Government Response to the Health Select Committee on Commissioning

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

July 2010

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Government Response to the Fourth Report of the House of Commons Health Committee for the Session 2009/10 'Commissioning'

Introduction

1. On 30 March 2010, the House of Commons Health Select Committee published the Fourth Report of Session 2009–10 entitled 'Commissioning'.

2. The report followed an inquiry by the Health Committee which sought evidence from the then Minister of State for Health, Mike O'Brien MP on 4 February 2010 along with Department of Health officials. We have carefully considered the Committee's report and the issues that it raises.

3. Since the Health Committee's inquiry, there has been a change of administration following a general election in May 2010. The following paper therefore sets out the present Coalition Government's response to the Health Committee's fourth report of the session 2009/10.

Overview

4. Commissioning is a crucial process in the NHS. It ensures that the health and care services provided effectively meet the needs of the population. It is a complex process with responsibilities ranging from assessing population needs, prioritising health outcomes, procuring products and services to managing service providers.

5. The Committee commented on the previous Government's reforms since 2000. The Committee makes clear that, under those reforms, progress in improving commissioning was not sufficiently fast or comprehensive. This Government agrees with this assessment. The White Paper, *Equity and Excellence: Liberating the NHS* published on 12 July 2010, sets out our proposals for transforming the quality of commissioning by devolving decision-making to local consortia of GP practices supported by an independent NHS Commissioning Board.

6. The weaknesses identified in commissioning 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 spent. We have set out in the White Paper a clear sense of direction,

with new rigour and the commitment to put commissioning decisions in the hands of those who are closest to patients themselves – GP practices and other primary care professionals.

7. Under our proposals, GPs and practice teams will work in consortia, building on the pivotal and trusted role that primary care professionals already play in coordinating patient care. This will bring together responsibility for management of care with the management of resources. This is an essential component of a more effective commissioning structure.

8. We will establish an independent and accountable NHS Commissioning Board to allocate and account for NHS resources, leading on quality improvement and promoting patient involvement and choice.

9. Quality standards, based on clinical evidence and patients' views, will inform the commissioning of all NHS care and the design of the system levers.

10. Commissioners will draw from the NICE library of standards as they commission care. GP commissioning consortia and providers will agree local priorities for implementation each year, taking account of the NHS Outcomes Framework. Quality standards will be reflected in commissioning contracts and financial incentives. Together with essential regulatory standards, these will provide the national consistency that patients expect from their national health service.

11. These proposals form part of a wider strategy, set out in the White Paper, for liberating the NHS and creating a more responsive, patient-centred NHS, which achieves outcomes that are among the best in the world.

12. *Liberating the NHS* involves a cultural change at every level of the NHS. Decisions will be made closer to patients. Tiers of management will be reduced. Quality will be central, based on clinical criteria. This will transform the balance of power in the service. Power will be more in the hands of patients, more devolved, more clinically-led. Commissioning will reflect this design. The change in management will therefore be considerable.

13. The Department will shortly publish a framework for managing key aspects of the transition.

Responses to the conclusions and recommendations

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

[Reference to the paragraph number after the recommendations (bold, in italics) refer to the Health Committee's report]

Costs of Commissioning

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

14. We support the Committee's recommendation. Management costs in PCTs and SHAs increased by over £1 billion since 2002-03 and the costs now stand at £1.85 billion. This represents an increase of over 120%. As part of the commitment to cut the cost of NHS administration, and to transfer resources to the frontline, the June 2010 Revision to the 2010/11 Operating Framework included the statement that "The overall ceiling for Management Costs in PCTs and SHAs will now be set at two thirds of the 2008/09 Management Costs (£1,509 million), the ceiling will therefore be £1,006 million."

15. The 2009/10 Management Cost definitions for SHAs and PCTs have been updated to replace out of date terminology. PCTs and SHAs must ensure they fully comply with this guidance when reporting their management costs. The reported figures are subject to audit, based on compliance with the definitions within the guidance.

16. The White Paper, *Liberating the NHS*, includes a commitment to reduce the NHS administrative running costs of non-front-line

services by more than 45% over the next four years. PCTs – with administrative costs of over a billion pounds a year – and practice-based commissioners will together be replaced by GP commissioning consortia. Strategic Health Authorities will be abolished.

17. Our proposals for GP commissioning include setting a maximum allowance for management costs. We will ensure that there is a consistent way of classifying and recording management costs, both for GP commissioning consortia and for the NHS Commissioning Board.

Commissioning for specialised services

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

18. We agree that there are variations between Specialised Commissioning Groups (SCGs) in commissioning of services at the regional level.

19. SCGs should be commissioning all services in the Specialised Services National Definitions Set (SSNDS) and the National Specialised Commissioning Team (NSCT) in London SHA is asking for reports from SCGs on progress.

20. SCGs are working closely together both on specific services, for example, pulmonary hypertension and spinal cord injuries and on cross cutting issues such as finance, public health and mental health networks.

21. As set out in the White Paper, *Liberating the NHS*, the NHS Commissioning Board will in future commission services set out in the Specialised Services National Definition Set. This will ensure that patients with rare conditions can be sure of high-quality and cost-effective treatment and are treated equitably with people who have more common conditions. It will also help ensure more effective implementation of Sir David Carter's 2007 review.

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

22. The final sections which form the 3rd edition of the Specialised Services National Definitions Set (SSNDS) were published in April 2010. The role of the SSNDS is to help identify those services which require commissioning for a population of over 1 million. The 3rd edition was developed on the basis of a systematic process which involved the participation of a wide range of stakeholders.

23. The Department of Health will work with the National Health Service to publicise the SSNDS and promote its use. In future, the NHS Commissioning Board will need to ensure the strong engagement of GP commissioning consortia in the arrangements for specialised commissioning and ensure a smooth interface between GP commissioners and specialised services.

24. We will, of course, keep the SSNDS under review. As part of our forthcoming engagement on the proposed new NHS commissioning arrangements, we will work with stakeholders to ensure the most appropriate fit between specialised services commissioned by the NHS Commissioning Board and those commissioned by GP consortia.

Worryingly, the evidence which we received indicates that many PCTs are still disengaged from specialised commissioning. Furthermore, there is a danger that the low priority many PCTs give to it will mean that funding for specialised commissioning will be disproportionately cut in the coming period of financial restraint. In addition, specialised commissioning is weakened by the fact that, as a pooled responsibility between PCTs, it sits in a "limbo", where it is not properly regulated, performance managed, scrutinised or held to account. There is much to commend the Specialised Healthcare Alliance's proposal to bypass the PCTs altogether, making the National Commissioning Group and the Specialised Commissioning Groups into commissioners in their own right, although there is some risk that this could lead to a lack of co-ordination of, and disruption to services. We recommend that the DH undertake a review of the problems we have highlighted, taking into account the Specialised Healthcare Alliance's proposal (Paragraph 56).

25. We are concerned by the evidence submitted by the Specialised Healthcare Alliance (SHCA) that the current mechanisms for

commissioning of specialised services are not always supporting patients with rare conditions. The Department of Health and the National Specialised Commissioning Team agree the need to strengthen these commissioning arrangements. As set out in the White Paper, *Liberating the NHS*, we intend that the new NHS Commissioning Board will have responsibility for all national and regional specialised services in order to help address the problems identified.

Weaknesses in commissioning

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

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

Weaknesses are due in large part to PCTs' lack of skills, notably poor analysis of data, lack of clinical knowledge and the poor quality of much PCT management. The situation has been made worse by the constant re-organisations and high turnover of staff (Paragraphs 106 - 108).

26. We agree with the Committee's assessment of the weaknesses in PCT commissioning. We have set out plans for far-reaching changes to the way in which NHS services are commissioned. Many of the problems identified by the Committee are related to insufficient involvement and engagement of clinicians in commissioning. The proposals set out in *Liberating the NHS* will ensure that GPs, working alongside the full range of health and care professionals, are able to use their clinical knowledge and understanding of patients' needs to challenge providers and deliver the best care and the best value for their patients.

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

efficiency measures are written into all contracts with providers of health care (Paragraph 109).

27. As part of the transition to the new commissioning arrangements set out in *Liberating the NHS*, we are committed to working with the NHS and with shadow GP commissioning consortia to ensure that the NHS Commissioning Board is able to maintain an effective set of commissioning guidelines, model contracts, tariffs and other financial incentives, and accessible information on commissioner performance to support GP consortia in promoting improvements in quality and efficiency across provider services.

28. This will build on the existing NHS Standard Contracts, which provide a range of mechanisms to motivate providers including penalties for poor quality and rewards for quality improvement through the Commissioning for Quality and Innovation (CQUIN) payment framework. This is currently subject to an independent academic evaluation.

29. We agree that PCT commissioners do not always have sufficient capacity or skills to take full advantage of the levers available to them to motivate providers to improve the services they offer. Furthermore, we consider that there are currently insufficient robust quality measures available to underpin contractual levers and to incentivise quality improvements. *Liberating the NHS* sets out plans to develop a new NHS Outcomes Framework and for the NHS Commissioning Board to develop this framework into a more comprehensive set of indicators. These indicators will in turn reflect the quality standards that are being developed by NICE setting out each part of the patient pathway. The first three quality standards on stroke, dementia and prevention of venous thromboembolism were published in June.

30. The Department will refine the basis of current Payment by Results tariffs, with an emphasis on incentivising results throughout the system. We will explore the scope for developing a benchmarking approach to price-setting, will progress the development of pathway tariffs for use by commissioners, and will rapidly accelerate the development of best-practice tariffs that pay providers according to the costs of high quality care rather than average price. We will extend the scope and value of the CQUIN payment framework to support local quality improvement goals, with increasing emphasis on improving patient experience and patient-reported outcomes.

Government reforms

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

31. We agree that NICE's guidance should identify the relevant clinical and cost-effectiveness of services and treatments, related to outcomes. It is important to recognise the contribution that NICE already makes in this area through its existing guidance. Clinical guidelines provide the NHS with guidance on best practice in a particular care pathway and often make recommendations that have the potential to deliver savings through the optimised use of an intervention.

32. NICE technology appraisals evaluate technologies against existing comparator treatments. Although NICE's guidance generally results in a net increase in costs for the NHS, this is often partially offset by the potential reduction in the use of an existing, less cost-effective technology or through reduced administration costs. NICE has recognised that, in the current financial climate, it can do more to highlight this activity and has identified and published "recommendation reminders" from over 30 of its existing technology appraisals and clinical guidelines that have the potential to deliver savings in the NHS.

33. NICE has made specific efforts to identify opportunities for "disinvestment" from particular health technologies or interventions, both by encouraging topic suggestions and by actively trawling the research database held by the Cochrane Collaboration. This exercise revealed very little by way of current NHS practice that is simply ineffective. This should not obscure, however, the opportunities for more effective technologies and services. NICE can offer advice, but it will be for commissioners and providers of healthcare to lead in delivering those efficiency gains.

34. NHS Evidence was launched in April 2009 to provide easy online access for anyone working in health and social care to a wide range of healthcare information. The NHS Evidence service is hosted by NICE and is building a library of evidence-based practice recommendations and case studies that provide opportunities for quality and productivity improvement. These can be accessed on the NHS Evidence website and are drawn from a range of quality-assured sources, including material submitted by individual NHS bodies based on their own experience.

35. We envisage that NICE will continue to build on its work in this area.

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

36. We note that an independent study[1] has indicated that administrative costs in PCTs and hospital trusts associated with the introduction of Payment by Results (PbR) were relatively modest, representing about 0.2% of the total cost of activity covered by PbR.

37. With regard to the incentive for hospitals to generate activity to increase their income, the Government notes that the Code of Conduct for the operation of PbR[2] says that PbR is not a mandate for providers to supply activity. We would expect commissioners to challenge trusts where there are concerns over activity levels. There is a clear risk that PbR incentivises activity rather than outcomes or efficiency.This Government notes that audits of clinical coding in hospitals undertaken by the Audit Commission have found no evidence of clinical coding being manipulated by hospitals to increase income.

38. Whilst one of the intentions of PbR at its inception was to encourage an increase in hospital activity to reduce waiting times, the Government is now committed to developing and expanding a

[1] *The administrative costs of Payment by Results*, Centre for Health Economics at the University of York in July 2006, available at www.york.ac.uk/inst/che/pdf/rp17.pdf

[2] Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_112265

payment system that rewards quality outcomes for patients and a more joined up approach to care. We will explore options for refining the basis on which tariff prices are set, including the use of a benchmarking approach. We will look to allow greater local flexibility in the application of tariff rules. There will be more best practice tariffs and a number of pathway (or year of care) tariffs. Hospitals will be responsible for patients for the 30 days after discharge and if a patient is readmitted within this time, the hospital will not receive further payment for the additional treatment if it was avoidable. We are prioritising an expansion of the tariff into mental health and community services.

39. These developments will be accompanied by the use of contract level financial incentives including the Commissioning for Quality and Innovation (CQUIN) payment framework, which will be extended, and mechanisms to give commissioners the ability to impose contractual penalties and fines for never events. Taken together these reforms will not only refocus PbR on quality and efficiency, they will also encourage stronger commissioning and greater attention to quality within the contracting process.

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

40. The reference here is to the previous Secretary of State. We have set out our policy in this area in our White Paper. Our vision is for a new direction in health that is founded on improving outcomes, empowering patients and delivering more patient-centred services through autonomous providers and empowered professionals. The role of competition in this vision is as a principal driver of improvements, allowing a more patient-centred system based on the principle of any willing provider that meets NHS standards within NHS prices.

41. Our proposals for GP commissioning will enable primary care professionals to work on a more collaborative basis with other health and care professionals to develop more efficient and effective patient pathways that improve, building where appropriate on emerging lessons from integrated care pilots. This will ensure that, when patients make choices about their care and treatment and about the

organisation or team that provides that care, they can be increasingly confident that they will receive joined-up care along the pathway. This will not in any way undermine the central importance of choice and control for patients. The White Paper sets out how we will increase and extend patient choice.

42. Payment by Results enables funds to go the services chosen by patients and to any provider, whether NHS or independent sector, who can treat patients at tariff and to NHS standards.

Although there has been slightly less emphasis on market reforms recently, the NHS remains characterised by tensions between purchasers and providers. The weakness of commissioners faced by powerful providers means that the reforms have threatened to undermine some of the Government's key aims, such as switching care from hospitals to the community (Paragraph 132).

43. Our plans to introduce a new commissioning system led by groups of GPs at local level and overseen nationally by an independent NHS Commissioning Board are intended to transform quality of care and health outcomes for patients. Giving GP consortia more responsibility and control over commissioning budgets will align clinical decisions with their financial consequences. We have set out more detail on these proposals in our White Paper.

44. A clear split between commissioning and provision is vital in ensuring that commissioners act in the best interests of the patients and communities they serve by commissioning the best possible care and treatment from the best providers to meet health needs. This separation is essential in motivating providers to provide innovative, high quality, cost-effective services for patients.

45. Underpinned by patient choice, this split drives greater efficiency and increases quality. We want to reform the system even further to produce better care and significant savings. By putting GP consortia in charge of commissioning, reducing bureaucracy, and freeing NHS providers from direct control, we will release substantial resources to reinvest in front-line health care. Planned changes to the payment system will also help to create more integrated services across boundaries. For example, we will make hospitals responsible for patient care for the first 30 days following discharge, and this will be reflected in the Payment by Results tariff. This will encourage more joined-up working between hospitals and social care.

46. We recognise that in some areas of the country commissioners are faced with powerful acute sector providers and that alternative service providers are sometimes not available. In addition to devolving commissioning power to GP consortia that will have a stronger understanding of local health needs, we intend to address this by establishing an economic regulator for the health sector with powers to address barriers to entry and anti-competitive behaviour and by extending patient choice and the Any Willing Provider model.

Government's attempts to improve commissioning

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

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

It is not clear to us that WCC is going to address the lack of capacity and skills at PCT level and weak clinical knowledge. Furthermore there are concerns that WCC will be no more than a "box ticking" exercise whereby people expend a lot of energy merely demonstrating they have the right policies in place, rather than actually transforming patient outcomes and cost effectiveness (Paragraphs 148 - 150).

47. The plans set out in *Liberating the NHS* will ensure that, in future, commissioning is clinically-led and is informed by primary care professionals' clinical insight and knowledge of local healthcare needs.

48. Primary care practitioners will not, however, be expected to carry out all commissioning activities themselves: Whilst they will be likely to coordinate most of the clinical aspects of commissioning themselves, consortia will be able to employ staff or buy in support from external organisations, including local authorities, voluntary organisations and independent sector providers. Consortia will have the freedom to decide which aspects of commissioning activity they undertake fully

themselves and which aspects require collaboration across several consortia, for instance through a lead commissioner managing the contract with a large hospital or commissioning low-volume services not covered by national and regional specialised services.

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

49. A quality framework for the NHS was developed to put reporting of service quality on a statutory footing in the Health Act 2009. There was subsequent consultation and engagement with the NHS, the professions, and patient and the public on the detailed content of Quality Accounts for the acute sector, followed by an evaluation leading to a set of detailed proposals. There was consultation on these proposals in Autumn 2009 and on regulations in Spring 2010. The process was overseen by a stakeholder group comprising public and private providers, commissioners, clinical professions, and public and patient groups.

50. A similar process is currently under way for the introduction of Quality Accounts for community services and primary care providers; and for a proposed methodology for enhanced third party assurance for Quality Accounts (work led by Monitor). The initial structure for Quality Accounts will be evaluated over summer 2010, with a view to introducing in 2011 improvements for acute sector Quality Accounts, a roll-out to community services and primary care providers, and a new assurance methodology.

51. The collection and reporting of Patient Reported Outcome Measures (PROMs) data by providers of elective hip and knee replacements, groin hernia and varicose vein surgery to NHS patients is a requirement of the standard NHS Contract for acute services and came into force on the 1st April 2009. Implementation of this requirement was announced in the 2008/9 Operating Framework and followed research and piloting commissioned by the Department of Health. The report of the pilot exercise is published and available to download from the internet: "Patient Reported Outcome Measures (PROMs) in Elective Surgery: Report to the Department of Health." Browne J et al

(2007). London School of Hygiene and Tropical Medicine and Royal College of Surgeons Clinical Effectiveness Unit[3]. Further expansion of PROMs will be informed by the available evidence

52. The Government agrees with the Committee concerning "never events". The scope of two of the eight Never Events was widened under the original NHS Operating Framework for 2010/11. The revision to this Operating Framework that the Department issued on 21 June 2010 included the commitment to expand the list of "never events" so that no payment is made for services which compromise patient safety. These changes for 2011/12 will be detailed in the tariff guidance to be issued later this year. The Government is also considering whether to impose fines for this expanded list of "never events". If fining organisations for Never Events is introduced, we will need to ensure that this is balanced by incentives for quality improvements.

53. An independent academic evaluation of the CQUIN framework started in December 2009 and will produce its final report in March 2012, with an interim report in September 2010.

54. The CQUIN framework will be one part of a more comprehensive, transparent and sustainable structure of payment for performance. It will enable commissioners to pay for achievement of local quality improvement goals, helping to promote a culture of continuous quality improvement in patient services, as set out in the Coalition Agreement. The framework puts power into the hands of local clinicians and managers to decide what changes are needed to improve outcomes for patients, and to innovate.

55. The main aim of the evaluation is to assess the impact of the framework, particularly around behavioural changes that support real quality improvement; and how we can learn from different approaches to implementation.

56. There will be both qualitative and quantitative elements to the evaluation.

- Firstly, we have agreed that the evaluators will undertake in-depth case studies in a number of local health economies across the country, intended to capture maximum variation. Each case study

[3] Available at: http://www.lshtm.ac.uk-hsru-research-PROMs-Report-12-Dec-07.pdf

will be based on local commissioning organisations and their relationships with acute, ambulance, community and mental health providers from both the NHS and the independent sector. Case study work is now underway.

- Secondly, there will be a comparative overview of different approaches to using the framework, including analysis of the content of CQUIN schemes from across the country.

- Thirdly, quantitative analysis will be used to assess whether CQUIN schemes lead to quality improvements, whether in the areas targeted by CQUIN goals or in other areas.

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

57. Our plans for GP commissioning include a maximum allowance to cover management costs. It will be for consortia to decide how far they use this allowance to undertake commissioning activities themselves and how far they buy in support from other organisations, including local authorities, voluntary organisations and the independent sector. GP consortia will be held to account for the outcomes they achieve and for their effective stewardship of NHS resources.

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

58. As part of the forthcoming engagement on our plans for NHS commissioning, we will be inviting views on what support GP commissioning consortia will need to access and evaluate external providers of commissioning support to help ensure value for money.

The way forward

The Government has announced a 30% reduction in management costs in PCTs and SHAs from 2010 to 2013. While some PCTs do a good job with low overheads, we are not convinced that taking money away from weaker PCTs will automatically encourage them to improve their performance. At a time when we are expecting so much of PCTs, it seems risky to be cutting their management costs by 30% when they need better skills and more talent. We note that the Minister indicated the potential to make savings from SHAs; we agree that they should bear the brunt of any cuts (Paragraph 200).

59. As set out above, the June 2010 Revision to the 2010/11 Operating Framework included the statement that "The overall ceiling for Management Costs in PCTs and SHAs will now be set at two thirds of the 2008/09 Management Costs (£1,509 million), the ceiling will therefore be £1,006 million." SHAs will therefore be part of this initial savings requirement.

60. The White Paper, *Liberating the NHS*, includes a commitment to reduce the NHS administrative running costs of non-front-line services by more than 45% over the next four years. PCTs – with administrative costs of over a billion pounds a year – and practice-based commissioners will together be replaced by GP commissioning consortia. Strategic Health Authorities will be abolished.

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

61. As set out in the White Paper, the NHS Commissioning Board will be responsible for providing national leadership on commissioning improvement. This will include setting commissioning guidelines on the basis of clinically approved quality standard developed with the advice of NICE, designing model contracts for local commissioners to adapt and use with providers, designing the structure of tariff and other financial incentives, hosting some clinical commissioning networks (for example for rarer cancers and transplant services) to pool specialist expertise, making available accessible information on commissioner performance and tackling inequalities in outcomes of healthcare.

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

62. Effective commissioning is pivotal to the success of NHS services, and we are of the view that commissioning is at its most effective when clearly split from the provision of NHS services. The split between commissioners purchasing health care, and providers delivering it, remains an essential check and balance, ensuring that the NHS responds to the interests of patients. At the same time, there needs to be more effective collaboration between health and care professionals from across commissioning and provider organisations to design care pathways that provide more joined-up and efficient care and higher-quality outcomes.

63. As set out in the White Paper, we will ensure that the NHS has a commissioning system fit for purpose: a system based on the principles of shifting decision-making as close as possible to individual patients, aligning responsibility for clinical decisions and for the financial consequences of those decisions, and freeing up healthcare professionals from top-down managerial control.

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