



House of Commons
Health Committee

Commissioning

Fourth Report of Session 2009–10

Volume I



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Report, together with formal minutes

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The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

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Footnotes

In the footnotes of this Report, references to oral evidence are indicated by 'Q' followed by the question number, and these can be found in HC 268-II, Session 2009–10. Written evidence is cited by reference in the form 'Ev' followed by the page number; Ev x for evidence published in HC 1020, Session 2008–09, on 15 January 2010, and COM x for evidence to be published in HC 268-II, Session 2009–10.

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Summary

Nearly twenty years ago the then Government introduced the purchaser/provider split whereby services were purchased or commissioned from provider bodies. The stated aim was a more efficient health service and one run more in the interests of patients than hospital doctors. The nature of commissioning systems have changed several times since 1998. It is now primarily undertaken by 152 PCTs.

Whatever the benefits of the purchaser/provider split, it has led to an increase in transaction costs, notably management and administration costs. Research commissioned by the DH but not published by it estimated these to be as high as 14% of total NHS costs. We are dismayed that the Department has not provided us with clear and consistent data on transaction costs; the suspicion must remain that the DH does not want the full story to be revealed. We were appalled that four of the most senior civil servants in the Department of Health were unable to give us accurate figures for staffing levels and costs dedicated to commissioning and billing in PCTs and provider NHS trusts. We recommend that this deficiency be addressed immediately. The Department must agree definitions of staff, such as management and administrative overheads, and stick to them so that comparisons can be made over time.

There are examples of good work being undertaken by PCTs. However, many PCTs believe they are working effectively although the evidence would suggest otherwise.

As the Government recognises, weaknesses remain 20 years after the introduction of the purchaser/provider split. Commissioners continue to be passive, when to do their work efficiently they must insist on quality and challenge the inefficiencies of providers, particularly unevicenced variations in clinical practice.

Weaknesses are due in large part to PCTs' lack of skills, notably poor analysis of data, lack of clinical knowledge and the poor quality of much PCT management. The situation has been made worse by the constant re-organisations and high turnover of staff.

Commissioners do not have adequate levers to enable them to motivate providers of hospital and other services. We recommend the Department commission a quantitative study of what levers should be introduced to enable PCTs to motivate providers of services better and a review of contracts to ensure that rigid, enforceable quality and efficiency measures are written into all contracts with providers of health care.

Particular arrangements are made for specialised commissioning for rare diseases and conditions. These were reviewed by Sir John Carter in 2006. The implementation of the Carter Review has made significant improvements. However, we are concerned that insufficient progress has been made, with significant local variations; and that some important issues remain outstanding.

Carter recommended the revision of the National Definitions Set; this does not appear to have gone far enough. The DH must indicate what it will do to ensure that the fourth edition commands wider confidence and support among commissioners.

Worryingly, the evidence which we received indicates that many PCTs are still disengaged from specialised commissioning. Furthermore, there is a danger that the low priority many PCTs give to it will mean that funding for specialised commissioning will be disproportionately cut in the coming period of financial restraint. In addition, specialised commissioning is weakened by the fact that, as a pooled responsibility between PCTs, it sits in a “limbo”, where it is not properly regulated, performance managed, scrutinised or held to account. There is much to commend the Specialised Healthcare Alliance’s proposal to bypass the PCTs altogether, making the National Commissioning Group and the Specialised Commissioning Groups into commissioners in their own right, although there is some risk that this could lead to a lack of co-ordination of, and disruption to, services. We recommend that the DH undertake a review of the problems we have highlighted, taking into account the Specialised Healthcare Alliance’s proposal.

The Government has embarked on a series of sometimes contradictory reforms which have had significant effects on commissioning. In the first wave of reforms undertaken when the Rt Hon Frank Dobson was Secretary of State, NICE was created. This has led to threats and opportunities for PCTs. Potentially, PCTs could insist that hospitals use NICE guidelines to provide the best, cost effective care; unfortunately, they have done this less often than they should have. On the other hand, there is a tendency for NICE guidance to be “inflationary” in its effect on spending by PCTs, obliging them to pay for certain expensive treatments. We repeat our regular injunction that NICE should do more to specify where disinvestment should take place.

The next wave of reforms, made when the Rt Hon Alan Milburn was Secretary of State, sought to achieve a more market-oriented NHS; they included the introduction of PbR. We were informed that this has had a number of disadvantages for commissioners. PbR threatens to increase transaction costs and, in part because of the weakness of commissioning, provides hospitals with an incentive to generate more activity to increase their income.

More recently the DH has appeared to place less emphasis on the market-based approach. The present Secretary of State has stated that the NHS is the “preferred provider” and Integrated Care Pilots have been introduced. It is unclear how this policy relates to earlier measures such as PbR.

Although there has been slightly less emphasis on market reforms recently, the NHS remains characterised by tensions between purchasers and providers. The weakness of commissioners faced by powerful providers means that the reforms have threatened to undermine some of the Government’s key aims, such as switching care from hospitals to the community.

The Government has sought to address the weaknesses of commissioners by its World Class Commissioning programme which seeks to improve commissioners’ “competencies” and FESC which provides access to outside consultants to fill skill gaps. CQUIN, PROMs and Quality Accounts are intended to give commissioners better levers in relation to providers.

Ridiculous though the term is, much of the World Class Commissioning initiative is unexceptionable. It is clearly too early to judge the success of WCC but the Committee

notes there are serious concerns about the capability of PCTs to make the huge step changes required. We recommend that the Care Quality Commission use the eleven competencies of World Class Commissioning to judge PCTs.

We are concerned that PCTs might be too complacent to make the necessary improvements. A survey we commissioned from the NAO revealed a remarkable degree of misplaced confidence on the part of PCTs about how well think they are doing.

It is not clear to us that WCC is going to address the lack of capacity and skills at PCT level and weak clinical knowledge. Furthermore there are concerns that WCC will be no more than a “box ticking” exercise whereby people expend a lot of energy merely demonstrating they have the right policies in place, rather than actually transforming patient outcomes and cost effectiveness.

The Government believes that CQUIN, PROMs, Quality Accounts and Never Events will improve commissioning, shifting power away from providers and enhancing the quality of care. However, we remain concerned that the Government is not piloting and rigorously evaluating these ideas before implementation, as we have previously said.

PCTs clearly do lack the skills that they need for commissioning and engaging consultants is one way of helping to address this situation. However, we are concerned that FESC is an expensive way of addressing PCTs’ shortcomings. The Minister of State himself expressed concern about the extent to which consultants are being used. The Department must do more to determine whether or not the taxpayer is getting real value for money out of this costly exercise. Whatever the possible benefits of using consultants, we doubt the ability of PCTs to use consultants effectively.

The Government has announced a 30% reduction in management costs in PCTs and SHAs from 2010 to 2013. While some PCTs do a good job with low overheads, we are not convinced that taking money away from weaker PCTs will automatically encourage them to improve their performance. At a time when we are expecting so much of PCTs, it seems risky to be cutting their management costs by 30% when they need better skills and more talent. We note that the Minister indicated the potential to make savings from SHAs; we agree that they should bear the brunt of any cuts.

If we are to keep PCTs they need to be strengthened. In particular, they require a more capable workforce, with people able to analyse and use data better to commission services. They also need to improve the quality of management, attracting and developing talent. As we have argued in previous reports, the NHS Graduate Management Training Scheme could play a major role in achieving this. However, commissioning cannot be improved in isolation from the rest of the health service. PCTs will need to have more power in dealing with providers. It needs to be able to offer more evidence-based financial incentives to providers to improve its relationship with providers. We trust our successors will follow the CQUIN initiative carefully. It must, however, be properly evaluated. If successful it should be expanded significantly. At the moment the Government has proposed some sort of qualitative analysis, which amounts to little more than asking participants how they feel about it. We recommend the Government institute a rigorous quantitative assessment.

In conclusion, a number of witnesses argued that we have had the disadvantages of an

adversarial system without as yet seeing many benefits from the purchaser/provider split. If reliable figures for the costs of commissioning prove that it is uneconomic and if it does not begin to improve soon, after 20 years of costly failure, the purchaser/provider split may need to be abolished.

1 Introduction

1. The great majority of English people do not know what commissioning is or what a Primary Care Trust (PCT) is. Yet commissioning is a key function of the NHS and PCTs are important institutions which spend about 80% of the NHS's annual budget of £100 billion. In part because of the central role PCTs play in the NHS, they are constantly subject to criticism. Scarcely a week passes without the revelation of new failings. The week before this report was agreed PCTs were criticised for not spending Government allocations earmarked for carers.¹ We held an evidence session on the use of EEA doctors in out-of-hours services, which presented us with an appalling catalogue of the negligent behaviour of some PCTs.²

2. Many of our reports have been critical of PCTs. On dentistry, we found that many PCTs had failed adequately to assess the needs of their population or commission services.³ On patient safety, we concluded that PCTs had not paid attention to the quality of services hospitals were providing.⁴ None of the examples of appalling care provided by hospitals in recent years had been detected by the local PCT. In our report on Lord Darzi's *Next Stage Review* we doubted whether PCTs had the ability to implement the reforms he advocated.⁵ Given our repeated expressions of concern about PCTs, we decided to undertake a more thorough study of commissioning with the following terms of reference:

- “World-Class Commissioning”: what does this initiative tell us about how effective commissioning by PCTs is?;
- The rationale behind commissioning: has the purchaser / provider split been a success and is it needed?;
- Commissioning and “system reform”: how does commissioning fit with Practice-based Commissioning, “contestability” and the quasi-market, and Payment by Results?;
- Specialist commissioning;
- Commissioning for the quality and safety of services.

3. We received 121 memoranda and held 4 oral evidence sessions. We would like to thank all those who gave evidence and our advisers, Dr Daphne Austin and Professor Alan Maynard who provided us with expert guidance about this complex subject.⁶

1 “Millions of pounds promised for carers has been diverted to plug NHS debts”, *Daily Telegraph*, 6 March 2010

2 Oral evidence taken before the Health Committee on 11 March 2010, HC 441

3 Health Committee Fifth Report of Session 2007–08, *Dental Services*, HC 289–I

4 Health Committee, Sixth Report of Session 2008–09, *Patient Safety*, HC 151–I

5 Health Committee First Report of Session 2008–09, *NHS Next Stage Review*, HC 53–I

6 They declared the following interests: Dr Daphne Austin declared her interest as Chair of the UK Commissioning Public Health Network, and Consultant in Public Health, West Midlands Specialised Commissioning Team, and Professor Alan Maynard declared his interest as Chair of the York Hospitals NHS Foundation Trust, Professor of Health Economics, Department of Health Sciences, and Hull-York Medical School, University of York

2 Commissioning 1948–2010

What is commissioning?

4. Commissioning is a function which is at present primarily exercised within the NHS in England by Primary Care Trusts (PCTs), which exist to ensure that healthcare services are provided for their “responsible populations”. Put more bluntly, the core role of commissioners has been to buy services for their populations, although it has always been more than this.

5. The Department of Health described to us its understanding of the roles of a health service commissioner as:

To be the advocate for patients and communities—securing a range of appropriate high-quality healthcare services for people in need,

To be the custodian of tax-payers money—this brings a requirement to secure best value in the use of resources.

The Department added:

Commissioners increasingly need to be advocates for health and wellbeing, encouraging and enabling individuals, families and communities to take greater and shared responsibility for staying healthy and managing their health and conditions. This means understanding better the determinants of health, effective engagement and enablement of people and populations and strengthened partnership working to improve health and wellbeing. As a result the role of commissioners has grown from a traditional fairly narrow base of needs assessment and contracting. The challenges to commissioning capability has risen accordingly.⁷

History

1948–1991

6. At the inception of the NHS in 1948 a wholly nationalised system of healthcare funding was created. Comprehensive care was to be provided free of charge for all on the basis of need, funded from taxation. The provision of that healthcare was set up substantially on a nationalised basis, but not entirely. Secondary care in the NHS was to be provided by a national network of NHS-owned hospitals; and community services (such as district nursing), public health services and ambulance services were also to be publicly provided (initially by local councils and from 1974 by the NHS itself). However, primary care (i.e. general medical, dental and ophthalmic services, and pharmaceutical services) was to be provided by independent practitioners, acting as contractors to the NHS.⁸

7 Ev 2, Department of Health

8 Geoffrey Rivett, *History of the NHS*. www.nhshistory.net

7. The NHS in its initial form planned services that it provided itself, in particular in hospitals, and through a national contract and local committees procured services from independent providers, which were largely “cottage industries” run by self-employed clinicians who became, particularly in the case of GPs, closely bound in with the NHS.

8. While health policy for several decades after 1948 can be characterised as fairly modest adjustments to the original design of the NHS, the need to restrict public expenditure growth from the mid-1970s led to an increasing focus on how to make the NHS more efficient. Eventually, this resulted in the most significant cultural shift since the inception of the NHS with the introduction of the “internal market”, outlined in the 1989 White Paper *Working for Patients*⁹ and passed into law as the NHS and Community Care Act 1990. The then Government stated that the reforms would increase the responsiveness of the service to the consumer, foster innovation and challenge the monopolistic influence of hospitals. Proposals were made to make hospitals compete for resources in an internal market and to make doctors more accountable and involve them more effectively in management. These changes were implemented in 1991.¹⁰

The purchaser/provider split 1991–2010

9. The 1991 market reforms were based on the **purchaser-provider split**. It was thought that, whereas in the past providers, usually hospital doctors, had largely determined what services would be provided, now commissioning bodies would act on behalf of patients to purchase the services which were really needed. “Purchasers” (health authorities and some family doctors) were given budgets to buy health care from “providers” (acute hospitals, organisations providing care for people with mental health problems, people with learning difficulties, older people and ambulance service). To become a “provider” in the internal market, health organisations became NHS “trusts”, separate organisations with their own management. This split between purchaser and provider underwent several changes over the next 20 years, as Box 1 shows, but in essentials remained the same.

9 Department of Health, *Working for Patients*, Cm 555, January 1989

10 Ev 337

Box 1: Commissioning models in the NHS since 1991

Period	Purchasers	Secondary care providers	Choice of provider exercised by
1991–98	192 District Health Authorities (100 Health Authorities from 1996) and GP Fundholders	NHS Trusts (becoming independent from District Health Authorities in a series of waves during 1991–6)	District Health Authorities (Health Authorities from 1996) and GP Fundholders
1998–2002	100 Health Authorities (in conjunction with 481 Primary Care Groups from 1999, descending in a series of waves, with some mergers, into 303 Primary Care Trusts by 2002)	NHS Trusts	Health Authorities
2002–06	303 Primary Care Trusts (in conjunction with Practice-Based Commissioners from 2005)	NHS Trusts and NHS Foundation Trusts (descending from NHS Trusts in a series of waves from 2004)	Primary Care Trusts (with Practice-based Commissioners from 2005)
2006 to present	152 PCTs in conjunction with Practice-Based Commissioners	NHS Trusts, NHS Foundation Trusts and independent sector providers on local menus (also on Extended Choice Network from 2007, then “any willing provider” from 2008 – qualified in 2009 by the Secretary of State declaring that the NHS itself is the “preferred provider” of NHS services)	Patients through Choose and Book (initially from local menus; also from Extended Choice Network from 2007; then on the basis of “free choice” from 2008), Primary Care Trusts with Practice-based Commissioners

1991–98

10. The role of “purchasers” within the post-1991 NHS came to be defined as “commissioning”. This term has had numerous definitions over the past two decades and continues to be contested, but it is intended to indicate that being a “purchaser” is, or should be, about much more than simply contracting with and paying “providers” for supplying healthcare services.

11. Under the initial model of the purchaser/provider split there were two kinds of purchasers: District Health Authorities (DHAs) and GP Fundholders. DHAs had been created in 1982 to run local health services (apart from primary care), which meant they directly managed local acute hospitals. As NHS Trusts broke free from DHA control, DHAs became purchasers of healthcare services from the Trusts.

12. In successive “waves” of development from 1991 to 1997, many family doctors were given budgets with which to buy health care from NHS trusts (and also the private sector) in a scheme called **GP fundholding**. The scheme was voluntary but each year more and more GPs joined. Those who did not have their own budgets had services purchased for them by health authorities that bought “in bulk” from NHS trusts. Patients of GP fundholders were often able to obtain treatment more quickly than patients of non-fundholders.

13. During the 1990s some GP fundholders came together in networks (multi-funds or fundholding consortia). This was to enable smaller practices to participate in fundholding schemes, and to create organisations which could pool resources and share financial risks. Non-fundholding GPs also started to work together as GP commissioning groups as a means of gaining influence over health authorities purchasing decisions.

14. In 1994, the government decided to develop a “primary-care led NHS”, which included the addition of **total purchasing** pilot schemes which gave volunteer fundholding practices a delegated budget to purchase all of their hospital and community services, i.e. increase further the variety of commissioning models.

15. There were advantages and disadvantages of fundholding in the 1990s. There were accusations that the NHS was operating a two tier system, contrary to the founding principles of the NHS of fair and equal access for all to health care. Supporters said fundholding saved money and was more efficient. Researchers found that GP fundholding exerted downward pressure on secondary care admissions for elective surgery, but it also had disadvantages, including the creation of a two-tier system and high transaction costs.¹¹

Primary care groups: 1997–2001

16. In May 1997 the incoming Labour Government decided to abolish the internal market. In December of that year the Government set out a 10 year vision for the English NHS with the White Paper, *The New NHS—Modern, Dependable*.¹² The purchaser-provider split was retained and overall responsibility for commissioning health services remained with health authorities, but fundholding was abolished, leading to a search for other ways to give primary care power and influence over the use of money in the hospital sector.

17. **Primary Care Groups** (PCGs) were established; membership of them was compulsory for all GPs and primary care professionals. PCGs effectively took on the purchaser role, but were also providers of some community services. The core functions of PCGs were:

- to improve the health of the local population,
- to develop primary and community services,
- to commission secondary and tertiary services.

11 Ian Greener & Russell Mannion, “A realistic evaluation of practice-based commissioning”, *Policy & Politics*, vol 37 (2009), pp 57–73 (2009)

12 Department of Health, *The New NHS—Modern, Dependable*, 1997.

Primary Care Trusts, 2001 to 2005

18. The Government launched its *NHS Plan*¹³ in 2000, backed up by a significant increase in funding. The key problems the Plan identified were: a lack of money; a lack of national standards; old-fashioned demarcations between staff and barriers between services; lack of clear incentives and levers to improve performance; over-centralisation; disempowered patients. Its key reforming principles were:

- A patient-focussed service, offering patient choice and an expanding independent sector,
- Competitive providers, giving hospitals and GPs incentives to change, including Payment by Results, money following patients and the possibility that organisations might fail,
- Active purchasers, including PCTs (successor organisations to PCGs) and practice-based commissioning,
- Cost-effectiveness and affordability.

19. Under the *NHS Plan* all PCGs were to become **Primary Care Trusts (PCTs)** by April 2004. *Shifting the Balance of Power*, published in 2002,¹⁴ brought forward this date to April 2002. In addition, the 100 Health Authorities were to be abolished and 28 new **Strategic Health Authorities (SHAs)** created, essentially local offices of the Department of Health. SHAs were to develop a strategic framework, agree annual performance agreements and build capacity and support performance improvement. The number of SHAs was reduced from 28 to 10 in 2006.

20. After the 2002 Budget, funding increased. Alan Milburn, the Secretary of State for Health, published *Delivering the NHS Plan* which introduced important new ideas:¹⁵

- Payment by Results: a change in the pattern of financial flows in the NHS using a tariff system paying providers for the work they actually did,
- Foundation Trusts: hospitals established as public interest companies outside Whitehall control,
- Patient Choice: where patients would be given information on alternative providers and would be able to switch hospitals to have shorter waits,
- Primary Care Trusts freed to purchase care from the most appropriate provider, public, private or voluntary.

21. Since 2003, the **Primary Care Trust (PCT)** has been the main local public health commissioning organisation in England. Early criticisms included their increasingly management-focused or “corporate” strategy and culture and a falling away of clinical

13 Department of Health, *NHS Plan: a plan for investment, a plan for reform*, 2000.

14 Department of Health, *Shifting the Balance of Power: the next steps*, 2002.

15 Department of Health, *Delivering the NHS Plan: next steps on investment, next steps on reform*, 2002.

engagement and support. This was addressed with the introduction in 2005 of **Practice-Based Commissioning (PBC)**¹⁶ designed to reignite clinical enthusiasm and involvement.

22. PCTs were expensive organisations. PCT staff had many different backgrounds and skills. PCTs had to develop new and commercial commissioning skills as their decisions were open to challenge, particularly when independent contractors tendered.

23. PCTs began to experiment with new organisational patterns, from commissioning confederations (Manchester, Cheshire and Merseyside) to vertical community and acute service mergers (Isle of Wight, Winchester and Cheshire).¹⁷

2005 to 2010; larger PCTs and major reforms

24. Labour's election manifesto in 2005 made a commitment to reduce management costs in the NHS by £250 million. *Creating a Patient-Led NHS*¹⁸ (March 2005) promised to move money from management to “front line” services and reduce the number of SHAs, PCTs and Ambulance Trusts. Following the 2005 General Election a further wave of organisational change began.

25. It was decided to reduce the number of PCTs from 303 to 152 in May 2006, as the DH realised there were insufficient skilled personnel for so many PCTs and to reduce costs. New chairmen were appointed and the new PCTs were established from 1st October 2006.

26. While GP fundholding had been abolished in 1997, in 2005 the Government introduced **practice-based commissioning** to give GPs a larger role in commissioning. Unlike with GP fundholding, which gave GPs the money, PBC gives GPs only “indicative” budgets to commission services on behalf of their patients, while the PCT still does the contracting.

27. Reforms were also made to the commissioning of services for rare conditions, known as **specialised commissioning**. In June 2006 the Department published a review of these services by Sir David Carter, which *inter alia* recommended the establishment of a National Specialised Commissioning Group.¹⁹

28. In the same year there was a reduction in the number of Strategic Health Authorities from 26 to 10. Their new role was to develop plans for improving health services in their local area, performance managing PCTs, improving the quality of these organisations and ensuring they met national priorities.

29. PCTs were central to the running of the NHS, but concern about their weaknesses remained as the Committee concluded in several recent reports.²⁰ To bring about improvement, the Government introduced its **World Class Commissioning** initiative in

16 Department of Health, *NHS Improvement Plan—putting people at the heart of public services*, 2004

17 Geoffrey Rivett, *History of the NHS*, www.nhshistory.net, Chapter 6

18 Department of Health, *Creating a Patient-led NHS, Delivery the NHS Improvement Plan*, 2005

19 Review of Commissioning Arrangements for Specialised Services. Independent Review requested by the Department of Health, May 2006

20 Health Committee, Fifth Report of Session 2007–08, *Dental Services*, 289–1, First Report of Session 2008–09, and *NHS Next Stage Review*, HC 53–1, Sixth Report of Session 2008–09, *Patient Safety*, HC 151–1

2007. In addition PCTs, lacking in-house expertise, were encouraged to buy this from outside agencies. The **Framework for procuring External Support for Commissioning (FESC)** was established in the same year.

30. In 2008 the Lord Darzi's *Next Stage Review* established as key objectives promoting health and improving the quality of care. The review announced the introduction of CQUIN, Quality Accounts and patient reported outcome measures (PROMs) to bring about an improvement in quality.²¹

31. In our report on the Darzi Review, we voiced concerns about its implementation, because we doubted that PCTs were currently capable of doing the task successfully. We concluded:

PCT Commissioning is too often poor. In particular PCTs lack analytical and planning skills and the quality of their management is highly variable.²²

32. As already mentioned, the Government has made other far reaching changes to the NHS, including the introduction of Payment by Results and Foundation Trusts, which have had significant effects on how commissioning bodies operate.

Transaction Costs

33. According to the official historian of the NHS, Dr Charles Webster, the service:

has traditionally scored highly on account of its low cost of administration, which until the 1980s amounted to about 5% of health-service expenditure. After 1981 administrative costs soared; in 1997 they stood at about 12% [...]²³

34. An estimate of administrative costs since 1997 has been made by a team at York University, in a study commissioned by the DH but never published. This concluded that:

management and administration salary costs represent, as a very crude approximation, around 23% of NHS staff costs, and around 13.5% of overall NHS expenditure.²⁴

35. The report noted that "Historically, Beveridge-type systems like the "old" NHS (pre-1991 reform) have been relatively inexpensive to manage and administer", in contrast to systems involving insurance, which have high "transaction costs". It noted that

In the English NHS, the purchaser-provider split, private finance, national tariffs and other policies aiming to stimulate efficiency in the system and create a mix of public and private finance and provision mean almost unavoidably that the more

21 Department of Health, *High Quality for All: NHS Next Stage Review*, 2008

22 *Ibid.* p 20

23 Charles Webster, *The National Health Service: a political history* (2002), p 203

24 Karen Bloor *et al.*, "NHS Management and Administration Staffing and Expenditure in a National and International Context", March 2005, p 8. We are grateful to York University for providing us with a copy of this Report

information is needed to make contracts, hence transactions costs of providing care have increased, and may continue to increase.²⁵

36. This seems to be contradicted by evidence the Department has provided to us in response to our Public Expenditure Questionnaires, indicating consistently low management and administration costs, ranging from 3–8%.²⁶ However, our questioning of DH officials has shown that there is a considerable lack of clarity and consistency in the way that management and administration costs are defined in these data.²⁷

37. Whatever the benefits of the purchaser/provider split, it has led to an increase in transaction costs, notably management and administration costs. Research commissioned by the DH but not published by it estimated these to be as high as 14% of total NHS costs. We are dismayed that the Department has not provided us with clear and consistent data on transaction costs; the suspicion must remain that the DH does not want the full story to be revealed. We were appalled that four of the most senior civil servants in the Department of Health were unable to give us accurate figures for staffing levels and costs dedicated to commissioning and billing in PCTs and provider NHS trusts. We recommend that this deficiency be addressed immediately. The Department must agree definitions of staff, such as management and administrative overheads, and stick to them so that comparisons can be made over time.

Present System

38. Such is the history of commissioning. We now look in more detail at how commissioning works, considering

- The role of PCTs and the World Class Commissioning Initiative
- Practice-based commissioning,

Commissioning for specialised services will be considered in the next chapter.

The role of PCTs

PCTs commissioning

39. Eighty percent of the NHS annual budget of £96 billion (in 2008/9) currently flows through PCTs.²⁸ In this section, we look briefly at the methods used by PCTs to decide how to spend this money. There are three main elements to commissioning:

- The assessment of needs and development of a strategy for each condition, groups of conditions or client group within a population. This strategy determines the

25 *Ibid.*, p 32

26 Health Committee, Session 2009–10, *Public Expenditure on Health and Personal Social Services 2009*, HC 269–i, Ev 179, Table 59A and Ev 252, Table 90

27 Health Committee, HC (2008–09) 28–i, Qq 66–69 and HC (2009–10) 269–ii, Qq 22–26

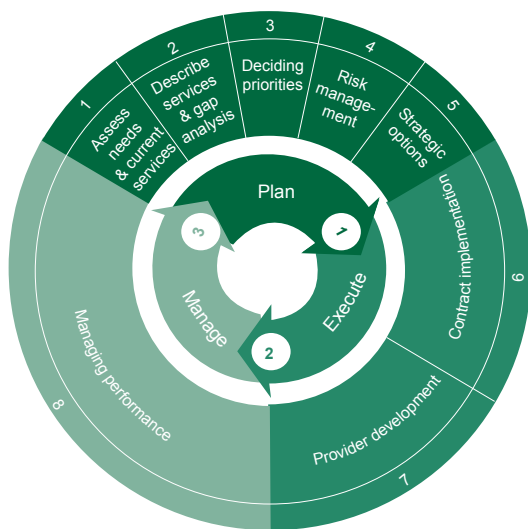
28 Department of Health, *2009–10 and 2010–11 PCT Allocations*, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_091447.pdf

services which are required and the minimum standards they should meet and provides a framework within which purchasing services takes place.

- Purchasing services which is done through formal contracts between purchasers and providers.
- Monitoring and evaluation of services.

The diagram below (the Commissioning cycle) outlines how the Department of Health envisages commissioning should be done.

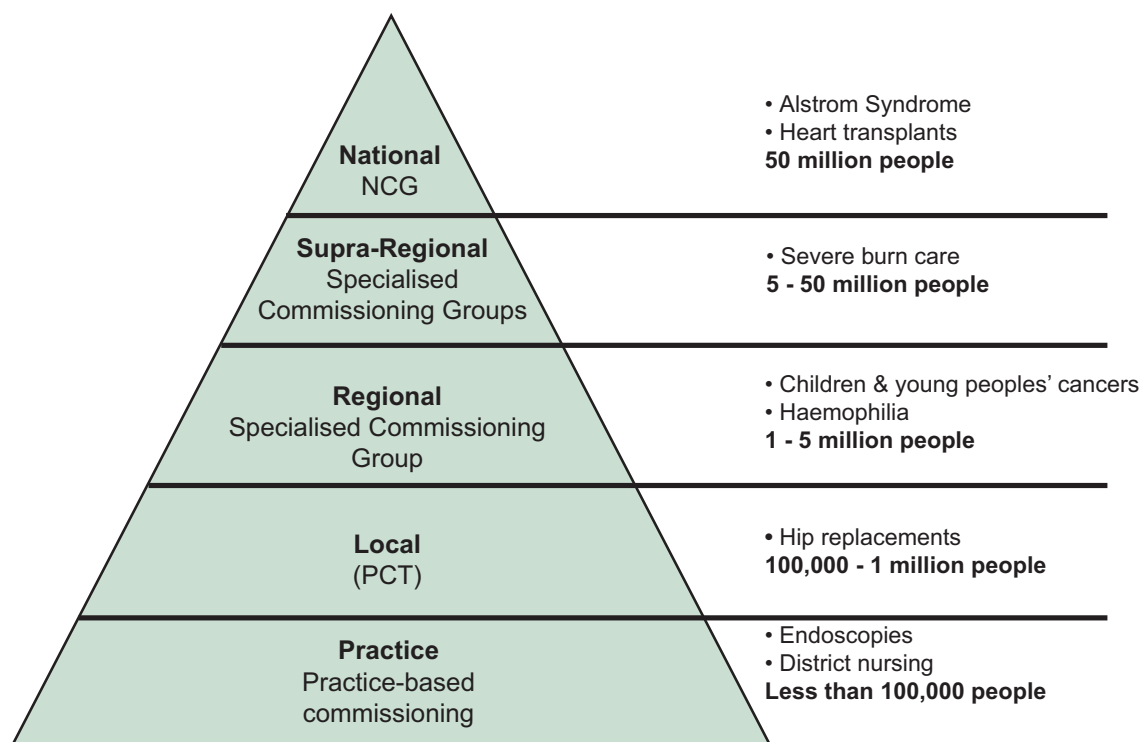
Commissioning cycle



1. **Assessing needs:** through a systematic process, understanding of the health and health care needs of the PCTs resident population.
2. **Describe services and gap analysis:** reviewing the services currently provided and based on the needs, defining the gaps (or over provision).
3. **Deciding priorities:** given a list of desirable actions, using available evidence of cost effectiveness and based on a robust and defensible ethical framework, prioritise areas for purchase.
4. **Risk management:** understanding the key health and health care risks facing the PCT and deciding on a strategy to manage it.
5. **Strategic options:** bring together all the available information into a single strategic commissioning plan that outlines how the PCTs will deliver its core objectives (including those of the SHA and DH).
6. **Contract implementation:** put those strategic plans into action through contracting.
7. **Provider development:** (including care pathway re-design and demand management): support provider improvements or introduce new providers to deliver the services required (including setting up demand management systems and designing new care pathways). This includes supporting providers in decommissioning of services where appropriate.
8. **Managing provider performance:** monitor and manage the performance of providers against their contracts, especially against KPIs.

Source: NHS Isle of Wight (as amended)

40. The figure below shows commissioning responsibilities according to the size of the catchment population involved.



Source: National Specialised Commissioning Group website (FAQs)

Practice-based commissioning

41. Practice Based Commissioning (PBC) is a reform designed to give GPs and practice nurses more say in how the NHS provides services for patients.²⁹ Since 2005, GPs have been able to hold an “indicative” budget to spend on secondary services. The intention is that they will reflect their patients’ preferences, leading to greater variety of services from a greater number of providers and for more conveniences for their patients, as well as a more efficient use of resources. Practices can combine together to commission services. Box 2 shows how PBC is expected to work.

Box 2: Practice-based Commissioning

According to the Department of Health, practice-based commissioning (PBC) continues to play a vital role in health reform. It puts clinicians at the heart of PCT commissioning and allows groups of family doctors and community clinicians to develop better services for their local communities.

Primary care trusts (PCTs) are the budget holders and have overall accountability for healthcare commissioning, however practice-based commissioning is crucial at all stages of the commissioning process.

In particular, practice based commissioners, working closely with PCTs and secondary care clinicians, will lead the work on deciding clinical outcomes. They also play a key supporting role to PCTs by providing valuable feedback on provider performance.

PBC is about engaging practices and other primary care professionals in the commissioning of services. Through PBC, front line clinicians are being provided with the resources and support to become more involved in commissioning decisions.

Practice based commissioning will lead to high quality services for patients in local and convenient settings. GPs, nurses and other primary care professionals are in the prime position to translate patient needs into redesigned services that best deliver what local people want.

DH website 30 June 2009

42. PBC is still voluntary but most practices are now involved, even if only nominally. However the *Next Stage Review* (2008) acknowledged a “widespread view” that PBC had not yet lived up to its potential, and pledged to reinvigorate it and give greater freedoms and support to high performing GP practices.³⁰

3 Commissioning for Specialised Services

The structure of specialist commissioning

43. Although services in the NHS are commissioned by PCTs, there are particular arrangements for commissioning specialised services. Specialised commissioning seeks to ensure that the needs of those with rare diseases, or who require specialised services not available in all local hospitals, are met effectively. Examples of such services include heart, lung and liver transplants, children's heart surgery and neurosurgery, specialised burn care and the treatment of illnesses such as severe immune deficiency or rare neuromuscular disease.³¹ These services are often expensive and unpredictable so PCTs have come together to commission such services collectively and thereby share the financial risk. These services are often best provided in a small number of regional specialist centres so doctors and nurses can develop their skills by seeing as many such patients as possible.

44. Following the Carter Review³² (see Box 3 below) in 2006 these services are commissioned in the following ways, as the National Specialised Commissioning Group informed us:

The National Specialised Commissioning Group has responsibility for overseeing specialised commissioning in England. It facilitates collaborative working between the Specialised Commissioning Groups, for example through national programmes such as the national paediatric cardiac surgery and paediatric neurosurgery programmes, which are currently underway. It also oversees the national commissioning function. Its voting members are 10 PCT Chief Executives representing the 10 regional Specialised Commissioning Groups.

The 10 Specialised Commissioning Groups in England, coterminous with the 10 Strategic Health Authorities, commission services on behalf of their constituent PCTs. They plan and commission those services from within the Specialised Services National Definitions Set that their PCTs direct them to commission. Together they have an annual budget of about £4.5 billion; approximately 5% of NHS spend. This does not represent all spending on specialised services as some services continue to be commissioned locally by PCTs. The Strategic Health Authorities are responsible for the performance management of the Specialised Commissioning Group in their region.

The National Commissioning Group is a standing sub committee of the NSCG. It is predominantly a clinical group and commissions over 50 services nationally for England (and in some cases for Wales, Northern Ireland and Scotland) with an annual budget of about £480 million.

The National Specialised Commissioning Team commissions services on behalf of the National Commissioning Group and supports the work of the National

31 Ev 182 and <http://www.ncg.nhs.uk/>

32 Review of Commissioning Arrangements for Specialised Services. Independent Review requested by the Department of Health, May 2006

the National Commissioning Group, and of 10 regional Specialised Commissioning Groups, one for each SHA. Carter laid down that services should be funded through budgets pooled between constituent PCTs in each SCG on the basis of weighted capitation. There was also to be a review of the Specialised Services National Definitions Set.^{35,36}

45. The National Definitions Set contains a list of 35 services which SCGs are supposed to commission.

Box 4: Specialised Services National Definitions Set

There are 35 specialised service definitions covered by the Specialised Services National Definitions Set.³⁷ The second edition of the Specialised Services National Definitions Set (SSNDS) was completed in December 2002. The third edition is being created during 2009–10.

The purpose of a definition is to identify the activity that should be regarded as specialised and therefore within the remit of PCT collaborative commissioning. A service is specialised if the planning population (i.e. catchment area) for that service is greater than one million people. This means that a specialised service would not be provided by every hospital in England; generally, it would be provided by less than 50 hospitals.

Each definition is drawn up by an iterative process involving providers (clinicians, hospital managers, and information and coding staff), commissioners, patients' groups and the Department of Health. It is then endorsed by the relevant national organisations, signed off by the National Specialised Commissioning Group (NSCG) and published on the NSCG website.

Criticisms of specialised commissioning

46. It seems to be widely acknowledged that the implementation of the Carter Review has had a significantly positive effect on the commissioning of specialised services. The creation of SCGs in particular has been welcomed as a step forward and we received encouraging evidence on the work of some of these,³⁸ as well as that of a supra-regional consortium of SCGs.³⁹ However, we were told that progress in implementing the Carter Review is slow and patchy, meaning that there is significant inconsistency between different parts of the country.⁴⁰ In addition, some witnesses thought that the Carter Review had left some substantial issues unaddressed.

35 The third edition of the National Definitions Set is being released in spring 2010.

36 <http://www.ncg.nhs.uk/index.php/key-documents/the-carter-review/>

37 <http://www.ncg.nhs.uk/index.php/key-documents/specialised-services-national-definitions-set/>

38 Ev 149–151, 262–263

39 Ev 151–154

40 Ev 272, 299

47. We heard that, while the revision of the National Definitions Set is welcome, many still regard it as too rigid in defining a specialised service as one “with a planning population of more than one million people”.⁴¹ Deborah Evans, Chair of the South West SCG, told us:

there are lots of things that have come under the definition set we now regard as matters that PCTs can and would expect to commission within their normal pathways.⁴²

She cited as examples cardiology and cardiac surgery, and child and adolescent mental health services, in both of which cases SCGs were only involved in commissioning “the very complex end” of service provision. Getting the right “dynamic [...] between the PCT and specialised levels” was particularly important in creating better care pathways for people with chronic conditions, helping to join specialised commissioning at the local level with other services, including social care.⁴³

48. The most important criticism of the Carter Review which we heard was that it had not gone far enough in strengthening specialised commissioning. We were told that, while the creation of SCGs and the NCG had reinforced specialised commissioning, they were hobbled by the fact that PCTs still retained ultimate responsibility for specialised commissioning and control of the purse strings. The Specialised Healthcare Alliance told us:

Carter depends on the willingness of PCTs to share sovereignty and resources in a way which is counter to their instincts and the rhetoric of localism.⁴⁴

According to the Alliance, PCTs were often reluctant to pool risk properly, by combining funding with other PCTs on a weighted capitation basis.⁴⁵

49. We were informed that SCGs had no authority over PCTs, since the former were actually sub-committees of the latter. This means that SCGs have no power to oblige PCTs to participate in collective commissioning, or to make them commission services locally when they are not commissioned at the regional level.⁴⁶ Mr Murray, the Director of the Alliance, told us about lack of attendance by PCT Chief Executives at SCG meetings, indicating that the PCTs concerned were treating specialised commissioning as a low priority.⁴⁷

50. The Alliance further told us that the status of SCGs meant that they existed in a kind of “limbo”, unable to be subjected to regulation, performance management, scrutiny and accountability in the way that PCTs were.⁴⁸ This meant, for instance, that while the DH had

41 Ev 108

42 Q 253

43 Q 259; cf. Ev 35, 75, 197

44 Ev 271

45 Ev 272, 274

46 Ev 145, 258

47 Q 261

48 Ev 273; cf. Ev 146

developed a “World Class Specialised Commissioning” programme for SCGs, this was not mandatory in the way that WCC was for PCTs.⁴⁹

51. The Alliance voiced the fear that, during the impending period of financial restraint, PCTs would “look to protect local services in the downturn to the detriment of clinically and cost effective specialised care”, something which SCGs would be powerless to prevent.⁵⁰

52. Accordingly, the Alliance argued strongly in favour of making SCGs commissioners in their own right, channelling funds directly to them instead of giving them to PCTs and locating them at SHA level (rather than being hosted by a PCT). The Alliance also made the same argument in respect of the NCG, arguing that it should be funded directly (rather than through top-slicing of PCTs, as at present) and performance managed by the DH, with Ministers continuing to be involved in decisions about service provision.⁵¹

53. However, Ms Evans told us that this would cut across patient pathways and could damage the quality of care:

I do not believe it is in the interests of patients to take all the money to do with specialised commissioning away from PCTs and put it with another body [...] the challenge but also the strength of PCTs is that they look after a whole population and look across a whole pathway. I do not think it makes sense to take the very specialised end of, say, renal services and give it to another body and then say that all the other aspects of renal services, like looking after people in primary care, early detection of disease and end-of-life care, should be put elsewhere [...] The best interests of patients are for us to make the dynamic between PCT commissioning and SCG commissioning work. Rather than give up on it we should make it work better and that is in the interests of patients.⁵²

Conclusions

54. The implementation of the Carter Review has made significant improvements to the commissioning of specialised services over the past four years. However, we are concerned that insufficient progress has been made, with significant local variations; and that some important issues remain outstanding.

55. Carter recommended the revision of the National Definitions Set; this does not appear to have gone far enough. The DH must indicate what it will do to ensure that the fourth edition commands wider confidence and support among commissioners.

56. Worryingly, the evidence which we received indicates that many PCTs are still disengaged from specialised commissioning. Furthermore, there is a danger that the low priority many PCTs give to it will mean that funding for specialised commissioning will be disproportionately cut in the coming period of financial restraint. In addition,

49 Ev 144, 274; Qq 256-258

50 Ev 272

51 Ev 271, 274; cf. Q 267

52 Q 254

specialised commissioning is weakened by the fact that, as a pooled responsibility between PCTs, it sits in a “limbo”, where it is not properly regulated, performance managed, scrutinised or held to account. There is much to commend the Specialised Healthcare Alliance’s proposal to bypass the PCTs altogether, making the National Commissioning Group and the Specialised Commissioning Groups into commissioners in their own right, although there is some risk that this could lead to a lack of co-ordination of, and disruption to, services. We recommend that the DH undertake a review of the problems we have highlighted, taking into account the Specialised Healthcare Alliance’s proposal.

4 Weaknesses in Commissioning

57. As we have seen in a previous chapter, the NHS has been trying to develop commissioning effectively since the introduction of the purchaser/provider split in 1991. However, PCT commissioning is widely regarded as the weakest link in the English NHS.⁵³ In this chapter we discuss the weaknesses in local commissioning (including PBC) and the reasons for them.

How do PCTs think they are doing?

58. During the inquiry we were provided with examples of good work done by PCTs. The DH mentioned Oxfordshire PCT's work on Joint Commissioning of Primary Child and Adolescent Mental Health Services (Ev 11), Somerset PCT, Chronic Obstructive Pulmonary Disease service (Ev 11), Tower Hamlets PCT, Self Care for Diabetes (Ev 27), NHS Bristol, Commissioning of IVF Services (Ev 147) and NHS Norfolk Stroke Services (Ev 38).

59. The Care Quality Commission in its report on *The state of healthcare and adult social care in 2009* assessed PCTs for the quality of their commissioning, examining their performance against core standards, existing commitments and national priorities.⁵⁴ The great majority of PCTs either “fully” or “almost” met the standards overall, with “100% of PCTs as commissioners ... complying with the 14 core standards” although there were some concerns about records management, staff training and human rights. It should be noted that this report was based on PCT's self- assessments.

60. A further indication that PCTs themselves believe they are doing a good job is evidence from a survey which we commissioned from the National Audit Office for our inquiry. The National Audit Office conducted a telephone survey of commissioners on behalf of the Committee with startlingly positive results, as Box 5 below shows.⁵⁵

53 Ev 251, Ev 261

54 *The State of Healthcare and Adult Social Care in England: key themes and quality of services 2009*. Care Quality Commission.

55 COM 119

Box 5: Findings of NAO Telephone Survey of PCT Commissioners, January 2010

- 95% PCT commissioners were generally very positive about the state of commissioning in its entirety across the PCT.
- 84% commissioners felt that WCC had had a positive impact on commissioning, with 61% feeling it had delivered measurable benefits to patients.
- Commissioning has improved from where it was a year or two ago, but there is clear evidence of the need to improve further.

Key challenges facing PCT commissioners were:

- Financial pressures and constraints (58%)
- Commissioning acute services (21%)
- Clinical engagement to support change (15%)
- Improving commissioning skills within the PCT (14%)
- Greater commissioning capacity within the PCT (14%)
- Ability to decide how to prioritise services (10%)

Weaknesses

61. However, PCTs' positive perceptions of commissioning were significantly at odds with extensive evidence which we received pointing to weaknesses in the system. The submission from the National Audit Office cautioned that the telephone survey results needed to be set in the context of recent NAO value for money reports which had highlighted weaknesses at PCT level in all three stages of the commissioning cycle: strategic planning, procuring services and monitoring and evaluation.⁵⁶

62. Numerous submissions to the inquiry, including those from the National Pharmacy Association, the National Rheumatoid Arthritis Society, Weight Watchers, and Which?, highlighted the variability in the quality of commissioning across the country.⁵⁷

63. The 2009 World Class Commissioning assurance process confirmed that the quality of commissioning by PCTs was largely poor to mediocre.⁵⁸ There was a sizeable gap between what was being delivered and the standards expected within the WCC programme.

64. We received evidence about three particular problems, namely that PCTs were:

⁵⁶ COM 119, para 1.9

⁵⁷ Ev 32, Ev 60, Ev 64 and Ev 124

⁵⁸ *Health Service Journal*, 5th March 2009

- Too passive vis à vis providers
- Failing to improve the quality of services
- Failing to change patterns of service provision

Passivity vis à vis providers

65. In the first evidence session, officials from the Department admitted to the Committee that commissioning was weak.

It is only in the last two or three years that we have realised we need to help commissioners to become much stronger, to help them develop and to help them have an equal footing with providers so that we can have some tension in the system to improve care for the local population.⁵⁹

66. Weaknesses highlighted by the 2009 WCC assurance process also included poor management of relationships with providers and failure to engage in constructive performance discussions to ensure continuous quality improvement.⁶⁰

Failure to improve the quality of services

67. The quality of services is of vital importance. As we showed in our report on Patient Safety PCTs and SHAs failed to realise the appalling treatment of patients in some of the hospitals they were commissioning services from.⁶¹ Professor Chris Ham told us:

I do not think any of us would say hand on heart that PCTs have done a great job in being the active, intelligent commissioners leading the debate about quality and outcomes, putting lots of stuff in their service specifications and standards. That is very much work in progress.⁶²

Failure to change patterns of service provision where necessary

68. Government has repeatedly stressed its policy to move care out of hospitals and into the community and primary care sectors.⁶³ However, PCTs have made little progress. The Audit Commission in November 2009 published a report into productivity and efficiency in the NHS. It found that in 2008–09 PCTs did increase their spending on community services, by 13.2%, which reflected the relative priority investment between primary and community services in that year. However, in the same year, provider trusts also increased their income from PCTs by 6.6%. The report concluded:

59 Q 71

60 Ev 251

61 Health Committee, Sixth Report of Session 2008–09, *Patient Safety*, HC 151–I

62 Q 503

63 Department of Health, *Our Health, Our Care, Our Say*, 2006

whatever the anecdotal local evidence, the headline national figures suggest that PCTs made little or no in-road in 2008–09 to transferring care from hospitals into the community or in dampening demand, either in terms of investment or activity.⁶⁴

69. This view was supported by the Royal College of General Practitioners:

We are encouraged that World Class Commissioning is putting pressure on PCTs to engage with GPs, particularly PBC groups. However, not enough services have been moved to the community and there has been too little investment in generalist person-centred services (as opposed to specialist disease-focussed services).⁶⁵

70. PCTs have the power to re-commission a service (shifting to an alternative provider) or simply decommission a service (stop funding it altogether). Some PCTs have re-commissioned services, e.g. Norfolk PCT's IVF services. Commissioners should not be paying providers to keep providing outdated and poorly evidenced treatments.⁶⁶

we went through a complete tendering process which meant that some providers of IVF services that were not getting the sorts of quality results that we wanted were no longer providing that service to patients in the East of England and other providers that were offering good quality services were given the contract,

John Parkes, from Northamptonshire PCT told us, "I really would not be expecting to be seeing large numbers of tonsillectomies being undertaken."⁶⁷ The Science and Technology Committee was informed during its recent inquiry into homeopathy that West Kent PCT had decommissioned homeopathy services.⁶⁸ However, PCTs appear to find decommissioning hard and there is a tendency to commission what has always been done.⁶⁹ A survey by the *Health Service Journal* revealed that in 2007 the majority of PCTs had failed to decommission any services.⁷⁰

Reasons for weaknesses

71. Witnesses gave several explanations for the weakness in commissioning. These were:

- Shortcomings in data;
- Lack of necessary skills;
- Lack of levers of influence over providers; and
- Impact of Government policies.

64 Audit Commission, *More for Less: Are productivity and efficiency improving the NHS?*, November 2009

65 Ev 283

66 Q 338

67 Q 335

68 Science and Technology Committee, Fourth Report of Session 2009–10, *Evidence Check 2: Homeopathy*, HC 45, para 12

69 Ev 158, 166

70 *Health Service Journal*, 9 October 2008

Shortcomings in data and data analysis

72. The collection and use of data are of vital importance to the NHS in general and PCTs in particular. Data on what services are being provided and the health outcomes that are being obtained through those services allow the NHS to see whether it is getting value for the money it is spending, including whether or not services are adequate in both quality and safety.

73. There are two concerns about PCTs' use of data. First, whether they are making the best use of the data they already have and secondly, their failure to obtain important data that they lack. The Care Quality Commission (CQC) informed us:

In our work we have commonly identified significant concerns about the availability and use of relevant and reliable data to inform accurate assessments of service need—for example in our most recent review of statin prescribing, stop smoking services and cardio vascular disease.⁷¹

74. It seems that many people in PCTs have no idea how to use the data. PCTs employ large numbers of staff, but too few of them seem able to analyse data effectively. The King's Fund told us that a recent survey of GPs and PCT managers had found that many felt deficient in the skills of data analysis.⁷² We were informed that there was a reluctance among commissioners to use the data that is available to challenge providers and a reluctance among providers to be transparent about variations, as they are often unwilling to challenge clinical “norms” which may often be inefficient. This “information asymmetry” had enabled large providers to resist change.⁷³

75. The CQC criticised the assessment and monitoring of providers by PCTs:⁷⁴

Our reviews highlight how performance data could be better utilised by commissioners to drive continuous improvement—for example in the context of maternity services and prisons.

76. David Stout of the NHS Confederation's PCT Network admitted that data had been weak and the Department admitted to the Committee that PCTs had not properly analysed the health needs of their local populations, although they were now starting to do so under the WCC programme.⁷⁵

77. There is the issue of failure to obtain important data which they lack. The Royal College of Midwives argued that one of the key obstacles to effective commissioning of maternity services was the absence of a national or regional data set for maternity services with providers keeping information in different formats and PCTs having different information requirements.⁷⁶ The fpa (formerly the Family Planning Association) argued that

71 Ev 287

72 Ev 252

73 *Ibid*

74 Ev 287

75 Q 75 and Q 76

76 Ev 53

commissioning for sexual health was not supported by the strong data required.⁷⁷ BUPA highlighted the need for more emphasis on data and information acquisition to give managers the tools they needed to manage demand more effectively.⁷⁸ BUPA recommend more emphasis on requiring PCTs to link existing GP, social care and national inpatient data to support practice based commissioners. The British Dental Association highlighted the importance of “properly interpreted and well managed data” as the backbone of high-quality commissioning and the failure of many PCTs to collect it.⁷⁹ The Royal College of Psychiatrists also raised concerns about the scarcity of information:

Local populations vary considerably in their mental health needs and commissioning should respond to that. But there is a lack of good quality local information on population needs, including unmet needs, which is important because those who are in most need may be less able to seek help. Poor use of evidence by commissioners may be the reason why the fivefold variation per person in NHS budget for mental health services does not seem to follow known patterns of prevalence or need but appears to be almost random.⁸⁰

78. John Parkes, Chief Executive of Northamptonshire PCT, also thought that PCTs still lacked the data that they needed:

I would really like to have access to the data that, for example, is held within primary care and I would like to have access to that data to put it alongside the hospital data and social care data because we have got the ability now, if we had all of that data together, to then share it back to, for example, GPs, “Here is somebody with more than one long-term condition. Here is the particular risk for that individual. Here is how that risk can be managed”, or, “Here is somebody for whom a prescription has been prescribed, never been filled, not being taken at the right frequency”. We could use that information in a joined-up way.⁸¹

79. Dr Jennifer Dixon, Director of the Nuffield Trust, told us:

producers have much more information than the commissioners have and in what they are doing they have huge amounts of discretion and cannot easily be challenged. There is not much information about clinical care to help commissioning.⁸²

Lack of other skills and knowledge

80. In addition to lacking the ability to analyse data, there is also evidence of a deficiency in other skills amongst commissioners. The King’s Fund told us:

More recently, renewed emphasis on how to make commissioning effective has led to a series of review studies. Each supports the view that the commissioning function

77 Ev 90

78 Ev 190

79 Ev 227

80 Ev 291

81 Q 309

82 Q 499

has yet to reach full maturity and that those responsible for it lack many of the necessary skills required.⁸³

Clinical Knowledge

81. One of the key weaknesses described in evidence is the lack of clinical knowledge in PCT commissioning. Dr Brambleby stressed the importance of ensuring that commissioning decisions were based on a sound medical evidence.⁸⁴ Unfortunately, numerous submissions highlighted PCT's lack of clinical knowledge and the negative impact that this had on patient care.

82. Although PCTs have public health physicians (albeit in declining number), they often do not have the capacity to deal with clinical specialists whose knowledge base is far superior. For instance, the fpa argued that commissioning for sexual health could be extremely complex.⁸⁵ But a review of the National Strategy for Sexual Health and HIV in 2008 found that a quarter of sexual health and HIV commissioners had been in their posts for less than a year and 11% of posts were vacant.⁸⁶ In addition commissioners responsible for sexual health were often not sufficiently senior to have influence and many had responsibility for a range of competing commissioning roles. BASHH (British Association for Sexual Health and HIV) had come across commissioners who clearly had little or no knowledge of how services were run let alone what patients' needs were.⁸⁷

83. Several other submissions raised concerns about poor clinical knowledge, including Heart UK, the Royal College of Midwives, the National Rheumatoid Arthritis Society, the Urology Trade Association, Wakefield Local Pharmaceutical Committee, the British Dental Association and MEND.⁸⁸ The Royal College of Psychiatrists thought individual commissioners often lacked a broad enough knowledge of mental health services: "They may have responsibility only as part of a portfolio, or be in a temporary role. They may have no direct contact with provider services".⁸⁹ Neurological Commissioning Support argued that neurological conditions were complex and many PCT commissioners did not have sufficient knowledge or expertise to plan these services in a way that fully met WCC competencies.⁹⁰

84. Professor Ham informed us of the lessons he learnt from a visit to Marks and Spencer's HQ in the early 1990s and contrasted that company's staffs' knowledge of their products with PCTs' knowledge of the services they commissioned:

the people who were doing the buying for Marks & Spencer had a history, a career, an expertise in the things that they were responsible for buying. They had worked in

83 Ev 252

84 Q 220

85 Ev 91

86 MedFASH, *Progress and Priorities: working together for high quality sexual services* – Review of the National Strategy for Sexual Health and HIV (London: Independent Advisory Group on Sexual Health and HIV, 2008)

87 Ev 240

88 Ev 45, Ev 53, Ev 63, Ev 130, Ev 137, Ev 227 and COM 120

89 Ev 291

90 Ev 297

food, industry, the clothing sector; they brought that deep knowledge and they were adding value to the suppliers of Marks & Spencer because they themselves were experts. Look at who we have in PCTs. Do we have expert GPs and clinicians across a range of specialties who have got the same depth of knowledge? No, we do not. That is why we have the difficulties we do.⁹¹

85. Some witnesses, such as BUPA, argued that the way to improve clinical knowledge was to involve more clinicians in core day to day commissioning activity which could result in more appropriate care being delivered more consistently.⁹² Others emphasised the need for non-clinical PCT staff to glean more clinical knowledge.⁹³

Training

86. Several submissions highlighted the need for better training for commissioners. The Royal College of General Practitioners argued that commissioners required education and training to equip them with the skills required to deliver appropriate services to patients.⁹⁴

87. The Alzheimer's Society raised concerns that commissioners had insufficient understanding of what good dementia care was and called for them to be involved in multi-disciplinary training so that they could commission appropriately.⁹⁵

88. MEND argued that there is an urgent need for training in the basics, such as how to commission a service and how to assess value for money.

PCT management and staff have had much organisational, cultural and process change foisted upon them in an uncoordinated, inconsistent and unclear manner. They have received insufficient instruction, guidance and training and support in many fundamental areas.⁹⁶

Turnover of staff

89. A compounding factor in the lack of skills was the high turnover of staff. Neurological Commissioning Support told us:

an added challenge and frustration for patient involvement in commissioning is the regular turnover of commissioning staff and the resulting loss of organisation knowledge and history of commissioning decisions.⁹⁷

Professor Ham observed:

91 Q 514

92 Ev 189

93 Ev 53 and Ev 91

94 Ev 282

95 Ev 238

96 COM 120

97 Ev 297

There is [...] a lot of turnover in Primary Care Trusts of the people who have those commissioning responsibilities compared with much more stability on the provider side. I remember talking to a very experienced manager in a large Acute Trust in London two or three years ago who had been in that post for about ten years, was very experienced and able, and her reflection was that the commissioners that she negotiated with chopped and changed about every 12, 18 months, were generally quite junior people making their career very bright but were not in post long enough to be able to take on commissioning effectively.⁹⁸

Quality and status of commissioners

90. There is also clearly a weakness in the quality of management. We were informed that commissioners were not sufficiently professional.⁹⁹ It appears that most good quality managers are attracted to work in big hospitals where the pay is better. The King's Fund said:

it has proved difficult to recruit the brightest and best into the commissioning side of the NHS with senior positions in the acute sector attracting higher pay and status.¹⁰⁰

Dr Dixon told us that commissioners:

have not been able to settle and develop talents and a lot of managerial talent resides in hospitals and not in PCTs.¹⁰¹

Professor Ham informed us:

The reasons for the slow development of commissioning include...the lack of staff with the skills needed to commission health care to a high standard, and the greater attractions for many of the top managers and clinical leaders of working for provider organisations like Foundation Trusts (in itself linked to the higher salaries and rewards available in these organisations). For these reasons, it remains doubtful whether world class commissioning can be implemented in the timescale demanded by impending NHS financial constraints.¹⁰²

91. The Department itself acknowledged that in the past:

commissioning had often been seen within the NHS as a less attractive career options and of lower status than managing acute NHS Trusts, and consequently the calibre of leadership was often weaker, particularly at middle management level.¹⁰³

98 Q 499

99 Q 75

100 Ev 252

101 Q 499

102 Ev 331

103 Ev 3

DH policy development

92. Several witnesses, including Professor Ham, Mr Stout and Mr Belfield, told us that in recent years the DH had focused on policies to improve the provider side of the English healthcare system, but neglected to develop policy for the commissioning side. Professor Chris Ham said:

in the Health Reform programme as a whole a lot of the early emphasis was placed on the development of new kinds of providers like the Foundation Trusts and the ISTCs; only latterly has the same focus been put on the commissioners, both PCTs and Practice Based Commissioners through the World-Class Commissioning programme, and I am sure we will discuss that in more detail, so there was that late start in recognising that a lot needed to be done alongside the development of providers.¹⁰⁴

This view was reinforced by Mr Stout, of the NHS Confederation:

The Prime Minister's Delivery Unit did a review in 2007 on commissioning and basically concluded that there was not a clear story of what commissioning was. There was not a proper programme of support there. We are starting to combine policy levers that are designed for commissioning and a programme that supports the development of skills and capacity within commissioners to use those tools. That is why it has been weak but also why it is now strengthening.¹⁰⁵

93. Mark Britnell, formerly of the DH, told the Committee:

My analysis, as I came into the post back in the summer of 2007, was that if people did not know what was expected of commissioners, it was almost impossible to professionalise them as a class of managers or clinicians.¹⁰⁶

Effects of NHS reorganisations

94. We heard that the numerous NHS "reorganisations" of recent years have tended to disrupt the work of commissioners and undermine their effectiveness.¹⁰⁷ Dr Dixon, of the Nuffield Trust, told us:

there has been a lot of organisational turbulence amongst commissioners over time. They have not been able to settle and develop talents¹⁰⁸

We likewise heard from the King's Fund that:

lack of a skill base has been compounded by constant reorganisation. Skills and knowledge that were built up have been lost and fragmented as organisations have been forced to repeatedly reinvent themselves. Moreover it has proved difficult to

104 Qq 71, 74, and 499

105 Q 74

106 Q 83

107 Ev 15

108 Q 499

recruit the brightest and best into the commissioning side of the NHS with senior positions in the acute sector attracting higher pay and status. Although relationships vary there is often an adversarial component to the commissioner/provider split and this has not helped PCTs to engage with secondary care clinicians.¹⁰⁹

Imbalance of power and lack of levers

95. The evidence we received indicated that, even in the absence of the factors so far identified, PCTs would still struggle to make an impact as commissioners since there is a seemingly perennial imbalance of power between providers and commissioners. When the purchaser/provider split was introduced it was intended that purchasers would have the power that customers are supposed to have in real markets, where “the customer is king.” However, it is often argued that, in practice, power has mainly resided with NHS providers. Dr David Colin-Thomé, the National Clinical Director for Primary Care at the DH, agreed that providers had retained a “dominant position” and admitted that “maybe we have made it worse” by being “obsessed by the provider side” in policy development.¹¹⁰

96. The King’s Fund, citing findings from joint research with the University of Birmingham, explained how various strands of DH policy had seemingly combined to inhibit effective commissioning by PCTs:

For elective care, the payment by results tariff, patient choice and the “any willing provider” requirement mean that PCTs have little control over what they pay or where patients are treated while quality standards are set nationally. The increasing concentration of some services in specialist centres effectively creates more local monopolies and large acute hospital trusts can be even more dominant in their local provider markets [...] The ability of commissioning to be an effective lever for change has, therefore, yet to be proven.¹¹¹

97. A key problem is that it is difficult for PCTs to control the volume of hospital activity in their local health economies, which Payment by Results (PbR) has served to exacerbate, since constraints on activity have been removed and tariffs are fixed nationally.¹¹²

98. There is a widespread view that, in order for commissioning to be more effective, it needs more powerful financial levers with which to assert control over providers. Professor Bevan argued that:

Effective commissioning ought to: ensure that patients are treated safely and appropriately across the care pathway; put pressure on providers to improve quality and reduce cost; make hard choices that optimise outcomes for populations within available budgets. This requires good systems to set priorities prospectively and assess performance retrospectively. Effective commissioning challenges provider

109 Ev 252

110 Q 73 and Q 74

111 Ev 252

112 Q421

dominance, may threaten the stability of poorly-performing providers and is undermined if government nullifies such challenges and threats.¹¹³

Professor Street told us:

ensure that PCTs have the levers and instruments available to them to give them budgetary control.¹¹⁴

99. The DH concedes that in the past “the necessary system levers and enablers were not in place to support, resulting in unbalanced relationships and influence between providers and commissioners”.¹¹⁵ However, as we discuss in Chapter 6, the Department is taking various steps that it believes will give PCTs the necessary degree of leverage over providers.

Practice Based Commissioning

100. The evidence that we received from PCTs indicated confidence in the success of PBC, albeit with some admission that the policy was slow in taking off.¹¹⁶ The National Primary Care Research and Development Centre (a DH-sponsored unit at the University of Manchester) also offered a largely optimistic account of the impact of PBC. According to the Centre’s research, there is considerable engagement with PBC among GPs with positive impacts, including: the development of new services, engagement in the redesign of patient pathways, the development of systems to review and reduce hospital referrals and a new willingness amongst GPs to engage with peer review of performance. The Centre did, though, also outline areas of difficulty, including: calculation of budgets and savings; managerial and information support; integration of PBC into the wider commissioning agendas of PCTs; and patient and public involvement. The potential longer term impact of PBC in affecting the pattern and delivery of local services, we were told by the Centre, “depends upon the extent to which PBC becomes integrated with the wider commissioning agenda of the PCT”. This requires PCT managers to be prepared to cede some control and to provide managerial resources and GPs to engage beyond their “comfort zones” addressing population health needs and taking managerial responsibility.¹¹⁷

101. The King’s Fund’s 2009 survey of PBC found that commitment to PBC was high and that progress had been made towards developing formal agreements and structures.¹¹⁸ However enduring problems remained including:

- Confusion over roles
- Low engagement among clinicians
- Lack of clarity over purpose and vision of PBC at a local level

113 Ev 335

114 Q 179

115 Ev 3

116 Qq 343, 366, 418

117 Ev 86–90

118 The King’s Fund, *PBC two years on: Moving forward and making a difference?*, July 2009

- Delays in decision making at PCT level.

102. One particular finding was that getting ideas commissioned by PCTs was a slow task, rarely being achieved within the eight weeks specified by the DH. Twenty-nine per cent of respondents who submitted a business case said that on average it took more than 25 weeks to get approval; 35% said it took more than 25 weeks; and in almost half of all cases it took almost a year from a business case being submitted to service change taking place. The King's Fund argues these results suggest that cumbersome bureaucracy (and "disproportionate governance processes") remains a problem in fostering PBC.

Research has revealed that PBC has largely brought about small-scale projects involving the re-provision of elements of services outside hospital rather than large-scale strategic redesign. This is largely because the incentives embedded within PBC reward GPs for short-term gains and do not encourage longer-term investment. Thus far, PBC has not demonstrated that it can advance commissioning, especially of secondary care, and it is therefore not clear that PBC provides value for money.¹¹⁹

103. The DH admitted in evidence that PBC was "patchy".¹²⁰ Dr Colin-Thomé went much further in an interview late last year, stating that DH efforts to reinvigorate PBC did not seem to be taking off and concluding: "I think the corpse is not for resuscitation. There doesn't seem to be much traction."¹²¹ When we questioned him about this, however, he insisted that he had only been asking a rhetorical question ("Are we trying to reinvigorate a corpse?") and had been somewhat misquoted.¹²²

104. Professor Ham argued that PCTs had been slow to encourage GPs to get involved. He also questioned whether the incentives were strong enough to encourage them to do so.¹²³ Dr Dixon, of the Nuffield Trust, told us that the lack of a "hard budget" (i.e. allowing GPs to control funds directly, as occurred with Fundholding) was key to understanding seeming GP apathy about PBC.¹²⁴

105. Dr Pauline Brimblecombe, who is herself a practice-based commissioner, argued that GPs needed to pool their resources in "clusters" in order to have the requisite managerial skills and public health information to be able to commission effectively.¹²⁵

Conclusions

106. There are examples of good work being undertaken by PCTs. However, many PCTs believe they are working effectively although the evidence would suggest otherwise.

119 Ev 252

120 Q 153

121 *Health Service Journal*, 14 October 2009

122 Q 153

123 Q 534

124 *Ibid*

125 Q 460

107. As the Government recognises, weaknesses remain 20 years after the introduction of the purchaser/provider split. Commissioners continue to be passive, when to do their work efficiently they must insist on quality and challenge the inefficiencies of providers, particularly unevidenced variations in clinical practice.

108. Weaknesses are due in large part to PCTs' lack of skills, notably poor analysis of data, lack of clinical knowledge and the poor quality of much PCT management. The situation has been made worse by the constant re-organisations and high turnover of staff.

109. Commissioners do not have adequate levers to enable them to motivate providers of hospital and other services. We recommend the Department commission a quantitative study of what levers should be introduced to enable PCTs to motivate providers of services better and a review of contracts to ensure that rigid, enforceable quality and efficiency measures are written into all contracts with providers of health care.

110. The Government has introduced new initiatives with the intention of improving commissioning. On the other hand, the situation may have been made worse by inconsistent Government policies which have tended to undermine the attempts to create powerful commissioners. These issues are discussed in the following chapters.

5 The effects of wider reforms in the NHS on commissioning

111. Over the last decade the NHS has experienced constant reform, described by one witness as “redisorganisation”.¹²⁶ Some reforms, as we have seen, specifically aimed to strengthen commissioning, but most were concerned with other aspects of the NHS. Nevertheless, even these wider reforms have had an indirect effect on the work of commissioners. They have been inconsistent and some have made the work of commissioners more difficult. Professor Ham argued:

the freedoms available to NHS Foundation Trusts, the regulatory regime under which they operate with the requirement to generate financial surpluses for future investment, and the system of payment by results which creates incentives to increase hospital activity, present formidable obstacles to PCTs and PBCs in achieving financial balance and bringing about the shift in care closer to home that has been at the heart of recent policies and priorities.¹²⁷

He added

three sets of drivers [have] been put in the system. There is the Stalinism...targets, performance, management, drive the system hard from the centre—we also have increasing regulation through....a plethora of regulators trying to improve performance, and, thirdly, we have got the market-based reforms, World Class Commissioning, Foundations Trusts, Payment by Results. The logic was that over time we might migrate with less emphasis on Stalinism, a bit more emphasis on regulation and competition and choice would drive the system. Actually what has happened is they are co-existing with each other.¹²⁸

112. This chapter looks mainly at the market-based reforms, in particular the introduction of Payment by Results (PbR). While these reforms have tended to intensify the adversarial nature of the relationship between purchasers and providers, other changes have arguably tended to cut across this, notably the Integrated Care Pilots, which we also examine. We begin, however, by considering the consequences of one of the Government’s earliest reforms under the Rt Hon Frank Dobson, the creation of NICE.

NICE

113. The National Institute for Health and Clinical Excellence (NICE) was set up in 1999 with a remit to provide evidence-based information for the NHS on the effectiveness and cost-effectiveness of healthcare interventions.¹²⁹ NICE publishes mandatory technology appraisal guidance (stipulating interventions which must be funded by PCTs), as well as

126 Ev 15

127 Ev 331

128 Q 527

129 NICE was initially called the National Institute for Clinical Excellence. It changed its name in 2005.

advisory clinical guidelines and public health guidance (which PCTs are not obliged to implement).

114. PCTs could insist that providers adopt NICE's clinical guidelines thereby ensuring that the best care is provided in the most cost-effective way. Although NICE has been working on developing tools and resources to help commissioners put its recommendations into practice in their commissioning,¹³⁰ the evidence we received indicated that PCTs too often fail to do so. For instance, the Joint Epilepsy Council found that in 2009 more than 90% of acute trusts failed to meet the two-week guideline for a first appointment with a specialist.¹³¹ We were advised of similar failings in evidence received from the National Osteoporosis Society,¹³² HEART UK¹³³ and the National Rheumatoid Arthritis Society.¹³⁴

115. On the other hand, the mandatory technology appraisal guidance is expensive and PCTs think at times the money would be better spent on other priorities. The Minister of State admitted that implementing NICE guidance could be very costly for PCTs, but insisted they must adhere to it and manage their budgets in order to enable them to do so:

It can be inflationary, I suppose, if it is the case that they are implementing the NICE guidance without being prepared to decommission anything. The PCT has to ensure that it is delivering the best quality of care, and if NICE is saying to it, "This is the best quality of care" then the PCT really needs to think very hard if it is going to exercise some sort of discretion not to deliver the best quality of care. It would have to have a hell of a good reason for not doing it.¹³⁵

Payment by Results (PbR)

116. Historically, hospitals were paid through some form of bulk-buying contract.¹³⁶ Payment by Results (PbR) transformed this system so that "the money follows the patient".

130 Ev 232

131 Ev 321

132 COM 111

133 Ev 44

134 Ev 60

135 Q 621

136 A variety of contracts were used:

- Block contracts

Under a block contract the provider is paid an annual fee in instalments by the commissioner in return for access to a defined range of services. The provider receives a flat payment to care for the patient population regardless of the actual care given. A sophisticated block contract is similar to a simple block contract but requires the commissioner to monitor the provider to ensure that they are providing the required care.

- Cost per case contracts

Under a cost per case contract the commissioner agrees an allocation of funding for each patient treatment provided, so the provider is paid based on the cost of the medical services supplied.

- Cost and volume contracts

Under a cost and volume contract cost and activity are linked. The provider receives a sum in return for treating a specified number of cases. These types of arrangement allow for a variable cost per case adjustment between a threshold and a ceiling.

Hospitals are now paid a fixed price for each individual case treated. The amount hospitals are paid depends on how much work they do.

Box 6: Payment by results (PbR)

Before the introduction of PbR there was no incentive for providers to increase throughput since they got no additional funding for doing so.

PbR has addressed this issue and provides fixed tariffs for healthcare resource groups. Tariffs are set by the DH and the same price is paid by commissioners no matter which hospital provides the procedure. The prices contained in the national tariff are broadly speaking set on the basis of the average (mean) cost of providing a particular procedure, calculated using data from all NHS hospitals.

PbR is being phased in gradually. The system began in a small way in 2003–4. In 2006–7 the scope of PbR was extended to include non-elective, A&E, outpatient and emergency admissions for all Trusts. As at 2009–10 the main exclusions from PbR are primary care, community services, mental health services and the ambulance service. From April 2010 there are four “best practice” tariffs which encourage clinical change in areas such as stroke care. In an effort to shift funding to the community, emergency activity levels above 2008–9 levels will only be reimbursed 30% of tariff.

According to the DH, PbR is also intended to support patient choice and a “mixed economy of providers” as well as encouraging activity levels so as to reduce waiting times.

117. The NHS Confederation highlighted the positive aspects of PbR:

While the immediate economic constraints might make alternative payment systems appear attractive, the benefits, both delivered and possible through PbR are significant. For example, in the NHS Foundation Trust sector, PbR has supported the investment of £339 million in improved patient services in 2008–9 alone, with £353 million anticipated in 2009–10. PbR has enabled independent sector providers to enter the market competitively and further drive service improvement in areas where they provide services alongside incumbent providers. It is a system that maintains a national health service, avoiding the disruption of local pricing which would be inefficient and chaotic.¹³⁷

118. Other witnesses, however, argued that Payment by Results had several failings. In particular, it was claimed that PbR had:

- increased transaction costs;
- encouraged hospitals to generate more activity to increase their income; and
- made it more difficult to move healthcare into the community and primary care sectors.

119. It had been expected that PbR would reduce costs because it ended the need to negotiate prices and volumes. This had happened, but research commissioned by the Department found that any reduction in costs had been offset by an increase in other transaction and administrative costs.¹³⁸ Dr Meldrum of the BMA told us:

The problem I have with Payment by Results is that you either have a very crude system where you have a relatively small number of resource groupings, in which case it is easy for certain providers to cherry-pick the easy cases, leaving the more complex ones to the NHS who have got intensive care facilities and such like, and get paid the same. So you either do that, or else you go down a much more complicated route where you have many, many more disease groups and payment groups, but, of course, the more you go down, the more sophisticated you make that, the more bureaucratic it becomes and the more you get more onto the American system where almost for every aspirin you have to put a tick in the balance sheet. So I think there is a real *Catch 22* situation that actually, if you want to make it fairer, you have got to make it more bureaucratic. The more bureaucratic it is, the more costly it is to administer and to run and you will end up with administration costs of getting on to 30%, as they have in the American healthcare system.¹³⁹

120. Professor Street described Payment by Results as “Essentially an activity-based funding system”.¹⁴⁰ Although early assessments of PbR, such as that undertaken by the Audit Commission in 2005, found no evidence that PbR had increased activity, concerns about the incentives PbR created for hospitals to generate activity were widely expressed by witnesses, for example by the Cystic Fibrosis Trust,¹⁴¹ British Society for Gastroenterology¹⁴² and the National Childbirth Trust.¹⁴³ The Association of Greater Manchester PCTs informed us:¹⁴⁴

...we would also highlight the extent to which national policy can confound local economy efforts to balance supply and demand. NHS provider organisations tend to have a high fixed-cost base and are rewarded for increased volumes under the NHS financial regime payment by results. They therefore have a major incentive to increase activity in order to secure increased tariff income at full cost, running directly counter to the objectives of commissioners

121. While the NHS Confederation had been very positive about PbR in written evidence, a subsequent communication from Nigel Edwards, Deputy Director of the organisation, was critical of the way PbR creates incentives for providers to generate, rather than help manage, demand for secondary care:

138 Georgia Marini and Andrew Street, “The administrative costs of Payment by Results.” *CHE Research Paper 17*. York: Centre for Health Economics, (2006)

139 Q 33

140 Q 170

141 Ev 72

142 Ev 304

143 COM 118

144 Ev 50

Tariff systems can work in emergency care and for long term conditions but unless they are used carefully they have the risk of providing incentives that are not really aligned with what patients or the wider health system needs. In particular it has the potential to create incentives for providers to generate rather than help manage demand for secondary care.” (letter to Howard Stoate from Nigel Crisp, 8 Feb 2010)

122. The King’s Fund explained how PbR affected strategies to switch services out of hospitals:

PCTs have few of the freedoms afforded to foundation trusts—they are restricted by stringent governance and regulatory structures and must break even on an annual basis. As noted above, the power differential is exacerbated by a mismatch in the quality of information accessible to trusts and commissioners. Work undertaken in the acute setting is coded and costed very carefully to ensure that costs are covered, but there is a significant delay before commissioners receive that information. The lack of specialist knowledge at PCT level means that commissioners find it very difficult to challenge coding. The complexity of the pricing structure of PbR has combined with these incentives to restrict the ability of commissioners to act on strategies that seek to redesign services and/or shift care out of hospitals.¹⁴⁵

The Royal College of Physicians warned that care might be pushed into hospitals rather than the community.

More profoundly—for Care Closer to Home advocates—PbR may create perverse incentives, so that it appears financially easier to admit the patient rather than manage them outside the hospital or to commission separate specialist services in primary care, thus avoiding the fully tariff price of a consultant-delivered service in an outpatient clinic.¹⁴⁶

Integrated Care Pilots

123. It has long been argued that the different elements of healthcare and social care in England are too often poorly coordinated, failing to form seamless “pathways” that ensure the right care is delivered in the most effective way. This adversely affects patients’ quality of life and clinical outcomes, as well as efficiency in the use of resources. Addressing this is made all the more urgent as the population ages and the prevalence of chronic diseases increases.

124. Government policy sees the answer to this problem in greater integration of services, both “horizontally” (e.g. between primary care and social care) and “vertically” (e.g. between primary care and acute care). In April 2009, the DH launched a pilot programme, as proposed by Lord Darzi in *High Quality Care for All*, to test and evaluate several models of integrated care through 16 Integrated Care Pilots (ICPs) over two years. The Department has recently announced that, following successes in the original ICPs, the programme is being expanded to encompass a wider range of stakeholders nationally and identify further worthwhile initiatives.

¹⁴⁵ Ev 253

¹⁴⁶ Ev 124

125. We received evidence from some of the NHS organisations involved in the initial pilots. John Parkes, the Chief Executive of Northamptonshire PCT, told us that initiatives being pursued by his pilot including pooled mental health budgets and joint commissioning of mental health services with colleagues in social care.¹⁴⁷ From the provider side, Stephen Graves, of Cambridge University Hospitals NHS Foundation Trust, told us that the pilot in which his organisation was involved, relating to end-of-life care, was not proving straightforward: “I will be very clear; it is not easy”. Bringing together the information held by different organisations had turned out to be particularly difficult.¹⁴⁸ Mr Graves admitted that, even after a year, the pilot was still in its early stages: “it has taken a year for us to all get our brains round the issue”.¹⁴⁹

126. It is not clear how the integrated care pilots relate to other Government policies, for example how it relates to CQUIN, another policy with its origins in the Darzi review. In December 2008 guidance from the DH on CQUIN merely stated that:

in areas where Integrated Care Organisations are being piloted those involved may wish to discuss how to apply the principles of the CQUIN framework to the care they are providing.¹⁵⁰

127. Similarly, it is unclear whether the integrated care pilots are consistent with PbR. Several witnesses, including the BMA¹⁵¹ and the British Association for Sexual Health and HIV (BASHH)¹⁵², argued that PbR fragmented care. The fpa claimed that PbR created “disjunctions” in care pathways.¹⁵³ Dr Brambleby, a PCT director of Public Health, argued that PbR had drawn attention away from commissioning whole care pathways.

I am not by any means alone as a clinician working in the NHS to be deeply ambivalent about payment by results. We feel that it was a sincere and partially successful attempt to address the wrong question.... It is the overall health of the patient for which we want to commission. To that end payment by results has been a distraction and distortion and is tangibly counter-productive in some cases.¹⁵⁴

The overall impact of reforms on commissioning

128. It is not just that integrated care pilots sit uneasily with CQUIN and PbR, but several witnesses, including the King’s Fund, the RCP¹⁵⁵ and Professor Bevan, stressed that recent reforms were inconsistent. Professor Bevan told the Committee that it was not that there

147 Q 353

148 Q 467

149 Q 471

150 Department of Health, *Using the Commissioning for Quality and Innovation (CQUIN) payment framework*, December 2008, para 30

151 Ev 213

152 Ev 241

153 Ev 91

154 Q 206

155 Ev 123

were too many cooks, but that they were cooking different meals.¹⁵⁶ The King's Fund informed us that:

...when examined in detail and in the context of the system as a whole, it is apparent that there are areas where the various incentives and structures do not align. As a result commissioning remains weak. It is not that the policies themselves do not “fit” with WCC, but rather that the structures and mechanisms within which they are operating are working against the aspirations of WCC.¹⁵⁷

Conclusions

129. **The Government has embarked on a series of sometimes contradictory reforms which have had significant effects on commissioning. In the first wave of reforms undertaken when the Rt Hon Frank Dobson was Secretary of State, NICE was created. This has led to threats and opportunities for PCTs. Potentially, PCTs could insist that hospitals use NICE guidelines to provide the best, cost effective care; unfortunately, they have done this less often than they should have. On the other hand, there is a tendency for NICE guidance to be “inflationary” in its effect on spending by PCTs, obliging them to pay for certain expensive treatments. We repeat our regular injunction that NICE should do more to specify where disinvestment should take place.**

130. **The next wave of reforms, made when the Rt Hon Alan Milburn was Secretary of State, sought to achieve a more market-oriented NHS; they included the introduction of PbR. We were informed that this has had a number of disadvantages for commissioners. PbR threatens to increase transaction costs and, in part because of the weakness of commissioning, provides hospitals with an incentive to generate more activity to increase their income.**

131. **More recently the DH has appeared to place less emphasis on the market-based approach. The present Secretary of State has stated that the NHS is the “preferred provider” and Integrated Care Pilots have been introduced. It is unclear how this policy relates to earlier measures such as PbR.**

132. **Although there has been slightly less emphasis on market reforms recently, the NHS remains characterised by tensions between purchasers and providers. The weakness of commissioners faced by powerful providers means that the reforms have threatened to undermine some of the Government's key aims, such as switching care from hospitals to the community. Strengthening commissioners' powers and skills is vital and we now turn to Government attempts to do this.**

156 Q 62

157 Ev 252

6 How the Government has responded to weaknesses in commissioning

133. In chapter four we outlined the weaknesses in commissioning. The Government is well aware of these weaknesses and in recent years has begun trying to address them. Its main attempts to do so have been through:

- World Class Commissioning (WCC)
- The Darzi Reforms (CQUIN, PROMs, Quality Accounts and Never Events)
- Framework for External Support for Commissioning (FESC)

In this chapter we discuss these policies.

World Class Commissioning

134. In 2007 the Government introduced its World Class Commissioning (WCC) initiative, which seeks to make commissioning more professional and improve the competencies of NHS commissioners. Its very existence is an admission that commissioning has been a weak link in the English NHS and a great deal rides on its success.

135. The WCC programme includes four strands:

- A vision for World Class Commissioning;
- Eleven Organisational competencies;¹⁵⁸
- An assurance system to hold commissioners to account and reward performance and development;
- Support and development tools.¹⁵⁹

158 The competences are:

- 1) Locally lead the NHS
- 2) Work with community partners
- 3) Engage with public and patients
- 4) Collaborate with clinicians
- 5) Manage knowledge and assess needs
- 6) Prioritise investment
- 7) Stimulate the market
- 8) Promote improvement and innovation
- 9) Secure procurement skills
- 10) Manage the local health system
- 11) Make sound financial investments

159 www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/Vision/index.htm

136. The WCC vision and competencies are supported by a commissioning assurance system which is an annual process that reviews PCTs' progress towards achieving better health outcomes for their populations and provides a common basis for agreeing further development.

137. Mark Britnell, the architect of WCC at the Department, explained:

I wanted to create something which had the discipline and rigour of the foundation [trust] assessment exercise and the stretch that gave people the ambition to raise their sights [...] we defined these 11 competencies—which I do not think anybody really disagreed with. It might strike you as slightly odd—it did me coming into the department—that no-one had defined what good commissioning was in 20 or 30 years.¹⁶⁰

138. The first year assurance results were published in March 2009. At the end of WCC assurance Year 2 (July 2010), nationally calibrated PCT results will be published by the DH. As we have already noted, the process has uncovered weaknesses, particularly in the commercial aspects of commissioning.¹⁶¹

139. WCC will require a very significant change for most PCTs. Many of the aspirations of WCC are supposed to have applied to the NHS over the last 20 years, but few have been achieved systematically throughout the NHS in England.¹⁶² The Minister of State acknowledged the programme's importance:

we need to increase the power of the purchaser so that the purchaser is better able to represent the taxpayer and the patient, and better able to manage the way in which NHS funding is spent, and better able to counterbalance the provider interest in this equation. All of that is around improving the quality of commissioning—and that is why World Class Commissioning as a process is so important.¹⁶³

140. While, as we have seen, the first year assessment exercise demonstrated the weaknesses in the system, in subsequent years PCTs are expected to progress rapidly. DH officials told us that they were in a more decisive phase with serious action being taken against PCTs who have not improved enough.¹⁶⁴

141. The WCC initiative was widely welcomed and seen as helping PCTs to focus their minds on what needed to be done. The Chief Executive of Northamptonshire PCT found it helpful to show him where he needed to be going.¹⁶⁵ Monitor argued that WCC fits well with commissioning for quality.¹⁶⁶

160 Q 83

161 Ev 251

162 Ev 335

163 Q 582

164 Q 602

165 Q 390

166 Ev 236

142. However, concerns were raised by Monitor and others. The Royal College of Midwives stressed that the developments of commissioning were very recent and there was a lot of ground for commissioning bodies to make up. It was too early to judge whether it will be successful or not:

These developments are however recent, especially when compared with the developments on the provider side. This means that commissioning organisations are now playing catch-up and it will take some time before all the benefits associated with the recent reforms become apparent.¹⁶⁷

143. The key question is whether WCC will be enough to address the enduring weakness of commissioning. Although WCC seeks to bring about a “step change” in the capacity and capability of PCTs to act as effective commissioners, some witnesses thought that the enduring weakness of commissioning was unlikely to be addressed by WCC alone.¹⁶⁸

144. Health Mandate drew attention to the fact that approximately a third of PCTs have opted to focus on more “indicators” where their performance is already better than the national average than where it is worse. This calls into question the extent of the ambition of some PCTs and casts doubt on whether the WCC agenda will in itself address inequalities of performance.¹⁶⁹ This would imply that PCTs are “gaming” the assurance system.

145. There are further concerns about the assurance process itself. Professor Ham stressed that better outcomes of care and better value for money were not inherent in the assurance process, and thus queried whether assurance was asking the right questions.¹⁷⁰

146. The Royal College of General Practitioners felt that WCC needs to be properly scrutinised by Strategic Health Authorities (who have a performance management role in respect of PCTs), otherwise it risks being “a paper-based exercise”.¹⁷¹ The results of the NAO survey suggested that PCTs were concerned that the assurance process could become a “tick box” exercise, taking a long time to complete and distracting staff from their core jobs.¹⁷² Survey respondents also raised concerns about the balance between the assurance programme and the development programme within WCC.

147. The King’s Fund also made the really important point that even if WCC is successful it leaves unaddressed the incoherence in system reform, as we discussed in the previous chapter:

It is not that the policies themselves do not “fit” with WCC. But rather that the structures and mechanisms within which they are operating are working against the aspirations of WCC.¹⁷³

167 Ev 52

168 Ev 77, Ev 99, Ev 123, Ev 132, Ev 159, Ev 166, Ev 192, Ev 228 and Ev 283

169 Ev 80

170 Q 522

171 Ev 283

172 COM 119

173 Ev 252

148. Ridiculous though the term is, much of the World Class Commissioning initiative is unexceptionable. It is clearly too early to judge the success of WCC but note there are serious concerns about the capability of PCTs to make the huge step changes required. We recommend that the Care Quality Commission uses the eleven competencies of World Class Commissioning to judge PCTs.

149. We are concerned that PCTs might be too complacent to make the necessary improvements. A survey we commissioned from the NAO revealed a remarkable degree of misplaced confidence on the part of PCTs about how well they think they are doing.

150. It is not clear to us that WCC is going to address the lack of capacity and skills at PCT level and weak clinical knowledge. Furthermore there are concerns that WCC will be no more than a “box ticking” exercise whereby people expend a lot of energy merely demonstrating they have the right policies in place, rather than actually transforming patient outcomes and cost effectiveness.

151. WCC does not address the systemic imbalance of power between commissioners and providers. The DH has developed other policies that do seek to address this, to which we now turn.

Darzi Reforms

152. Lord Darzi was commissioned by the previous Secretary of State to undertake the Next Stage Review. He published his final report, *High Quality Care for All*, in 2008.¹⁷⁴ As part of his aspiration to bring about better quality of care he proposed giving PCTs a number of means whereby they could more effectively exert pressure on providers to improve their services. These are forms of “pay for performance” (P4P) or “value-based purchasing”, an idea which has been developed in the USA. We examine these below.

CQUIN

153. The Commissioning for Quality and Innovation (CQUIN) framework, which was launched in April 2009, facilitates providing financial incentives payments for good quality care. The Minister of State told the Committee:

CQUIN is going to be increasingly important, particularly to encourage stretch and innovation. It will give a greater degree of negotiating power to PCTs.¹⁷⁵

154. However, the Committee received evidence of concerns. Professors Bloor and Maynard have argued that it is not yet clear whether incentive schemes will result in improved patient outcomes and justify the cost of implementing them. Evidence for US incentive schemes is weak and the impact of the new scheme in the English NHS is not predictable:

¹⁷⁴ Department of Health, *High Quality Care for All: NHS Next Stage Review*, 2008

¹⁷⁵ Q 587

Experience from the US suggests that a balance needs to be struck between the motivational effects of potential penalties and the possible costs of destabilising organisations. In addition, if penalties are a real possibility and are on occasion levied, their motivational effects are likely to be short lived.¹⁷⁶

155. Witnesses also expressed concern that CQUIN would destabilise providers if it were successful, particularly as from 2011 the potential income losses will be 10% of revenue. Mr Parkes told us:

I just think that there is 1.5% in CQUIN and an expectation of 3.5% efficiency. We just need to be careful that we are not destabilising our providers but getting the right focus on improving quality.¹⁷⁷

156. It was also thought CQUIN could lead to the worst of all worlds, increasing tensions between commissioners and providers while achieving little. Professor Bevan told us:

There obviously is a conflict here between paying primary care trusts a fair share of the NHS budget for their population and paying providers for the volume of services that they supply. There is no guarantee, of course, that these two will equate, and as we are entering very hard times in the NHS, it is difficult to see how these tensions will be resolved. If you look at the evidence on pay for performance, which is very fashionable in the United States, there is very weak evidence of it having been an effective innovation.¹⁷⁸

157. Despite the misgivings that some people have about CQUIN, it is regarded by others as having significant potential to improve commissioning. When we considered the *Next Stage Review* we supported using financial incentives to improve quality but recommended that the Department “proceed with caution”, piloting and rigorously evaluating all such schemes before their adoption by the wider NHS.¹⁷⁹

158. The Government stated in its response to our report on patient safety:

The CQUIN framework was launched in April 2009. Although it is not being formally piloted, the first year is very much regarded as developmental and the Department is working closely with NHS partners to share learning and to inform how the framework develops in future.¹⁸⁰

It transpires that evaluation will be very difficult because the DH has allowed for local variation in the implementation of CQUIN. As we stressed in our report on health inequalities, evaluation of policy is of the utmost performance.¹⁸¹

176 Alan Maynard and Karen Bloor. *Will financial incentives and penalties improve hospital care?* BMJ 2010;340:c88

177 Q 379

178 Q 34

179 HC (2008–09) 53–1, para 86

180 Cm 7709, October 2009

181 Health Committee, Third Report of Session 2008–09, *Health Inequalities*, HC 286–1

PROMs

159. CQUIN requires information about quality and since 1 April 2009 the NHS has become the first healthcare system in the world to routinely collect patient-reported outcome measures (PROMs). Hospitals are obliged to measure the physical and psychological well-being of patients before and after four elective procedures: hip and knee replacements, varicose veins and hernia repairs. The resulting data are to be published on the NHS Choices website and in Quality Accounts (which we discuss further below).

160. The potential impact of PROMs is profound for patients and the public, as they offer a quantified measure of both the generic and disease-specific quality of care that patients receive from the NHS. Patients will have a measure of quality to help them make properly informed decisions when exercising their right to choose, and PCTs will have the sort of information they need to identify the best-performing providers and exert evidence-based pressure on those who are underperforming.

161. A number of threats to the success of PROMs have been identified.¹⁸² A crucial issue is the adequacy of the response rate. Work by the London School of Hygiene and Tropical Medicine found a response rate of at least 80% was needed which may be difficult given that patient compliance is voluntary.¹⁸³ Another problem is that of adjusting PROMs for the longer term benefits of interventions. Someone who has just undergone a hernia operation is likely to suffer significant pain immediately after the procedure, having previously had no pain; but this is not necessarily a sign of failure as the operation will have removed the risk of strangulation of the hernia.

Quality Accounts

162. Another way of collecting information about the quality of care is Quality Accounts. This is an annual report to the public about the quality of services delivered, which all providers of NHS healthcare services should produce. The Health Act 2009, which comes into force on April 1st 2010, makes this a legal obligation for all providers of acute, mental health, learning disability and ambulance services to produce a Quality Account. Further work is underway to develop Quality Accounts for primary care and community services providers with the aim of making these obligatory by June 2011.

163. The regulations require providers to submit a list of the national clinical audits¹⁸⁴ and national confidential enquiries¹⁸⁵ that they participated in and a description of the action that the provider intends to take to improve the quality of healthcare following a review of the reports.

182 Maynard, A and Bloor K. Patient Reported Outcome Measurement: learning to walk before we can run. *J R Soc Med* 2010; 103: 1–4

183 John Browne et al, "Patient Reported Outcome Measures (PROMs) in Elective Surgery": Report to the Department of Health. *London School of Hygiene and Tropical Medicine* (2007) <http://www.lshtm.ac.uk/hsru/research/PROMs-Report-12-Dec-07.pdf>

184 National Clinical Audits are intended to engage clinicians in systematically evaluating their clinical practice against benchmark standards, to support and encourage improved quality.

185 National Confidential Enquiries take anonymised information about deaths relating to a particular condition or aspect of healthcare and analyse it to produce recommendations for improved practice.

Never Events

164. Never Events are adverse events that are both serious and largely, or entirely, preventable. The current list, compiled by the National Patient Safety Agency, is very conservative, i.e. the events are extremely serious and clear-cut lapses in patient safety, such as leaving an instrument in a patient or wrong site surgery.¹⁸⁶

165. We noted in our report on patient safety in 2009 that the DH had not yet come to a settled view about whether Never Events would be linked to payment, i.e. whether commissioners would be able to withhold payment from providers where these events occurred.¹⁸⁷ Lord Darzi himself noted misgivings about this idea, with some fearing that it could suppress reporting of adverse events, running counter to the NHS policy of fostering an open, reporting and learning culture.¹⁸⁸

166. In our report on patient safety we supported the use of Never Events but said we had “doubts about whether they should involve a financial penalty”, recommending that this be the subject of a pilot project.¹⁸⁹ The Government noted this but did not respond directly to it.¹⁹⁰

167. The Government believes that CQUIN, PROMs, Quality Accounts and Never Events will improve commissioning, shifting power away from providers and enhancing the quality of care. However, we remain concerned that the Government is not piloting and rigorously evaluating these ideas before implementation, as we have previously said. The Government’s list of *Never Events* is too conservative.

Framework for External Support for Commissioning (FESC)

168. The Framework for Procuring External Support for Commissioners (FESC) is an initiative that the Government has undertaken with the stated purpose of helping overcome the lack of skills in PCTs. The services of 14 private sector companies have been procured centrally by the DH and PCTs can call on these for support with commissioning.¹⁹¹ This is a way for PCTs to purchase additional skills in services such as data analysis and contract management. While each company has been appointed to FESC

186 Department of Health, *Operating Framework for the NHS in England, 2010–11*. From April 2010 no payment will be made were treatment results in one of the following 7 never events:

- 1) Wrong site surgery;
- 2) Retained instrument post-operation;
- 3) Wrong route of administration of chemotherapy;
- 4) Misplaced naso- or orogastric tube not detected prior to use;
- 5) Inpatient suicide by use of non-collapsible rails;
- 6) In-hospital maternal death from post-partum haemorrhage after elective caesarean section; and
- 7) Intravenous administration of mis-selected concentrated potassium chloride

187 Health Committee, Sixth Report of Session 2008–09, *Patient Safety*, HC 151–1

188 *Ibid.*, para 212

189 *Ibid.*, para 256

190 Department of Health, *The Government Response to the Health Select Committee Report “Patient Safety”*, Cm 7709, p 26

191 Department of Health, *Framework for Procuring External Support for Commissioners (FESC)*, February 2007

by the DH it is down to individual PCTs to decide if they wish to engage one of them, and what areas they specifically want to commission them to help with. The PCTs remain the commissioners of local healthcare.

169. In early 2009 the King's Fund conducted a survey of PCTs in England, examining the use of external support for commissioning and eliciting views on world class commissioning.¹⁹² The survey revealed PCTs are increasingly turning to external organisations, and the private sector in particular, in the attempt to improve the quality of commissioning.

170. Although using external support is a relatively recent phenomenon, as many as 76% of PCTs who responded said they were doing so. The value of these contracts ranged from several thousand pounds for short-term consultancy work, to several million pounds in the case of more ambitious schemes. These contracts are mainly with private sector organisations (40%) or freelance consultants (30%).

171. FESC provides one route through which commissioners can engage the support of external organisations. However, the majority of PCTs in the King's Fund survey opted to use other channels for procurement—only 27% of PCTs using external support did so through FESC. Responses indicate that many PCTs consider FESC to be “inflexible”, “too time-consuming”, “cumbersome”, and inappropriate for shorter-term work.

172. The FESC framework was designed, in part, to provide a route through which commissioners could use longer-term outsourcing. However, the King's Fund survey shows there is little enthusiasm for this. Instead, PCTs are using external support as a means of boosting their commissioning capacity and building up in-house skills. External support is being used across all stages of the commissioning function, and in particular for the purposes of developing a strategic commissioning plan, creating and managing contracts with providers, and reviewing gaps in current service portfolios.

173. There are seemingly two reasons why PCTs might bring in consultants.¹⁹³ One is that PCT staff themselves lack skills (capacity), the other is that staff lack the necessary skills (capability). Using consultants to supplement capacity raises the question why PCTs are not properly staffed; bringing in consultants would seem to be an expensive way of boosting staff numbers. BUPA, one of the FESC providers, told us that it did bring in important skills which PCTs lacked. Their submission highlights the need for more emphasis on data analysis and information acquisition to give managers the tools they need to manage demand more effectively.¹⁹⁴ However, UNISON raised concern that the skills being purchased from external consultants were not being transferred to PCT staff:

The idea is that once companies have been brought in to advise commissioners they should ensure that there is a transfer of skills back to the NHS, but it remains doubtful that this is taking place or will do so in the future.¹⁹⁵

192 The King's Fund, *Building 'world class commissioning': What role can external organisations play? Results from a survey of PCTs, 2009*

193 Q 396

194 Ev 189

195 Ev 104

174. When we tried to find out the overall cost of FESC, we were initially told the DH could not give us precise figures of what is spent on external consultants.¹⁹⁶ Although they subsequently provided the committee with some data that showed that in January 2010 there were £49.9m worth of signed FESC contracts.¹⁹⁷ But this does not equal the total amount spent on external consultants, as PCTs are not obliged to use FESC contractors and King's Fund research indicated that often consultants not on the FESC list were employed.¹⁹⁸

175. The Minister for State in oral evidence raised concerns about the expenditure on external consultants:

It is obvious that PCTs should be good at this stuff, but making them good at this stuff is much more difficult. I am concerned about the expenditure on management consultants by PCTs. Frankly, some of it is senior managers covering their backs. They get in, they have to make a difficult decision, and rather than make it, as they are paid to do, some of them are getting in some management consultants to look at it, paying these management consultants a lot of money, in order to protect the chief executive's back. That should not be happening.¹⁹⁹

The Department has told us that it accepts the need to collect and publish data on NHS expenditure on management consultants and will be making this available with effect from a financial return for 2009–10.²⁰⁰

176. PCTs clearly do lack the skills that they need for commissioning and engaging consultants is one way of helping to address this situation. However, we are concerned that FESC is an expensive way of addressing PCTs' shortcomings. The Minister of State himself expressed concern about the extent to which consultants are being used. The Department must do more to determine whether or not the taxpayer is getting real value for money out of this costly exercise.

177. Whatever the possible benefits of using consultants, we doubt the ability of PCTs to use consultants effectively.

196 Q 139

197 UNISON (Ev 104) cites HC Deb, 15 July 2009, Col 545W that £15 million had been spent on FESC

198 The King's Fund, *Building 'world class commissioning': What role can external organisations play? Results from a survey of PCTs*, 2009

199 Q 589

200 Department of Health, *The Government's Response to the Health Select Committee's report on The use of management consultants in the NHS and the Department of Health*, Cm 7683, October 2009, p 2

7 The way forward

178. In this inquiry we have found that while there are undoubtedly some examples of good practice, after 20 years of the purchaser/provider split commissioning remains a weak link in the English NHS. PCTs are too often passive, ineffectual players in the health economy. They have failed to adequately challenge providers and have accepted services of an inadequate quality. As we have seen, these weaknesses are partly due to structural imbalances in the system, but also to PCTs' staffs' lack of skills, knowledge and talent and the failure of successive governments to remedy these deficiencies. PCTs are expensive and employ large numbers of staff, but too often not the right staff. In particular, they need people who are better at collecting data and at making use of the large amount of data they already have to inform decision making. PCTs have not been helped by constant reorganisations and high levels of turnover of personnel. Too many of the best managers have been attracted to work in hospitals where pay is higher and the work environment is more rewarding, having been the focus of two decades of reform to improve patient care and ensure value for money. This compares with PCT work which is traditionally undervalued and of marginal immediate impact on patient welfare.

179. The DH recognises the problem and has introduced a number of initiatives to try and improve the situation, including the absurdly named World Class Commissioning. However, as we noted in our report on Lord Darzi's review, it is not clear that PCTs have the talent to support their aim of getting commissioners to do a better job and bring about the radical improvements which are clearly needed.

180. We received several suggestions as to how to improve the situation. Witnesses' proposals can be roughly divided into five groups:

- i. Abolish PCTs and re-introduce health authorities; i.e. replace the quasi-market system with a planned one
- ii. Retain PCTs but introduce more integrated care
- iii. Retain PCTs, but introduce "local clinical partnerships", under which GPs would directly control commissioning budgets
- iv. Retain PCTs but commission services from hospitals centrally
- v. Retain and strengthen PCTs

The two main choices are to give PCTs more power or give them up as a bad job.

Abolition of PCTs

181. The most radical option would be to abolish the purchaser-provider split, as Wales and New Zealand have. The BMA argued that the split between purchaser and provider had been expensive, inhibited clinician involvement in planning services, and fostered a

system which is dominated by cost containment by PCTs and income generation by providers.²⁰¹

182. The current health system with the purchaser/provider split is expensive to run with high administrative and management costs. As we have seen in chapter 2, we have tried rather unsuccessfully over the years to extract information about these costs from the Department and have received a variety of figures ranging from 3–8%; academic research has concluded that the costs are much higher amounting to 20–25% of total staff costs or 14% of the total cost of the NHS, i.e. the staggering sum of £13 bn per year.

183. The Medical Practitioners Union agreed with the BMA that the purchaser-provider split had limited the scope for clinicians to cooperate in the planning of care:

The creation of a market nexus between commissioners and providers is not an essential part of commissioning. Nor is it particularly useful. The p-p separation has limited the scope for clinicians to cooperate in the planning of care across the GP/consultant boundary.²⁰²

184. The abolition of PCTs would generate significant financial savings in a period of considerable financial pressure, would also involve another major reorganisation with all the attendant disadvantages. The successor system would be likely to be even more dominated by providers and act in their interests.

Keep PCTs but do more to integrate care

185. The Royal College of Physicians²⁰³ and others thought PCTs should be retained but hospital clinicians and GPs should work more closely together. Professor Ham argued that:

There should be progressive migration towards clinically integrated systems building on the most promising aspects of current reforms and drawing on evidence that shows the benefits of integration and the challenges of making a commissioner/provider split system function effectively.²⁰⁴

186. Professor Ham sees integrated systems in the US (Kaiser Permanente and Veterans Health Administration) as potential models for integrating care in England. Such systems perform well by engaging clinicians in the quest for improvement, ensuring that the incentives that face the organisation align with those of key front-line decision makers.

187. Moreover, integrated care requires the component parts of the NHS to work together rather than remain fragmented as now with hospitals, primary care and community care/social care each defending their incomes and their empires. Kaiser and the US-Veterans Health Administration are single systems. Thus retaining PCTs and integrating care seems inconsistent with the development of CQUIN which seeks to increase the leverage PCTs have in respect of hospitals and other providers.

201 Ev 210

202 Ev 82

203 Ev 123

204 Ev 332

Retain PCTs, but introduce “local clinical partnerships”

188. The Nuffield Trust informed us that “there are key changes to the policy environment that are required if commissioning is to stand a chance of becoming effective in the way that was originally intended.” These included:

Finding ways of incentivising and motivating GPs “beyond practice-based commissioning”, with an opportunity to hold hard capitated budgets..[and]

Extending the concept of PBC to enable integrated care organisations or multispeciality clinical groups to take responsibility for funding and providing a wide range of care for their registered population.²⁰⁵

The memorandum added that the Trust was to publish a report in November 2009. This report has been published and proposed local clinical partnerships with real budgets.²⁰⁶

189. Local clinical partnerships look very like the system of GP-fund-holding and might be expected to have the advantages and disadvantages of that system.

The Department of Health commissions services from hospitals

190. Professor Street proposed that PCTs should cease to commission services from hospitals. Instead, this would be done centrally by the DH. Freed from having to deal with hospitals directly, PCTs could then concentrate on improving care in the primary and community care sectors.

Professor Street’s proposal

The more radical option would involve the Department of Health funding hospitals directly instead of having payments pass through PCTs. This is typical of PbR-type arrangements that operate in other countries, where “local commissioning” does not feature.

The arrangement combines the best feature of block contracting—certainty of expenditure—with the incentive properties of PbR since an individual hospital will receive more money if it treats more patients.

Again hospitals might be paid the national tariff up to a planned level, with a marginal price applying thereafter. Crucially, though, the planned level need not be negotiated between hospitals and PCTs but can be specified for the hospital as a whole.

The transfer of responsibility would allow the Department of Health to sharpen the incentives of PbR, using the tariff more effectively to control volume, and it would better facilitate free patient choice of hospital.

Freed from having to deal with hospitals directly, PCTs could then concentrate on improving care in the primary and community care sectors.

205 Ev 261

206 The Nuffield Trust, *Beyond Practice-based commissioning: the local clinical partnership*. November 2009

The arrangement requires a change to resource allocation, with PCTs receiving funds to pay for primary and community care only, with payments for hospital care made directly to hospitals by the Department of Health.

PCTs that are successful at keeping patients out of hospital would receive a proportionately greater budget for primary and community care. This proportion would increase over time if strategies to reduce referrals and to substitute hospital care for primary or community services prove successful.

Professor Andrew Street: COM 113

191. While this option has attractions, it would move the commissioner away from the provider. Other witnesses have argued that effective commissioning requires commissioners to develop long term relationships. While this does not currently happen as much as it should, Professor Street's option would make it more difficult, although a similar system does work for major retailers and supermarkets.

Retain and strengthen PCTs

192. Despite their failings there are strong arguments for retaining PCTs. There have been too many reorganisations in recent decades and there would need to be very strong arguments for another upheaval.

193. On the other hand, the system of PCTs cannot continue as it is. Moreover, the Government's proposals for improvement by themselves are unlikely to bring about the improvements required. If we are going to keep PCTs they need to be given more teeth and more talent.

194. PCTs employ large numbers of staff, but too many are not of the required calibre. PCTs need to become better at collecting data, for example of the needs of their population, and at analysing it. In particular, it is essential to exploit existing and developing data sources to provide comparative performance information in terms of cost, activity and outcomes. This would facilitate the early identification of "outliers" such as Mid Staffs, Bristol and Shipman. As we noted in our report on the "Next Stage Review" PCTs lack the analytical skills or motivation to handle and interpret performance and routine administrative data. With the introduction of PROMs and other quality related measures this issue is becoming ever more important. There is little evidence that WCC has yet brought about improvements in these areas.

195. There is also an urgent need to improve the quality of management. Research undertaken under the auspices of the NHS Institute for Innovation and Improvement in 2008 into improving the quality of care concluded:

a significant investment of time, resources and leadership effort will be required to create the capability for large-scale change across the whole of the NHS.²⁰⁷

²⁰⁷ NHS Institute for Innovation and Improvement, *The next leg of the journey: How do we make High Quality for All a reality?* H, Bevan, C, Ham and P, Plsek., 2008.

196. In our report on the Next Stage Review²⁰⁸, the Committee pointed to the potential of the National Training Programme:

The National Training Programme has attracted graduates of great ability. They should be encouraged to take appropriate academic qualifications and be given sustained career support to ensure that their talent is exploited to the full throughout their careers.

The NHS should make far better use of the Graduate Management Training Scheme to provide highly able managers.

197. As we have discussed CQUIN, PROMs and Quality Accounts legislation²⁰⁹ are potentially important levers to enable PCTs to provide financial incentives to hospitals to improve their services. As we noted we are alarmed that they have not been properly evaluated. The CEO of the NHS, David Nicholson, said the NHS would learn from local experiments. This approach has all the failings we condemned in our report on Health Inequalities.²¹⁰ CQUIN is important and must be properly evaluated. As we have noted above, the list of *Never Events* is very conservative.

198. It has been argued that the power of PCTs should also be increased by increasing the number of providers; thus PCTs would have a greater choice of provider and could cease to purchase from those who were providing an unsatisfactory service. This would in theory provide incentives to established providers to improve their performance.

199. The Government did take steps in this direction, for example by introducing ISTCs, but seems subsequently to have changed direction. The ISTC programme has been curtailed and the Secretary of State has announced that NHS organisations are the “preferred providers” of NHS care.

Impending Cuts

200. The Government has announced a 30% reduction in management costs in PCTs and SHAs from 2010 to 2013.²¹¹ While some PCTs do a good job with low overheads, we are not convinced that taking money away from weaker PCTs will automatically encourage them to improve their performance. At a time when we are expecting so much of PCTs, it seems risky to be cutting their management costs by 30% when they need better skills and more talent. **We note that the Minister indicated the potential to make savings from SHAs; we agree that they should bear the brunt of any cuts.**

208 Health Committee, First Report of the Session 2008–9, *NHS Next Stage Review*, HC 53–1

209 Quality Accounts legislation comes into effect in April 2010. Outlined in *High Quality Care for All*, 2008, Quality Accounts aim to enhance accountability to the public and engage the leaders of an organisation in their quality improvement agenda. From April 2010, all providers of acute, mental health, learning disability and ambulance services will be required to produce a Quality Account. Further work is underway to develop Quality Accounts for primary care and community services providers with the aim to bring these providers into the requirement by June 2011 subject to a testing and evaluation exercise.

210 Health Committee, Third Report of 2008–09, *Health Inequalities*, HC 286–I

211 In its publication, *NHS 2010–2015: from good to great. preventative, people-centred, productive*, Cm 7775, December 2009, the Department of Health stated: “We will significantly reduce management costs in PCTs and strategic health authorities (SHAs) by setting a clear goal of reducing costs by 30% over the next four years” (para 4.35).

Conclusions

201. If we are to keep PCTs they need to be strengthened. In particular, they require a more capable workforce, with people able to analyse and use data better to commission services. They also need to improve the quality of management, attracting and developing talent. As we have argued in previous reports, the NHS Graduate Management Training Scheme could play a major role in achieving this. However, commissioning cannot be improved in isolation from the rest of the health service. PCTs will need to have more power in dealing with providers. It needs to be able to offer more evidence-based financial incentives to providers to improve its relationship with providers. We trust our successors will follow the CQUIN initiative carefully. It must, however, be properly evaluated. If successful it should be expanded significantly. At the moment the Government has proposed some sort of qualitative analysis, which amounts to little more than asking participants how they feel about it. We recommend the Government institute a rigorous quantitative assessment.

202. A number of witnesses argued that we have had the disadvantages of an adversarial system without as yet seeing many benefits from the purchaser/provider split. If reliable figures for the costs of commissioning prove that it is uneconomic and if it does not begin to improve soon, after 20 years of costly failure, the purchaser/provider split may need to be abolished.

Conclusions and recommendations

Costs of Commissioning

1. Whatever the benefits of the purchaser/provider split, it has led to an increase in transaction costs, notably management and administration costs. Research commissioned by the DH but not published by it estimated these to be as high as 14% of total NHS costs. We are dismayed that the Department has not provided us with clear and consistent data on transaction costs; the suspicion must remain that the DH does not want the full story to be revealed. We were appalled that four of the most senior civil servants in the Department of Health were unable to give us accurate figures for staffing levels and costs dedicated to commissioning and billing in PCTs and provider NHS trusts. We recommend that this deficiency be addressed immediately. The Department must agree definitions of staff, such as management and administrative overheads, and stick to them so that comparisons can be made over time. (Paragraph 37)

Commissioning for specialised services

2. The implementation of the Carter Review has made significant improvements to the commissioning of specialised services over the past four years. However, we are concerned that insufficient progress has been made, with significant local variations; and that some important issues remain outstanding. (Paragraph 54)
3. Carter recommended the revision of the National Definitions Set; this does not appear to have gone far enough. The DH must indicate what it will do to ensure that the fourth edition commands wider confidence and support among commissioners. (Paragraph 55)
4. Worryingly, the evidence which we received indicates that many PCTs are still disengaged from specialised commissioning. Furthermore, there is a danger that the low priority many PCTs give to it will mean that funding for specialised commissioning will be disproportionately cut in the coming period of financial restraint. In addition, specialised commissioning is weakened by the fact that, as a pooled responsibility between PCTs, it sits in a “limbo”, where it is not properly regulated, performance managed, scrutinised or held to account. There is much to commend the Specialised Healthcare Alliance’s proposal to bypass the PCTs altogether, making the National Commissioning Group and the Specialised Commissioning Groups into commissioners in their own right, although there is some risk that this could lead to a lack of co-ordination of, and disruption to, services. We recommend that the DH undertake a review of the problems we have highlighted, taking into account the Specialised Healthcare Alliance’s proposal. (Paragraph 56)

Weaknesses in commissioning

5. There are examples of good work being undertaken by PCTs. However, many PCTs believe they are working effectively although the evidence would suggest otherwise. (Paragraph 106)
6. As the Government recognises, weaknesses remain 20 years after the introduction of the purchaser/provider split. Commissioners continue to be passive, when to do their work efficiently they must insist on quality and challenge the inefficiencies of providers, particularly unevidenced variations in clinical practice. (Paragraph 107)
7. Weaknesses are due in large part to PCTs' lack of skills, notably poor analysis of data, lack of clinical knowledge and the poor quality of much PCT management. The situation has been made worse by the constant re-organisations and high turnover of staff. (Paragraph 108)
8. Commissioners do not have adequate levers to enable them to motivate providers of hospital and other services. We recommend the Department commission a quantitative study of what levers should be introduced to enable PCTs to motivate providers of services better and a review of contracts to ensure that rigid, enforceable quality and efficiency measures are written into all contracts with providers of health care. (Paragraph 109)

Government reforms

9. The Government has embarked on a series of sometimes contradictory reforms which have had significant effects on commissioning. In the first wave of reforms undertaken when the Rt Hon Frank Dobson was Secretary of State, NICE was created. This has led to threats and opportunities for PCTs. Potentially, PCTs could insist that hospitals use NICE guidelines to provide the best, cost effective care; unfortunately, they have done this less often than they should have. On the other hand, there is a tendency for NICE guidance to be "inflationary" in its effect on spending by PCTs, obliging them to pay for certain expensive treatments. We repeat our regular injunction that NICE should do more to specify where disinvestment should take place. (Paragraph 129)
10. The next wave of reforms, made when the Rt Hon Alan Milburn was Secretary of State, sought to achieve a more market-oriented NHS; they included the introduction of PbR. We were informed that this has had a number of disadvantages for commissioners. PbR threatens to increase transaction costs and, in part because of the weakness of commissioning, provides hospitals with an incentive to generate more activity to increase their income. (Paragraph 130)
11. More recently the DH has appeared to place less emphasis on the market-based approach. The present Secretary of State has stated that the NHS is the "preferred provider" and Integrated Care Pilots have been introduced. It is unclear how this policy relates to earlier measures such as PbR. (Paragraph 131)
12. Although there has been slightly less emphasis on market reforms recently, the NHS remains characterised by tensions between purchasers and providers. The weakness

of commissioners faced by powerful providers means that the reforms have threatened to undermine some of the Government's key aims, such as switching care from hospitals to the community. (Paragraph 132)

Government's attempts to improve commissioning

13. Ridiculous though the term is, much of the World Class Commissioning initiative is unexceptionable. It is clearly too early to judge the success of WCC but note there are serious concerns about the capability of PCTs to make the huge step changes required. We recommend that the Care Quality Commission uses the eleven competencies of World Class Commissioning to judge PCTs. (Paragraph 148)
14. We are concerned that PCTs might be too complacent to make the necessary improvements. A survey we commissioned from the NAO revealed a remarkable degree of misplaced confidence on the part of PCTs about how well they think they are doing. (Paragraph 149)
15. It is not clear to us that WCC is going to address the lack of capacity and skills at PCT level and weak clinical knowledge. Furthermore there are concerns that WCC will be no more than a "box ticking" exercise whereby people expend a lot of energy merely demonstrating they have the right policies in place, rather than actually transforming patient outcomes and cost effectiveness. (Paragraph 150)
16. The Government believes that CQUIN, PROMs, Quality Accounts and Never Events will improve commissioning, shifting power away from providers and enhancing the quality of care. However, we remain concerned that the Government is not piloting and rigorously evaluating these ideas before implementation, as we have previously said. The Government's list of *Never Events* is too conservative. (Paragraph 167)
17. PCTs clearly do lack the skills that they need for commissioning and engaging consultants is one way of helping to address this situation. However, we are concerned that FESC is an expensive way of addressing PCTs' shortcomings. The Minister of State himself expressed concern about the extent to which consultants are being used. The Department must do more to determine whether or not the taxpayer is getting real value for money out of this costly exercise. (Paragraph 176)
18. Whatever the possible benefits of using consultants, we doubt the ability of PCTs to use consultants effectively. (Paragraph 177)

The way forward

19. We note that the Minister indicated the potential to make savings from SHAs; we agree that they should bear the brunt of any cuts. (Paragraph 200)
20. If we are to keep PCTs they need to be strengthened. In particular, they require a more capable workforce, with people able to analyse and use data better to commission services. They also need to improve the quality of management, attracting and developing talent. As we have argued in previous reports, the NHS Graduate Management Training Scheme could play a major role in achieving this. However, commissioning cannot be improved in isolation from the rest of the health service.

PCTs will need to have more power in dealing with providers. It needs to be able to offer more evidence-based financial incentives to providers to improve its relationship with providers. We trust our successors will follow the CQUIN initiative carefully. It must, however, be properly evaluated. If successful it should be expanded significantly. At the moment the Government has proposed some sort of qualitative analysis, which amounts to little more than asking participants how they feel about it. We recommend the Government institute a rigorous quantitative assessment. (Paragraph 201)

21. A number of witnesses argued that we have had the disadvantages of an adversarial system without as yet seeing many benefits from the purchaser/provider split. If reliable figures for the costs of commissioning prove that it is uneconomic and if it does not begin to improve soon, after 20 years of costly failure, the purchaser/provider split may need to be abolished. (Paragraph 202)

Formal Minutes

Thursday 18 March 2010

Members present:

Mr Kevin Barron, in the Chair

Sandra Gidley
Dr Doug Naysmith

Dr Howard Stoate
Dr Richard Taylor

Draft Report (*Commissioning*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 202 read and agreed to.

Summary agreed to.

Resolved, That the Report be the Fourth Report of the Committee to the House.

Ordered, That the Chairman make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Written evidence was ordered to be reported to the House for printing with the Report.

[Adjourned till Thursday 25 March at 9.30 am

Witnesses

Thursday 22 October 2009

Professor Gwyn Bevan, London School of Economics and Political Science, and **Dr Hamish Meldrum**, Chairman of Council, British Medical Association

Gary Belfield, Acting Director General of Commissioning and System Management, and **Dr David Colin-Thomé**, National Clinical Director for Primary Care, Department of Health, **David Stout**, Director, Primary Care Trust (PCT) Network, NHS Confederation, and **Mark Britnell**

Thursday 14 January 2010

Professor Andrew Street, University of York, and **Dr Peter Brambleby**, Director of Public Health, North Yorkshire and York PCT

Professor Rod Griffiths, Chair, National Specialised Commissioning Group, **John Murray**, Director, Specialised Healthcare Alliance, **Deborah Evans**, Chief Executive, Bristol PCT, and chair of South West Specialised Commissioning Group, and **Teresa Moss**, Director, National Specialised Commissioning Group

Thursday 28 January 2010

John Parkes, Chief Executive, Northamptonshire PCT, and **Julie Garbutt**, Chief Executive, Norfolk PCT

Maureen Donnelly, Chair, and **Dr Paul Zollinger-Read**, Chief Executive, Cambridgeshire PCT, **Stephen Graves**, Director of Corporate Development, Cambridge University Hospitals NHS Foundation Trust, and **Dr Pauline Brimblecombe GP**,

Thursday 4 February 2010

Professor Chris Ham, University of Birmingham, and **Dr Jennifer Dixon**, Director, The Nuffield Trust

Rt Hon Mike O'Brien QC MP, Minister of State for Health, **Gary Belfield**, Director General of Commissioning and System Management, and **Dr David Colin-Thomé**, National Clinical Director for Primary Care, Department of Health

List of written evidence

The following memoranda were published as Commissioning: Written evidence, HC 1020, Session 2008–09

COM

- 1 Department of Health
- 2 Richard Lohman
- 3 Mary E Hoult
- 4 Dr Peter Davies
- 6 Abbott UK
- 7 Dr Jon Orrell
- 8 David Elliott
- 9 NHS Dorset
- 10 NHS Tower Hamlets
- 11 National Pharmacy Association
- 12 CLIC Sargent
- 13 NHS Norfolk
- 14 IMPRESS
- 15 Wolverhampton City PCT
- 16 HEART UK
- 17 NHS South Birmingham
- 18 Association of Greater Manchester Primary Care Trusts
- 19 The Royal College of Midwives
- 20 Dr N D R Luscombe
- 21 National Rheumatoid Arthritis Society
- 22 Weight Watchers UK
- 23 Cystic Fibrosis Trust
- 24 NHS Ealing and NHS Harrow
- 25 The Children's Trust, Tadworth
- 26 Royal College of Radiologists
- 27 Health Mandate
- 28 Medical Practitioners' Union
- 29 Professor Stephen Harrison, Dr Kath Checkland and Dr Anna Coleman
- 30 fpa
- 31 NHS Sheffield
- 32 Beating Bowel Cancer
- 33 Roche
- 34 UNISON
- 35 Dr Jonathan Howell
- 36 LIFT Council
- 37 West Midlands Specialised Commissioning Group
- 38 Bayer Schering Pharma
- 39 Royal College of Physicians

- 40 Which?
- 41 Urology Trade Association
- 42 Assura Group
- 43 NHS Stockport
- 44 Wakefield Local Pharmaceutical Committee
- 45 East of England PCTs
- 46 Company Chemists' Association and the Association of Independent Multiple Pharmacies
- 47 Muscular Dystrophy Campaign
- 48 NHS Bristol
- 49 South West Specialised Commissioning Group
- 50 South of England Spinal Injuries Board
- 51 Smokefree South West
- 52 Terrence Higgins Trust
- 53 Bliss
- 54 NHS North Somerset
- 55 NHS South of Tyne and Wear
- 56 Royal College of Nursing
- 57 Northamptonshire PCT
- 58 Medical Technology Group
- 59 Baxter Healthcare Ltd
- 60 Professor Rod Griffiths CBE
- 61 National Specialised Commissioning Group
- 62 British Society for Rheumatology
- 63 Bupa
- 64 NHS Hammersmith and Fulham
- 65 Federation of Specialist Hospitals
- 66 NHS Sickle Cell and Thalassaemia Screening Programme
- 67 Genetic Interest Group and Rare Disease UK
- 68 Pharmaceutical Services Negotiating Committee
- 69 Association of British Dispensing Opticians, the Association of Optometrists and the Federation of Ophthalmic & Dispensing Opticians
- 70 NHS East & North Hertfordshire and NHS West Hertfordshire
- 72 British Medical Association
- 73 Cancer Research UK
- 74 NHS Alliance Pharmacy Services Commissioning (PSC) Network
- 75 NHS Somerset
- 76 South East Coast PCT Alliance
- 77 British Dental Association
- 78 National Institute for Health and Clinical Excellence (NICE)
- 79 Monitor
- 80 Alzheimer's Society
- 81 British Association for Sexual Health and HIV (BASHH)
- 82 Health Foundation
- 83 Tribal and the Chief Executive of Ashton Leigh and Wigan PCT

- 84 The King's Fund
- 85 Specialist Orthopaedic Alliance
- 86 Nuffield Trust
- 87 NHS Richmond
- 88 East of England Specialised Commissioning Group
- 89 National Patient Safety Agency
- 90 Together We Must
- 91 Specialised Healthcare Alliance
- 92 UnitedHealth UK
- 93 Alec Fraher
- 94 Royal College of General Practitioners
- 95 Care Quality Commission
- 96 Sue Ryder Care
- 97 Royal College of Psychiatrists
- 98 Neurological Commissioning Support
- 99 British Society of Gastroenterology
- 100 Primary Care Trust Network
- 101 NHS Confederation Provider Networks
- 102 Royal College of Speech and Language Therapists
- 103 Chartered Society of Physiotherapy
- 104 Joint Epilepsy Council (JEC)
- 105 Consortium of External Commissioning Contractors
- 106 NHS Birmingham East and North
- 107 Professor Chris Ham
- 108 NHS Institute for Innovation and Improvement
- 109 Professor Gwyn Bevan

List of further written evidence

The following written submissions were received after the publication of Commissioning: Written evidence, HC 1020, Session 2008–09. They are reproduced with the Oral evidence in Volume II of this Report.

- 1 Department of Health (COM 01A)
- 2 Specialised Healthcare Alliance Survey Results (COM 91A)
- 3 Patients Association (COM 110)
- 4 National Osteoporosis Society (COM 111)
- 5 Keep Our NHS Public (KONP) (COM 112)
- 6 Professor Andrew Street (COM 113)
- 7 NHS Alliance (COM 114)
- 8 Dr Daphne Austin (COM 115)
- 9 Dr Daphne Austin (COM 115A)
- 10 Dr Pauline Brimblecombe (COM 116)
- 11 Cambridgeshire Primary Care Trust (COM 117)
- 12 National Childbirth Trust (NCT) (COM 118)
- 13 National Audit Office—Telephone Survey of PCT Commissioners (COM 119)
- 14 MEND (COM 120)
- 15 John Ford (COM 121)

List of Reports from the Committee during the current Parliament

The following reports have been produced by the Committee in this Parliament. The reference number of the Government's response to the Report is printed in brackets after the HC printing number.

Session 2009–10

First Report	Alcohol	HC 151(Cm 7832)
Second Report	Work of the Committee 2008–09	HC 152
Third Report	Social Care	HC 22

Session 2008–09

First Report	NHS Next Stage Review	HC 53 (Cm 7558)
Second Report	Work of the Committee 2007–08	HC 193
Third Report	Health Inequalities	HC 286 (Cm 7621)
Fourth Report	Top-up fees	HC 194 (Cm 7649)
Fifth Report	The use of management consultants by the NHS and the Department of Health	HC 28 (Cm 7683)
Sixth Report	Patient Safety	HC 151 (Cm 7709)
First Special Report	Patient Safety: Care Quality Commission, Monitor, and Professor Sir Ian Kennedy's Responses to the Committee's Sixth Report of Session 2008–09	HC 1019

Session 2007–08

First Report	National Institute for Health and Clinical Excellence	HC 27 (Cm 7331)
Second Report	Work of the Committee 2007	HC 337
Third Report	Modernising Medical Careers	HC 25 (Cm 7338)
Fourth Report	Appointment of the Chair of the Care Quality Commission	HC 545
Fifth Report	Dental Services	HC 289 (Cm 7470)
Sixth Report	Foundation trusts and Monitor	HC 833 (Cm 7528)
First Special Report	National Institute for Health and Clinical Excellence: NICE Response to the Committee's First Report	HC 550

Session 2006–07

First Report	NHS Deficits	HC 73 (Cm 7028)
Second Report	Work of the Committee 2005–06	HC 297
Third Report	Patient and Public Involvement in the NHS	HC 278 (Cm 7128)
Fourth Report	Workforce Planning	HC 171 (Cm 7085)
Fifth Report	Audiology Services	HC 392 (Cm 7140)
Sixth Report	The Electronic Patient Record	HC 422 (Cm 7264)

Session 2005–06

First Report	Smoking in Public Places	HC 436 (Cm 6769)
Second Report	Changes to Primary Care Trusts	HC 646 (Cm 6760)
Third Report	NHS Charges	HC 815 (Cm 6922)
Fourth Report	Independent Sector Treatment Centres	HC 934 (Cm 6930)