary of State considers that at this stage it is not necessary to impose any requirements in relation to any of the objectives.

inequalities, seeking continuous improvement in quality and promoting the NHS Constitution.

- **Regulations** made under the Act will set more detailed legal requirements including, for example, regulations defining exactly what services the Board should commission. "Standing rules" regulations will set legal requirements on the way the Board and CCGs commission services, and will be used to ensure that rights for patients in the NHS Constitution continue, such as the right for patients to access services within maximum waiting times. They will also be used to maintain existing policies, such as the eligibility rules for NHS continuing healthcare.[3]

b) standard government accountability procedures

- As with other arm's-length bodies across government, there will be a **framework agreement** outlining how the Board and the Department of Health will work together. For example, this will include details about financial management and financial reporting, and will describe how the Board will help the Department to respond to questions from Parliament.
- The Department will make a limited number of **financial directions** under the Act to set technical controls on the Board's spending, to ensure it is managed in line with Treasury requirements.

1.13 In addition, there are some public health services which in future will be the legal responsibility of the Secretary of State, but which the Board will commission on the Department's behalf. The details will be set out in a formal **"section 7A" agreement** under the Act, which will be published alongside the final mandate. The services it will cover include immunisation and screening programmes, public health services for young children and for people in custody, and the commissioning of sexual assault referral centres and of child health information systems.

1.14 The mandate is designed as a specific accountability mechanism for the Board, to recognise the scale of the Board's responsibilities and the size of the budget it will oversee. But there is no need for the mandate to duplicate requirements that are made elsewhere.

1.15 Some people have asked how the mandate relates to the NHS Constitution. The key distinction is that the NHS Constitution is about the entire NHS – public, patients and staff – and captures the essence of what people can expect from the NHS *now*. The mandate is a formal accountability document for the Board (therefore, for example, it says relatively little about staff, because the vast majority of staff in the NHS are

3 NHS continuing healthcare is a package of continuing care arranged and funded solely by the health service for a person to meet physical or mental health needs which have arisen as a result of illness.

employed by providers of healthcare services), and deals mainly with the Government's ambitions for improving the NHS *in future*. While the Constitution is an enduring document, the mandate will evolve over time, as objectives are achieved and new priorities emerge.

1.16 We have asked the NHS Future Forum to consider how the NHS Constitution can be strengthened and reinforced for the future. The Forum plans to engage on potential changes over the summer. In light of its advice, we will launch a public consultation on any changes to the Constitution later this year.

2. Our approach to the mandate

2.1 The draft mandate we have published draws on an extensive process of consultation, listening and engagement. For example:

- We have already held full consultations on many of the elements within the draft mandate, including the NHS Outcomes Framework and our plans for extending shared decision-making and patient choice.
- We have had many informal discussions about developing the mandate with stakeholders and representative bodies, and drawn on feedback and recommendations from the work of the NHS Future Forum.
- The mandate was debated extensively in Parliament during the passage of the Health and Social Care Bill.
- We have worked very closely with the NHS Commissioning Board Authority (the preparatory body for the Commissioning Board).

2.2 Because this is the first mandate, and the start of a new system of commissioning, there has been much debate about high-level questions such as: how detailed the mandate should be; whether it should include objectives about the way the Board implements reforms as well as about the ultimate purpose of those reforms; and how to assess the Board's progress against the mandate.

2.3 However, some common themes have emerged. We have heard many people support the ideas that the mandate should be:

- based primarily around **outcomes** and the NHS Outcomes Framework – while at the same time recognising that the Board must be clearly accountable and that there are other important objectives that the Government will want to set;
- **aligned** with other parts of the NHS, and promoting an integrated approach with social care, public health and other public services;
- **affordable**, recognising the sustained financial challenge facing the NHS over the coming years; and
- **focused** on a core set of priorities, in line with the principle of promoting front-line autonomy, to ensure that commissioners have the headroom and flexibility to respond to local needs. Extending ambition in one area can only come at the expense of ambition in other areas. Many people have highlighted the risk that the mandate could turn into a long "shopping list" unless the Government is restrained in selecting its priorities.

2.4 We have reflected these points in the draft mandate.

2.5 Another point where we heard much agreement was that it would be helpful for the Government to consult on a draft version of the mandate, rather than simply on principles or high-level proposals. Many people said that, in order to avoid the consultation becoming abstract or theoretical, it would be easier to engage properly if they had seen an actual document. This is why we have published a draft mandate as the basis for consultation and discussion.

Structure of the draft mandate

2.6 The draft mandate is divided into five core sections:

- **Improving our health and our healthcare**. This section explains how we intend to set ambitions for improving healthcare outcomes and reducing inequalities, while upholding core performance standards such as on waiting times. It also includes an objective for strengthening the priority given by the NHS to preventing illness and supporting people to improve their health.
- **Putting patients first**. A core part of improving the quality of care, especially for the rising numbers of people living with long-term conditions, is to empower patients, families and carers, and support them to manage their health better. This section sets objectives to extend shared decision-making and choice, improve information, make services more integrated around the needs of individuals, and improve the support the NHS gives to carers. We have also published a draft "choice framework" alongside the draft mandate, explaining where and how patients can expect to be able to make choices.
- **The broader role of the NHS**. This section emphasises that the NHS is in a unique position to work with other public services to help achieve broader social and economic objectives. The NHS can, by working well with its partners, go beyond the traditional boundaries of the healthcare system, such as in providing support for children with special educational needs and disabilities, or helping to reduce reoffending. The draft mandate highlights some areas where partnership working between services is particularly important or needs to be improved. This section also includes an objective about the role of NHS commissioners in supporting research and contributing to economic growth through the life sciences industry.
- **Effective commissioning**. This section sets a small number of objectives about the way that the Board introduces the new commissioning system: to help achieve the full benefits of clinically-led commissioning, while at the same time managing the transition in a way that safeguards service performance and finances. There is a specific objective for the Board to be able to account transparently for the quality and value of the services that it commissions directly.

- **Finance and financial management**. This section will set the Board's budget (the figures are not included in this draft mandate but will be published in the final version). It also includes some principles for the Board to allocate resources in a fair and transparent way, and sets the Board an objective to make efficiency savings. However, most of the detailed financial requirements on the Board will be set out elsewhere – in particular in the framework agreement.

2.7 Because setting outcome-based objectives is a radically new approach for the NHS, the next chapter of this document gives some more background on this, and we have published a technical annex on the NHS Outcomes Framework with more detail. But we have not included a section-by-section commentary on the other parts of the draft mandate; instead, we have included some consultation questions in the draft mandate itself (these are listed in Chapter 6 below). We would welcome your views on these questions and on our approach to developing the mandate generally.

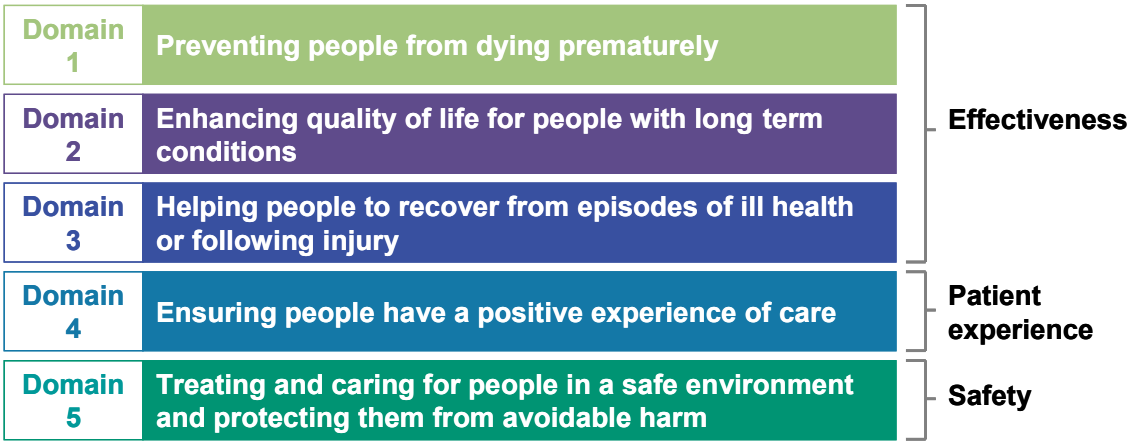
3. Setting outcome-based objectives

3.1 The core purpose of the mandate, and of the NHS Commissioning Board itself, is to help improve people's health and the outcomes of healthcare. The main way we propose to do that through the mandate is by setting objectives for improvement against the NHS Outcomes Framework.

The NHS Outcomes Framework

3.2 The NHS Outcomes Framework is a set of national outcomes goals and supporting indicators which patients, the public and Parliament will be able to use to judge the overall progress of the NHS, and which the Department of Health will be able to use in holding the Board to account.

3.3 The Framework, which has already been subject to extensive consultation, is structured around five "domains", capturing the NHS's role in reducing premature deaths, enhancing quality of life, helping people to recover from ill-health and injury, providing a good experience of care, and providing a safe care environment. The domains were chosen to reflect the three elements of good quality care: effectiveness, patient experience and safety.



3.4 Twelve overarching indicators cover the broad aims of these five domains, and 60 indicators in total capture the breadth of NHS activity. The NHS Outcomes Framework sits alongside similar frameworks for public health and adult social care. The distinct frameworks reflect the different delivery systems and accountability models for the NHS, public health and adult social care. But the frameworks are aligned and contain shared indicators to drive collaboration and integration.

Outcome-based objectives

3.5 The draft mandate sets an objective for the Board to ensure continuous improvement across all of the 60 indicators in the NHS Outcomes Framework. This is in line with the Board's legal duty about continuously improving the quality of care. But we do not propose to set specific objectives for individual indicators, or for particular clinical conditions or groups.

3.6 Instead, our intention is to set the Board a stretching ambition to improve against each of the five domains as a whole, based on an aggregate measure of performance for each domain. To reflect the fact that there can be a time-lag in changing outcomes, we plan to set ambitions to achieve within two, five and ten years.

3.7 We think there are several advantages of setting objectives at domain level:

- This focuses attention, in a transparent way, on the **ultimate outcomes of care** that matter to patients and professionals: saving and improving lives, enhancing patients' experience, and reducing harm.
- It provides a "**balanced scorecard**", which gives commissioners freedom to decide how to improve quality and outcomes in ways that are most important for their local populations. Setting prescriptive objectives for individual indicators would reduce local autonomy and risk distorting clinical priorities.
- The biggest healthcare challenge of the future is the rise in the number of people living with long-term conditions. Increasingly, many people have complex needs, with more than one condition at once. Therefore it is better for the mandate to take a **holistic approach** that looks at quality of life and quality of care as a whole, rather than focusing primarily on the treatment of individual clinical conditions.

3.8 As the draft mandate makes clear, there are specific areas of NHS care, such as care for people with cancer, where the Government has already set out ambitions for improvement. Many of these are reflected in the NHS Outcomes Framework, and we intend that they will be captured in the outcomes objectives we set the Board. There is no doubt that these areas will be priorities for the Board and for CCGs. However, we want the mandate to focus on the Board's performance as a whole, across the range of healthcare services.

Setting levels of ambition

3.9 A separate technical annex on the NHS Outcomes Framework describes the detailed methodology for constructing the levels of ambition. In summary, we are looking to create levels of ambition that take into account recent and likely future trends in outcomes (where these are known), and which set an additional challenge to the Board, which is achievable within the current resources available to the NHS.

3.10 More data on outcomes will become available during the consultation period. As the technical annex explains, we currently have a partial assessment of what could be included in a level of ambition for each domain. Our aim is therefore to develop the levels of ambition over the summer before they are published in the final mandate, so that they are as comprehensive as possible. The draft mandate includes suggestions of how these objectives might be phrased. The technical annex includes examples of what these levels of ambition may contain, and invites views.

3.11 We think it is right to use outcomes as the basis for assessing the performance of the health service. But we recognise that this approach is a significant shift from the past, and we are still at the early stages of a journey. It is likely that the ambitions included in the final mandate will still include some gaps – because of lack of evidence or measures. The Department of Health and the Board will need to work together over the coming years to develop and improve the NHS Outcomes Framework and the information and indicators that support it, and we have established an advisory group (the Outcomes Framework Technical Advisory Group – OFTAG) to provide expert input. Views expressed during this consultation will be particularly helpful in informing this longer term work.

3.12 We want the mandate to set a clear sense of direction and challenge to the Board. But some of the detail of the ambitions, especially the 10-year ambitions, is likely to be refined and updated in future mandates in the light of experience and improving information.

Reducing inequalities

3.13 A particular area where there is a need for further work is in measuring outcomes for different groups of people, to assess the impact on equality and inequalities.

3.14 The Health and Social Care Act has, for the first time, created legal duties about tackling inequalities in access to services and the outcomes of healthcare – in line with the Government's aim of improving the health of the poorest fastest. Legal duties about reducing health inequalities build on the existing duties of all public bodies in relation to promoting equality. The focus on localism and clinical leadership within the new NHS commissioning system, together with the creation of local Health and Wellbeing Boards, will produce new opportunities to address health inequalities in every area across the country, by focusing on disadvantaged groups which experience poor health outcomes, including those who are vulnerable or socially excluded.

3.15 Our approach to the NHS Outcomes Framework supports this: by highlighting data across a wide range of indicators, it will shine a light on areas that need to be tackled and expose unjustified variations in outcomes.

3.16 The draft mandate includes a specific objective to reduce inequalities in domain 1 of the NHS Outcomes Framework (preventing people from dying prematurely), where there is sufficient evidence to be able to set a level of ambition. To add more focus on inequalities in the other domains, the draft mandate includes a general objective for the Board to assess and seek to reduce inequalities while achieving the overall outcome objective. Our aim is that, as information and evidence improves and the methodology develops, this will provide a basis for setting more targeted goals in future mandates.

4. Assessing progress

4.1 The mandate is a formal mechanism for the Government to hold the NHS Commissioning Board to account for its performance, on behalf of patients and taxpayers. It is important to be able to judge clearly how well the Board has performed. Therefore, we have published an annex to the draft mandate (Annex B) describing for each objective how we intend to assess the Board's progress. In some cases, there is an obvious measure of performance to use. But for many objectives, there is no existing indicator, and we will be asking the Board to develop and provide evidence of what has been achieved.

4.2 In line with our commitment to transparency, the Government will be interested in evidence that can be objectively measured and, wherever appropriate, independently reported.

The accountability cycle

4.3 The mandate is one part of a wider cycle of accountability for the Board. The Health and Social Care Act makes clear that:

- The Board must publish a **business plan** each year, saying how it intends to carry out its functions and deliver the objectives and requirements in the mandate.
- The Secretary of State must **keep the Board's performance under review**, including how it is performing against the mandate.
- The Board must publish a **report** at the end of each year saying how it has performed.
- The Secretary of State must then publish an **assessment** of the Board's performance.

4.4 Besides these formal requirements, there will be an ongoing sponsorship relationship between the Department of Health and the Board, which will be described in the framework agreement. In particular, the Secretary of State will hold formal accountability meetings with the Chair of the Board, normally every two months, and the minutes of these meetings will be published. These meetings will be an opportunity for Ministers to discuss progress or raise any emerging priorities or concerns. If there were particular concerns about performance, Ministers could, for example, ask the Board to report publicly on what action had been taken, or ask the Chair to write a letter setting out a plan for improvement.

4.5 The Department of Health intends to carry out assessments of all its arm's-length bodies, looking not only at how they have carried out their functions, but also to give assurance about their "organisational health": the strength of their governance and their relationships with other bodies. In the same way as for other arm's-length bodies, we intend to use a range of hard and soft evidence to assess the Board's performance, including feedback from stakeholders such as patients, commissioners, GPs and other clinicians, as part of a balanced scorecard approach. We would be interested in your views about the best way of achieving this.

5. The consultation process

5.1 This consultation will run from 4th July to 26th September 2012.

5.2 You can find out more and respond to this consultation at: http://mandate.dh.gov.uk. You can contact us via: mandate-team@dh.gsi.gov.uk.

Criteria for consultation

5.3 This consultation follows the 'Government Code of Practice', in particular we aim to:

- formally consult at a stage where there is scope to influence the policy outcome;
- consult for at least 12 weeks with consideration given to longer timescales where feasible and sensible;
- be clear about the consultation's process in the consultation documents, what is being proposed, the scope to influence and the expected costs and benefits of the proposals;
- ensure the consultation exercise is designed to be accessible to, and clearly targeted at, those people it is intended to reach;
- keep the burden of consultation to a minimum to ensure consultations are effective and to obtain consultees' 'buy-in' to the process;
- analyse responses carefully and give clear feedback to participants following the consultation; and
- ensure officials running consultations are guided in how to run an effective consultation exercise and share what they learn from the experience.

5.4 The full text of the code of practice is on the Better Regulation website at:

http://www.bis.gov.uk/policies/bre/consultation-guidance/subscribers-to-code-of-practice

Comments on the consultation process itself

5.5 If you have concerns or comments which you would like to make relating specifically to the consultation process itself please contact:
Consultations Coordinator
Department of Health
3E48, Quarry House
Leeds
LS2 7UE
e-mail consultations.co-ordinator@dh.gsi.gov.uk

Please do not send consultation responses to this address.

Confidentiality of information

5.6 We manage the information you provide in response to this consultation in accordance with the Department of Health's Information Charter at http://www.dh.gov.uk/en/FreedomOfInformation/DH_088010.

5.7 Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

5.8 If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

5.9 The Department will process your personal data in accordance with the DPA and, in most circumstances, this will mean that your personal data will not be disclosed to third parties.

Summary of the consultation

5.10 A summary of the response to this consultation will be made available before or alongside any further action, such as laying legislation before Parliament, and will be placed on the Consultations website at http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/index.htm

6. Consultation questions

Our approach to the mandate

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

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

3. 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?

Assessing progress

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

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

Improving our health and our healthcare

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

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

8. How could this approach develop in future mandates?

Putting patients first

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

10. Do you support the idea of publishing a "choice framework" for patients alongside the mandate?

The broader contribution of the NHS

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

Effective commissioning

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

2900200 July 2012
Produced by Williams Lea for the Department of Health