Government Response to the House of Commons Health Select Committee Fifth Report of Session 2010-11: Commissioning

Presented to Parliament
by the Secretary of State for Health
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Government Response to the House of Commons Health Select Committee Fifth Report of Session 2010-11: Commissioning – further issues.

1. On 5 April 2011, the House of Commons Health Committee published the Fifth Report of Session 2010–11 entitled 'Commissioning – further issues'. On 6 April, the Government announced a listening exercise to seek further views on the proposals that were set out in *Equity and Excellence: Liberating the NHS*. The listening exercise was led by the NHS Future Forum, a group of 45 leading professionals from across health and social care, chaired by Professor Steve Field. The listening exercise focused on four themes:

   - how advice from across a range of healthcare professions can improve patient care;
   - how to ensure public accountability and patient involvement in the new system;
   - the role of choice and competition in improving the quality of care; and
   - how new arrangements for education and training can support the modernisation process.

2. The Health Committee's recommendations have therefore been considered alongside the views of participants in the listening exercise. Ministers and members of the NHS Future Forum attended over 250 events and meetings, in every region of the country, and over 8,000 people took part directly in providing their views. The events involved over 250 stakeholder organisations, including patient groups, professional bodies and unions, voluntary sector groups and local authorities, as well as patients and members of the public.

3. With the Committee's agreement, we postponed our formal response to Parliament until the listening exercise concluded. Many of the issues raised by the Health Committee have been considered in detail by the NHS Future Forum in its reports published on 13 June 2011.[1]

4. This Command Paper sets out the Government's direct response to the specific recommendations of the Health Committee's report, but should be read in conjunction with the Government's response to the NHS Future Forum, which provides a summary of the proposed changes we intend to make the Health and Social Care Bill, as well as proposals for non-legislative actions in response to the Forum's report.

Government response to the Committee's conclusions and recommendations

5. These responses correspond to the conclusions and recommendations of the Health Committee's report. Paragraph numbers after the recommendations (bold, in italics) refer to the Health Committee's report. Where appropriate, we have considered related paragraphs together and taken recommendations out of sequence where appropriate.

[1] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127443

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)

6. We agree with the Committee's view that effective commissioning is key to the delivery of the challenge of improving the quality of services while delivering efficiency improvements of up to £20bn. In order to ensure that commissioners are focused and supported in delivering this challenge we have taken a number of steps:

   - in order to ensure that delivery of the Quality, Innovation, Productivity and Prevention (QIPP) programme is an integral part of NHS planning, local NHS organisations have been developing single integrated plans, which bring together their proposals for improving quality and productivity over the next four years with the shorter term delivery commitments and milestones that underpin them;

   - engagement with the local QIPP agenda has been one of the pre-requisites for the establishment of clinical commissioning group 'pathfinders'; and

   - through the QIPP programme we have made available a variety of tools, guidance and support for commissioners to identify and deliver quality and efficiency improvements across a range of areas.

<u>Commissioning accountability</u>

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)

7. The NHS Future Forum report was clear that the NHS should be free from day to day political interference but that the Secretary of State must remain accountable for the NHS and that the Bill should be amended to make this clear.

8. The Forum's report highlighted concern that the Bill, as drafted, could weaken the Government's accountability for the health service. This was never the Government's intention. The policy is that the Secretary of State will be responsible – as now – for promoting a comprehensive health service. The wording of section 1(1) of the 2006 NHS Act will remain unchanged in legislation, as it has since the founding NHS Act of 1946. This will be underpinned by the new duties that the Bill already places on the Secretary of State around promoting quality improvement and reducing inequalities.

9. We want to reinforce the principles and values of the NHS and strengthen overall Ministerial accountability. We intend to make clear that the Secretary of State will also retain ultimate accountability for securing the provision of services although rather than securing services directly, the Secretary of State will be exercising his duty in future through his relationship with the NHS bodies to be established through the Health and Social Care Bill. We will also make clear that Ministers are responsible not for direct operational management, but for overseeing and holding to account the national bodies.

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)

10. The NHS Future Forum made a clear recommendation about the need to respect the autonomy of clinical commissioning groups and the NHS Commissioning Board. The Bill establishes the legislative framework needed to remove central micromanagement of the NHS and places the responsibility for making day-to-day operational decisions on organisations with the expertise and clinical insight to make such decisions. Unlike now, where the Secretary of State delegates his functions to Strategic Health Authorities and Primary Care Trusts, the NHS Commissioning Board and commissioning consortia (which we propose to refer to as 'clinical commissioning groups' from now on) will have their own responsibilities defined in law. This will give them a greater degree of operational independence from Ministers. The Secretary of State will set the objectives for the NHS Commissioning Board through the mandate and the standing rules and will hold it to account for performance.

11. Both the Secretary of State and the NHS Commissioning Board will be under a duty as to promoting autonomy, thereby minimising the burden on the NHS. They will need to ensure that organisations, including the national bodies, clinical commissioning groups and providers, have the freedom to exercise their health service functions in the ways that they consider most appropriate and avoid imposing on them unnecessary burdens. The duty will require the Secretary of State and the Board, when considering whether or not to place requirements on the NHS, to make a judgement as to whether these are in the interests of the health service. If challenged, they would have to be able to justify why these requirements were necessary.

12. The NHS Commissioning Board would always need to demonstrate reasonable grounds before intervening in relation to a commissioning group. In certain circumstances and after consultation with the commissioning groups concerned, the Board might need to vary a group's membership or geographic area in order to ensure that all GP practices are members of commissioning groups and that there is comprehensive geographic coverage. In exceptional circumstances, the Board might also need to dissolve a commissioning group in the event of significant failure, subject to consultation with the group concerned, local authorities and other appropriate parties. In both cases, there will be regulations, to ensure that there are fair and transparent procedures used. Regulations will also make provision for the procedures to be used in relation to any other types of intervention by the Board.

13. Clinical commissioning groups will need to pass a rigorous authorisation test before they are given the freedom to manage local NHS budgets and take on other functions,

and will be held to account by the NHS Commissioning Board for ensuring they maintain these standards. This is essential to maintain public confidence and consistency with the overall accountability of the Secretary of State. Once established, however, the NHS Commissioning Board will not be granted a general power of direction over clinical commissioning groups, which will be responsible for taking commissioning decisions that best reflect patients' needs. The NHS Commissioning Board will provide guidance and commissioning tools, such as tariffs and model contracts, and set meaningful outcome goals to support clinical commissioning groups in achieving high quality care for their patients.

14. We will amend the Bill to clarify the frequency of the mandate. Under the Bill, the Secretary of State must set a mandate for the NHS Commissioning Board which includes all of the Government's requirements and expectations for the NHS. The NHS Future Forum's report notes concern that the Bill as currently drafted, implies that a new mandate would be set every year. There are concerns that this could lead Ministers to take an overly prescriptive approach. This is not what we intended. Our aim is for the Secretary of State to set the mandate as a whole over a three-year period, with the ability to make any necessary changes to it on an annual basis. This will provide the system with greater stability in the long term. We will therefore amend the Bill to set a clear expectation that the Secretary of State's mandate to the NHS Commissioning Board is a multi-year document.

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)

15. At the heart of our proposals – and one of the fundamental aims of our plans for the NHS – is the principle that decisions about local services should be made as close to patients as possible, by those who are best placed to work with patients and the public to understand their needs. The NHS Future Forum agreed with us that patients and carers should be at the heart of the NHS, through shared decision-making about their care and meaningful involvement in how health services are organised. We view these as core strands of our modernisation plans if we are to achieve healthcare outcomes that are among the best in the world.

16. Every clinical commissioning group will have a governing body with decision-making powers to ensure that decisions about patient services and use of taxpayers' money are made in an open, transparent and accountable way. The governing body will include at least two lay members – one with a lead role in championing patient and public involvement and one with a lead role in overseeing key elements of governance.

17. We propose to strengthen the collective voice of patients and carers in the system at both a local and national level. We are strengthening the duties on clinical commissioning groups to involve patients and the public in commissioning decisions, including a new duty to consult publicly on annual commissioning plans. We are further strengthening the role of Health and Wellbeing Boards to ensure more joined-up local services through close working between the Boards and clinical commissioning

groups. Health and Wellbeing Boards will also have a stronger role in leading on local public involvement in assessing local needs and deciding on strategic priorities for improving the health and wellbeing of local communities.

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 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)

13. 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)

18. The NHS Future Forum concluded that there must be transparency and openness wherever taxpayers' money is being spent and that all accountable individuals should abide by the Nolan principles for conduct in public life. The Forum recommended that commissioning consortia should not be given total freedom to determine their own governance arrangements, but should as a minimum have a governing body, with independent membership, which holds meetings in public and consults publicly on commissioning plans. These safeguards will help secure the best outcomes for communities and help guard against any conflicts of interest.

19. We fully accept the value of a governing body, both in ensuring that proper checks and balances are in place for the stewardship of public money, and as a means of ensuring public trust in the clinical commissioning groups. We will accordingly amend the Health and Social Care Bill to require all commissioning groups to have a governing body with decision-making powers, to ensure that decisions about patient services and use of taxpayers' money are made in an open, transparent and accountable way.

20. We intend that the governing body will include at least two lay members, one with a lead role in championing patient and public involvement, the other with a lead role in overseeing key elements of governance such as audit, remuneration and managing conflicts of interest. One of the lay members will undertake either the role of Deputy Chair or Chair of the governing body. If Deputy Chair, the lay member would take the Chair's role for discussions and decisions involving any conflict of interest for the Chair. These arrangements will ensure that there is independent oversight of these key governance arrangements.

21. The Forum's report states that it would be unhelpful for clinical commissioning group governing bodies to be representative of every group. We agree. The prime purpose of a governing body should be to take key decisions and make sure that clinical commissioning groups have the right systems in place to their job well. It is these systems that will ensure they involve the full range of health and care professionals in commissioning. We do not intend to prescribe in detail the wider professional membership of the governing body, but it will have to include at least one registered nurse and one doctor who is a secondary care specialist. They must have no conflict of interest in relation to the clinical commissioning group's responsibilities (for example, they must not be employed by a local provider with whom the group contracts).

22. To enhance transparency and accountability, governing bodies will be required to meet in public and publish their minutes, and clinical commissioning groups will have to publish details of contracts with health services.

23. We are also strengthening the existing duties that will be placed on the NHS Commissioning Board and on clinical commissioning groups to secure professional advice and ensure this advice is from a full range of health professionals where relevant. For example, commissioners will need to work with public health experts and in line with public health guidance.

14. 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)

24. The Department disagrees. The NHS Future Forum was highly supportive of the proposals, suggesting that local authorities and NHS staff saw them as having "huge potential … [in] becoming the generators of health and social care integration and in ensuring the needs of local populations and vulnerable people are met."[2] We agree. We want to enhance the local democratic legitimacy of health services and the most appropriate way to do this is by giving councils much greater influence over the commissioning of local health services. We consulted extensively over proposals either to place these functions on local authorities and commissioning groups, or to require them to be discharged through a statutory Health and Wellbeing Board. The response to the consultation and the listening exercise has been overwhelmingly in favour of statutory Health and Wellbeing Boards within local authorities.

25. We consider that statutory Health and Wellbeing Boards will provide stronger institutional arrangements, within local authorities, to support integration of services and partnership working across the NHS, social care and public health.

26. We disagree that the Health and Wellbeing Boards will place an additional bureaucratic burden on local commissioners. They will provide a flexible framework to support locally determined integrated working. There will be no burdens imposed on the members of these Boards that would not be part of best practice for joint working, whether or not the Health and Wellbeing Boards existed. Most of the detail of day-to-day activity and procedures will be up to the Board and its members to decide, and they will be able to shape the Board to best meet their local needs. The Health and Wellbeing Board early implementer network will be led by local authorities, so councils and their local partners will lead on designing the detailed working of the Boards to ensure they are fit for purpose and are effective.

27. We welcome the support of the committee for the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy. However, while we strongly agree that local commissioners across health and social care should contribute to their development, we also believe that democratic representatives and Local HealthWatch have an important role to play in shaping local priorities. Indeed, we are strengthening our proposals in light of the NHS Future Forum's report to ensure that there is a clear duty for Health and Wellbeing Boards to involve the public in developing the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy.

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[2] *NHS Future Forum: Summary Report on Proposed Changes to the NHS,* p.12

28. We also think that local communities may wish their Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy to go beyond health and social care. For example, they may wish to examine local housing needs or other wider determinants of health and how services can be more closely integrated with health and social care. There may also be significant scope for encouraging close working with other statutory services. We have given the Health and Wellbeing Boards the flexibility to be open-ended vehicles to allow them to do this, if local people wish. Beyond the minimum membership of local councillors, commissioning groups, Local HealthWatch and Directors of Public Health, Social Services and Children's Services, Health and Wellbeing Boards would have the flexibility to include additional members, such as community organisations, where appropriate.

29. The NHS Future Forum has strongly advised against 'token' requirements for commissioning groups relating to particular professional groups. We support this fully, and are acting in the same spirit in choosing not to make it a mandatory requirement for governing bodies to have a social care representative or an elected member nominated by the local authority.

30. We consider the arrangements proposed for Health and Wellbeing Boards will provide a robust basis for ensuring that commissioning groups work effectively with local authorities to design more integrated health and social care services. Health and Wellbeing Boards will bring together locally elected representatives with those responsible for health services and social care to consider local needs and agree strategically how best to meet them.

31. In light of the NHS Future Forum's recommendations, we have also strengthened our expectations that commissioners will act in accordance with the Joint Health and Wellbeing Strategy. We propose that clinical commissioning groups will have a duty to involve Health and Wellbeing Boards from the start in developing commissioning plans and that Health and Wellbeing Boards will have a right to refer commissioning plans to the NHS Commissioning Board if they do not think they have had proper regard to the Joint Health and Wellbeing Strategy.

15. 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)

32. The Department welcomes the support of the Committee for our proposals to extend the scrutiny powers of local authorities to cover all providers of NHS funded services. We agree that the local authority scrutiny function is highly valuable. That is why we are reforming and extending it and allowing local authorities more flexibility to shape their scrutiny arrangements to best meet their needs. Our approach will help ensure that commissioners and providers are held to account locally and will enable scrutiny committees to take a more holistic view of the local health and social care system.

16. 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)

33. We think the first part of the Committee's recommendation is based on a misunderstanding. HealthWatch will be able to scrutinise both commissioners and providers of services. This continues the current arrangements for LINKs: the *Local Government and Public Involvement in Health Act 2007* defined "services-provider" to include commissioners as well as providers of services.[3]

34. We agree with the Committee that local commissioning bodies should involve local Healthwatch but do not consider that it is necessary to create a bespoke consultation duty to achieve this. In response to the NHS Future Forum, we are proposing stronger patient and public involvement duties for clinical commissioning groups, including the duty to consult publicly on annual commissioning plans. Local HealthWatch will also have a seat on the local authority Health and Wellbeing Board, which (as set out in paragraph 31 above) will agree local strategic priorities and be involved in developing commissioning plans. Local HealthWatch will therefore be able to play a significant role alongside other local partners in shaping decisions about local services.

17. 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)

18. 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)

35. Every clinical commissioning group will be required to have a governing body, with decision making powers to ensure that decisions about patient services and the use of taxpayers' money are made in an open, transparent and accountable way.

36. The Bill already provides that, as part of its application to be established, each clinical commissioning group must nominate an Accountable Officer, who would then be appointed by the NHS Commissioning Board. The Accountable Officer will be responsible among other matters for ensuring that the commissioning group complies with its financial obligations and that it exercises its functions in a way which provides good value for money. We intend that the Accountable Officer would be a member of the commissioning group's governing body. Each commissioning group will also have a chief financial officer; we intend that the group should decide whether or not this officer should be a full member of the governing body.

37. The governing body will include at least two lay members, one with a lead role in championing patient and public involvement and the other with a lead role in overseeing key elements of governance. One of the lay members will undertake either the role of Deputy Chair or Chair of the governing body. If Deputy Chair, the lay member would take the Chair's role for discussions and decisions involving a conflict of interest for the

[3] Local Government and Public Involvement in Health Act 2007, S224, (2) and S225 (7)

Chair. These arrangements will ensure that there is independent oversight of these key governance arrangements, including systems for managing conflicts of interest.

38. We do not consider it appropriate for the Chair of the governing body to be appointed by the NHS Commissioning Board. The accountability of the clinical commissioning group to the Board would be exercised through the Accountable Officer.

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)

39. We agree that the term used to describe local commissioning bodies should avoid the impression that commissioning would be undertaken by GPs alone. We propose to use the term 'clinical commissioning groups'.

<u>Primary care commissioning</u>

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)

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)

40. The Government has announced a substantial set of proposed changes to its NHS commissioning reforms to provide greater confidence that the full range of healthcare professionals are involved in commissioning. At the same time, we continue to regard it as essential for future NHS commissioning arrangements to be rooted in, and build upon, the central role that general practice plays in coordinating patient care and acting as the patient's advocate. The NHS Future Forum's report agrees that general practice has a unique role to play. When people need healthcare, general practice is often the first place to which they turn, giving GPs and other practice staff a strong relationship with patients and a strong overview of their community's health needs. GPs can link patients to other patients and carers and to a range of different clinicians, and can link those clinicians to each other and to other health and social care professionals. They are central to the integration of patient care.

41. It is essential that the new NHS commissioning arrangements command public confidence and are shown to be based upon principles of transparency and fairness. There would be inherent conflicts of interest in giving commissioning groups the duty of commissioning core primary medical services from their own practices. Public confidence in the system is best ensured by having the NHS Commissioning Board commission GP services.

42. This means that the NHS Commissioning Board would, amongst other responsibilities, hold contracts with GP practices, negotiate changes to contractual requirements to improve quality and value for money, make decisions on awarding new contracts, and take action where there is evidence that contractual requirements have not been met. It would carry out some of these functions on a national basis and other functions through its local arms.

43. Clinical commissioning groups will have a shared interest with the NHS Commissioning Board in helping improve the quality of general practice and reduce variation. This reflects the crucial role that general practice plays in relation to the wider quality of NHS care and use of NHS resources through (for instance) referral and prescribing decisions and the effectiveness with which it supports management of long term conditions. There is already evidence that peer review and challenge can play a significant role in improving quality of general practice. There has been widespread support for the proposal that clinical commissioning groups should, therefore, have an explicit duty to support the NHS Commissioning Board in securing continuous improvement in the quality of primary medical services.

44. We also consider that the NHS Commissioning Board is best placed to commission other primary care services. General medical practice generally has little or no involvement in NHS dentistry. The great majority of people access NHS dentistry directly and the majority of referrals to specialist dental services come from primary care dentists rather than from GPs. We do not consider it appropriate for clinical commissioning groups to determine who should dispense the medicines that their members prescribe, or where and how the increasing range of pharmaceutical services on offer should be available.

45. We envisage, however, a strong role for local networks of primary care practitioners in supporting the local arms of the NHS Commissioning Board to promote quality improvement in primary care services, including working with Health and Wellbeing Boards to ensure that Joint Strategic Needs Assessments address primary care needs and working with clinical commissioning groups to promote collaboration and integration.

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)

46. We fully support the need for more integrated services, shaped around the needs of patients and service users. We do not, however, agree that this requires a single commissioner for all those services. There are distinctive issues involved in commissioning primary care services that are accessed on a 'first contact' basis rather than forming part of referral pathways. The pivotal role that we are proposing for

general practice in the new arrangements will nonetheless enable clinical commissioning groups to redesign how their GP practices provide care in more integrated ways, without the need for clinical commissioning groups to hold the contracts for those practices. In addition, there are already examples of NHS commissioners and local authorities joining together to devise more integrated health and social care services, and the introduction of Health and Wellbeing Boards is designed to give much greater impetus to this. The NHS Commissioning Board and clinical commissioning groups will have the flexibility to work together to design more integrated services across primary and secondary care. In line with the NHS Future Forum's recommendations, our proposed changes to the Bill will introduce more explicit duties on all commissioners to promote integration of services.

47. The NHS Commissioning Board will promote innovative ways of demonstrating how care can be made more integrated for patients: for example, by developing tariffs for integrated pathways of care, and exploring opportunities to move towards single budgets for health and social care. We will work with organisations such as the King's Fund and the Nuffield Trust to develop these ideas further.

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)

48. The NHS Future Forum emphasised the need to get the pace of change of the reforms right, in the best interests of quality and safety. For commissioning, it recommended that there should be a comprehensive system of commissioning consortia but that they should take on their full range of responsibilities only when they can demonstrate that they have the right skills, capacity and capability to do so.

49. The process of authorisation will be undertaken flexibly, in line with the Forum's suggestion of following the principle of 'earned autonomy'. Clinical commissioning groups will not be authorised to take on any part of the commissioning budget until they are ready and willing to do so. This will be determined through a robust process of authorisation, run by the NHS Commissioning Board, with input from emerging Health and Wellbeing Boards and local clinicians. Where a commissioning group is not able to take on some or all aspects of commissioning, the local arms of the NHS Commissioning Board will commission on its behalf.

50. All groups will have the right to take on full responsibility, once they have demonstrated they are ready. The NHS Commissioning Board will work with the GP practices and other stakeholders in these areas to develop fully operational commissioning groups and hand over commissioning responsibility to them as they become ready, so that we move, over time, to avoid a two-tier system of commissioning in the NHS.

51. The process of authorisation will be undertaken flexibly, in line with the Forum's suggestion of following the principle of 'earned autonomy'. Clinical commissioning groups will not be authorised to take on any part of the commissioning budget until they are ready and willing to do so. This will be determined through a robust process of authorisation, run by the NHS Commissioning Board, with input from emerging Health and Wellbeing Boards and local clinicians. Where a commissioning group is not able to take on some or all aspects of commissioning, the local arms of the NHS Commissioning Board will commission on its behalf.

26. The Committee welcomes Sir David's commitment to consult all stakeholders during the authorisation process. (Paragraph 92)

52. As part of the authorisation process, the NHS Commissioning Board will seek the views and advice of a range of stakeholders, including emerging Health and Wellbeing Boards, clinical senates and patient groups. We will publish further details shortly on the proposed authorisation process.

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)

53. We agree that local knowledge will be required for the authorisation and assurance of commissioning groups, as well as for some of the NHS Commissioning Board's other duties such as commissioning primary care, and the Board will ensure that it has access to such knowledge.

54. Primary Care Trust clusters will play a vital role during the transition period, and will help emerging commissioning groups to develop their skills, in preparation for authorisation. The Primary Care Trust cluster arrangements will be reflected in the local arrangements of the NHS Commissioning Board. Those local arrangements will be established before Primary Care Trusts are abolished. Further details on the proposed local structure of the Board will be set out in a paper due to be published by Sir David Nicholson shortly.

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)

55. The NHS Commissioning Board will be responsible for holding commissioning groups to account for their stewardship of public funds and the outcomes they achieve. The NHS Commissioning Board will develop a Commissioning Outcomes Framework to hold groups to account for their contribution to improving outcomes and to support ongoing improvements in the quality of commissioning. Clinical commissioning groups will have to develop annual commissioning plans which set out, among other matters, their plans for improving quality and managing NHS resources.

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)

56. We agree that it is essential that the NHS is able to continue to improve and modernise services, both to deliver higher quality care to the patient and better value to the taxpayer. This is why our reform programme is designed to empower local clinical commissioners to develop and design services that will best meet the needs of patients.

57. Ensuring multi-professional involvement in commissioning will help ensure that commissioners design more integrated services across the local health economy that improve quality and ensure best use of public funds. We will continue to expect commissioners to involve local authorities, patients and the public in service reconfiguration. Health and Well-Being Boards will provide a significant opportunity for commissioners to develop integrated strategies with local authorities, and with input from local HealthWatch.

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. (Paragraph111)

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)

58. We have been clear that any service reconfigurations must be grounded, first and foremost, in improving services for patients. Where service design is needed in order to deliver efficiencies, it should continue to underpin high quality care and the development of patient choice.

59. It is right that commissioners have the capability, capacity and freedoms to make the changes they determine are necessary to put the NHS on a long term sustainable financial footing. The NHS Commissioning Board will work closely with commissioners in supporting them to achieve the changes required. This will include ensuring that any service reconfigurations continue to satisfy the Secretary of State's four tests: support from clinical commissioning groups; a clear clinical evidence base;

robust patient and public engagement; and support for the development of patient choice.

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)

60. The NHS Future Forum's report was clear that managers have a critical role to play in working with and supporting clinicians and clinical leaders, and that experienced managers must be retained in order to ensure a smooth transition and to support clinical leaders in tackling the financial challenges facing the NHS.

61. We agree that good management is essential in improving the quality of front-line services and ensuring that money is well spent. We will take steps to boost the quality of management and leadership: for example, by retaining the best talent from Primary Care Trusts and Strategic Health Authorities in the new system, and through a commitment to the ongoing training and development of managers.

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. (Paragraph 117)

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 118)

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)

62. Our full response to the NHS Future Forum report published today sets out the further steps we are taking to promote the integration of health and social care. We are proposing a new duty for clinical commissioning groups to promote integrated services for patients, both within the NHS and between health, social care and other local services, and we will strengthen the existing duty on the NHS Commissioning Board.

63. The NHS Commissioning Board will promote innovative ways of demonstrating how care can be made more integrated for patients: for example, by developing tariffs for integrated pathways of care, and exploring opportunities to move towards single budgets for health and social care. We will work with organisations such as the King's Fund and the Nuffield Trust to develop these ideas further.

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)

64. Clinical commissioning groups will have a duty to promote integrated health and social care around the needs of users. We accept the recommendation of the NHS Future Forum that their boundaries should not normally cross those of local authorities, with any departure needing to be clearly justified.

65. Any clinical commissioning groups seeking establishment on the basis of boundaries that would cross local authority boundaries will be expected to demonstrate to the NHS Commissioning Board a clear rationale in terms of benefit to patients. There may be cases where a different approach would reflect local patient flows, or enable groups to take on GP practices where, overall, this would secure a better service for patients. Commissioning groups proposing boundaries that cross local authority boundaries would also need to provide a clear account of how they would achieve better integration between health and social care services.

66. The NHS Commissioning Board will need to agree proposed boundaries as part of the establishment process. Before establishing any clinical commissioning group, the Board will be required to seek the views of emerging Health and Wellbeing Boards, which may choose to object. The NHS Commissioning Board will always have to satisfy itself that any such objections have been taken properly into account.

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)

67. The Advisory Committee on Resource Allocation (ACRA) will make recommendations to the Secretary of State in July on the formulae for the future distribution of NHS resources. It continues to be our aim to publish shadow allocations for clinical commissioning groups by the end of the year, based on our best understanding of the likely group membership at that time. We also intend to publish ACRA's

recommendations and the final research reports that describe the detail of the recommended formula.

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)

68. Under the proposals set out in the Health and Social Care Bill, the NHS Commissioning Board will be responsible for overseeing risk pooling arrangements between itself and clinical commissioning groups and it will set out guidance for prospective groups. As part of the authorisation process, groups will need to demonstrate robust financial risk management plans, which may include risk pooling arrangements. The NHS Commissioning Board will have the power to adjust individual group allocations to reflect deficits and surpluses in prior years, in order to create the right incentives for prudent financial management. In doing so, the Board will need to reflect cross-Government rules set by HM Treasury.

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 145)

69. We agree that Primary Care Trusts have many important responsibilities and duties to fulfil over the next two years including ensuring that all legacy debt issues are dealt with. We also agree that it is important that Primary Care Trusts maintain their capability to deliver those responsibilities and duties during the transition period as we move to new commissioning arrangements. That is why, in the Operating Framework for 2011/12, we set out our intention to cluster Primary Care Trusts together in order to sustain management capacity and provide greater security for the delivery of current Primary Care Trust functions in terms of statutory duties, quality, finance, performance, QIPP and NHS Constitution requirements. Further guidance on cluster implementation was published in January 2011. By June, 51 clusters of Primary Care Trusts were in place covering the whole of England, each under a single executive team. The Department is working with the NHS to produce a shared operating model for clusters to support them further.

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)

70. As part of the planning process for 2011/12, the Department is assuring itself of the underlying financial position in each Primary Care Trust through Strategic Health Authorities. Clinical commissioning groups will not be responsible for Primary Care Trust debts arising from before 2011/12, and pathfinders will work closely with Primary Care Trust clusters to ensure financial control and balance during the transition process.

<u>Choice and competition</u>

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 155)

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 162)

71. The Government agrees that regulation of healthcare must reflect the particular circumstances and needs of the sector. A dedicated health regulator would be able to better understand the NHS and the relevant issues and factors that need to be considered to ensure that patients interests are protected and promoted. Following the NHS Future Forum report, we will be putting forward amendments to the Health and Social Care Bill so that, in carrying out its functions, Monitor's core duty will be to protect and promote patients' interests, by promoting value for money and quality in the provision of services.

72. We will also remove Monitor's powers to "promote" competition as if it were an end in itself. Monitor will be limited to tackling specific abuses and unjustifiable restrictions that demonstrably act against patients' interests, to ensure a level playing field between providers. Monitor will also be required to support the delivery of integrated services for patients where this would improve quality of care for patients or improve efficiency.

73. Reflecting the NHS Future Forum's support for increasing patient choice and the report's recommendation on choice, the Secretary of State's mandate to the NHS

Commissioning Board will set clear expectations about offering patients choice: a 'choice mandate'. It will be the role of commissioners to determine and shape service provision in line with the choice mandate set by the Secretary of State. This means that commissioners will decide (within the mandate) to which services choice of 'Any Qualified Provider' would apply and, where it applies, commissioners would determine pathways, referral thresholds and relevant local quality standards.

74. The NHS Commissioning Board, in consultation with Monitor, will set out guidance on how choice and competition should be applied to particular services, guided by the mandate set by the Secretary of State and following engagement with HealthWatch England. This will include guidance on how services should be bundled or integrated.

75. The regulations under the Bill setting out rules on procurement will make clear that it is for commissioners to determine the shape of services, according to patients' preferences and needs.

76. Reflecting the NHS Future Forum's recommendation, we will maintain our commitment to extending patients' choice of 'Any Qualified Provider', but we will do this in a much more phased way, and will delay starting until April 2012. Choice of Any Qualified Provider will be limited to services covered by national or local tariff pricing, to ensure competition is based on quality. We will focus on the services where patients say they want more choice, for example starting with selected community services, rather than seeking blanket coverage. There will be some services, such as A&E and critical care, where Any Qualified Provider will never be practicable or in patients' interests.

77. The Department will publish advice to the NHS on the approach to extending patient choice of provider, based on what we have heard through our engagement with patients, clinical experts and NHS commissioners. We will continue to work closely with the NHS to explore how this can be led by commissioners, based on the needs of their patients.

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)

78. We agree. By devolving commissioning responsibility for the majority of NHS services to clinical commissioning groups, we are giving local clinicians unprecedented freedom to make decisions that they judge will achieve the best outcomes within the financial resources available to them. Clinical commissioning groups will be very strongly placed to work with patients, public and other local stakeholders to plan and commission the services that most effectively and efficiently meet local needs.

79. We will free the local NHS from political interference and bureaucracy, giving clinicians autonomy to innovate and improve services. Accountability for quality improvement will be based on outcomes, with the Secretary of State holding the NHS Commissioning Board to account for improvements against the NHS Outcomes Framework and the Board holding commissioning groups accountable for improvements against a Commissioning Outcomes Framework.

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)

80. We welcome the Health Committee's support for what we consider to be the two central themes of our proposals for the NHS, which our proposed improvements to the Health and Social Care Bill will strengthen: empowering clinicians to develop integrated services to best meet the needs of patients, and empowering patients to be fully involved in decisions about their care. We have set out above our proposals to strengthen the rights of patients and service users to be involved in assessing needs and developing commissioning plans. We also regard it as essential for patients to be fully empowered to exercise choices in accessing services and for patients and carers to be involved in decisions about an individual patient's care.

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)

81. The Government is committed to integrated services that improve quality of care for patients and improve efficiency. We want to achieve this as much through cultural and behavioural change as through statutory requirements, and our proposals are intended to create a facilitative environment for the commissioning of integrated services. The amendments we have proposed to the Bill include a new duty on clinical commissioning groups to exercise their functions with a view to securing that health, social care and health related services are provided in an integrated way, where such integration would improve quality or reduce inequalities. We also propose to strengthen the Bill's existing duty on the NHS Commissioning Board to mirror this new duty for clinical commissioning groups. In addition, Monitor will be required to support the delivery of integrated services for patients where this would improve quality of care for patients or improve efficiency.

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