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

Presented to Parliament
by the Secretary of State for Health
by Command of Her Majesty

January 2011

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Introduction

1. On 18 January 2011 the House of Commons Health Committee published the Third Report of Session 2010–11 entitled 'Commissioning'.

2. The report followed an inquiry by the Health Committee which sought evidence from the Secretary of State for Health, Andrew Lansley MP on 15 December 2010 along with Department of Health officials. We have carefully considered the Committee's report and the issues that it raises.

3. This paper sets out the Coalition Government's response to the Health Committee's Third Report of the Session 2010/11.

Overview

4. One of the most fundamental responsibilities in the NHS is to decide what services will best meet the needs of patients and local communities and to commission these services in ways which ensure high-quality outcomes, maximise patient choice and secure efficient use of NHS resources.

5. This is the central theme of NHS commissioning: understanding the health needs of a local population or a group of patients, as well as of individual patients; working with patients and local communities and involving the full range of health and care professionals, to decide what services will best meet those needs and to design these services; creating a clinical service specification which forms the basis for contracts with those providers; establishing and holding a range of contracts which offer choice for patients wherever practicable; and monitoring to ensure that services are delivered to the right standards of quality.

6. The starting point for this Committee's inquiry has been the previous Committee's findings on the significant shortcomings of the current arrangements for commissioning in the NHS. The report states "we are motivated by the desire to deliver high quality care to patients and good value to the taxpayer; and we see the need for an effective instrument to drive innovation and quality if these objectives are to be met." We welcome the Committee's conclusion that more effective commissioning is the key to delivery of efficiency gains.

7. On 12 July 2010, the Government published the White Paper *Equity and Excellence: Liberating the NHS*, setting out our long-term vision for the NHS. It is founded on our enduring commitment to the values and principles of the NHS as a comprehensive service, available to all, free at the point of use and based on clinical need, not the ability to pay. The White Paper describes a coherent programme designed to help deliver our objective of a health service that achieves outcomes amongst the best in the world.

8. The proposals consist of three mutually-reinforcing parts:

    - putting patients at the heart of the NHS: transforming the relationship between citizen and service through the principle of 'no decision about me without me';
    - focusing on improving outcomes: orientating the NHS towards focusing on what matters most to patients – high quality care, not narrow processes;
    - empowering local organisations and professionals, with a principle of assumed liberty rather than earned autonomy, and making NHS services more directly accountable to patients and communities.

9. *Liberating the NHS* set out a new direction for the future of commissioning, intended to give consistency of strategy and to put commissioning decisions in the hands of those closest to patients themselves: GP practices.

10. Under the proposals, we intend to shift decision-making as closely as possible to individual patients, by devolving power and responsibility for commissioning most healthcare services to consortia of GP practices, to enable those decisions to be more sensitive and responsive to the needs and wishes of patients. GP consortia will be supported by the establishment of an independent NHS Commissioning Board. Commissioning decisions will be underpinned by clinical insight and knowledge of local healthcare needs. This change will build on the pivotal and trusted role that primary care professionals already play in co-ordinating patient care, through the system of registered patient lists and bring together responsibility for the management of care and the management of resources. This is seen as an essential part of a more effective commissioning structure. GP commissioning builds on the key role that GP practices already play in co-ordinating patient care and acting as advocates for patients.

11. Our proposals will also address the long standing local democratic deficit in the NHS. The establishment within local authorities of statutory Health and Wellbeing Boards underpins the Government's policy of bringing the NHS and local government into a closer working relationship. The new Boards will be responsible for leading work on assessing population needs and developing the joint strategy for meeting those needs across health, social care and public health commissioners. The Health and Social Care Bill will significantly strengthen collaborative and integrated working across the health and social care interface with duties on local authorities, the NHS Commissioning Board and GP consortia supported by an extension of the remit of the National Institute for Health and Clinical Excellence (NICE) to develop Quality Standards for social care.

12. The Government has undertaken an extensive process of consultation and engagement around the White Paper proposals and how best to implement them. On 15 December 2010 we published our response *Liberating the NHS: Legislative Framework and Next Steps.* The consultation responses provided a rich array of perspectives and have helped to shape the proposals for primary legislation which will define the specific powers and duties of consortia, the NHS Commissioning Board and those of the Secretary of State. The consultation has also informed plans for implementation and for managing the transition.

13. The Health and Social Care Bill was introduced into Parliament on 19th January. It takes forward the changes to the NHS set out in the White Paper and further developed in December's *Legislative framework and next steps*, including the establishment of GP-led commissioning consortia, converting Monitor into the economic regulator for NHS-funded health care, and setting up statutory Health and Wellbeing Boards in every upper-tier local authority.

14. England's health outcomes are lagging behind. The cost of healthcare is rising and we will need to be able to deliver more care without a corresponding rise in resources. The NHS needs to change. Without a modernising of structures and change in culture, improvements in quality and efficiency can only go so far. The Bill will reshape the health service so that it is built around patients, led by health professionals and focused on delivering world-class healthcare outcomes.

Government response to the Committee's conclusions and recommendations

These responses correspond to the conclusions and recommendations of the Committee's report.

[Paragraph numbers after the recommendations (bold, in italics) refer to the Health Committee's report.]

Current weaknesses in NHS Commissioning

The starting point of our inquiry has been our predecessors' findings on the significant shortcomings of the current arrangements for commissioning in the NHS. Like the previous Committee, we are motivated by the desire to deliver high quality care to patients and good value to the taxpayer; and we see the need for an effective instrument to drive innovation and quality if these objectives are to be met. It is from this perspective that we have sought to ask "How do we make commissioning effective?" and reached our conclusions about the Government's proposals. (Paragraph 22)

15. We support the Committee's position. The weaknesses in commissioning identified by the previous Committee are symptomatic of a system that did not emphasise the importance of clinical involvement in decisions about how the precious resources of the NHS should be used. Currently, commissioning responsibilities largely rest with Primary Care Trusts (PCTs). We consider that the reality of PCT commissioning did not live up to the aspirations – including the aspiration of greater clinical involvement. We consider that PCT commissioning did not in practice give clinicians sufficient control or influence over service design and that PCTs were too remote and disconnected from the day-to-day work of GPs whose clinical practice has such an important impact on wider patterns of NHS activity and expenditure. The White Paper has set out our clear policy intentions to pursue and achieve these aspirations. It provides a blueprint to establish the architecture we firmly believe will make commissioning effective.

16. The Health and Social Care Bill takes forward the changes to the NHS set out in the White Paper and further developed in December's *Legislative framework and next steps*. The changes are necessary to create a sustainable NHS for the future and in order to make efficiency savings we have to improve commissioning.

The White Paper proposals

The Committee accepts that it follows from the unprecedented scale of the Nicholson Challenge, and the widespread recognition of the weakness of existing commissioning structures in the NHS, that action to enhance the effectiveness of NHS commissioning is essential if the NHS is to deliver the pace of change implicit in the Nicholson Challenge — and therefore in the Comprehensive Spending Review. It is against this immediate challenge that the Committee believes the White Paper process should be judged. (Paragraph 31)

17. We agree that the scale of the quality and productivity challenge the NHS faces means that the status quo is no longer sustainable. England's health outcomes lag behind those of the best international healthcare systems. For example, some of our cancer survival rates are amongst the worst in the OECD. Furthermore, despite significant spending increases in the last decade, productivity has fallen whilst costs will continue to rise to deliver new technologies, and to meet the challenges presented by a growth in obesity, an ageing population and diseases linked with these. We must act now to modernise the NHS, to cut waste and improve performance.

18. The financial context is extremely challenging and the scale of the efficiency challenge is such that it can only be met by a system-wide programme of modernisation. Successful delivery of plans to improve quality and productivity is not something separate from making early progress with structural change – they are closely linked.

19. The Coalition Government's programme for the NHS should be seen in the broader context of getting the most from the NHS. The proposals are a system-wide approach to improve quality and efficiency. We do not support a focus on costs to the exclusion of quality. Clearly, we need to meet the financial challenge, but as part of a much more ambitious, and much needed process of change, to make the NHS a modern, successful public service, with increased productivity and better outcomes, where the focus is on meeting the patient's needs, giving them choice and control over the care they and their families receive, and improving their health and quality of life.

20. As part of our system wide approach, our proposals will create a commissioning landscape where the activities of health, social care and public health commissioners will be aligned to meet identified population needs through the development of joint health and wellbeing strategies. The Health and Social Care Bill will give local government a new role in promoting integrated commissioning and both the NHS Commissioning Board and GP consortia will have duties to support this activity. The NHS Commissioning Board will have a duty to promote integration and collaborative working across the system in general and in particular the use of flexibilities under section 75 of the NHS Act 2006 (e.g. pooled budgets, lead commissioning and joint commissioning).

There was a significant policy shift between the Coalition Programme, published on 20 May 2010, and the White Paper, published on 12 July 2010. The Coalition Programme anticipated an evolution of existing institutions; the White Paper announced significant institutional upheaval. The Committee does not believe that this change of policy has yet been sufficiently explained given the costs and uncertainties generated by the process. (Paragraph 36)

21. *Liberating the NHS* represents a blend of Conservative and Liberal Democrat plans. Nearly all the NHS White Paper proposals were in the Conservative and Liberal Democrat manifestos - for example, GP commissioning, the creation of an independent NHS Commissioning Board, changing the role of Monitor, abolishing Strategic Health Authorities (SHAs), increasing democratic input into the NHS and the policy of 'Any Willing Provider'. The changes that were not in

the manifestos, particularly the abolition of PCTs, are a logical consequence of the Government's proposals. For example, the Coalition Programme envisaged a continued role for PCTs, with directly elected individuals on the PCT board. However, because of the proposed transfer of commissioning functions to the NHS Commissioning Board and GP consortia and the return of public health to local government, the Government has concluded that PCTs should be abolished. Instead, we propose an enhanced role for elected local councillors and local authorities through Health and Wellbeing Boards, as a more effective way to boost local democratic engagement. The Secretary of State's evidence to the Committee (*House of Commons Health Committee, Commissioning. Third Report of Session 2010-11, Volume II, Oral and Written Evidence*, Ev. 108: Wednesday 15 December 2010) explained this development of policy between the election and the White Paper to the Committee.

At a time when the primacy of the Nicholson Challenge should have focused the minds of NHS senior management on the need to secure unprecedented efficiency gains, we have been presented with evidence of widespread uncertainty about the Government's intentions. In addition to its inevitable effect on management morale, the Committee believes this will have had the effect of blunting the ability of the NHS to respond to the Nicholson Challenge. (Paragraph 42)

22. We consider that the changes are essential to enable the NHS to respond to the productivity challenge. Our plans are essential both to drive efficiency in the short term, and help ensure that the NHS is financially sustainable in future, through cutting bureaucracy and duplication, delivering real autonomy for providers matched by transparency and accountability within a regulated system, and creating stronger incentives for quality and efficiency. The Government's intentions were made clear in the White Paper, nine weeks after the election.

23. The majority of consultation respondents supported the vision and principles of *Liberating the NHS*, which sets out a clear vision of a more streamlined health system and a range of measures designed to improve quality and efficiency. For example, GP commissioning gives greater control and responsibility to the professionals whose decisions commit most NHS spend. Aligning the clinical and financial aspects of commissioning will generate efficiency savings by enabling clinicians to prioritise the best and most appropriate care for local populations.

24. Savings will be used to drive up the quality of services to patients and make them more efficient, as well as supporting the transition towards the new arrangements. Reducing the costs of administration across the health system by one third in real terms will save £1.7bn per year by 2014/15.

In the Committee's view the policy described in the White Paper introduces significant institutional upheaval into the NHS, without significantly changing its policy objectives. The Committee broadly shares the policy objectives so it therefore welcomes the fact that these are substantially unchanged. It does not believe however that the approach adopted by the Government represents the most efficient way of delivering those objectives. (Paragraph 43)

25. The Committee is right to suggest that the Government remains committed to the principles and values of the NHS. However, we consider that our plans are essential if we are to sustain and improve services in the face of a tough economic climate. They will reduce bureaucracy and remove duplication, give providers greater freedom and incentives to innovate and improve quality and productivity, and give greater control and responsibility to the professionals whose decisions commit the most NHS spend. These are not new ideas for the NHS. We are building on the best of what already exists and extending policies of the previous government – for example, practice-based commissioning (PBC), foundation trusts, and patient choice. The Government is clear that policy objectives, focused on patient empowerment and world-class outcomes, as well as strengthened public health services, demand institutional change and the proposals in the White Paper are essential to their achievement.

Like most observers, the Committee was surprised by the change of approach between the Coalition Programme and the White Paper. The White Paper proposes a disruptive reorganisation of the institutional structure of the NHS which was subject to little prior discussion and not foreshadowed in the Coalition Programme. (Paragraph 44)

26. There has not been a significant change of approach. The Coalition Programme set out a vision of an NHS that is free from political micromanagement, with increased patient participation and greater accountability to the patients it serves – a vision that the *Liberating the NHS* programme is designed to achieve. The Coalition Programme included a number of principles that are reflected in *Liberating the NHS*, including introducing GP commissioning, establishing an independent NHS board, setting up Monitor as a new economic regulator, strengthening the Care Quality Commission's role as an effective quality inspectorate, and giving patients greater control, including control of their health records and choice of any provider that meets NHS standards within NHS prices.

27. It is important to emphasise that the proposals do not involve fundamental structural changes to the organisations that provide the great majority of NHS care. They do not entail changes to acute care, community services or primary medical care services, which account for the greater part of NHS expenditure. The changes are to the organisations which commission these services. Our proposals aim to place clinicians in control of commissioning, in contrast to the muddled approach of the past where responsibility was shared between PCTs and practice-based commissioning groups.

28. It was entirely appropriate for us to use the White Paper as the basis for a full public consultation on our proposals. We engaged extensively with healthcare professionals, NHS staff, local authorities and the voluntary sector. We received

over 6,000 responses to the consultation, many of which raised issues or made suggestions about specific details, which have helped us to strengthen our proposals. For example, we have refined our approach to implementation, allowing a longer and more phased transition period, with time to plan and test through pathfinders and early implementers.

29. The Government's plans are essential to sustain and improve services. We intend to undertake structural modernisation only once, and the changes we are introducing now will provide a platform for greater long-term stability. An incremental approach would be wholly insufficient to achieve our shared goals of focusing on outcomes, empowering clinicians, and improving integration and developing whole system thinking across the NHS, public health and social care.

While such a "surprise" approach is not necessarily wrong, it does increase the level of risk involved in policy implementation. It allows less time to understand complexity and detail, and less time to develop and explain policy; and it leads to less understanding of objectives by staff, patients and local communities. (Paragraph 46)

30. Transition will occur through a carefully designed and managed process, phased over the next four years (both under the current legislative framework and that introduced by the Bill), to allow for rapid adoption, system-wide learning, and effective risk management. In line with responses to the consultation, the Government is proposing a phased transition, allowing enthusiasts to go early, as well as giving time to plan, to test, and to learn, under existing legal and accountability arrangements.

31. Key aspects of the transition are ensuring clear accountability during the transitional period, and ensuring that capacity and capability are sustained. We acknowledge that risk is associated with any organisational change, which is why we have asked the National Quality Board (NQB), which brings together all the key national bodies currently responsible for overseeing the NHS system, to lead a national piece of work advising on how to enhance resilience measures for quality and safety during the transition and report on any additional measures which should be taken to strengthen the system's ability to identify and respond to serious failings in quality. There will be two phases to the review. Phase 1 will consider how best to maintain quality and safety during the transition, with a view to providing guidance early in 2011. Phase 2 will consider how the NHS "early warning system" – reviewed by the NQB after the events at Mid Staffordshire – might work once the new architecture for the NHS is in place, and will provide ongoing policy advice to Ministers.

32. At their heart, our plans for improving the NHS are all about people: giving patients more choice; trusting professionals to do the right thing, and rewarding innovation and quality; and giving local leaders the responsibility that comes with increased autonomy. Staff, patient and local authority engagement will therefore be key to effective implementation. We are working closely with those organisations and partnerships who are already helping with implementing the new arrangements, for example through early implementer Health and Wellbeing Boards, to ensure that the learning on how to make cultural change

happen can be shared. The focus of this work will be on building new and strong relationships between the local NHS, local authorities and representatives of patients and the public in order to transform how services are commissioned which ultimately result in better outcomes for local people and communities.

A successful "surprise" strategy requires clarity and planning, but the Committee does not think that the White Paper reflected these qualities. There appears to have been insufficient detail about methods and structures during the transitional phase. The failure to plan for the transition is a particular concern in the current financial context. The Nicholson Challenge was already a high-risk strategy and the White Paper increased the level of risk considerably without setting out a credible plan for mitigating that risk. (Paragraph 47)

33. We disagree with the Committee's premise that there was a surprise strategy and the finding that we have not planned for the transition or provided sufficient detail about these plans. *Liberating the NHS: legislative framework and next steps* set out the framework for implementation with clear plans to manage this with, for example, shadow running of the new arrangements. Sir David Nicholson also wrote to all NHS Chief Executives on 15 December, setting out the vision for the new system and a roadmap for transition, which describes the characteristics of the approach that will be taken, key milestones in the transition process, and critical elements of support to the transition programme. This accompanied the 2011/12 Operating Framework, which sets out how delivery will be maintained whilst the new system is being created, including how Primary Care Trust clusters will increasingly be used to deliver business and to work as transition vehicles that will oversee and account for delivery, undertake direct commissioning of those services not delegated to emerging GP consortia, and support the development of the new commissioning system.

34. An integrated programme for the whole of the transition across the NHS, public health and social care is in place. The Programme is made up of a number of separate workstreams, covering the transition for the NHS, the Department of Health (DH), Arms Length Bodies and local government together with cross-cutting functional workstreams. A Transition Board has been established to provide the formal governance for the management of the Transition Programme across the NHS, public health and social care, providing scrutiny of cross-cutting issues on behalf of the Transition Board, the DH Management Committee and the NHS Management Board and taking transition-specific decisions within remits agreed by them. Strong programme and change disciplines are being applied across the programme, supported by an Integrated Programme Office, with a strong emphasis and commitment to managing risks effectively - discussed at all Boards.

35. The benefits, costs and risks of implementing the policies proposed in the White Paper that require legislative changes have been set out in Impact Assessments that have been published alongside the Bill. The policy proposals have also been subject to public consultation.

36. Alongside this work, an HR strategy is being developed, and an update on this was also published on 15 December. The HR strategy will help support business continuity during transition, establish mechanisms to retain the knowledge and skills of people currently working in the affected organisations, encourage the development of new roles and skills of staff who will work in the new system, provide tools to help future leaders lead the transition and future organisations, and seek to avoid compulsory redundancies, maximise redeployment and avoid unnecessary redundancy costs.

Events since the White Paper

The Committee acknowledges the development of PCT clusters as a pragmatic response to the situation that developed following the publication of the White Paper. (Paragraph 64)

37. We welcome the committee's acknowledgement that PCT clusters are a pragmatic way of managing the transition period. They are also integral to our transition planning. We believe that they are a practical way to maintain a firm grip on quality and service delivery during the transition period, while at the same time freeing up resources to support the development of GP commissioning consortia.

38. Implementation of the cluster approach is underway building on the approach to managed consolidation of PCT capacity already taken in London and the North East. Further guidance has been issued to ensure early local implementation.

The Committee welcomes the fact that the Government has acted promptly to fill the post. It believes that this decision represents an important step in developing a commissioning function which will allow the NHS to achieve the efficiency gains which are required during the lifetime of this Parliament. (Paragraph 65)

39. The Department agrees with the Committee that the clarity and continuity provided to the NHS by the announcement concerning the role of Chief Executive of the NHS Commissioning Board will be helpful in meeting the challenges ahead.

The formation of clusters must not, however, serve as merely a short-term expedient. The way that the clusters are constituted needs to be consistent with long-term objectives for the NHS. (Paragraph 66)

40. PCT clusters will continue to act as transition vehicles until at least April 2013; therefore cluster configurations are required to be sustainable until this date when PCTs will be abolished. Beyond April 2013, it will be for the NHS Commissioning Board to determine how it organises itself. The NHS Commissioning Board is expected to take an early view of any local support structure it needs and the extent to which clusters can act as a pathway to that structure.

41. The Board will work alongside PCT clusters from 2011/12, once it is established in shadow form. It will work with the clusters to ensure that focus is maintained

during the transition period and that the new commissioning structures develop appropriately.

Although the Committee welcomes the establishment of PCT clusters it remains concerned that the relatively protracted timescale is undermining the effectiveness of the NHS response to the Nicholson Challenge. The Committee believes it cannot be too often repeated that the commitment to generate 4% efficiency gains four years running is extremely challenging and it believes there must be a clear and effective management every step of the way if the NHS is to have a realistic chance of meeting the objectives it has been set. (Paragraph 68)

42. We believe that the pace of transition which we have set is entirely justified and enables GP commissioning consortia to take on their new responsibilities at a pace that is right for them, while at the same time driving efficiencies and improvement during the transition period. This is a vital part of our plans to drive efficiency in the short-term, and they will help ensure that the NHS is financially sustainable in the future. Our proposals are essential to sustain and improve services in the face of a tough economic climate.

43. The cluster process has been designed with the specific intention of ensuring we have the capacity and focus on the critical task of delivering the efficiency requirements facing the NHS. The focus of the Committee on this issue is matched by the focus of the Department.

44. There will be a carefully staged transition towards full implementation of the new commissioning arrangements. Throughout 2011/12 a growing number of groups of GP practices will become pathfinders and start to take on increasing responsibilities for commissioning, using powers and budgets delegated to them by PCTs within the current statutory framework. They will also test the different elements involved in GP-led commissioning.

45. The work in 2011/12 will provide the foundations for a final transitional year in 2012/13 during which consortia will be established under the new statutory framework set out in the Bill and typically take on increasing responsibility for commissioning healthcare services on behalf of PCTs, ahead of becoming fully statutorily accountable from April 2013 onwards.

The Committee recommends that PCT clusters should be in place by 1 April 2011, in order to ensure that they are able to manage the delivery of the Nicholson Challenge effectively. The Committee believes it is important that clusters "own" the change process; as the focus for financial control, they should be responsible for the development of commissioning in their area. (Paragraph 69)

46. We share the Committee's belief that it is important to have clusters in place at the earliest opportunity, and we are committed to doing so. They are already coming together in parts of the country, and the remainder will be completed, at the latest, by June 2011, which is the earliest date consistent with statutory requirements to consult with staff where the development of clusters is a new development.

47. The NHS Commissioning Board will be established in shadow form as a special health authority in 2011/12 and will work closely with the PCT clusters to support the development of GP consortia and involve them in the commissioning cycle where feasible. However, PCTs working together in sub-regional clusters, will remain statutorily responsible for commissioning up until April 2013.

The development of Pathfinder commissioning consortia represents a further important step in clarifying future commissioning responsibility. The Committee remains very concerned however that a timescale which involves a further 15 month delay in establishing full coverage represents a serious risk to the quality of commissioning decisions during that period. It means that a total of two years will have elapsed since the formation of the Government during which responsibility for managing an unprecedented efficiency challenge will have been unnecessarily weakened and diffused. (Paragraph 73)

48. We are seeing a great deal of enthusiasm and appetite amongst groups of GP practices to become pathfinders. On 8th December 2010, the first 52 pathfinders were announced with a further 89 on 17th January 2011. This takes the total to 141 groups of GP practices providing healthcare to 28.6 million people across England. This means over 50% of the population is already starting to benefit from their doctors' proven clinical leadership, good partnership working with local authorities, and innovative ways of engaging with patients and the local community. The Department is delighted with the scale of interest shown, which substantially exceeded expectations for this stage of the implementation process.

49. During 2011/12 these organisations will test the different elements involved in GP-led commissioning, supported by SHAs and PCTs and enabling emerging consortia to get more rapidly involved in current commissioning decisions. Pathfinders will also take on additional responsibilities for commissioning, under existing arrangements, but in line with the greater responsibilities described in the White Paper. The programme will support a managed transition of commissioning responsibilities from PCTs to consortia, whilst allowing time for consortia to develop the relationships, leadership and support arrangements that they will need in the future. The degree of GP interest is such that we expect the coverage of pathfinders to continue to grow throughout 2011/12 with further pathfinders appointed.

50. Pathfinders will all contribute to the delivery of the local QIPP agenda in their locality and operate in the context of existing service and financial plans in the health communities they are working in. It is envisaged that, from the beginning of the final transitional year 2012/13, consortia will be well supported to take on lead responsibility for commissioning healthcare services, ahead of them becoming fully statutorily accountable from April 2013 onwards.

51. The delivery of efficiency gains is and will remain a key priority for the emerging consortia, PCT clusters and SHAs during the transition period. The NHS Commissioning Board will play a key role from April 2012 in assuring the

efficiency challenge is met and will use its shadow year in 2011/12 to prepare to take on this role.

Changes have taken place in the management structures of the NHS in advance of Parliament having the opportunity to debate and approve them. We think this is unsatisfactory. However, given that these changes have been made, it is important that they are put in place as quickly as possible in order to ensure that the system is managed effectively. (Paragraph 74)

52. We have initiated some changes to the management support structure – not the nature of statutory organisations – in order to respond to the requirement to reduce management and administration costs whilst maintaining a focus on delivery of the efficiency challenge.

53. Such changes which have taken place – most significantly PCT clustering – are relatively minor in scale. PCTs nationally are currently developing into clusters to deliver reductions in running costs and to provide a system of commissioning support, which will continue to deliver economies of scale during the transition period and a concentration of expertise both during the transition and beyond.

54. Our focus so far has been on engaging with the public, health professionals and other stakeholders in developing and consulting on proposals, preparing for their consideration by Parliament, and beginning to put in place the foundations in the NHS for a staged transition.

55. Commissioning organisations are developing at pace. As mentioned above, we are seeing a great deal of enthusiasm and appetite amongst GPs in these changes and already over 50% of the population are covered by pathfinders. All prospective GP consortia, whether pathfinders or not, will receive a broad range of development support from their PCT and their SHA. This includes financial support, as well as the assignment of personnel with key skills, such as senior finance managers.

56. The NHS Commissioning Board will be established in shadow form as a Special Health Authority for the year 2011/12 prior to becoming a full non-departmental public body from April 2012. Once the Secretary of State has appointed the chair, the Secretary of State will make an establishment order to come into force on 1 June 2011.

57. SHAs are responsible for ensuring that the system develops at pace, and effectively. Given the scale of change, and the need to ensure continuity of expertise and capacity in the NHS, a proportionate, managed approach, which balances a steady pace of development, with careful testing and scrutiny of proposals is essential, and our projected timescales are intended to achieve this.

The committee notes that there has been a change in the intended use of at least some of the reserved sum of £1.7 billion. Some of the money which was originally reserved for "service transformation" is now being used to fund "management transformation". At a time when delivery of the Nicholson Challenge is going to a require a substantial commitment to service

transformation, the Committee is concerned that some of the money originally set aside to support this service change is now being used to fund management change. (paragraph 82)

58. The £1.7 billion is intended to be non-recurrent expenditure from recurrent resources and was introduced in the 2010/11 Operating Framework to manage risk and support change. The requirement for a 30% reduction in management costs was also introduced in the 2010/11 Operating Framework. Therefore, the one-off costs associated with the management cost reduction were always likely to form part of the non-recurrent expenditure.

The Committee acknowledges that delivery of the efficiency gains required by the Nicholson Challenge will require some difficult decisions about service levels. It believes, however, that this unavoidable prospect underlines the importance of effective commissioning structures that are able to make decisions which reflect defensible clinical and managerial priorities. It is concerned that there appears to be a growing perception that the emerging pattern of service developments reflects management instability and weakness in the organisations on which this responsibility rests. (Paragraph 77)

59. The changes initiated in the system to form PCT clusters are designed to retain essential commissioning capacity focussed on the commissioning of effective services through this period.

60. The proposed improvements are essential if the NHS is to become a modern, successful public service, delivering the best health outcomes, on a secure financial basis. As such, they are only in part a response to the financial constraints facing all public services. We do not underestimate the challenge facing the NHS in identifying and releasing the efficiency savings of up to £20b. However, the programme of modernisation is not driven by an immediate need to prioritise services in the face of financial constraints, nor is the timing linked to any specific current pressure or instability in the PCTs.

61. It does however reflect the need to tackle in a comprehensive and systematic way how care is commissioned and provided, a need to increase the control patients have over their care, in terms of the choice of treatment available to them, and the way in which the NHS is accountable to them, a need to reorient the NHS away from years of imposed targets and top-down requirements, to focus instead on outcomes for patients, removing the accumulated bureaucracy which has stifled innovation and responsiveness, giving doctors and other health professionals real autonomy in planning and delivering services.

62. The transition to the new arrangements should not impact on patients. We would challenge accusations that hospitals are cancelling or postponing operations because of the proposals.

The uncertainties described in chapter 4 will almost certainly have added both to the direct costs of transition, as well as the indirect costs incurred as a result of poor decision making by Commissioners. We welcome the Secretary of State's commitment to publish a full Impact Assessment at the

time of publication of the forthcoming Health Bill and expect that it will include a full assessment of the transition costs likely to be incurred as a result of the White Paper proposals. (Paragraph 84)

63. The Government published a full Impact Assessment[1] on the White Paper proposals on 19 January 2011, accompanying the introduction of the Health and Social Care Bill to Parliament. The Impact Assessment lays out a full assessment of the costs of transition.

64. As part of the plans set out in the White Paper, there will be a reduction of one-third in administrative spending across Whitehall, (which is assumed to cover the functions of the Department of Health, Strategic Health Authorities (SHAs), Primary Care Trusts (PCTs) and Arms Length Bodies (ALBs) that are not directly frontline services). The Government has committed to making these savings, and the policies outlined within the White Paper and legislated for within the Health and Social Care Bill are the proposed means of delivering the reduction in administrative spending. To achieve these reductions, some staff who are currently employed by PCTs, SHAs, ALBs and the Department of Health will be made redundant.

65. The White Paper recognised this, and made clear there would need to be transitional costs in making these changes. However, the changes will help to ensure that the NHS can deliver quality care efficiently in the longer term.

66. We have been clear that although there are some one-off costs associated from establishing the new arrangements, they will be more than offset by the benefits to be gained from the more effective NHS which will result. Our aim is to contain costs through a managed process of development and transition, and to meet them from the existing Spending Review settlement.

Priorities for strengthening commissioning

We intend to examine further the assurance regime which it is proposed to establish around commissioning consortia in order to satisfy itself that the NHS Commissioning Board has sufficient authority to deliver its objectives defined in its Commissioning Outcomes Framework. (Paragraph 89)

67. The NHS Commissioning Board will have a responsibility for considering applications from groups of GP practices to be established as a consortium and for determining those applications, or in other words authorising the consortium. In determining an application for a consortium to be established as a statutory body, the Board will have to satisfy itself among other matters that the proposed constitution complies with the requirements and that the applicants have made appropriate arrangements to enable the consortium to discharge its functions. The process of authorisation will be an important element of ensuring that consortia are ready to take on their responsibilities.

[1] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_123583

68. Following establishment, consortia will be accountable to the NHS Commissioning Board for managing public funds and for the outcomes they achieve. In turn, each consortium will have internal arrangements to ensure the accountability to the consortium of its members. These internal arrangements will be for consortia to determine, within a framework set out in legislation and guidance, which is likely to include, among other things, adherence to the 'Nolan Principles' of good governance. Each consortium must, for example, have an accountable officer, responsible for ensuring that the consortium complies with its financial duties, promotes continuous improvements in the quality of the services it commissions and provides good value for money and fulfils its duties in relation to quality improvement.

69. The Board's process for holding consortia to account will assess whether consortia have carried out their duties in ways that secure continuous improvements in the quality of services provided to patients, with particular regard to the effectiveness and safety of those services and to patient experience. In support of these provisions, we propose that the NHS Commissioning Board, supported by NICE, develop a commissioning outcomes framework so that there is clear, publicly available information on the quality of healthcare services commissioned by consortia, including patient-reported outcome measures and patient experience. The framework would also seek to capture progress in reducing health inequalities.

70. The Board will have the power to intervene if a situation arises where a consortium is not performing one or more of its functions adequately or at all, or there is a significant risk that it will not perform one or more of its functions adequately or at all.

71. We have been clear in our response to the consultations on *Liberating the NHS* that the work developing the commissioning outcomes framework will be for the shadow NHS Commissioning Board to take forward work during 2011/12.

72. The rolling programme of GP consortia pathfinders we have established, along with early implementers of Health and Wellbeing Boards, will test some of the different elements involved in GP led commissioning and explore some of the issues involved in ensuring effective implementation across the country.

We intend to review the arrangements proposed in the Bill for defining the lines of accountability between the NHS Commissioning Board, the Department of Health and the Secretary of State to prevent potential future conflicts arising. (Paragraph 91)

73. The Health and Social Care Bill sets out the role of national organisations such as the NHS Commissioning Board and defines the role of the Secretary of State for Health in relation to national bodies.

74. 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.

75. 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. The Secretary of State will consult upon and set a Mandate for the NHS Commissioning Board (issued on a three-year basis with an annual update) and will hold the Board to account against the Mandate. The Mandate will include the objectives and requirements for the Board during that period. Each year the Government will report publicly on the performance of the health service.

76. This will give the public and Parliament a clear basis for holding the Government to account. In addition, Parliament will continue to be able to scrutinise decisions and actions in the normal way (through parliamentary questions, select committee inquiries and debates).

The Committee endorses the principle of clinical engagement in commissioning. We heard evidence from doctors about how they had already become involved in commissioning and they welcomed the emphasis on clinical engagement in the White Paper. (Paragraph 95)

77. We welcome the Committee's endorsement of clinical engagement in commissioning. GPs play a critical role in determining the use of wider NHS resources, through the daily decisions they make in referring patients to hospital and prescribing medicines, and through the quality and accessibility of the services they provide for patients and the impact they have on emergency and urgent care provided elsewhere in the system. Previous policies such as practice-based commissioning for example, have enabled GP practices to play a greater role, together with other healthcare professionals, in influencing the way existing services were provided, by assessing the health needs of local populations and playing a stronger role in designing and commissioning wider healthcare services for local practice populations.

78. We recognise that as well as clinical engagement we need to ensure that GPs have the necessary capability and capacity to undertake their new roles effectively. We are very clear that our programme of modernisation will devolve the power and responsibility for commissioning the majority of healthcare services to consortia of GP practices, to enable those decisions to be more sensitive and responsive to the needs and wishes of patients. Consortia will have the freedom to make commissioning decisions that they judge will achieve the best outcomes within the financial resources available to them. Commissioning decisions will be underpinned by clinical insight and knowledge of local healthcare needs. We are building on the pivotal and trusted role that primary care professionals already play in co-ordinating patient care, through the system of registered patients lists, and bringing together the responsibility for management of care with the management of resources.

79. The level of interest we have received from GPs to become part of the GP Consortia Pathfinder programme is testament to the level of support from this community for the proposals for clinically-led decision making set out in the White Paper.

80. We are establishing a national learning network for the pathfinders. The network will complement the support given to pathfinders by SHAs and PCTs and has the objective of accelerating the development of GP commissioning by ensuring that the learning of pathfinders is shared through the wider GP community. This network will be supported by national primary care stakeholders to ensure that national events and seminars are co-ordinated; that learning from pathfinders is shared across the wider GP community; that there is a strategic overview, particularly to ensure that connections are made between pathfinders working on similar areas and that there is a pool of new GP champions.

81. In addition, the Department of Health, the National Leadership Council and GP stakeholders are working together to support clinical leadership in commissioning.

The Committee believes it is essential for clinical engagement in commissioning to draw from as wide a pool of practitioners as is possible in order to ensure that it delivers maximum benefits to patients. GPs have an essential role to play as the catalyst of this process, and under the terms of the Government's changes they, through the commissioning consortia, will have the statutory responsibility for commissioning. They should, however, be seen as generalists who draw on specialist knowledge when required, not as the ultimate arbiters of all commissioning decisions. The Committee therefore intends to review the arrangements proposed for integrating the full range of clinical expertise into the commissioning process. (Paragraph 96)

82. Our proposals are clear that we will expect consortia to obtain appropriate advice from relevant health and social care professionals from all sectors in helping design care pathways or care packages that achieve more integrated delivery of care, higher quality, and more efficient use of NHS resources. Indeed, the Health and Social Care Bill provides that consortia will have specific duties to involve patients and healthcare professionals in the discharge of their functions. The GP practice and the registered patient list will be the building blocks of commissioning consortia, but successful commissioning will clearly also be dependent on the wider involvement of other health and care professionals. We will work with the NHS and professional bodies in the transition to the new arrangements to promote multi-professional involvement.

83. Our proposals, by enhancing the role of local authorities in public health, and strengthening local accountability, through Health and Wellbeing Boards, will provide a basis for partnership working across the NHS and local government to identify ways of achieving more integrated delivery of services at a local level.

Real or otherwise, the perception of a potential legal challenge of commissioning decisions may be sufficient to deter GPs from engaging their secondary care colleagues in pathway redesign. We recommend that the Government addresses these concerns by clarifying the law on this issue. (Paragraph 101)

84. One of the key aims of the White Paper is to promote greater collaboration and dialogue between general practice clinicians and clinicians in provider organisations. Where services are to be commissioned on an Any Willing

Provider basis, commissioners will need to ensure that those services (and the associated patient outcomes) are specified in a way that does not give an unfair advantage to any provider. But this does not preclude working with a range of local clinicians to design better and more integrated pathways of care.

85. There is nothing in our proposals to prevent networks of providers developing integrated solutions, and bidding appropriately to meet the needs identified by commissioners. Recent research (e.g. Natasha Curry and Chris Ham, *Improving health outcomes through clinical and service integration,* The King's Fund, 2010) has highlighted current obstacles to integration, which the White Paper proposals will address, such as simplifying commissioning arrangements, extension of the use of the tariff and NHS contracts, and removing local monopolies.

86. We expect, as set out in existing DH procurement guidance, that commissioners should continue to work with a range of providers and practitioners to develop service models which are innovative, deliverable, and contribute towards improvements in quality and productivity. We intend to provide guidance, developed and tested with relevant stakeholders, on the appropriate behaviours of commissioners and providers in the procurement of services; from April 2012 the economic regulator and the NHS Commissioning Board will be responsible for ensuring the commissioners and providers are fully aware of their responsibilities, and for monitoring their behaviour to ensure they act in manner which is fair and transparent, and which does not inhibit competition.

Although the Committee understands the value of separation of the commissioner and provider functions it believes it is important that this function separation is not allowed to obstruct the development of high quality and cost effective service solutions. We therefore intend to review the arrangements proposed in the Bill for reconciling these conflicts. (paragraph 102)

87. GP commissioning consortia will not in themselves be able to provide services. However, we agree that GP commissioning consortia should be able to commission services from GP practices, where those services are over and above the scope of what would normally be provided within general practice. Consortia would need to ensure sufficient safeguards are in place to ensure fairness and transparency and to protect choice and competition. The NHS Commissioning Board will work with consortia and with other interested parties to develop safeguards that consortia can apply to do this.

The Committee agrees that local engagement with the commissioning of primary care services is important and therefore welcomes this development. The potential conflict of interest between consortia and local primary care providers does however remain. We therefore intend to review the arrangements proposed in the bill for the commissioning of primary care services. (Paragraph 104)

88. We welcome the Committee's support for our proposals for the commissioning of primary medical care. The NHS Commissioning Board will be responsible for

commissioning primary medical care. We believe that most GPs will support this approach because of its removal of any potential conflict of interest.

89. We agree however, that there are likely to be cases where GP-led commissioning consortia wish to commission other services (over and above the scope of primary medical care) from GP practices, or where practices wish to bid to provide such services or wish to be one of a number of 'any willing providers'.

90. In these cases, consortia will need to ensure sufficient safeguards are in place to ensure fairness and transparency and to promote choice and competition. The NHS Commissioning Board will develop safeguards that consortia can apply to do this.

The commissioning of services that either work across boundaries, or are intimately linked is therefore an issue to which the Committee attaches great importance, and we intend to review the effectiveness of the structures proposed in the Bill which are designed to safeguard co-operative arrangements which already exist and promote the development of new ones (paragraph 107)

91. We also attach great importance to the ability to commission integrated services that work across boundaries. The Health and Social Care Bill provides the necessary flexibility for GP consortia to commission services jointly with local authorities. We intend also that existing partnership arrangements will transfer to the relevant GP consortia. Health and Well-being Boards will play an important new role in promoting greater strategic coordination between consortia and local authorities in designing and commissioning integrated services.

We intend to review the arrangements proposed in the Bill to enable commissioning consortia to address these issues effectively; this will include a review of the ability of the new system to encourage commissioning consortia to cooperate in achieving the benefits to patients which may be available from major service reconfiguration. (Paragraph 110)

92. One of the benefits of GP commissioning is that decisions about future service reconfigurations will be much more clinically-led and made closer to the patient, rather than being imposed from the top-down by remote management. The Committee recognises the success some PBC groups have had in redesigning pathways; however, PBC did not give GP commissioners sufficient scope and leverage to initiate, where necessary, large scale changes within secondary care. The proposed commissioning arrangements go far beyond the limited approach represented by PBC in empowering local clinicians to lead service reconfiguration. They will finally give GP commissioners the ability to drive forward such changes.

93. Local doctors (and other health professionals), as commissioners, will have unprecedented influence over how healthcare services are delivered locally, and the opportunity to lead service redesign. The Government agrees that the planning and implementation of service reconfigurations works best when there

is local co-operation between commissioners, providers and local authorities. There are examples where PCTs have worked successfully together on schemes that have crossed commissioning boundaries. We want to ensure that this learning is captured and built upon through the development of the Pathfinder programme. We are also considering the role the NHS Commissioning Board may have in supporting consortia in service reconfiguration. However, it is also important that consortia have the freedom to determine how they will work together and the nature of any support they may require.

94. Successful reconfiguration also requires close collaboration between the NHS and local government, as this brings an important element of local democratic legitimacy into decisions on major service change. Health and Wellbeing Boards will play a key role in bringing together local authorities with GP consortia, HealthWatch and providers where appropriate, so that reconfiguration proposals can be developed within a broader health and social care context and can be informed by the joint health and wellbeing strategy (see paragraph 107). Furthermore, our proposals retain and extend the remit of local health overview and scrutiny.

95. Consortia will be able to work closely with secondary care, other health and care professionals and with community partners to design joined-up services that make sense to patients and the public. This is not simply about changing the mechanism; the proposals give the responsibility for commissioning to those with knowledge of the healthcare needs of the local population, clinical insight into the needs of their own patients, and expertise in how care is delivered locally.

96. Patient influence over service redesign will be greatly increased through new networks of engagement and accountability. Consortia will have a duty to inform, engage and involve the public in identifying needs, planning services and considering any proposed changes in how those services are provided, reporting on the likely impact on patients of their commissioning decisions. Health and Wellbeing Boards and health overview and scrutiny will allow the public and local stakeholders to scrutinise planned changes to services.

The Committee intends to review the arrangements proposed in the Bill for enabling consortia to reconcile this potential conflict by enhancing patient choice at the same time as delivering the consortium's clinical and financial priorities. (Paragraph 115)

97. Providing patients with real choice lies at the heart of our proposals for the NHS; if we are to put patients and the public first, it is essential that patients, service users, carers, and families are given far greater influence over the NHS, and far greater control over where and when they can go to receive treatment, and over the sort of treatment and care they receive. Moreover, giving patients greater choice of providers, will stimulate improvements, innovation and increases in productivity. We believe that extending patient choice is key to empowering service users, ultimately driving up patient satisfaction and quality of services.

98. We are exploring with patients and professionals how we can proceed in implementing new approaches to patient choice, right across the patient pathway, from choosing where to register with a GP practice, to choice of diagnostic testing, and choice of a named consultant-led team for elective care, where clinically appropriate.

99. This will not conflict with the clinical or financial priorities of a consortium. It is only by ensuring that the NHS is responsive to people's needs and wishes that commissioners will achieve the clinical outcomes which we all expect of a modern health service. Allowing patients this level of control over their experience of the NHS should not be in conflict with the priority of ensuring maximum benefit from the investment we make. Indeed, by allowing patients to make a completely free choice of all willing providers, competing on quality and innovation, will ensure they can get the best service which is available, and commissioners, the best value for money.

100. Local HealthWatch organisations will provide people with information that they need to make choices and access services. In addition, as members of the proposed Health and Wellbeing Board, they will be able to help join up the commissioning of services and in doing so, will represent the views and experiences of people who may use services. Services that are sensitive and responsive to people's experiences and needs will help drive up quality and provide meaningful choices.

101. Choice need not necessarily cost more. We will do our best to limit any bureaucracy that could be associated with the implementation of choice. It is about enabling patients to make informed decisions about their treatment and care based on information about the outcomes and quality. Commissioners have the task of matching patients needs and demands to services. This is not about creating unnecessary extra capacity or administrative systems.

102. The consultation on implementing greater choice and control closed on 14 January. We are currently considering approximately 800 responses received with a view to publishing our response and draft guidance for commissioners and providers in due course. We would welcome the Committee's views.

In the light of these concerns, we recommend that the Shadow NHS Commissioning Board publishes its proposed funding formulae for consortia as a matter of urgency. (Paragraph 116)

103. Shadow allocations for GP consortia for 2012-13 will be published towards the end of this year. The intention is to make full details of the allocations methodology used available at this time. The NHS Commissioning Board will publish actual allocations to GP consortia for 2013-14 in late 2012.

The Committee does not find the current stance on patient and public engagement in commissioning persuasive. The National Health Service uses taxpayers' resources to deliver a service in which a high proportion of citizens take a close interest both as taxpayers and actual or potential patients. While the Department may be right to point out that there is no special virtue in uniformity of structure, the Committee regards the principle

that there should be greater accountability by commissioners for their commissioning decisions as important. We therefore intend to review the arrangements for local accountability proposed in the Bill. (Paragraph 118)

104. We welcome the committee's observation that *Liberating the NHS: Commissioning for patients* sets out a clear agenda for patient and public engagement in the process of commissioning and their intended review of the arrangements for local accountability proposed in the Bill These modernisations place increased power and responsibility to improve health services in the hands of NHS professionals who see and talk to patients every day.

105. The Health and Social Care Bill will close a long-standing democratic gap – for far too long remote, unelected PCTs and SHAs have had control of £100 billion of health service decisions, with little involvement from the public or the people they serve.

106. Councils, with their local democratic mandate, will now have a far greater influence over how the NHS is shaped, through new health and wellbeing boards in every upper-tier local authority. Health and Wellbeing Boards will have responsibility for developing the JSNA and a new joint health and wellbeing strategy (JHWS).

107. The JSNA will provide a robust evidence base on which to base local commissioning decisions, while the JHWS will be a concise summary of how local commissioners will address the health and wellbeing needs of their local community, including how they will address key priorities such as reducing inequalities in health. The strategy should provide the overarching framework within which commissioning plans for the NHS, social care, public health and other relevant services are developed.

108. This unprecedented step will promote joint working and integrated services across health and social care, as well as involving democratically elected councillors and representatives of local HealthWatch.

109. We are also significantly extending the scrutiny powers available to councils. For the first time, councils will have the powers to scrutinise any NHS funded services, whoever provides them. Currently local authorities only have the power to scrutinise NHS commissioners and providers. The Bill will enable councils to require all commissioners and providers of NHS funded services to attend scrutiny meetings, provide relevant information to the local authority and be subject to requirements to consult the local authority when proposing substantial service reconfigurations.

110. We are taking forward further work to ensure that the commitments given in *Equity and Excellence*, and the consultation on information and choice, *Greater Choice and Control,* are acted upon to deliver a genuine shift in the relationship between service and citizen. Through a dedicated programme of work we want to ensure that individuals and communities increasingly experience 'no decision about me, without me'.

111. *Equity and Excellence* sets out a new vision for the NHS, but one which restates the principles laid out in the NHS Constitution, through its commitment to put patients at the heart of the NHS with greater choice and control and to make the NHS Commissioning Board a champion of patient and carer involvement. To support this, the Health and Social Care Bill places a duty on consortia to make arrangements to involve individuals to whom services are being or may be provided in planning commissioning arrangements; in developing and considering proposals for changes in the commissioning arrangements where those proposals would have a significant impact on how services are provided or the range of health services available; and in decisions affecting the operation of commissioning arrangements that would likewise have a significant impact. The Board will be able to champion effective involvement and engagement in its dialogue with consortia, through the provision of commissioning and contract guidelines and outcomes frameworks.

112. One way in which the Board could promote the involvement of patients, carers and public in decisions about healthcare provision is to publish guidance for consortia on how to discharge their duties as to patient and public involvement, drawing on existing best practice. When the Board publishes this guidance, consortia must have regard to it. This guidance could cover effective ways of engaging and seeking views from members of the public, including how to engage people who do not regularly access healthcare services or who are from disadvantaged communities. This guidance could also help consortia decide in what circumstances the duty to involve patients and the public might most appropriately be met by providing information and in what circumstances a consortium should actively seek people's views through consultation.

113. Additionally, the proposed arrangements to extend scrutiny to all providers of all publicly funded healthcare will ensure that local authorities are effective in holding to account the local NHS on behalf of local people. Commissioning plans should be informed by the work of Health and Wellbeing Boards and shaped by good public engagement.

114. The NHS Commissioning Board will have direct responsibility for commissioning services that it would be less appropriate for GP consortia to commission, such as primary care, specialised services and high security psychiatric services. For all areas of direct commissioning, the NHS Commissioning Board will be required to develop and demonstrate its own arrangements for patient and the public involvement and the impact of that involvement on its commissioning decisions will be published in its Annual Report.

115. In response to feedback and support from the consultation for a stronger patient, carer and public voice, *Liberating the NHS: Legislative framework and next steps*, proposes strengthening the national and local consumer voice through the establishment of HealthWatch. Local HealthWatch organisations will have a role in service design and delivery by promoting and supporting public involvement in the commissioning, provision and scrutiny of local health and social care services. It will place greater public accountability on the commissioning process to improve the quality of health and social care services.

116. In *Liberating the NHS: Legislative framework and next steps* we set out our view that the best outcomes can only be achieved by putting people at the heart of their care and involving patients and carers in decisions as much as they wish to be. It also set out that government will work with local authorities to develop pathfinder organisations specifically to help in the development of local HealthWatch. These HealthWatch pathfinders will test governance and accountability structures and explore how patient engagement organisations can work together. GP consortia pathfinders will need to work with HealthWatch pathfinders and the existing LINks as they consider how best to involve patients and the public in commissioning.

The Committee urges the Government to clarify the management allowance arrangements as a matter of urgency including when the higher figures will be phased in, as this will have a significant impact on commissioning capacity of consortia. (Paragraph 121)

117. The detailed financial regime for the new health system is still being developed. The expectation is that GP consortia will have an allowance for running costs that could be in the range of £25 to £35 per head of population by 2014/15. We will not determine the exact amount until further work has been undertaken with pathfinders. This work will explore the optimal balance between ensuring sufficient investment in organisational sustainability with maximising resources for front line services. Before this, during their development phase, the running costs will be locally agreed within the running cost envelope for each region.

The Government must support consortia and existing commissioning organisations to form clear and credible plans for debt eradication and for tackling structural deficits within their local health economy. The Committee intends to further review this issue in its further work. (Paragraph 123)

118. PCTs and clusters must ensure that through planning in 2011/12 and 2012/13, all existing legacy issues are dealt with. During this period we expect developing GP consortia to work closely with PCTs to ensure that financial control and balance is maintained to prevent PCT deficits in those years.

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