



House of Commons
Health Committee

Commissioning: further issues

Fifth Report of Session 2010–11

Volume I

Volume I: Report, together with formal minutes

Additional written evidence is contained in Volume III, available on the Committee website at www.parliament.uk/healthcom

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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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The Reports of the Committee, the formal minutes relating to that report, oral evidence taken and some or all written evidence are available in printed volume(s).

Additional written evidence may be published on the internet only.

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¹ Mr Stephen Dorrell was elected as the Chair of the Committee on 9 June 2010, in accordance with Standing Order No. 122B (see House of Commons Votes and Proceedings, 10 June 2010).

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1 Introduction

1. On 18 January 2011 the Health Committee published its report on Commissioning, responding to the proposed reforms set out in the White Paper *Equity and excellence: Liberating the NHS* (12 July 2010) and associated documents, including the Command Paper *Liberating the NHS: Legislative framework and next steps* (15 December 2010). The Government issued its response to the Committee's report on 31 January 2011.

2. The Committee believes that effective commissioning is a precondition to the successful delivery of the requirement for the NHS to achieve an efficiency gain of 4% per annum over the four years from 2011–12 (“the Nicholson Challenge”). Failure to deliver this requirement would undermine either the quality or the availability of care for patients—which would in turn lead to pressure for extra resources.

3. This report therefore examines those issues that we highlighted previously as requiring further consideration. Our aim has been to produce further analysis for the House of Commons when it reaches the report stage of the Health and Social Care Bill. **As in our first report on this issue, we remain convinced that meeting increasing demand for high quality health care while delivering 4% efficiency gains year on year remains the biggest challenge that faces the NHS. Effective commissioning is key to that target being achieved.**

4. In this second inquiry we have taken evidence from the Department of Health; Local Government Association; National Association of Local Involvement Networks; The Moore Adamson Craig Partnership LLP; Professor Jonathan Tritter, Warwick Business School; Dr Charles Alessi; Royal College of General Practitioners; Royal College of Nursing; NHS Alliance; Professor Calum Paton, Keele University; Professor Paul Corrigan CBE; Beachcroft LLP; Monitor; Medical Practitioners' Union; King's Fund, Royal College of Surgeons; East London and the City Alliance PCT Cluster; Dr Paul Hobday; Seán Boyle, London School of Economics; Healthcare Financial Management Association; Noel Plumridge; Audit Commission; and Professor Margaret Whitehead, University of Liverpool. We have also received 50 written submissions. We are grateful to all of those who have contributed to the inquiry. Professor Kieran Walshe of Manchester Business school was an adviser to the Committee for the inquiry and we are grateful to him for his assistance.

2 Commissioning Accountability

The role of the Secretary of State

5. The Government has proposed that the new commissioning system:

will devolve day-to-day decision-making as close as possible to individual patients, so that those decisions can be more sensitive and responsive to their needs and wishes.²

This devolution is emphasised in the definition of the future role of the Secretary of State. The Government says that under the Health and Social Care Bill, the powers of Secretary of State will be substantially curtailed:

For the first time, the scope for Ministerial interference in day-to-day issues in the NHS will be constrained. The Bill places the Secretary of State under an explicit duty to promote autonomy in the health service, and removes his general power of direction while setting out his functions in clear terms. The Secretary of State retains the duty to promote a comprehensive health service; and is responsible for setting the strategic direction and legislative framework for the NHS.³

6. The Secretary of State has the duty to secure continuous improvement in the quality of healthcare, must consider the need to reduce health inequalities when exercising their duties⁴ and must take care not to impose undue burdens on the NHS.⁵ Any regulations made in respect of consortia and the Board will be subject to the affirmative procedure in Parliament.⁶ As such, the Secretary of State's powers of direction over the NHS are to be circumscribed.

7. Witnesses to the inquiry expressed doubt, however, about whether the Secretary of State would in practice be able to leave issues connected with the day-to-day operation of the NHS to the NHS Commissioning Board and consortia. Stephen Hocking of Beachcroft LLP said:

Whatever the Bill has to say, I have no doubt that [voters] will continue to think that the Secretary of State for Health, or the Government of the day or Parliament generally—whatever it may be—is accountable for the way the taxpayers' funds are spent in the Health Service. Perhaps that is no bad thing.⁷

Professor Paul Corrigan agreed with this, saying that:

2 Cm 7993, para 4.147

3 Department of Health, *Government Response to the House of Commons Health Select Committee Third Report of Session 2010–11: Commissioning*, Cm 8009, January 2011, paras. 74–5

4 Explanatory Notes to the Health and Social Care Bill [Bill 132 (2010–11)] paras. 69–73

5 *Ibid.*, paras. 74–77

6 *Ibid.*, para 162

7 Q 104

Irrespective of the Bill, the Secretary of State will be held to account for the Health Service at the next election—whatever the Bill says—because the public will expect that to be the case.⁸

8. The Committee welcomes the stated intention of decentralising power within the NHS and loosening political control of day-to-day decision making. Voters will, however, rightly continue to regard the Secretary of State as accountable for the development of the NHS—there can and should be no doubt that ultimate responsibility rests with him. The Government must therefore put in place structures which enable the Secretary of State to respond to this political reality.

Central/Local Balance

9. Opinion has been divided on whether the proposals in the Health and Social Care Bill will lead to a change in the balance between central and local decision making, and if so in which direction. The Government has stated its intention to circumscribe the powers of the Board over consortia. In the White Paper, *Equity and Excellence: Liberating the NHS*, the Government stated that:

The headquarters of the NHS will not be in [...] the new NHS Commissioning Board but instead, power will be given to the front-line clinicians and patients. The headquarters will be in the consulting room and clinic.⁹

10. The Command Paper suggests a rather different balance:

The NHS Commissioning Board will hold consortia to account for the quality outcomes they achieve and for financial performance.¹⁰

11. Nigel Edwards, Acting Chief Executive of the NHS Confederation appeared to share the view that the effect of the Bill will be to decentralise power when he suggested that it moves it “[...] from a centrally managed system to a regulated industry, similar to the gas and telecoms sector”.¹¹ This suggests considerable freedom for consortia, to operate within a regulated marketplace.

12. Stephen Hocking from Beachcroft LLP has however described the powers of the Commissioning Board within the Bill as “surprising”. He confirmed this view in evidence to the Committee:

That leaves the Board, it seems to me, with a very wide discretion as to how it interprets those enabling powers.¹²

13. In his letter to the NHS on 17 February 2011, Sir David Nicholson emphasised that the Board would have a strong role:

8 Q 110

9 Department of Health, *Equity and excellence: Liberating the NHS*, Cm 7881, July 2010 para 1.12

10 Cm 7993, para 4.52

11 “NHS reforms are misunderstood” *Independent website*, 31 January 2011, www.independent.co.uk

12 Q 83

The Board will be confident about leading change at scale—not through top down diktat, but neither being shy about claiming a leadership role.¹³

14. In order to clarify this point the Committee asked Sir David Nicholson where the real accountability lies in the new NHS. He stated:

The commissioning consortia are accountable to the Commissioning Board. That is really straightforward and not complicated at all. But, of course, they account to a whole series of different people.¹⁴

15. At the same session he also stated:

[...] the NHS Commissioning Board is a corporate entity. It is one organisation for the whole country. It is not a set of statutory organisations all working together with an organisation. It is one. As such, it is a really important and powerful mechanism to get consistency of service across the NHS in a way we have not been able to do before.¹⁵

16. Although the Committee endorses the need for clear national accountability of commissioners to the Commissioning Board, it agrees with the Government that NHS structures should aim to reinforce responsible devolution of authority. It is, however, concerned that this objective is unlikely to be delivered by the provisions of the Health and Social Care Bill.

17. Effective devolution requires a rebalancing of incentives and influence within the system. The natural pressures for centralisation remain strong:

- i. Resources will continue to come from tax revenue voted by Parliament and will be allocated to Commissioning Consortia by the Commissioning Board;
- ii. There is considerable public support, reinforced by national quality standards and national institutions such as NICE, for the “national” element of the National Health Service;

18. The Committee believes that these influences create the danger of an overcentralised service and it believes that, although they will always remain strong, the most effective counterbalance to the pressures for centralisation is a strong local voice in the commissioning system. To be effective, however, this voice needs to be able to speak authoritatively for local stakeholders; the Committee is concerned that the proposed structure of GP Commissioning Consortia does not achieve this objective. The proposals in this report are intended, among other things, to address this weakness.

13 Department of Health, *Equity and Excellence: Liberating the NHS – Managing the Transition*, 17 February 2011

14 Q 267

15 Q 286

3 Local Commissioning Governance

Good governance

19. **The local commissioning bodies proposed by the Bill will be public authorities responsible for more than half of the largest of all public service expenditures. Voters and taxpayers are entitled to expect that the legislation which establishes them reflects standards of good public sector governance.**

20. The Government has stated:

Our objective is to ensure that there are clear and transparent arrangements for governance, whilst at the same time recognising that different styles of governance will suit different organisations.¹⁶

It has also stated that there is potential for some “confusion between a lack of prescription over governance requirements and a lack of governance altogether”.¹⁷ To manage this confusion, the NHS Commissioning Board will “develop guidance to help consortia ensure that they have good governance arrangements, including transparency of decision-making and clear procedures for declaring interests”.¹⁸ The NHS Confederation told the Committee that:

[...] it is still unclear how it will be ensured that consortia governance arrangements are adequate.¹⁹

21. The Health and Social Care Bill makes provision for an authorisation process for local commissioning bodies which requires the Commissioning Board to approve arrangements for constitutional structure and financial accountability proposed by the bodies themselves.

22. Although the Committee acknowledges the view that the detailed operating arrangements for local commissioning are not best dealt with in primary legislation, it does not believe that the arrangements for governance of NHS commissioning authorities should be delegated to NHS management. It therefore believes that the Bill should place a duty on the Secretary of State to bring forward secondary legislation which prescribes structures for local commissioning bodies which meet the objectives set out in the following paragraphs, the principles of which should be set out in the Health and Social Care Bill.

Governance structures

23. The Government intends to delegate the responsibility for determining governance arrangements to agreement between commissioning bodies and the NHS Commissioning

¹⁶ Cm 7993, para 4.29

¹⁷ *Ibid.*

¹⁸ Ev 117

¹⁹ Ev 127

Board. It has stated: “We are clear that requiring there to be a statutory management board for each consortium would be over-prescriptive”.²⁰

24. The Committee does not agree that it would be “over-prescriptive” to require local commissioning bodies to adopt governance structures which meet basic standards of good governance. As statutory NHS bodies, spending large sums of taxpayers’ money, they should be legally required to have a governance structure (including a formal Board) which complies with minimum requirements set out by the Secretary of State in secondary legislation.

Clinical Involvement

25. It is widely acknowledged that it has been a central weakness of existing commissioning structures that they have failed to fully engage the clinical community. It is, therefore, a key objective of the Government, which the Committee endorses, to involve clinicians in the commissioning process.

26. In its previous report on commissioning, the Committee expressed the view that this commitment to clinical engagement in commissioning needs to include all clinicians—not simply the GP community. It therefore undertook to review the proposed arrangements for integrating the full range of clinical expertise into the commissioning process.

27. In its memorandum the Department says that:

The Bill places a statutory duty on consortia to obtain appropriate advice from health experts, but does not seek to prescribe precisely how they meet this duty. We consider that a more prescriptive approach would risk tokenism and would not achieve the meaningful engagement and collaboration that will underpin successful commissioning.²¹

28. There was unanimity amongst the witnesses representing GPs that we spoke to on this issue that all clinicians (and not just GPs) should be involved in the commissioning process.²² As Dr Charles Alessi of the Kingston Pathfinder GP consortium, told us:

I believe that the [Bill] changes things [...] This is not going to be easy, but unless everybody is involved I don’t think we are going to succeed.²³

29. Dr Clare Gerada, Chair of the Royal College of GPs, told the Committee that engagement of the whole clinical community “should be written into the Bill”, and that “there should be a duty of collaboration, co-operation and shared working”.²⁴

30. In their evidence to us, the Royal College of Physicians (RCP) told us that they would like to see an approach termed “commissioning without walls” where a broad spectrum of

20 Cm 7993, para 4.37

21 Ev 116

22 See, for example, Qq 215–217.

23 Q 42

24 Q 43

clinicians is involved in the commissioning process.²⁵ However, they go on to state that the Bill provisions are “too loose”, leaving the involvement of clinicians as a matter dependent on local relationships alone:

The RCP is calling for a tighter requirement in the Bill for the NHS Commissioning Board and consortia to involve a full range of health professionals. [We propose] a duty to involve specialists. As it stands, we fear that the duty to obtain appropriate advice may become a tick box exercise, which has the potential to damage patient care.²⁶

The RCP go on to suggest that consortia publish information on how they have involved other clinicians, and that the Board assess the extent of clinical involvement in commissioning in their annual assessment.²⁷

31. In addition to the full range of medical expertise, the Committee also received evidence about the importance of ensuring that commissioners have access to the expertise of nurses, therapists, pharmacists and other healthcare professionals.

32. In his evidence to the Committee, the Secretary of State illustrated the very useful role that nurses can and do play in the process of commissioning:

[...] nurses are very often in a very strong position to see the whole care pathway, whereas doctors are very often in a position of understanding rather better the particular issue of diagnosis or treatment rather than seeing all the components of care.²⁸

33. It has been argued to the Committee that, although there is a very strong consensus that commissioning should reflect the full range of clinical expertise, that consensus is not, in itself, an argument for including the full range within the governance structures of the commissioning consortia. It is suggested, as an alternative, that consortia should be required to make arrangements to consult the full range of clinical expertise, and reflect those opinions in its decisions.

34. The Committee believes that the lesson of history is against this view:

- i. It reflects a continuation of the official orthodoxy which has been developed in the 21 years since commissioning was introduced into the NHS; consultation has not worked yet and the Committee sees no reason why it should work better in future:
- ii. The proposed establishment of GP-led commissioning bodies is effectively an acknowledgement of the failure of this approach with respect to GP opinion, but the new consortia represent the inclusion of only part of the clinical community, with the danger that others may feel even more excluded than they have done in the current arrangements.

25 Ev w57

26 *Ibid.*

27 *Ibid.*

28 Q 512

35. The leading role proposed for GPs in the commissioning process reflects the broad basis of their exposure both to patients and the wider health service. The Committee accepts that this experience gives GPs a unique role in the commissioning process and agrees that this role forms the basis of the concept of GP-led commissioning. It also believes, however, that it is important to recognise that effective commissioning requires a balancing of often conflicting objectives, and that it is profoundly unhelpful to allow the perception to develop that the commissioning function is a GP preserve where other considerations are secondary.

36. The Committee therefore recommends that the statutory governance arrangements for local commissioning bodies should prescribe that GPs should be a majority of the members of the Board, but that other places should be preserved to reflect the range of other (clinical and non-clinical) considerations which impact on effective commissioning.

37. The Committee also recommends that the statutory governance arrangements for local commissioning bodies should prescribe that the membership of the Board should include representatives of nurses and of secondary care doctors.

38. The Government has stated that reducing health inequality is at the core of its proposed reforms of the NHS. Both local commissioning bodies and the NHS Commissioning Board will be under a duty to reduce inequality in healthcare provision.²⁹ Public health professionals provide crucial input into the commissioning process, and their ongoing input will be essential in order to achieve any reductions in health inequality.

39. The Association of Directors of Public Health argued in evidence to our earlier inquiry that:

[...] Perhaps the greatest challenge to the new NHS will be how to put prevention at the heart of commissioning. Given that the new structure will put health care and prevention into separate organisations with different outcome frameworks, geographical boundaries, cultures and systems for accountability, there are considerable risks.³⁰

40. The Royal College of Physicians stated that:

Specialists and public health doctors must be involved at the highest level of governance in consortia. In practice, we would like to see all consortia being required to have a board where specialists sit to input into commissioning decisions.³¹

We received other evidence raising concerns about the danger of losing direct public health involvement in commissioning.³²

41. The Committee recommends that the statutory governance arrangements for local commissioning bodies should prescribe that Directors of Public Health or a public

29 Cm 7993, para 4.60

30 Third Report from the Health Committee, Session 2010–11, *Commissioning*, HC 513-II, Ev 47

31 Ev w74

32 See, for instance, Ev w3 and Ev 126.

health professional nominated by them should sit on the boards of Commissioning Authorities.

Accountability to local communities

42. The Royal College of General Practitioners emphasised the importance of patient and public involvement in the governance of commissioning as a mechanism to support an open culture:

Lay representation will be important to assist identification of any serious conflict of interests and maintain transparency.³³

43. In its first evidence session for this inquiry the Committee heard from Alyson Morley, of the Local Government Association. She stated that one way to involve patients and the public in consortia would be to:

[...] have advisory members or you could have an advisory panel. In an awful lot of areas councils and PCTs have really good mechanisms for patient and public involvement.³⁴

44. At the same session, Malcolm Alexander, from the National Association of Local Involvement Networks (LINKs) Members, told the Committee that some Scottish Health Board Chairs are being elected. Regarding local involvement in consortia, he stated that:

I can't see any reason why 50% of the members of a commissioning board can't be lay, and I can't see any reason why some of those people, or all of them, couldn't be elected locally.³⁵

45. The Health and Social Care Bill proposes the establishment of Health and Wellbeing Boards (HWBs) in each upper-tier local authority area. Their key roles would be to lead the preparation of the Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy (JHWS) and promote integrated working between NHS, public health and social care commissioners.³⁶ The core membership for a HWB would be a representative of local GP consortia, the Director of Adult Social Services, the Director of Children's Services, the Director of Public Health (jointly appointed by the local authority and Public Health England), at least one elected local authority member (a councillor or an elected Mayor) and Local Healthwatch.³⁷ The commissioning consortium representative can be one member representing multiple consortia.³⁸

46. Under the Bill's proposals, consortia would need to discuss their commissioning plans with their relevant HWB(s) to ensure that they reflect the JSNA and JHWS.³⁹ HWBs may

33 Ev w57

34 Q 2

35 Q 22

36 Cm 7993, paras 5.21–5.32

37 *Ibid.* para 5.13

38 *Ibid.*, para 5.11

39 *Ibid.*

write to the NHS Commissioning Board, consortia or Local Authority if they feel that their commissioning plans fail to reflect the JSNA or the JHWS, and consortia would have to tell the NHS Commissioning Board whether or not their HWB agrees that their plans have due regard to these documents.

47. The Committee has considered these proposals and believes they are unnecessarily bureaucratic. It agrees with the government that it is important to encourage the development of collaborative working between NHS commissioners and local authorities, and it also believes it is important to broaden the basis of stakeholders who are involved in the NHS commissioning process. Rather than creating additional structures and processes, it believes that this is best achieved by including key stakeholders in the membership of the Boards of Commissioning Authorities.

48. **The Committee therefore recommends:**

- i. **The proposal to establish Health and Wellbeing Boards separate from both NHS commissioning and local authority structures should be dropped.**
- ii. **Responsibility for preparing Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies, and for promoting integrated working between commissioners, should be shared jointly by the Commissioning Authorities, local authorities and Public Health England.**
- iii. **The statutory governance arrangements for local commissioning bodies should prescribe that the membership of the Board should include:**
 - **a professional Social Care representative;**
 - **an elected member nominated by the local authority.**

Scrutiny Committees

49. We heard in evidence that local authority scrutiny of health services has become well established and is done well in many (but not all) areas. There is strong support for the continuation of a separate scrutiny function of this type, as was shown in the negative response to the Government's initial proposal (now dropped) to subsume it under the HWBs.⁴⁰

50. In its response to the Committee's previous report on commissioning, the Government stated that it was significantly extending the scrutiny powers of Local Authorities.⁴¹ Under the Government's proposals, Health Overview and Scrutiny Committees (HOSCs) may continue to scrutinise local health services. However, the Bill confers the powers of scrutiny on Local Authorities directly, not on HOSCs in their own right and Local Authorities are not compelled to have a HOSC.⁴² For the first time, Local Authority scrutiny of health services will be extended to all providers of NHS care and treatment, including the private

40 Qq 2, 19, 24, 39, 40

41 Cm 8009, para 109

42 Q 39

sector and independent practitioners in primary care (GPs, dentists, pharmacists and opticians), as well as covering all NHS bodies.⁴³

51. The Committee believes that the local authority scrutiny function has become established and supports its continued development. The Committee welcomes the extension of the health scrutiny powers of Local Authorities to private sector providers of NHS care and independent practitioners in primary care.

Healthwatch

52. Public engagement in commissioning is important if services are genuinely to meet the needs of the population of an area. The Bill proposes the establishment of local consumer champion organisations called local Healthwatch. Born from the existing LINks, they will aim to represent the views of patients, carers and the public to commissioners, support the public in making choices about healthcare and provide local intelligence for Healthwatch England, a statutory committee of the CQC.⁴⁴ Local Healthwatch will adopt the functions currently undertaken by LINks including supporting and promoting public involvement in commissioning. They will also have some additional powers and responsibilities, such as escalation of concerns about services to Healthwatch England.⁴⁵ Providers of health and social care services must respond to requests for information from Healthwatch, must respond to reports or recommendations and must grant access to premises under certain circumstances.⁴⁶

53. The Committee heard from Malcolm Alexander, Chair of the National Association of LINks Members, that:

[...] we need Healthwatch to be there, sitting, observing and participating in commissioning decisions. We need Healthwatch to be working actively with local authorities, but independence is the key.⁴⁷

54. The Committee attaches particular importance to the role of Healthwatch as the voice of patients in the commissioning process. The proposals contained in this report would, if adopted, provide a broad basis of accountability to the different stakeholders (both clinical and non-clinical) in local health services. They would not, however, provide a direct voice for patient representatives. The Committee has concluded that an attempt to introduce a broadly based patient voice into the governance structure of local commissioning bodies, while maintaining the representative balance described in the report, would make the Board unmanageably large. It therefore believes that the patient voice in collective decision making is best secured by placing an obligation of the local commissioning body to engage in regular consultation with Healthwatch and placing an obligation on Healthwatch itself to engage in regular formal consultation with patients, patient representative groups and the wider public.

43 Health and Social Care Bill cl. 175

44 Health and Social Care Bill cl. 167

45 Cm 7993, para 2.41

46 Explanatory Notes to the Health and Social Care Bill [Bill 132 (2010–11)] para 924

47 Q 7

55. **Although Local Healthwatch can demand information from healthcare providers, the Bill does not provide for Local Healthwatch to demand information from commissioning consortia.⁴⁸ This effectively continues current arrangements in respect of LINKs, whose power to request information relates only to services-providers.⁴⁹ The Committee regards the lack of power on the part of Local Healthwatch to request information from commissioners as a deficiency which should be corrected. Local commissioning bodies should be under a duty to consult Healthwatch when making decisions about service provision.**

Executive Members

56. Although the Committee has endorsed the concept of GP-led commissioning, the effect of the proposals in this chapter is to emphasise the status of the local commissioning bodies as public authorities which draw membership reflecting different stakeholder interests, and which have the duty to try to reconcile sometimes conflicting pressures. One effect of these proposals is to emphasise the distinction between governance (the concern of the Board) and management (the concern of staff appointed by, and accountable to, the Board).

57. Dame Barbara Hakin told us in evidence that, in order to be authorised, consortia:

need to have the leadership capacity and capability [...] they have to have an accountable officer and they have to have a chief finance officer. I am sure none of us here underestimates that successful organisations have very high calibre leadership.⁵⁰

However, while the Bill makes clear that each consortium must have an accountable officer,⁵¹ it does not make the same stipulation as regards having a Chief Finance Officer.

58. The Committee believes that good governance demands that a public authority has an identified Chief Executive and an identified Finance Director, and that both officials are full members of the Board.

Independent Chair

59. All corporate bodies benefit from effective chairmanship. This is particularly true when the body has a significant number of members, drawn from different backgrounds. The Committee's proposals to strengthen the governance and improve the accountability of local commissioning authorities' Boards will work most effectively if the resources and expertise which are available to the Board are coordinated by a chairman who is seen to be independent of any of the interests represented on the Board.

60. The Committee therefore recommends that there should be an independent Chair of the Board of each local commissioning body and that these individuals should be appointed by the NHS Commissioning Board.

48 Health and Social Care Bill cl 171

49 Local Government and Public Involvement in Health Act 2007, Section 224

50 Q 484

51 Health and Social Care Bill cl 21

Board Meetings

61. In its response to our earlier commissioning report, the Government stated:

We want to see all consortia develop robust arrangements that are tailored to local circumstances and driven by local initiative, rather than prescribe a single central approach.⁵²

As with other elements of consortium governance, the Government intends for the question of public meetings to be determined by consortia themselves.

62. The Committee has taken evidence on the matter of whether the Boards of consortia should meet in public. Professor Jonathan Tritter, from the Institute of Governance and Public Management, Warwick Business School, told us that, as the policy stands, “The accountability isn’t sufficient”.⁵³

63. The National Association of LINKs Members echoed this when they told us that:

In terms of openness, it is fundamental that [consortia] should always meet in public. We can’t understand why foundation trusts meet in private. All bodies making high-level decisions about health care and about resources must meet in public. I don’t think it is negotiable.⁵⁴

64. NHS Foundation Trust Boards are not under a duty to meet in public, but they have a number of mechanisms to ensure that the public voice is heard at board level and they do have a duty to be publically accountable.⁵⁵

65. The Committee believes that the public accountability arrangements for local Commissioning bodies are more important than those for FTs as it is the commissioning bodies which will be responsible for determining priorities for the use of taxpayer resources within the NHS. FTs need to be accountable for the quality of care they provide and for the way resources are used, but choices about health priorities and the shape of future health services are primarily matters for commissioners. These are decisions which should be made by public authorities sitting in public.

66. The statutory governance arrangements for local commissioning bodies should prescribe that Boards have a duty to meet in public and their papers should be available to the public.

Conflicts of interest

67. The proposals set out in this report for Board membership in local commissioning bodies are intended to provide a basis for involving key stakeholders in each local health economy in the commissioning process. This reflects the Committee’s belief that effective commissioning requires engagement by all stakeholders, in particular the clinical

52 Ev 121

53 Q 22

54 Q 22

55 Monitor, *Code of Governance for Foundation Trusts*, 10 March 2010

community. This approach will, however, inevitably have the effect that local commissioning bodies will sometimes be required to make decisions which either affect or appear to affect the private interests of Board members.

68. The Committee, therefore, proposes that local commissioning bodies should be required to adopt procedures for dealing with conflicts of interest of Board members which comply with the standards laid down by the Committee on Standards in Public Life. In particular all relevant private interests of Board members should be declared on a public record; no Board member should be present when decisions are made which affect their private interests, and all decisions of the Board should be made in public on the basis of papers which are available to the public.

Name

69. The Government's current proposals refer to local commissioning bodies as GP consortia. The Committee believes this description is misleading, even of the Government's own proposals. **The Committee, therefore, proposes that the new local commissioning bodies to be created by the Health and Social Care Bill should be referred to as NHS Commissioning Authorities.**

4 Primary Care Commissioning

70. Since publication of the White Paper in July 2010, the Government has maintained a consistent line on separating the commissioning of primary and secondary care services. The Government proposes that primary care be commissioned by the NHS Commissioning Board, and that secondary care will be commissioned principally by local commissioning bodies. The key concern has been to guard against the conflicts of interest that could arise from GPs both commissioning and providing primary care services.

71. In its previous inquiry into commissioning the Government told the Committee that it proposed that the NHS Commissioning Board will hold GP practice contracts and will hold GPs to account on that basis.⁵⁶ The Government envisages that local commissioning bodies will have a role to play in primary care commissioning in the form of helping the Board to secure continuous improvement in the quality of primary care.⁵⁷

72. The Department has told us that the consortia will undertake this function through:

[...] a collaborative approach to raising standards in primary care. There is a considerable appetite amongst consortia pathfinders to explore how this relationship will work, building on existing good practice in peer-driven quality improvement.⁵⁸

Sir David Nicholson acknowledged the complexity of the arrangements when he told the Committee:

In terms of the way the Commissioning Board will function, you are absolutely right that it has to function at a national level and a relatively local level, which is a challenge for any organisation. It is inconceivable to me that you will have a very centralised organisation, all based in London and Leeds.⁵⁹

There was agreement amongst our witnesses representing GPs that consortia would have some responsibility for performance managing their member practices.⁶⁰ However, Dame Barbara Hakin told us:

Of all the things that concern me in thinking about, “How are we going to get this absolutely right?”, this is one area that still requires attention and needs to be sorted out by working with the consortia.⁶¹

73. When questioned about the separation of primary and secondary care commissioning, the Secretary of State said “I don’t think that this is likely to be a serious problem”.⁶²

56 Third Report from the Health Committee, Session 2010–11, *Commissioning*, HC 513-II, Ev 131

57 Cm 7993, para 4.82

58 Ev 117

59 Q 262

60 Qq 57 to 62

61 Q 517

62 Q 513

74. **With local commissioning bodies being under the exclusive control of GPs, the Government has found itself having to devise a system that separates the commissioning of and provision of primary care services. The cited rationale for this is to protect GPs from allegations of conflict of interest. However, the Government has established that the NHS Commissioning Board will rely on GP-led local commissioning bodies to undertake the most significant task—that of improving primary care provision. Given the complexity of this proposal, the Committee has reviewed the Government’s proposals for primary care commissioning.**

75. The proposals to separate primary and secondary care commissioning do not draw a clear line between both activities, as local commissioning bodies are to have a pivotal role in primary care commissioning. Dame Barbara was asked if there was a need for “a single voice for commissioning the delivery of an integrated service, both primary and secondary care” for fear of reintroducing “a division between primary and secondary care”.⁶³ She told the Committee that how primary care is delivered has a significant impact on secondary care:

On the other hand, what you say is absolutely right, that the difference, the kind of provision of primary care services, is almost the start of the commissioning journey. The way that primary care is delivered and how well it is delivered has a huge impact on secondary care services [...]⁶⁴

[...] We are back to exploring and understanding the relationship between the Board and the consortia, not having a situation where we have got the Board over here commissioning primary care in isolation and the consortia commissioning secondary care, but a commissioning architecture that works together.⁶⁵

76. The Secretary of State echoed Dame Barbara’s point on integration when he stated to us:

We know that the best way to design those [community based] services is with primary care and secondary care working together, and not shift the resources into primary care and let primary care do it and simply cut the budget at the hospital.⁶⁶

77. Dame Barbara went on to say that, as well as working to secure the continuous improvement of primary care, some local commissioning bodies may have significant levels of delegated responsibility for primary care commissioning.

Inevitably, where it is confident that consortia are able to, the Board will delegate significant areas of this commissioning to the consortia [...] At the moment we will need to work through how that happens and I suspect, in the final analysis, some of it will almost need to be done on a case-by-case basis, depending on the maturity of the

63 *Ibid.*

64 Q 513

65 Q 517

66 Q 458

consortia and the ability of the consortia to discharge some of these functions on behalf of the Board.⁶⁷

78. Crucially, Dame Barbara went on to say that:

You are absolutely right. Once there is confidence in the governance arrangements of the consortia, it is much easier to delegate authority for these issues.⁶⁸

79. The Committee finds that the evidence provided by the Secretary of State and officials runs counter to the direction of policy. If integration of primary and secondary care commissioning is important, then separating them in order to support the proposed system architecture may cause significant harm to the commissioning system as a whole, and should be reconsidered.

80. The Committee agrees that confidence in the governance arrangements of local commissioning bodies is key to them taking on greater responsibility for primary care commissioning. The Committee considers that arguments for the complex arrangements set out by the Government fall away if our proposals for significantly strengthened governance in NHS Commissioning Authorities are accepted. Given this, the Committee recommends that NHS Commissioning Authorities should assume responsibility for commissioning the full range of primary care—including services such as pharmacy and dentistry as well as general practice—alongside their other responsibilities.

⁶⁷ *Ibid.*

⁶⁸ Q 519

5 Authorisation and Assurance of Commissioning Authorities

Authorisation of Commissioning Authorities

81. The Health and Social Care Bill proposes that all local commissioning bodies should be subject to an authorisation process conducted by the NHS Commissioning Board before commissioning authority is vested in them. The Bill envisages that all local commissioning bodies will satisfy the requirements of this authorisation process before 1 April 2013.

82. In her evidence to the Committee on 22 March 2011, Dame Barbara Hakin articulated the criteria against which the Board will assess each consortium before it is authorised to undertake its statutory commissioning functions. The NHS Commissioning Board will make judgements on:

- the clinical focus of consortia, including but not exclusively GPs,
- the degree of responsibility to patients and the public,
- whether consortia have the ability to improve service quality within its available resource,
- a consortium's ability to discharge its functions,
- the degree of collaboration with other consortia, and
- consortia leadership arrangements.⁶⁹

83. Dame Barbara Hakin told us that it is unlikely that all consortia will be ready to assume their full commissioning role on 1 April 2013.⁷⁰ As a contingency plan, the Government are proposing that the NHS Commissioning Board may apply different levels of authorisation to consortia, based on the assessment. These include:

- authorised to commission some services but not others,
- authorised to commission services but with support, and
- conditional authorisation.⁷¹

84. **The Committee notes that Dame Barbara anticipates that it is likely that authorisation will be a process rather an event, with the result that there will be a phased implementation of the changes to NHS commissioning, rather than a big bang. The Committee strongly endorses this approach.**

69 Q 484

70 Q 484

71 Q 484

85. In view of this change of policy emphasis the Committee was interested to establish the statutory basis on which this phased implementation would be carried out. The services that consortia are not authorised to commission will have to be commissioned by some other body. Dame Barbara told us that neighbouring consortia or the NHS Commissioning Board could undertake these functions whilst consortia developed their working practices in order to become fully authorised.⁷²

86. In earlier evidence Dame Barbara had said:

The Board will have a number of options where it feels a consortium doesn't meet all the criteria set out in the eventual authorisation process. First, it could confer partial authorisation on the consortium. It could choose to say, "For these services, which are slightly more straightforward to commission, we are happy for the consortium to commission them." But the Board itself, or another more effective consortium, might, in the short to medium term, take over the commissioning of the more complex services.⁷³

87. This answer implies that the NHS Commissioning Board will have a wide range of discretion about the pace and extent of authorisation of individual local commissioning bodies. It is important that there are powers in the Health and Social Care Bill to allow the NHS Commissioning Board to manage this process effectively.

88. The Government has repeatedly stated that its proposed reforms consist of three mutually reinforcing parts:

- no decision about me, without me;
- an increased focus on outcomes; and
- the principle of assumed liberty rather than earned autonomy.⁷⁴

89. In contrast to the third of those elements, Dame Barbara told the Committee that the principle of "earned autonomy" will inform the authorisation of local commissioning bodies.⁷⁵ **The Committee supports this change from the principle of "assumed liberty" to one where commissioners will earn autonomy, and are only authorised to commission once the NHS Commissioning Board is satisfied that they are competent and capable.**

90. Authorisation of consortia will clearly be very different to the process for authorisation of Foundation Trusts (FTs). The King's Fund told us that:

In stark contrast with the authorisation process [...] for aspiring Foundation Trusts, consortia will be new organisations with no track-record they can be judged against.⁷⁶

72 *Ibid.*

73 Q 254

74 Cm 7993, paras. 1.2, 4.76, 7.10, Cm 8009, para. 8

75 *Ibid.*

76 Ev 139

91. NHS Trusts applying to become FTs will have been trading for many years before their application and have established executive teams, networks and relationships with stakeholders. Sir David told the Committee that in the absence of “several years of trading” data the authorisation process for consortia will “have to be based on perspective”.⁷⁷

92. In evidence, Sir David Nicholson told us that:

I would like to see, as a principle, a 360° part of the process so that patients [...], local authorities, secondary care clinicians and other clinicians would be able to have their say in relation to the authorisation of that organisation.⁷⁸

The Committee welcomes Sir David’s commitment to consult all stakeholders during the authorisation process.

Annual Assurance

93. The Health and Social Care Bill stipulates that the NHS Commissioning Board must conduct an annual assessment of consortium performance,⁷⁹ sometimes known as commissioning assurance. Commissioning assurance will focus in particular on how a consortium is performing against its duty to secure the continuous quality improvement of health services.⁸⁰ The Board must have regard to the NHS Outcomes Framework in this assessment and any commissioning guidance issued.⁸¹ The Board can require written or oral explanation of any matter relating to how consortia are exercising their functions and it must publish its assessment of the performance of consortia.⁸² The Board will take the views of relevant Local Authorities and Health and Wellbeing Boards into account in its assessment of each consortium.⁸³

94. In its evidence to the Committee, the Royal College of Nursing told us that the Health and Social Care Bill has “insufficient detail around assurance and governance [of consortia]”.⁸⁴ Other organisations such as the BMA and the NHS Confederation have also expressed some concern about the level of detail available on this matter.

95. In her evidence to the Committee, Dame Barbara Hakin told us that the assurance process for consortia had not yet been decided and that the Board must have confidence that consortia can come together and develop “consistent commissioning plans across a wider, broader geography”.⁸⁵

77 Q 249

78 Q 249

79 Health and Social Care Bill cl.14Z1

80 *Ibid.*

81 Health and Social Care Bill. cl. 14Z2 to 14Z5

82 *Ibid.*

83 Cm 7993, para 4.56

84 Ev 147

85 Q 473

96. The King's Fund has told the Committee that they support the idea of an annual assessment process but suggests that this needs to be an opportunity for development as well as an annual assessment of achievement. It suggests that:

An assessment of core commissioning competencies would be of much value to consortia, particularly in the early years when they are developing skills and capacity.⁸⁶

97. As part of the Labour Government's World Class Commissioning system, all PCTs took part in an annual assurance process that measured their progress against achieving specific health outcomes, against core commissioning competencies as well as assessing their governance arrangements and the performance of their Board.⁸⁷

98. In his evidence to the Committee, the Secretary of State highlighted a key issue with regard to consortium failure.

It is the Board's responsibility to identify that prospect of failure and to intervene early, not to wait around for a failure to occur. We have had too many instances of waiting around for failures to occur.⁸⁸

99. The Committee was struck by these comments, in that we assume that the annual assurance assessment will take place at a fixed point in the year. The NHS Confederation echoed this, and they have expressed some concern about the period between annual assessments.

The Bill sets out a clear intervention regime for consortia that are failing or deemed at risk of failing, but there is no indication of how performance is monitored and managed prior to that point.⁸⁹

100. The Committee acknowledges the need for authorisation and assurance processes for local commissioning bodies, and for intervention by the NHS Commissioning Board when things are going wrong. However, these processes will be resource-intensive and require local knowledge that a national body may not possess. We recommend that when the PCT clusters become outposts of the Board in 2013 that their resources be directed towards authorisation, assurance and support of commissioning bodies.

101. Given their role in authorising and assessing local commissioning bodies, and their powers of intervention when commissioners are failing or likely to fail, the outposts of the Board have all of the characteristics of performance managers. The Committee welcomes the presence of performance management in the commissioning process and believes its role should be strengthened by requiring local commissioners to have regard to Support and Improvement Plans developed by or with the outposts of the Board.

86 Ev 139

87 "World Class Commissioning", *Department of Health website*, 7 April 2010, www.dh.gov.uk

88 Q 476

89 Ev w9

6 Service reconfigurations

102. The Nicholson Challenge requires the NHS to deliver 4% efficiency gain in each of the next four years. Although some of this efficiency is expected to reflect pay restraint among the staff of the NHS (if NHS earnings rise by 1% less than inflation in a year, the economic result is a 1% improvement in efficiency), the great majority of the efficiency gain will be the result of changes in the delivery of care.

103. This requirement for change is not simply driven by a requirement to achieve cost savings—it also reflects the changing nature of the demand for healthcare. As demand increases from elderly patients with long term complex conditions, it is important that the pattern of clinical care reflects their requirement for care which integrates primary, community and acute care into coordinated pathways which achieve early and effective intervention and avoid the tendency for patients to be referred around the system for uncoordinated episodes of care which are both expensive and poor quality.

104. Although change is a fact of life and the model of NHS care delivery needs to be constantly changing to keep up to date, change proposals are often strongly contested as a result of community and professional loyalty to local structures and institutions. Those who make the case for change in such circumstances are rightly required to make their case on the basis of evidence, and need to be able to sustain these arguments in discussion with local stakeholders.

105. The configuration of hospital and community health services is currently the responsibility of the local NHS; that is, PCTs as commissioners and SHAs as the local representatives of the DH. However, the DH has developed policies and guidance on which types of services should be provided in which settings in an effort to improve cost-effectiveness, quality and access in the health service.

106. Since 2002, local authority Health Overview and Scrutiny Committees (HOSCs) have had the power to refer decisions by the NHS to the Secretary of State for Health if they consider either that the public consultation process was inadequate or that the proposed change is not in the interests of the local area. In recent years the Secretary of State has, as a matter of course, sought advice on contested reconfigurations from the Independent Reconfiguration Panel, which is set up as a non-departmental public body. Before referral is considered all options for local resolution have to be explored.

107. In May 2010, the Coalition Agreement stated that “We will stop the centrally dictated closure of A&E and maternity wards, so that people have better access to local services”.⁹⁰ The Secretary of State subsequently suspended the planned far-reaching reconfiguration of services in London, pending a review, and said that such changes would in future need to be signed off by GPs.⁹¹

90 HM Government, Coalition Agreement, 11 May 2010, p. 24

91 “Lansley confirms London reconfiguration halted”, *Health Service Journal* website, 19 May 2010, www.hsj.co.uk

108. The revision to the Operating Framework for 2010–11, published in June 2010, imposed a moratorium on service reconfigurations, with any proposals now required to meet four tests before proceeding. These relate to:

- support from GP commissioners;
- public and patient engagement;
- clarity on clinical evidence; and
- consistency with patient choice.⁹²

109. The Command Paper says that the power to refer significant service reconfiguration decisions to the NHS Commissioning Board (and in exceptional cases to the Secretary of State) will apply in certain specific circumstances only. When deciding to refer services to the Board or Secretary of State, the Local Authority must in future:

[...] first take account of a wider range of considerations including the duties on NHS commissioners to improve the safety, effectiveness and patient experience of services, and the need for services to be financially sustainable.⁹³

This power should be exercised by a full meeting of the Council and not by the HOSC on its own.⁹⁴ Under the Government's proposals the power of referral will also only apply to designated services.⁹⁵

110. The Committee believes that the ability to manage service reconfiguration (i.e. keep service delivery up to date and in line with current best value and best practice) is fundamental to good stewardship of public funds and the delivery of high quality, good value healthcare. In particular it believes it is essential that local commissioning bodies are able to introduce changes to clinical care in their communities which reflect the changing needs of their patient populations.

111. The Committee also believes that the unprecedented scale of efficiency gain required by the Nicholson Challenge puts a particular emphasis on the ability of commissioners to facilitate necessary service reconfigurations.

112. The Committee is mindful that this unprecedented requirement to manage a process of change in the clinical model of the NHS will require effort and commitment from NHS managers whose work we believe should be valued, alongside the work of the clinical staff of the NHS. The Committee regrets the fact that the work of NHS management is sometimes the subject of unjustified populist criticism.

113. The Committee believes the recommendations it has made elsewhere in this report for broader clinical and non-clinical engagement in the commissioning process are fundamental to the delivery of necessary service reconfigurations.

92 Department of Health, *Revision to the Operating Framework for the NHS in England 2010/11*, 21 June 2010, pp 8–9

93 Cm 7993, para 5.44

94 Cm 7993, para 5.43

95 *Ibid.*, para 5.41

7 Interface between health and social care

114. The interface between health and social care is currently the source of substantial waste and inefficiency in the health and social care system. This manifests itself in multiple assessments, inadequate information transfer, conflicting priorities and, too often, crude budget shunting. The effect of these inefficiencies is not only financial cost, but also poor care for patients (often elderly) who are passed around the system like parcels.

115. The Committee is concerned that further institutional upheaval will both disrupt existing fledgling arrangements for improving this situation and distract staff from the urgent need to address the issue.

116. Against this background the Committee urges the NHS Commissioning Board to work closely with local commissioning bodies to facilitate budget pooling and service integration to reflect patient priorities.

117. Numerous services are jointly commissioned by PCTs and Local Authorities using the so called “Health Act flexibilities”. A PCT and a Local Authority can pool budgets and either can take the lead in commissioning these services.⁹⁶ Additionally, PCTs can also pool resources and arrange for one PCT to take a lead role in commissioning, for example, community dentistry or A&E services. Health and social care commissioning can also become fully integrated into one body, as in the example of the Torbay Care Trust, from who we took evidence in our previous commissioning inquiry.

118. The Committee believes it is essential that these “Health Act flexibilities” are retained and developed within the future structures of health and social care.

119. The Health and Social Care Bill proposes that a duty is placed on local commissioning bodies and local authorities to consider how they can pool budgets and arrange for “joint commissioning” of certain services with Local Authorities.⁹⁷ In addition it is proposed that local commissioning bodies should be allowed to pool resources with other commissioners and with the NHS Commissioning Board, or arrange for another commissioner to take a “lead commissioning” role on their behalf, or work collaboratively with others.⁹⁸ **The Committee welcomes these proposals and encourages the NHS Commissioning Board to promote their widespread use.**

120. The Committee believes it is important to promote the integration of health and social care commissioning, and develop coordinated packages of care for patients. It recommends that the Government should ensure that the proposed assurance regime for local NHS commissioning bodies is developed in association with Local Authority stakeholders and is capable of assessing joint commissioned services.

96 National Health Service Act 2006, Section 75

97 Health and Social Care Bill cl. 177

98 Health and Social Care Bill cl.14Q

121. **Aligning geographic boundaries between local NHS commissioning bodies and social care authorities has often been found to promote efficient working between the two agencies. There will in the first instance be more local NHS commissioning bodies than social care authorities; the Committee therefore encourages NHS commissioning bodies to form groups which reflect local social care boundaries for the purpose of promoting close working across the institutional boundary. History suggests that some such groups will find the opportunities created by co-terminosity encourage more extensive integration of their activities.**

8 Local Commissioning finances

Weighted Capitation

122. PCT resource allocation takes place through the medium of a “Weighted Capitation” formula. This formula is used to determine Primary Care Trusts’ target shares of available resources (on which actual allocations of funds are based). A PCT is allocated funds based both on the number of people permanently registered with a GP in their area and the number of people in the area who are not registered with a GP and for whom accurate national data are available.

123. The allocation formula includes a weighting formula designed to ensure that, as closely as possible, the distribution of resources reflects need. The weightings include:

- age- and sex-related need for healthcare;
- utilisation of healthcare, population health status, availability of healthcare services and the numbers of years someone can be expected to live without a disability;
- geographical variations in the unavoidable cost of providing healthcare covered by the Market Forces Factor—PCTs in high cost areas have higher allocations, all else being equal.

124. The Advisory Committee on Resource Allocation (ACRA) advises the Secretary of State for Health on the weighted capitation formula. ACRA is an independent expert body whose membership includes individuals with a wide range of expertise from within, and outside, the NHS.

The Government’s proposals

125. The Government has said that it is working with ACRA and others to develop an allocation formula based on practice-level allocations.⁹⁹ The challenge will be to develop a workable methodology which allows the formula to reflect need when patients are free to register with practices, and practices are free to join consortia, which do not reflect geography. This requires a more complex formula than a simple allocation to geographic communities, particularly when each consortium will have a population-based responsibility as well as a responsibility for the care of its practice population.

126. The Department is planning to make shadow allocations to consortia for the year 2012–13 to allow for testing in the year before full operation of the new system in April 2013.¹⁰⁰ As Professor Martin Rowland from the University of Cambridge told the Committee’s previous commissioning inquiry:

99 Cm 7993, para 4.146

100 *Ibid.*

If the government pilots nothing else, it must pilot a range of resource allocation formulas before giving commissioning groups their budgets.¹⁰¹

127. Sir David Nicholson told the Committee that:

Apart from getting the allocations out for 2012–13, we have done very little work on what will happen in 2013–14. [...] The kinds of formulae that we have now will be the kinds of formulae we will have in the future.¹⁰²

128. Professor Margaret Whitehead from the University of Liverpool expressed some concerns about the Government’s proposals regarding the approach to funding consortia commissioning of NHS services.

Trying to [...] give them a deprivation weighting, will be very difficult because you do not have the geographic footprint that previous commissioning authorities have had. You could get a situation where very aggressive, competitive consortia could configure themselves very favourably in terms of receiving money and using the commissioning budget in such a way that they are in a very good position to make profit, et cetera. In that respect, you could get a situation where some consortia are much better placed than others to thrive.¹⁰³

She also told us that finding an appropriate resource allocation for local commissioning bodies is an area that may be of particular concern:

Obviously, it is very important to test but I am also aware of all the difficulties. That is why I am saying it would be optimistic to think that things could be ready in time.¹⁰⁴

The need to provide shadow budgets for 2012–13 means that consortia need to be in place before this date, as opposed to fully authorised by April 2013.

129. The Department says that a new NHS funding formula is to be tested by local commissioning bodies in 2012–13. To make this a meaningful exercise, the geographic boundaries and constituent practices of all local commissioning bodies will need to have been established during 2011–12. The evidence we have heard suggests that this will be difficult to achieve. The Committee recommends that the Government should publish a detailed timetable for the implementation of the new resource allocation formula as soon as possible.

Risk pooling

130. The White Paper says that consortia will need to be “of sufficient size to manage financial risk and allow for accurate allocations”.¹⁰⁵

101 Third Report from the Health Committee, Session 2010–11, *Commissioning*, HC 513-II, Ev 129

102 Q 322

103 Q 404

104 Q 419

105 Cm 7993, para 4.22

131. The accompanying document *Commissioning for Patients* says that:

There are two broad categories of risk in the system:

- risks from unavoidable and natural fluctuations in the healthcare needs of a population, which are often described as ‘insurance risk’
- risks arising from controllable activities, such as poor prescribing or referral practices, sometimes known as ‘service risk’.

132. The challenge for risk management is in helping commissioners deal with the insurance risk through some form of risk pooling, while ensuring that commissioners are responsible for managing service risk. Empirically it can be difficult to separate out those risks. This means that the approach to managing financial risk will need to be carefully thought through and evolve over time as new evidence comes to light.¹⁰⁶

133. In its memorandum, the Department says that consortia can pool risk with each other or with the NHS Commissioning Board itself.¹⁰⁷ The Command Paper says that DH will explore some form of weighted insurance premium to ensure appropriate incentives for good financial management.¹⁰⁸ The Board may also establish a contingency fund to make payments to consortia where they are necessary for the Board or consortia to discharge commissioning functions.¹⁰⁹

134. Concerns have been raised about how consortium surpluses and deficits will be handled under risk-pooling arrangements. The British Medical Association (BMA) told the Committee:

The current proposals seem to differ little from existing arrangements in PCTs. There appears to be no incentive not to spend any remaining funds at the end of the financial year, on items or short-term projects that are of little long-term benefit, as there remains a risk that unspent money will not be carried over into the next year.¹¹⁰

135. Although there are arguments both for and against consortia being able to carry forward surpluses, the Committee considers that greater clarity is needed on commissioners’ financial procedures and risk pooling arrangements. The Department and HM Treasury must publish the arrangements for effective risk pooling and any plans for rolling surpluses or deficits forward.

Existing PCT debts

136. When the intention to introduce GP commissioning consortia was announced, there was some concern amongst GPs that, on assuming statutory commissioning

106 Department of Health, *Liberating the NHS: Commissioning for patients*, July 2010, paras. 5.7–8

107 Ev 115

108 Cm 7993, para 4.67

109 *Ibid.*

110 Third Report from the Health Committee, Session 2010–11, *Commissioning*, HC 513-II, Ev 109

responsibilities from 1 April 2013, these new organisations might inherit any debts accumulated by their local PCTs.¹¹¹

137. The DH made clear in the Command Paper that:

During the transition, the Department will require SHAs and PCTs to have an increased focus on maintaining financial control. GP consortia will have their own budgets from 2013/14. They will not be responsible for resolving PCT legacy debt that arose prior to 2011/12. PCTs and clusters must ensure that, through planning 2011/12 and 2012/13, all existing legacy issues are dealt with.¹¹²

The Department added that it was:

working with SHAs to address circumstances where PCTs have debts (whether they are related to actual deficits or to money owed under local brokerage arrangements), with the expectation that any debt will be fully resolved by the end of 2012/13.¹¹³

It rejected the case for allowing commissioning consortia to start with a financial clean sheet on the grounds that it:

would mean taking surpluses away from local health economies where GPs have been instrumental in generating those surpluses and would reduce incentives for emerging consortia to support PCTs in tackling existing deficits and in driving forward the QIPP agenda in 2011/12 and 2012/13.¹¹⁴

138. PCT clusters and emerging GP commissioning consortia are thus required to collaborate in achieving financial control during 2011–13, with consortia effectively having a vested interest in helping PCTs to reduce existing deficits in order to minimise the amount of debt they inherit in 2013.

139. When we took evidence from a group of experts on NHS finance we were told that, whilst it was easy to see which PCTs were in deficit in any given year, the underlying position was less easy to discern. Andy McKeon, Managing Director for Health at the Audit Commission, told us:

Last year there were only four PCTs with a deficit and there were six trusts which incurred a deficit. This year there is a forecast of four PCTs and three trusts which have a deficit. These are not significant sums. On the other hand, it is also clear that PCTs receive support from SHAs in one way or another. For example, last year North Yorkshire and York received some money as a non-payable transitional grant to enable them to get rid of their current problems in that year financially and to concentrate on a recovery package in the next year. I am afraid the message is that I can't give you a figure for the underlying position across the country on PCTs and trusts. Having said that, it is clear that there is probably enough money in the system

111 Debts are budget shortfalls that are carried forward from one year to the next (in contrast to deficits, which are in-year budget shortfalls).

112 Department of Health, *Liberating the NHS: Legislative framework and next steps*, December 2010, para 7.30

113 *Ibid.*, para 4.69

114 *Ibid.*, para 4.68

to deal with outstanding legacy debts but not whether a PCT is over-trading, for example, or a trust is over-trading, its costs are too high and it needs to do something with its cost base.¹¹⁵

140. Noel Plumridge, a freelance writer on NHS finances, explained that, although the DH had forecast (in September 2010) a surplus of £1.3 billion amongst PCTs, the real picture might not be so encouraging:

since September, we have seen a pattern at individual PCTs of deficits emerging. Some that have been publicised recently have been south-west Essex, a forecast deficit of £18 million, and Cumbria, a further £7 million. Those are some specifics in the last month or so. More generally, we have seen a pattern of restrictions, especially on access to surgery, being imposed by PCTs which suggests a need to make savings in a hurry, either through rationing or through delays.

Mr Plumridge also explained that, in addition, current efforts to reduce costs in the NHS tended to be concentrated within providers.¹¹⁶

141. Against this background, the planned arrangements for dealing with deficits have not met with universal approval. The Royal College of Nursing, for instance, told us:

Overall the proposed arrangements for debt eradication and tackling structural deficits are not sufficient. It appears that an adequate risk management regime has not been thought through, which could result in serious consequences for patient services and healthcare staff.¹¹⁷

142. We heard from GPs from Hackney, Cumbria and Hull (as well as the Chief Executive of Hull PCT and the Humber PCT cluster) about their progress towards establishing GP commissioning and eradicating of existing PCT deficits. The Chief Executive of Hull PCT was confident that the local commissioning consortium would begin functioning on 1 April 2013 with no deficits inherited from the PCT, though he was clear that this picture would not be replicated across the country.

143. By contrast, Dr Deborah Colvin, a GP leader from Hackney, told us that their PCT currently had deficits of £30m. A large PFI project was causing significant pressure on that particular health economy and she also expressed concerns that patient expectations around choice were being raised to unrealistic levels, given the state of PCT finances. Dr Peter Weaving, from Cumbria, told the Committee that the PCT there had accrued deficits of £6m.¹¹⁸ He added that he thought that

the more important question is why the gap has arisen rather than starting 2013 with a level playing field of financial balance. That is no use to me if the issues within the organisations that are going to take me back into financial deficit are still there.¹¹⁹

115 Q 392

116 Q 395

117 CFI 24

118 Q 201

119 Q200

144. Sir David Nicholson told the Committee that SHAs held “enough” funds to eliminate existing PCT deficits, although he did not specify in which budgets those funds were held.¹²⁰

145. **The Government has asked PCT clusters and the emerging GP commissioning bodies to eliminate their structural deficits over the next two years. The Committee recognises that had consortia been promised that the slate would be wiped entirely clean when they take over commissioning from 2013, this would have sent the wrong message to local commissioners—at a time when substantial efficiency savings urgently need to be made.**

146. **However, we are concerned that this is just one of many demands being made on local commissioners (present and future) as they seek to accomplish the complex transition in a relatively short period. They face a daunting list of tasks—just as the resources available for administration are substantially reduced, leading to significant administrative job losses.**

147. **We are also concerned at the apparent lack of robust data on the true underlying financial position in each PCT (as opposed to the in-year position). Without this information, it is impossible to know the true scale of the task that confronts PCT clusters and consortia.**

9 Choice and Competition

148. Concern has been expressed to the Committee that the Government's objective of extending the scope of competition in the NHS, and the associated objective of broadening the range of choices available to patients, may have the effect of undermining the ability of commissioners to develop optimum solutions for healthcare delivery.

149. The Committee has made clear its view that voters will continue to regard the Government in the person of the Secretary of State as responsible for the development of the NHS.¹²¹ It has also made clear its view that the most effective instrument available to the Secretary of State to deliver voters' objectives for the NHS is the development of effective commissioning. It believes it is important that this objective is not undermined by parallel policies on the development of choice and competition in the NHS.

150. The Government plans to go much further than its predecessor in the creation of what it calls a "social market"¹²² in the NHS. A set of major reforms is intended to facilitate this. From April 2012, Foundation Trusts (FTs) will cease to be regulated by Monitor. By April 2014, all NHS Trusts must become FTs. The commercial freedoms of FTs will be significantly enhanced, with the lifting of restrictions on their ability to borrow from commercial lenders and to treat private patients.

151. From April 2012, the Government proposes that Monitor will become the independent economic regulator for the NHS. From April 2013, Monitor would operate a joint licensing regime for all providers of NHS services, along with the quality inspectorate, the Care Quality Commission (CQC). Licensing would facilitate the discharge by Monitor of its three core functions:

- promoting competition;
- setting or regulating prices; and
- supporting the continuity of essential services (those "designated as subject to additional licence conditions") in the event of provider failure.

152. The Government proposes that Monitor will have significant statutory powers to enforce competition and a "fair playing field". This will be partly by means of placing licensing conditions on providers; and partly by enforcing pre-existing competition law, as well as new regulations specific to the NHS.

153. The Government has several times referred to its proposals in terms of the creation of a regulated market, akin to those in the privatised utilities (gas, electricity, water and sewerage) and railway and telecoms industries and has likened the future role of Monitor

¹²¹ See paragraph 8 above.

¹²² Cm 7881, paras 4.26 and 4.28; Department of Health, *Health and Social Care Bill 2011: Impact Assessments*, January 2011, paras B14 and B70

to that played in their respective industries by Ofcom, Ofgem and Ofwat.¹²³ So too, indeed, has the new Chair of Monitor, Dr David Bennett:

We, in the UK, have done this in other sectors before. We did it in gas, we did it in power, we did it in telecoms [...] We've done it in rail, we've done it in water, so there's actually 20 years of experience in taking monopolistic, monolithic markets and providers and exposing them to economic regulation.¹²⁴

154. Nigel Edwards, Acting Chief Executive of the NHS Confederation, commented that:

because we have tended to spend so much time concentrating on GP commissioning, it is worth pointing out that this is a fundamental shift in how providers relate to the NHS [...] This Bill takes providers out of the control of the state, which is a very fundamental shift. That is the first analogy with a regulated industry. Of course, there aren't customers in the way that there are for telecoms or other industries. You need a proxy for the customers and that is where the GPs come in.¹²⁵

155. The Committee does not find this comparison between healthcare and the privatised utilities either accurate or helpful. Competition in the privatised utilities helps to create a balanced relationship between individual customers and the utility; the government is not directly involved in the relationship. In the NHS, the position is fundamentally different because the government is directly involved as the commissioner.

156. The Government said in the White Paper that it would "Create a presumption that all patients will have choice and control over their care and treatment, and choice of any willing provider wherever relevant".¹²⁶ It further explained that:

Our aim is to free up provision of healthcare, so that in most sectors of care, any willing provider can provide services, giving patients greater choice and ensuring effective competition stimulates innovation and improvements, and increases productivity within a social market.¹²⁷

157. In a letter to all NHS Chief Executives dated 17 February 2011, Sir David Nicholson said that "Subject to the outcome of the consultation [on *Greater choice and control*], we would expect AWP to apply to many NHS-funded services in future".¹²⁸

His letter goes on to say, however:

Where service integration and continuity of care is important to secure the best clinical outcomes, patient experience and value for money (for example, in end of life

123 See, for instance, Cm 7993 paras 6.57 and 6.84

124 "NHS reforms raise prospect of Tesco-style hospital chains", *The Times*, 25 February 2011

125 Q 96

126 Cm 7881, p 17

127 *Ibid.*, para 4.26

128 Sir David Nicholson, Letter to NHS Chief Executives, 17 February 2011, Annex B, p. 14

care), the intention is that commissioners will be able to go to competitive tender and offer the service to one provider or ‘prime contractor’.¹²⁹

158. Dr Anna Dixon, Director of Policy at the King’s Fund, told us that “At the moment, there is a lack of clarity about the scope for where an Any Willing Provider market will be [...]”. Dr Dixon presumed, following Sir David Nicholson’s letter of 17 February 2011, that:

It is going to be the Commissioning Board, perhaps, that will be determining this and then the question will be that Monitor will check whatever of those models is happening, that if it is competition for patients, there is competition and they are under competitive behaviour by providers, and if there is a tendering process, that the commissioners are tendering in line with procurement guidance set down by the Department which says that these are the rules by which you have to compete. The Commissioning Board is key.¹³⁰

159. Dr Bennett, of Monitor, agreed with Dr Dixon that “the intention is that the Commissioning Board will broaden the scope [of AWP]”.¹³¹ Mr Sobanja, of the NHS Alliance, told us:

If “Any Willing Provider” is triggered by a commissioning desire, then it is satisfactory as an alternative to tendering [...] But if “Any Willing Provider” is to operate at any time such that any provider can enter the market, with their licence from CQC and Monitor and must be given a contract and not in response to a commissioning trigger, then it undermines commissioning. What we have to do is put more weight behind commissioning, at both primary and secondary care, not undermine it.¹³²

160. Dr Bennett also said that, under AWP, providers “are not being commissioned by the GP consortia. They are providing a service under Any Willing Provider, accredited in some way.”¹³³

161. In evidence, Sir David Nicholson told us:

the whole thing about Any Willing Provider is that we are on a kind of journey with it. There is not going to be a switch flicked on 1 April 2012, 2013 or 2014, which will suddenly open up the whole of the NHS to Any Willing Provider. That is not how it is going to work at all. We are slowly but surely experimenting, working and understanding before we move on to the next issue.¹³⁴

162. The Committee believes that Commissioners should determine the shape of service provision. It follows the extent of choice, the extent of application of Any

129 *Ibid.*

130 Q 127

131 *Ibid.* cf. Q 131

132 Q 65

133 Q 153

134 Q 297

Willing Provider, and the method of determination of entry into the AWP market all have to be consistent with that core principle.

163. **Monitor told us that providers operating under Any Willing Provider “are not being commissioned by the GP consortia”. The Department needs to explain how it will ensure that commissioners are not simply bill payers where Any Willing Provider applies.**

Is the model driven by patient choice or effective commissioning?

164. *Commissioning for patients* (July 2010) states that:

Within the scope of NHS services as defined by the Secretary of State, GP consortia will be free to decide commissioning priorities to reflect local needs, supported by the national framework of quality standards, tariffs and national contracts established by the NHS Commissioning Board. They will be able to adapt model contracts to include the quality dimensions that they judge will produce the best outcomes, subject to ensuring that patients have choice of any willing provider that can perform to these quality standards.¹³⁵

165. The DH’s memorandum to this inquiry says:

Giving patients this choice [of any willing provider] will not conflict with a consortium’s clinical priorities, as it will still very much be for commissioners to decide on the services to which they want to be able to refer their patients to have access and to establish quality criteria for these services. Only providers that meet the commissioner’s quality criteria will be eligible to provide these services.¹³⁶

166. Sir David Nicholson’s letter of 17 February 2011 took the same line when he said:

In essence, providers will need to be licensed (where this is required by CQC) and hold an appropriate NHS Standard Contract. They will be obliged to work within the standard business terms of that contract, including meeting specified national quality standards, where appropriate additional local standards and referral protocols, and the agreed price.¹³⁷

167. The Committee regards it as essential that NHS commissioners are able to choose the pattern of service delivery which reflects their clinical and financial priorities.

168. As part of the process of strengthening NHS commissioning, the Committee welcomes the continued development (initiated by the previous government), firstly, of the culture of open-minded consideration by commissioners of all options to meet their objectives, and, secondly, of engagement with patients to reflect their individual needs and priorities.

135 Department of Health, *Liberating the NHS: Commissioning for patients*, July 2010, para 5.1

136 Ev 120

137 Sir David Nicholson, Letter to NHS Chief Executives, 17 February 2011, Annex B, p. 14

Commissioning integrated pathways

169. A crucial part of effective commissioning is the ability to assemble stable and coherent pathways of care, with all their constituent elements seamlessly integrated. Such an approach is generally held to facilitate both the best outcomes for patients and value for money. It is particularly important where patients require complex, integrated packages of care, such as care for frail older people with multiple co-morbidities and end of life care.

170. Concerns have been expressed that effective commissioning of integrated care pathways could be compromised in the new system. Mr Sobanja, of the NHS Alliance, told us:

if the primary purpose of redesigning the service is about improving care to patients, improving integration, and so on, that, for me, would trump the issue of anticompetitive behaviour, recognising the statute to be complied with there. In that sense, to answer your question, Monitor ought to be a servant of good commissioning, not the determinant of good commissioning.

171. The White Paper (July 2010) promised that the Government would “accelerate the development of pathway tariffs for use by commissioners” from April 2011.¹³⁸ Similarly, according to the tariff guidance for 2011–12, the Department is:

committed to developing and implementing pathway and year of care tariffs in the future. In the meantime, commissioners and providers may wish to explore options for the local bundling of care into pathways, especially for patients with long term conditions and named patients with frequent admissions.¹³⁹

172. In discussing the issue of “fair playing field distortions”, the Department has, however, identified the “bundling” of services as an obstacle to competition, against which Monitor may need to act. The consultation document *Regulating healthcare providers* (July 2010) and the Command Paper both refer to the possibility of licence conditions requiring providers to accept services (such as diagnostic tests) which have been commissioned from other providers, where clinically appropriate.¹⁴⁰ The Impact Assessments for the Bill state that “The bundling of tariffs makes it difficult for providers to compete for services within the bundle (e.g. diagnostics)”,¹⁴¹ indicating that a fair playing field must mean there is contestability for individual components of care, rather than for whole pathways.

173. When the point was put to Dr Bennett of Monitor he said that Monitor had a “duty to promote and protect the interests of users of the system”. It would be contrary to the aims of the Bill “if we finished up with arrangements that did not enable commissioners to commission the services that were in the best interests of their patients”.¹⁴² He also said that:

138 Cm 7881, para 3.18 and p 52

139 Department of Health, *Payment by Results Guidance for 2011–12*, February 2011 (revised March 2011), para 431; cf. paras 64 and 108

140 Department of Health, *Liberating the NHS: Regulating healthcare providers*, July 2010, para 6.8; Cm 7993 para 6.82

141 Department of Health, *Health and Social Care Bill 2011: Impact Assessments*, January 2011, Table B1, p 43

142 Q 125

If you are looking at services where it is most important that you get integrated care, then those are the services where you are more likely to see them outside than inside the scope [of AWP].

In such a case, Monitor would only become involved if there were a complaint that a tendering exercise had not been truly open and competitive.¹⁴³

174. We asked the Secretary of State about Dr Bennett's statement that, were a provider to challenge a consortium's decision to commission a service as an integrated pathway (i.e. outside AWP), it would not be for Monitor to consider whether this was anti-competitive:

That is right. To put it in a nutshell, Monitor's role is only to intervene in circumstances where commissioners are behaving in a way which is both anticompetitive and acts against the public interest.¹⁴⁴

He later said:

If the commissioner sees it as being in the interests of the patients they look after to invite providers to provide a service in a particular way or to design a service in a particular way, bundling services together or securing services on a care pathway basis, that is their decision. I don't think there is any basis upon which a provider can go to anybody, be it the Commissioning Board, the consortia or anybody else, and say, "You're not allowed to do that." They are allowed to do that.¹⁴⁵

175. Although there has been much discussion of this issue during the passage of the Bill, the statements made to the Committee by the Secretary of State, the Chief Executive Designate, and the Chairman of Monitor have been consistent and clear, and bear only one interpretation: commissioners will have the power necessary to design, commission and monitor integrated pathways of care. We regard this as a vital commitment of principle which must not be prejudiced and which should be written into the Bill to avoid further ambiguity.

143 Q 127

144 Q 435

145 Q 453

List of recommendations

1. The Committee believes that effective commissioning is a precondition to the successful delivery of the requirement for the NHS to achieve an efficiency gain of 4% per annum over the four years from 2011–12 (“the Nicholson Challenge”). Failure to deliver this requirement would undermine either the quality or the availability of care for patients—which would in turn lead to pressure for extra resources. (Paragraph 2)
2. As in our first report on this issue, we remain convinced that meeting increasing demand for high quality health care while delivering 4% efficiency gains year on year remains the biggest challenge that faces the NHS. Effective commissioning is key to that target being achieved. (Paragraph 3)

Commissioning accountability

3. The Committee welcomes the stated intention of decentralising power within the NHS and loosening political control of day-to-day decision making. Voters will, however, rightly continue to regard the Secretary of State as accountable for the development of the NHS—there can and should be no doubt that ultimate responsibility rests with him. The Government must therefore put in place structures which enable the Secretary of State to respond to this political reality. (Paragraph 8)
4. Although the Committee endorses the need for clear national accountability of commissioners to the Commissioning Board, it agrees with the Government that NHS structures should aim to reinforce responsible devolution of authority. It is, however, concerned that this objective is unlikely to be delivered by the provisions of the Health and Social Care Bill. (Paragraph 16)
5. The Committee believes that these influences create the danger of an overcentralised service and it believes that, although they will always remain strong, the most effective counterbalance to the pressures for centralisation is a strong local voice in the commissioning system. To be effective, however, this voice needs to be able to speak authoritatively for local stakeholders; the Committee is concerned that the proposed structure of GP Commissioning Consortia does not achieve this objective. The proposals in this report are intended, among other things, to address this weakness. (Paragraph 18)

Local Commissioning governance

6. The local commissioning bodies proposed by the Bill will be public authorities responsible for more than half of the largest of all public service expenditures. Voters and taxpayers are entitled to expect that the legislation which establishes them reflects standards of good public sector governance. (Paragraph 19)
7. Although the Committee acknowledges the view that the detailed operating arrangements for local commissioning are not best dealt with in primary legislation, it does not believe that the arrangements for governance of NHS commissioning authorities should be delegated to NHS management. It therefore believes that the

Bill should place a duty on the Secretary of State to bring forward secondary legislation which prescribes structures for local commissioning bodies which meet the objectives set out in the following paragraphs, the principles of which should be set out in the Health and Social Care Bill. (Paragraph 22)

8. The Committee does not agree that it would be “over-prescriptive” to require local commissioning bodies to adopt governance structures which meet basic standards of good governance. As statutory NHS bodies, spending large sums of taxpayers’ money, they should be legally required to have a governance structure (including a formal Board) which complies with minimum requirements set out by the Secretary of State in secondary legislation. (Paragraph 24)
9. The Committee therefore recommends that the statutory governance arrangements for local commissioning bodies should prescribe that GPs should be a majority of the members of the Board, but that other places should be preserved to reflect the range of other (clinical and non-clinical) considerations which impact on effective commissioning. (Paragraph 36)
10. The Committee also recommends that the statutory governance arrangements for local commissioning bodies should prescribe that the membership of the Board should include representatives of nurses and of secondary care doctors. (Paragraph 37)
11. The Committee recommends that the statutory governance arrangements for local commissioning bodies should prescribe that Directors of Public Health or a public health professional nominated by them should sit on the boards of Commissioning Authorities. (Paragraph 41)
12. The Committee therefore recommends:
 - i. The proposal to establish Health and Wellbeing Boards separate from both NHS commissioning and local authority structures should be dropped.
 - ii. Responsibility for preparing Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies, and for promoting integrated working between commissioners, should be shared jointly by the Commissioning Authorities, local authorities and Public Health England.
 - iii. The statutory governance arrangements for local commissioning bodies should prescribe that the membership of the Board should include:
 - a professional Social Care representative;
 - an elected member nominated by the local authority.
 (Paragraph 48)
13. The Committee believes that the local authority scrutiny function has become established and supports its continued development. The Committee welcomes the extension of the health scrutiny powers of Local Authorities to private sector

providers of NHS care and independent practitioners in primary care. (Paragraph 51)

14. Although Local Healthwatch can demand information from healthcare providers, the Bill does not provide for Local Healthwatch to demand information from commissioning consortia. This effectively continues current arrangements in respect of LINKs, whose power to request information relates only to services-providers. The Committee regards the lack of power on the part of Local Healthwatch to request information from commissioners as a deficiency which should be corrected. Local commissioning bodies should be under a duty to consult Healthwatch when making decisions about service provision. (Paragraph 55)
15. The Committee believes that good governance demands that a public authority has an identified Chief Executive and an identified Finance Director, and that both officials are full members of the Board. (Paragraph 58)
16. The Committee therefore recommends that there should be an independent Chair of the Board of each local commissioning body and that these individuals should be appointed by the NHS Commissioning Board. (Paragraph 60)
17. The statutory governance arrangements for local commissioning bodies should prescribe that Boards have a duty to meet in public and their papers should be available to the public. (Paragraph 66)
18. The Committee proposes that local commissioning bodies should be required to adopt procedures for dealing with conflicts of interest of Board members which comply with the standards laid down by the Committee on Standards in Public Life. In particular all relevant private interests of Board members should be declared on a public record; no Board member should be present when decisions are made which affect their private interests, and all decisions of the Board should be made in public on the basis of papers which are available to the public. (Paragraph 68)
19. The Committee, therefore, proposes that the new local commissioning bodies to be created by the Health and Social Care Bill should be referred to as NHS Commissioning Authorities. (Paragraph 69)

Primary care commissioning

20. With local commissioning bodies being under the exclusive control of GPs, the Government has found itself having to devise a system that separates the commissioning of and provision of primary care services. The cited rationale for this is to protect GPs from allegations of conflict of interest. However, the Government has established that the NHS Commissioning Board will rely on GP-led local commissioning bodies to undertake the most significant task—that of improving primary care provision. Given the complexity of this proposal, the Committee has reviewed the Government's proposals for primary care commissioning. (Paragraph 74)
21. The Committee finds that the evidence provided by the Secretary of State and officials runs counter to the direction of policy. If integration of primary and

secondary care commissioning is important, then separating them in order to support the proposed system architecture may cause significant harm to the commissioning system as a whole, and should be reconsidered. (Paragraph 79)

22. The Committee agrees that confidence in the governance arrangements of local commissioning bodies is key to them taking on greater responsibility for primary care commissioning. The Committee considers that arguments for the complex arrangements set out by the Government fall away if our proposals for significantly strengthened governance in NHS Commissioning Authorities are accepted. Given this, the Committee recommends that NHS Commissioning Authorities should assume responsibility for commissioning the full range of primary care—including services such as pharmacy and dentistry as well as general practice—alongside their other responsibilities. (Paragraph 80)

Authorisation and assurance of commissioning authorities

23. The Committee notes that Dame Barbara anticipates that it is likely that authorisation will be a process rather an event, with the result that there will be a phased implementation of the changes to NHS commissioning, rather than a big bang. The Committee strongly endorses this approach. (Paragraph 84)
24. This answer implies that the NHS Commissioning Board will have a wide range of discretion about the pace and extent of authorisation of individual local commissioning bodies. It is important that there are powers in the Health and Social Care Bill to allow the NHS Commissioning Board to manage this process effectively. (Paragraph 87)
25. The Committee supports this change from the principle of “assumed liberty” to one where commissioners will earn autonomy, and are only authorised to commission once the NHS Commissioning Board is satisfied that they are competent and capable. (Paragraph 89)
26. The Committee welcomes Sir David’s commitment to consult all stakeholders during the authorisation process. (Paragraph 92)
27. The Committee acknowledges the need for authorisation and assurance processes for local commissioning bodies, and for intervention by the NHS Commissioning Board when things are going wrong. However, these processes will be resource-intensive and require local knowledge that a national body may not possess. We recommend that when the PCT clusters become outposts of the Board in 2013 that their resources be directed towards authorisation, assurance and support of commissioning bodies. (Paragraph 100)
28. Given their role in authorising and assessing local commissioning bodies, and their powers of intervention when commissioners are failing or likely to fail, the outposts of the Board have all of the characteristics of performance managers. The Committee welcomes the presence of performance management in the commissioning process and believes its role should be strengthened by requiring local commissioners to have regard to Support and Improvement Plans developed by or with the outposts of the Board. (Paragraph 101)

Service reconfigurations

29. The Committee believes that the ability to manage service reconfiguration (i.e. keep service delivery up to date and in line with current best value and best practice) is fundamental to good stewardship of public funds and the delivery of high quality, good value healthcare. In particular it believes it is essential that local commissioning bodies are able to introduce changes to clinical care in their communities which reflect the changing needs of their patient populations. (Paragraph 110)
30. The Committee also believes that the unprecedented scale of efficiency gain required by the Nicholson Challenge puts a particular emphasis on the ability of commissioners to facilitate necessary service reconfigurations. (Paragraph 111)
31. The Committee is mindful that this unprecedented requirement to manage a process of change in the clinical model of the NHS will require effort and commitment from NHS managers whose work we believe should be valued, alongside the work of the clinical staff of the NHS. The Committee regrets the fact that the work of NHS management is sometimes the subject of unjustified populist criticism. (Paragraph 112)
32. The Committee believes the recommendations it has made elsewhere in this report for broader clinical and non-clinical engagement in the commissioning process are fundamental to the delivery of necessary service reconfigurations. (Paragraph 113)

Interface between health and social care

33. Against this background the Committee urges the NHS Commissioning Board to work closely with local commissioning bodies to facilitate budget pooling and service integration to reflect patient priorities. (Paragraph 116)
34. Health and social care commissioning can also become fully integrated into one body, as in the example of the Torbay Care Trust, from who we took evidence in our previous commissioning inquiry.
35. The Committee believes it is essential that these “Health Act flexibilities” are retained and developed within the future structures of health and social care. (Paragraph 118)
36. The Committee welcomes these proposals and encourages the NHS Commissioning Board to promote their widespread use. (Paragraph 119)
37. The Committee believes it is important to promote the integration of health and social care commissioning, and develop coordinated packages of care for patients. It recommends that the Government should ensure that the proposed assurance regime for local NHS commissioning bodies is developed in association with Local Authority stakeholders and is capable of assessing joint commissioned services. (Paragraph 120)
38. Aligning geographic boundaries between local NHS commissioning bodies and social care authorities has often been found to promote efficient working between the two agencies. There will in the first instance be more local NHS commissioning

bodies than social care authorities; the Committee therefore encourages NHS commissioning bodies to form groups which reflect local social care boundaries for the purpose of promoting close working across the institutional boundary. History suggests that some such groups will find the opportunities created by co-terminosity encourage more extensive integration of their activities. (Paragraph 121)

Local Commissioning finances

39. The Department says that a new NHS funding formula is to be tested by local commissioning bodies in 2012–13. To make this a meaningful exercise, the geographic boundaries and constituent practices of all local commissioning bodies will need to have been established during 2011–12. The evidence we have heard suggests that this will be difficult to achieve. The Committee recommends that the Government should publish a detailed timetable for the implementation of the new resource allocation formula as soon as possible. (Paragraph 129)
40. Although there are arguments both for and against consortia being able to carry forward surpluses, the Committee considers that greater clarity is needed on commissioners' financial procedures and risk pooling arrangements. The Department and HM Treasury must publish the arrangements for effective risk pooling and any plans for rolling surpluses or deficits forward. (Paragraph 135)
41. The Government has asked PCT clusters and the emerging GP commissioning bodies to eliminate their structural deficits over the next two years. The Committee recognises that had consortia been promised that the slate would be wiped entirely clean when they take over commissioning from 2013, this would have sent the wrong message to local commissioners—at a time when substantial efficiency savings urgently need to be made. (Paragraph 145)
42. However, we are concerned that this is just one of many demands being made on local commissioners (present and future) as they seek to accomplish the complex transition in a relatively short period. They face a daunting list of tasks—just as the resources available for administration are substantially reduced, leading to significant administrative job losses. (Paragraph 146)
43. We are also concerned at the apparent lack of robust data on the true underlying financial position in each PCT (as opposed to the in-year position). Without this information, it is impossible to know the true scale of the task that confronts PCT clusters and consortia. (Paragraph 147)

Choice and competition

44. The Committee has made clear its view that voters will continue to regard the Government in the person of the Secretary of State as responsible for the development of the NHS. It has also made clear its view that the most effective instrument available to the Secretary of State to deliver voters' objectives for the NHS is the development of effective commissioning. It believes it is important that this objective is not undermined by parallel policies on the development of choice and competition in the NHS. (Paragraph 149)

45. The Committee does not find this comparison between healthcare and the privatised utilities either accurate or helpful. Competition in the privatised utilities helps to create a balanced relationship between individual customers and the utility; the government is not directly involved in the relationship. In the NHS, the position is fundamentally different because the government is directly involved as the commissioner. (Paragraph 155)
46. The Committee believes that Commissioners should determine the shape of service provision. It follows the extent of choice, the extent of application of Any Willing Provider, and the method of determination of entry into the AWP market all have to be consistent with that core principle. (Paragraph 162)
47. Monitor told us that providers operating under Any Willing Provider “are not being commissioned by the GP consortia”. The Department needs to explain how it will ensure that commissioners are not simply bill payers where Any Willing Provider applies. (Paragraph 163)
48. The Committee regards it as essential that NHS commissioners are able to choose the pattern of service delivery which reflects their clinical and financial priorities. (Paragraph 167)
49. As part of the process of strengthening NHS commissioning, the Committee welcomes the continued development (initiated by the previous government), firstly, of the culture of open-minded consideration by commissioners of all options to meet their objectives, and, secondly, of engagement with patients to reflect their individual needs and priorities. (Paragraph 168)
50. Although there has been much discussion of this issue during the passage of the Bill, the statements made to the Committee by the Secretary of State, the Chief Executive Designate, and the Chairman of Monitor have been consistent and clear, and bear only one interpretation: commissioners will have the power necessary to design, commission and monitor integrated pathways of care. We regard this as a vital commitment of principle which must not be prejudiced and which should be written into the Bill to avoid further ambiguity. (Paragraph 175)

Formal Minutes

Thursday 31 March 2011

[Afternoon meeting]

Members present:

Mr Stephen Dorrell, in the Chair

Rosie Cooper
Andrew George
Grahame M Morris
Chris Skidmore

David Tredinnick
Valerie Vaz
Dr Sarah Wollaston

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

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

Paragraphs 1 to 175 read and agreed to.

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

Ordered, That the Chair 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, together with written evidence to be published.

[Adjourned till Tuesday 26 April at 4 pm]

Witnesses

Tuesday 8 February 2011

Page

Councillor David Lines, Deputy Chair, Audit and Scrutiny Panel, Local Government Association, **Alyson Morley**, Senior Policy Consultant, LGA, **Malcolm Alexander**, Chair, National Association of Local Involvement Networks Members, **Caroline Millar**, Partner, The Moore Adamson Craig Partnership LLP, and **Professor Jonathan Tritter**, Institute of Governance and Public Management, Warwick Business School.

Ev 1

Dr Charles Alessi, Kingston Pathfinder GP Commissioning Consortium, **Dr Clare Gerada MBE**, Chair, Royal College of GPs, **Mike Sobanja**, Chief Executive, NHS Alliance, and **Dr Peter Carter OBE**, General Secretary and Chief Executive, Royal College of Nursing.

Ev 13

Tuesday 1 March 2011

Professor Calum Paton, Professor of Health Policy, Keele University, **Professor Paul Corrigan CBE**, Independent Consultant, **Nigel Edwards**, Acting Chief Executive, NHS Confederation, and **Stephen Hocking**, Partner, Beachcroft LLP.

Ev 25

Dr David Bennett, Chair, **Adrian Masters**, Director of Strategy, Monitor, **Dr Ron Singer**, Medical Practitioners' Union, and **Dr Anna Dixon**, Director of Policy, The King's Fund.

Ev 36

Tuesday 8 March 2011

Dr Peter Weaving, GP commissioning lead in Carlisle consortium, **Christopher Long**, Chief Executive Officer, Humber cluster of primary care trusts, **Dr Margaret Lovett**, GP commissioning lead in Hull consortium, and **Dr Deborah Colvin**, GP, Lawson Practice Hackney.

Ev 48

Sir David Nicholson KCB, CBE, Chief Executive, NHS and Chief Executive-designate, NHS Commissioning Board, **Dame Barbara Hakin DBE**, National Managing Director of Commissioning Development, **Tim Rideout**, Director of Commissioning Board Development, and **Ben Dyson CBE**, Director of Policy, Commissioning and Primary Care, Department of Health.

Ev 55

Tuesday 15 March 2011

John Black, President, Royal College of Surgeons of England, **Alwen Williams CBE**, Chief Executive, East London and the City Alliance PCT cluster, **Dr Paul Hobday**, Kent Local Medical Committee Spokesperson and ex-chair, BMA Maidstone Branch, and **Seán Boyle**, Senior Research Fellow, London School of Economics.

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Suzanne Tracey, President, Healthcare Financial Management Association and Director of Finance and Business Development, Royal Devon and Exeter NHS Foundation Trust, **Noel Plumridge**, Independent consultant and writer on NHS finances, **Andy McKeon**, Managing Director for Health, Audit Commission, and **Professor Margaret Whitehead**, Professor of Public Health, University of Liverpool.

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Tuesday 22 March 2011

Rt Hon Andrew Lansley CBE MP, Secretary of State, **Dame Barbara Hakin DBE**,
National Managing Director of Commissioning Development, and **Professor Sir
Bruce Keogh KBE**, NHS Medical Director, Department of Health.

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31	Weight Watchers UK Ltd	Ev w74
32	Professor Andrew Street	Ev w75
33	Rethink	Ev w77
34	British Society of Gastroenterology	Ev w79
35	Dr Sally Ruane	Ev w81
36	Parkinson's UK, MND Association, MS Society, Epilepsy Action, PSP Association, Sue Ryder Care, UK Acquired Brain Injury Forum, Neurological Alliance, and Neurological Commissioning Support	Ev w83
37	Directors of the National Institute for Health Research Collaborations for Leadership in Applied Health Research and Care	Ev w85
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