Sheffield Clinical Commissioning Group

Draft Response to the Consultation on the NHS Mandate

Governing Body meeting

5 September 2013

Author(s)/Presenter and title	Tim Furness, Director of Business Planning and Partnerships
Sponsor	Tim Furness, Director of Business Planning and Partnerships

Key messages

The Department of Health published a consultation document "*Refreshing the Mandate to NHS England: 2014-2015*" in July 2013, with a request for consultation responses to be submitted by 27 September 2013. The consultation document and the first mandate are available at http://consultations.dh.gov.uk/mandate/mandate-refresh/consult_view.

The final version of the mandate to NHS England will be a major influence on the planning guidance that NHS England issues to CCGs for 2014/15. It is therefore appropriate that NHS Sheffield CCG considers and responds to the consultation document.

The attached document is a proposed response to the consultation to be submitted by the CCG, for discussion by the Governing Body. It addresses those issues in the draft mandate that seem to particularly affect the CCG.

Assurance Framework (AF) (2012/13)

4.1 Ineffective commissioning practices

How does this paper provide assurance to the Governing Body that the risk is being addressed? Effective planning, including horizon scanning, is a key part of effective commissioning. This paper provides Governing Body with information about likely future demands on the CCG and a draft response to those proposed demands, to aid planning.

Is this an existing or additional control? Additional

Equality/Diversity Impact

Has an equality impact assessment been undertaken? NO. It is assumed that the DH will undertake an equality impact assessment of the proposed mandate.

Which of the 9 Protected Characteristics does it have an impact on? All

Public and Patient Engagement

There has been no CCG-led PPE on this as the consultation is open to the public and it is appropriate that the DH leads PPE rather than the CCG, which is a respondent to the consultation.

Recommendations
That the Governing Body reviews the consultation document and comments on and approves the attached proposed response.

Draft Response to the Consultation on Refreshing the Mandate to NHS England

Overview

We support the intent to refresh the mandate to NHS England, recognising that this will then be reflected in the planning guidance that NHS England gives to Clinical Commissioning Groups. It is right that the national requirements on the NHS are updated to reflect changing need and priorities.

We support the emphasis given to responding to the Francis and Winterbourne View inquiries, to making best use of resources, and to meeting the needs of vulnerable older people.

However, the requirements in some instances are quite specific and prescriptive. This is not consistent with the need for local innovation – which his recognised in the consultation document – as the requirements, unlike the mandate last year, describe how outcomes should be achieved, not just what outcomes should be achieved.

In addition, the sum effect of the new requirements contained in the mandate is likely to be a requirement for significant new investment. Although the document recognises this and states that the Government will need to consider adapting existing priorities, it does not describe how this will happen or ask comments on which existing priorities might be adapted. There is therefore a real risk that the requirements are unaffordable and an even greater risk that many CCGs will be left with no flexibility to address local needs.

Delivering Improvement

It is not possible, on the basis of the consultation document, to judge whether a target of avoiding 10,000 excess deaths per year by 2018 is possible. It is not clear to us how we can identify which deaths are “excess” and we suspect that the evidence will show that avoidance of many premature deaths is a long term undertaking, relying on public health interventions and action on the wider determinants of health rather more than healthcare interventions.

It does not seem to us appropriate that the mandate to the NHS should be so specific as to reflect the specifics of plans to strengthen A&E services – this is one of example of the proposals seeking define HOW the NHS delivers rather than WHAT it delivers.

We support the emphasis on mental health crisis interventions – however, we do not think that those services bear direct comparison with A&E as the nature of the need and the response is quite different. The wording of the proposal might therefore be altered.

New access or waiting time standards for mental health services will come at a cost, especially in the context of those services being required to make year on year efficiency savings. There is an implication in the wording that the Department might make additional funding available for this purpose – this should be more explicit.

We support the aim to improve care for vulnerable older people, and recognise in the proposals the work that we are doing in Sheffield to put in place multi-disciplinary care planning for people at risk of needing hospital care. As an applicant for integration pioneer status, we of course support those aims. We would note, though, that a patient's GP is already the named accountable clinician – they are the "someone" responsible for ensuring that care is co-ordinated. The mandate should recognise this, even if it is felt necessary to make sure this happens in practice.

With reference to information sharing, again we support the intent, but feel the need to point out that the new regulations regarding information prevent CCGs from accessing patient identifiable information, even though we often act as the provider of that information to practices, e.g. in risk stratification, and need to be able to track patient level activity to evaluate the impact of commissioned services.

We agree that the mandate should be updated to reflect the Francis and Winterbourne View inquiries, although we would hope that organisations are responding to those inquiries anyway. It should not be necessary, in the Mandate, to set out the details of the actions NHS England has signed up to. As in other areas, we would suggest the Mandate should focus on the what, not the how.

As noted above, we support the proposed reflection of "Integrated Care and Support". We also support reflection of the Better health outcomes for children and young people pledges and the extension of the friends and family test.

We have concerns about the "fair playing field" proposal – there is a tension between integration of services, which generally requires a partnership approach with current providers, and the proposed further extension of procurement requirements, which would tend to cause existing providers to be cautious about the nature of the partnership with commissioners that we need to develop if we are to integrate services.

We support the commitment to understanding variation and addressing unacceptable practice. We are wary of the consequences of reporting at practice and consultant level, and would hope that systems are in place to ensure that data is robust and that natural levels of variation are understood and distinguished from statistically significant variation.

With regard to supporting economic growth, we do not understand the rationale for including a very specific objective about genomics – if there is evidence that that is the single most effective act that will promote economic growth, the proposal might explain that.

In the section on making better use of resources, we would have hoped to see more on the support CCGs and NHSE Area Teams need to implanting major transformation of care. Whilst tackling fraud and fair charging are of course important, service transformation is the key to making better use of NHS resources, not better financial management.