LIBERATING THE NHS: COMMISSIONING FOR PATIENTS (ENGLAND) BMA SUMMARY

Background

On 12 July 2010 the Secretary of State for Health Andrew Lansley released a White Paper on health reform entitled Equity and Excellence: Liberating the NHS setting out an ambitious agenda for the NHS for the next five years.

As part of the White Paper consultative process Commissioning for patients was released on 22 July 2010. This consultation document provides greater detail on proposals for devolving commissioning responsibilities and budgets as far as possible to GP consortia, and the NHS Commissioning Board's role in supporting consortia and holding them to account. The new system will be set out in primary and secondary legislation. Responses to the consultation document are due by **11 October 2010.**

Introduction

The Government believes that current commissioning arrangements

- Have been too remote from the patients they are intended to serve; and
- Have been beset by political interference and micromanagement with a rhetoric of Primary Care Trusts (PCTs) being free to reflect local health priorities but the reality of having to pursue targets and Ministerial demands.

CHAPTER 2 – Summary of key points

Responsibilities of GP consortia

- The Department of Health (DH) will devolve power and responsibility for commissioning most healthcare services to groups of GP practices ('consortia').

GP consortia will commission the great majority of NHS services on behalf of patients, including:

- Elective hospital care and rehabilitative care;
- Urgent and emergency care (including out of hours services);
- Most community health services;
- Mental health; and
- Learning disability services.

GP consortia will NOT be responsible for commissioning

- Primary medical services;
- Other family health services of dentistry, community pharmacy and primary ophthalmic services;
- Regional and national specialised services;
- Maternity services; and
- Prison health services.

- The NHS Commissioning Board will calculate practice-level budgets and allocate these resources directly to consortia.
- Consortia will be responsible for managing these combined budgets, which will be kept separate from GP practice income.
- Consortia will be responsible for deciding how best to use these resources to meet the healthcare needs of their patients.

- Consortia will enter into contracts with providers and hold providers to account for meeting their contractual duties, including required quality standards and patient outcomes.

Relationship between consortia and individual practices

- The Government will discuss with the **BMA** and the profession how primary medical care contracts can best reflect new complementary responsibilities for individual GP practices, including a duty to be a member of a consortium and to support it in ensuring efficient and effective use of NHS resources.

Establishment of GP consortia

- **The intention is to put GP commissioning on a statutory basis with powers and responsibilities set out in primary and secondary legislation.**
- **Every GP practice will be a member of a consortium as a corollary of holding a list of registered patients.**
- **Within the legislative framework practices will have flexibility to form consortia in ways that they think will secure the best healthcare and health outcomes.**
- The NHS Commissioning Board will have a duty to ensure comprehensive coverage of GP consortia and the **Government envisages a reserve power for the Board to assign practices to consortia if necessary.**
- Consortia will be formed on a bottom up basis.
- **Consortia will need to be of sufficient size to effectively manage financial risk** notwithstanding their ability to work with other consortia to manage financial risk.
- **Consortia will need to have sufficient geographical focus to be able to:**
  - Agree and monitor contracts for locality-based services (e.g. urgent and emergency care);
  - Have responsibility for commissioning services for people not registered with a GP practice;
  - Commission services jointly with local authorities; and
  - Fulfil effectively their duties in areas such as safeguarding children.

Freedoms and accountabilities

- **The Government envisages that consortia will receive a maximum management allowance to reflect the costs associated with commissioning.**
- Consortia will have the freedom to use resources in ways that achieve the best and most cost effective outcomes for patients.
- **Consortia will have the freedom to decide what commissioning activities they undertake for themselves and for what activities they choose to buy in support from external organisations, including local authorities, private and voluntary sector bodies.**
- **Monitor** (the economic regulator) **and the NHS Commissioning Board will ensure transparency and fairness in spending decisions and promote competition,** for instance by ensuring wherever possible that any willing provider has an equal opportunity to provide services.
- **The DH will discuss with the NHS the safeguards that will be needed to achieve these objectives** (particularly in regards to consortia commissioning services from general practice over and above those services they have a duty to provide).
- **The NHS Commissioning Board will be responsible for holding consortia to account for the outcomes they achieve, for stewardship of NHS resources and fulfilling duties such as public and patient involvement and partnership with local authorities.**
- **The NHS Commissioning Board, supported by NICE, will develop a commissioning outcomes framework to ensure there is publicly available information on the quality of healthcare services commissioned by consortia and their management of NHS resources.**
- **The proposed commissioning framework would also seek to capture progress in reducing health inequalities.**

- **Each consortium will develop its own arrangements to hold its constituent practices to account.**
- The Government proposes subject to discussion with the **BMA** and the profession that a proportion of GP practice income should be linked to the outcomes that practices achieve collaboratively through commissioning consortia and the effectiveness with which they manage NHS resources.

The NHS Commissioning Board will need **powers to intervene in the event that a consortium is unable to fulfil its duties effectively or where there is a significant risk of failure.** The Government proposes working with the NHS to develop criteria or triggers for intervention.

Partnership

- The proposed new local authority health and wellbeing boards would enable consortia, alongside other partners, to contribute to effective joint action to promote the health and wellbeing of local communities.
- The Government will work with the NHS and the health and care professions to promote multi-professional involvement in commissioning.

The proposed implementation timetable is:

- **In 2010/11** – GP consortia begin to come together in shadow form (building on practice-based commissioning consortia where they wish);
- **In 2011/12** – a comprehensive system of shadow GP consortia to be in place and the NHS Commissioning Board to be established in shadow form;
- **In 2012/13** – formal establishment of GP consortia, together with indicative allocations and responsibility to prepare commissioning plans, and the NHS Commissioning Board to be established as an independent statutory body; and
- **In 2013/14** – GP consortia to be fully operational, with real budgets and holding contracts with providers.

CHAPTER 3 - Responsibilities

The NHS Commissioning Board will have responsibility – and the accompanying share of the NHS budget – for commissioning certain services:

- **Primary medical services** – the Board will be responsible for holding contracts with individual GP practices in their role as providers of primary medical care, although a role for consortia in improving the quality of general practice is envisaged;
- **Other family health services** – the Board will commission primary dental services, community pharmacy (and other dispensing services) and primary ophthalmic services. Consortia will be able to commission services from primary care contractors, e.g. if they want to commission optometrists to help treat glaucoma;
- **National and regional specialised commissioning** – the Board will have responsibility for commissioning highly specialised services, i.e. those covered by the Specialised Services National Definitions Set such as heart transplants, spinal injuries, burns and renal dialysis. This will ensure the provision of high quality and cost effective treatment for patients with rare conditions. It will also ensure more effective implementation of the recommendations from Sir David Carter's 2007 review. The Board will need to facilitate strong engagement of consortia in these arrangements to ensure a smooth interface between GP commissioners and specialised services;
- **Maternity services** – The Board will play a lead role in commissioning maternity and newborn care services with a view to promoting choice across a range of settings and services; and
- **Health services for those in prison or custody** - The Board will work with criminal justice agencies and GP consortia to determine the most appropriate arrangements for prison health services.

There may be other services such as low-volume services outside the scope of national or regional specialised commissioning that are better commissioned for larger populations than those of individual consortia.

- It is proposed that in accordance with their duties of partnership and engagement, consortia have the freedom and responsibility to decide for themselves at what level e.g. through a lead consortium, these services are best commissioned.

Duties and responsibilities of GP consortia

- **The NHS Commissioning Board will calculate practice-level budgets and allocate these directly to consortia.**
- **These budgets will need to reflect an appropriate share of health resources to include both people registered with practices in the consortium and local residents who are not registered with any practice.**
- Consortia will be responsible for ensuring the provision of comprehensive emergency services for any person in their area.
- Consortia will be responsible for managing their combined budget and for deciding how best to use these resources to meet healthcare needs.
- **Cross border arrangements with Scotland and Wales will not be affected.**
- The specific accountabilities, responsibilities and duties of consortia will be set out through primary and secondary legislation.

This will include accountability and responsibility for:

- **Determining healthcare needs**, including contributing to the wider joint strategic needs assessment led by local authorities;
- **Determining what services are required** to meet these needs and ensuring the appropriate clinical and quality specification of these services;
- **Entering into and managing contracts with providers;**
- Monitoring and improving the quality of healthcare provided through these contracts; and
- **Providing oversight with the NHS Commissioning Board, of healthcare provider's training and education plans.**

The legislation will outline consortia's duties in relation to financial management including:

- **Ensuring that expenditure does not exceed its allocated resources;**
- Requirements in relation to **reporting, audit and accounts;**
- Duties in relation to **equality and human rights and in relation to data protection and freedom of information;**
- Duties to **work in partnership with local authorities** for instance in relation to early years services, and to cooperate with local authorities and other agencies in relation to criminal justice; and
- **Duties to inform engage and involve the public** in identifying needs, planning services, and considering any proposed changes in how those services are provided. Where this is likely to result in **service reconfiguration**, consortia will be expected to report on the likely impact of those changes and the impact of public involvement on their commissioning decisions.

Relationship between consortia and individual GP practices

- Each consortium will develop its own arrangements to hold its constituent practices to account.
- **The Government will discuss with the BMA and the profession how primary medical care contracts can best reflect specific new complementary responsibilities for individual GP practices,** including being a consortium member and supporting the consortium in ensuring efficient and effective use of NHS resources.
- **With the exception of the management allowance previously mentioned, the consortium's commissioning budget will be used exclusively for commissioning of**

patient care. It will be distinct from income GPs earn under their primary medical services contract.

- **It is proposed that a proportion of GP practice income should be linked to the overall outcomes that practices achieve collaboratively through their role in a commissioning consortium.**
- **The Government proposes to work with the BMA and the profession to reform the Quality Outcomes Framework (QOF)** so that it better reflects and focuses on individual practices' contribution to health outcomes and provides incentives for continuous quality improvements.
- **Consortia should play a key role in working with individual GP practices to drive up the quality** of primary medical care and improve overall utilisation of NHS resources.
- The NHS Commissioning Board should have the power, where appropriate, **to ask consortia to carry out on its behalf some aspects of the work involved in managing primary medical services contracts,** e.g. by promoting quality improvement, review and benchmarking practice performance and ensuring clinical governance requirements are met.
- This would enable **consortia to apply peer review and challenge** in the first instance to areas where there appear to be unwarranted variations in practice or outcomes.
- **The Board would retain overall responsibility for commissioning and contractual decisions**.
- **A consortium may need to arrange for some of its GP practices to provide primary care services over and above those that they are already duty bound to provide**, subject to safeguards to ensure fairness, transparency and competition. The Government will take forward further work to identify the most suitable contractual framework for services of this kind.

Over time the Government will work with the profession to move to a **single contractual and funding model for GP practices** to promote quality improvement, deliver fairness for all practices, support free patient choice and remove unnecessary barriers to new providers.

This funding model would reflect the fundamental aspects of primary care services – those services that every patient should expect to be able to receive at their GP practice.

The role of the NHS Commissioning Board

The Board:

- **Will be an independent statutory authority** with a Chair, Chief Executive and both executive and non-executive board members;
- Will be free to determine its own organisational shape, structure and ways of working;
- Will carry out some functions currently performed by the DH, Strategic Health Authorities and PCTs but in a more streamlined way;
- **Will be accountable to the Secretary of State for managing the overall commissioning revenue limit and for delivering improvements against a number of health outcome measures; and,**
- **Will be responsible for reporting the consolidated financial position of consortia as part of its financial reporting obligations.**

The Secretary of State will set the Board an annual mandate, based on a multi-year planning cycle, which will be subject to public consultation and Parliamentary scrutiny. This will cover what the Government expects from the Board on taxpayer's behalf including:

- Progress against outcomes specified in the NHS Outcomes Framework;
- Delivering improvements in choice and patient involvement; and
- Tackling inequalities in healthcare outcomes.

The NHS Commissioning Board has five broad functions

1. **Providing national leadership on commissioning for quality improvement:**

- Setting commissioning guidelines on the basis of clinically approved quality standards developed with advice from NICE;
- Designing model NHS contracts for consortia to adapt and use with providers;
- Designing the structure of the tariff and other financial incentives whilst Monitor will set tariff levels;
- Having a role in determining technical and data standards to ensure there is consistency in the information commissioners and providers are using and compatibility between information systems; and
- Where appropriate, and by agreement of consortia hosting some commissioning networks e.g. cancer and coronary heart disease.

2. **Promoting and extending public and patient involvement and choice:**

- Championing effective patient and public involvement in commissioning decisions and greater involvement of patients and carers in decision making and managing their own care by working with consortia local authorities, patient groups and HealthWatch;
- Developing and agreeing with the Secretary of State the guarantees for patients about the choices they can make, taking account of advice from the economic regulator on the implications for competition;
- Promoting and extending information to support meaningful choice of what care and treatment patients receive, where it is provided and who provides it, including personal health budgets; and
- Commissioning information requirements for choice and for accountability, including patient reported outcome measures (PROMs).

3. **Ensuring the development of GP consortia and holding them to account** (as previously outlined).

4. **Commissioning certain services that are not commissioned by consortia** (as previously outlined).

5. **Allocating and accounting for NHS resources:**

- Calculating and allocating practice-level budgets directly to consortia on the basis of seeking to secure equivalent access to NHS services for all, relative to the prospective burden of disease;
- Responsibility for the overall financial sustainability of commissioners and for accounting to the Secretary of State for NHS commissioning expenditure, underpinned by robust financial management measures at consortium level; and
- The Board will have limited intervention powers outlined in legislation where a consortium is failing to fulfil its statutory duties or there is a significant risk that a consortium will fail to do so.

CHAPTER 4 – Establishment of GP consortia

- **Consortia once established will be statutory public bodies** with powers and responsibilities set out through primary and secondary legislation.
- By that time **each consortium would need to have chosen its own Accountable Officer and Chief Financial Officer** (with the latter potentially discharging this role for more than one consortium).
- The Government does not intend to set out detailed or prescriptive requirements in relation to the internal governance of a consortium beyond essential requirements e.g. financial probity and accountability, reporting and audit.

Forming consortia

- **Subject to discussions with the BMA and the wider profession the Government intends every practice** i.e. every holder of a primary medical care contract (whether GP partnership, nurse-led partnership, social enterprise, voluntary or independent sector organisation) **should be required to be a consortium member.**
- As outlined previously consortia will need to have sufficient geographical focus to fulfil their commissioning responsibilities.
- **Consortia will need to have boundaries that interlock so that taken together they cover England.**
- **The Government will not issue a blueprint for consortia geography** as GP practices are to decide for themselves.
- **The NHS Commissioning Board will have a duty to ensure comprehensive coverage of GP consortia across the country and a reserve power to assign GP practices to consortia if necessary.**
- **There is no prescriptive size for GP consortia** but the Board will need to satisfy itself that they are of a sufficient size to manage financial risk and allow for accurate allocations.

Authorisation

- **The NHS Commissioning Board will have the power to authorise consortia.**
- Where a consortium does not fulfil any minimum requirements for authorisation, the Board will need to be explicit in setting out the steps that need to be taken and the interim arrangements.
- There will need to be flexibility to allow consortia to evolve in terms of the groups of practices that they bring together and to ensure that new primary care providers are able to join.

CHAPTER 5 – Freedoms, controls and accountabilities

Freedoms

- GP consortia will decide the commissioning priorities to reflect local needs supported by the national framework of quality standards, tariffs and national contracts established by the NHS Commissioning Board.
- Consortia will decide how best to discharge their commissioning duties. They may choose to buy in support from external organisations or carry out a number of activities themselves.
- Consortia can choose to act collectively, e.g. adopting a lead commissioner model to negotiate and monitor contracts with large hospital trusts.
- Consortia will have the freedom to arrange for some commissioning activities to be undertaken at a sub-consortium or practice level, where it is appropriate and necessary internal controls are in place.
- These freedoms will ensure that GPs and other clinicians are able to focus their input on those aspects of commissioning that will most benefit from their clinical insight and expertise.
- In transition PCTs will provide many of these functions in support of shadow consortia, alongside the many organisations that already exist to provide commissioning support.
- The Government envisages that over time a more competitive market will develop for supplying some of these services.

Managing financial risk

- Consortia will have freedoms to invest resources in ways that achieve the best and most cost effective outcomes.
- **Consortia will control financial risk and meet their responsibility for breaking even on their commissioning budget.**
- **There are two broad categories of risk in the new system:**
    - Risks from unavoidable and natural fluctuations in the healthcare needs of a population, which are often described as **'insurance risk';** and

    - Risks arising from controllable activities, such as poor prescribing or referral practices, sometimes known as **'service risk'**.
- The challenge is helping commissioners deal with insurance risk through some form of risk pooling whilst ensuring their responsibility for managing service risk.
- The NHS Commissioning Board will have a significant role in managing financial risk e.g. through oversight of risk pooling within and between consortia.

The principles for managing under-spends (including whether any planned and managed under-spends can be carried over to future years to invest in services) and over-spends (including whether any actual over-spends will be deducted from the following year's allocation) will be agreed between the NHS Commissioning Board, the Department of Health and HM Treasury.

Key criteria are likely to be:

- **Minimising exposure to uncontrollable 'insurance risk';**
- **Allowing for the maximum proportion of funds to be allocated directly to patient services;**
- **Ensuring the right arrangements to manage the impact of over or under-spending by consortia, without a disproportionate amount of money needing to be held back as contingency;** and
- **Ensuring sufficient incentives and disciplines to manage financial risk properly, and service risk in particular, at the local consortium level.**

These arrangements will need to complement the incentives for consortia to manage risk, which will include benefits for good financial management such as the proposed quality premium. The NHS Commissioning Board will have powers to intervene in the event of poor financial management.

Transparency in fairness and investment decisions

- Monitor, as the economic regulator, and the NHS Commissioning Board will need to develop and maintain a framework that ensures transparency, fairness and choice.
- Wherever possible services should be commissioned that enable patients to choose from any willing provider (this will be particularly important where a consortium proposes to commission services from one or more of its constituent practices).
- Consortia will be commissioning organisations and will not be providing services in their own right.
- It is essential that individual practices or groups of practices have the opportunity to provide new services (over and above the primary care services they already have a duty to provide) where this will provide best value in terms of quality and cost.
- Further work will be taken forward to develop a framework that allows commissioning of new services whilst guarding against real and perceived conflicts of interest.
- Where services are commissioned on an any-willing-provider basis there are established protocols that can be used or adapted to report and audit the pattern of referrals.
- Where GP practices wish to bid in a major procurement, the procurement could be managed by another party such as the NHS Commissioning Board or a local authority.

Accountability to patients and the public

- The NHS Commissioning Board will be responsible for developing an assurance process for consortia.
- Supported by NICE and working with patient and professional groups the NHS Commissioning Board will develop a commissioning outcomes framework that measures the health outcomes and quality of care achieved by consortia (adjusted for patient mix).
- The framework would allow the NHS Commissioning Board to identify the contribution of consortia to achieving health improvement under the NHS Outcomes Framework.
- **It is proposed, subject to discussion with the BMA and the profession, that a proportion of GP practice income should be linked to the outcomes that they achieve**

collaboratively through commissioning resources and the effectiveness with which they manage financial resources.

- **It is proposed that this 'quality premium' be paid in the first instance to the consortium and that the consortium be free to decide how best to apportion it between its member practices.**

Accountability for the use of public resources

- The primary legislation will need to allow for the NHS Commissioning Board to intervene in the event that a consortium is unable to fulfil its duties effectively e.g. in the event of financial failure.
- **This could include powers to make continued authorisation dependent upon remedial action and in the last resort, to take over the consortium's commissioning responsibilities or assign them to a third party e.g. neighbouring consortium.**
- **The Government proposes working with the profession and the NHS to develop criteria for intervention which could be reflected in the consortium's terms of authorisation and to consult on these at a later date.**
- **It is envisaged that any intervention would typically be a staged process so that wherever possible a consortium has the opportunity to take remedial action.**
- **GP practices like any other provider of NHS services have a responsibility to use public resources responsibly and in the public interest.**
- **Where there are concerns that an individual practice is causing ineffective or wasteful use of NHS resources, its consortium would be expected to work with that practice to address the relevant issues.**
- **If problems persisted and there were concerns that a practice was not meeting its contractual duties, the NHS Commissioning Board would need to address this as part of its responsibility for managing primary care contracts.**

CHAPTER 6 – Partnership

Patients and the public

- GP consortia and the NHS Commissioning Board will need to find and evolve efficient and effective ways of engaging patients and the public so that commissioning decisions are increasingly shaped by people's expressed needs and wants.
- As part of the development of GP commissioning and the NHS Commissioning Board the DH will promote:
    - Patient, carer and public involvement in decision-making;
    - Responsiveness to the views and feedback of patients, carers and the public; and
    - Accountability to local people for the decisions about their health services made by consortia on their behalf.

Commissioners will need to establish and nurture new relationships with:

- Local HealthWatch (currently LINks) and the national body HealthWatch England;
- The Patient Participation Groups that GP practices are increasingly using;
- Local authorities; and
- Local voluntary organisations and community groups that often work with and represent the most disadvantaged.

Local government and public health

- Under proposals set out in a related consultation *Local democratic legitimacy in health* local government will have an enhanced responsibility for promoting partnership working and integrated delivery of public services across the NHS, social care and other services.
- One way in which this could occur is through the establishment of health and wellbeing boards

- **Local government will have an enhanced role in public health with direct responsibility and funding (allocated to local Directors of Public Health) for improving the health of local communities e.g. through reducing the incidence of smoking.**
- **Where there are currently Care Trusts that bring together commissioning responsibility for health and social care, their healthcare responsibilities will need to transfer to GP consortia.**
- The framework described below is designed to enable GP consortia to work with local government to ensure that the benefits achieved through Care Trusts are built upon.

This enhanced role for local government will provide a framework through which GP consortia alongside other partners:

- Contribute to a joint assessment of the health and care needs of local people and neighbourhoods;
- Ensure that their commissioning plans reflect the health needs identified in these assessments;
- Draw on the support of the proposed health and wellbeing board in relation to population health;
- Identify ways of achieving more integrated delivery of health and adult social care e.g. through pooled budgets;
- Support improvements in children's health and wellbeing;
- Play a systematic and effective part in arrangements for the safeguarding of children and vulnerable adults; and
- Cooperate with the criminal justice system e.g. in relation to tackling drug misuse.

Other healthcare professionals

- **The GP practice and registered patient list should form the building block of commissioning consortia.**
- **GP consortia are expected to involve relevant health and social care professionals** from all sectors in helping design care pathways or care packages that achieve more integrated high quality care and more efficient use of NHS resources.
- **The Government will not prescribe top-down processes or governance requirements on how this should be achieved.**
- **The DH will work with the NHS and professional bodies in the transition to the new arrangements to promote multi-professional involvement.**

CHAPTER 7 - Implementation and next steps

Preparing for GP commissioning

- **The DH will discuss with the NHS and the profession a number of practical steps that PCTs will need to take with GP practices and existing practice-based commissioning groups during 2010/11.**
- This will include identifying the likely future shape of consortia and enabling them to start taking increasing responsibility from PCTs.
- **This will mean PCTs increasingly putting management resources at the disposal of shadow consortia and working with them during the transition to ensure that appropriate skills and knowledge are retained.**

There are a number of areas where early progress is essential:

1. **Clinical leadership** – the DH will work with the National Leadership Council and professional groups to explore how best to provide support and development for GPs and other clinicians who want to take on leadership roles within consortia;

2. **Information –** The DH will work with the profession and NHS to identify how best to support consortia in accessing accurate, real-time data that can be used to support efficient and effective care; and
3. **Financial transactions –** The DH will work with the profession and the NHS to ensure effective systems that enable consortia to track expenditure, reconcile activity and expenditure and minimise transaction costs.

Timetable	
2010/11	GP consortia begin to form on a shadow basis (building on practice based commissioning consortia where they wish) and where they are ready to do so, begin to take on some PCT responsibilities supported by indicative budgets.
2011/12	Comprehensive system of shadow GP consortia in place taking on increased responsibility from PCTs, including increased responsibility for leading of the existing QIPP initiative. The NHS Commissioning Board established in shadow form as a Special Health Authority from April 2011 and to have a role in supporting the development of GP consortia.
2012/13	Formal establishment of GP consortia, together with indicative allocations. The NHS Commissioning Board established as an independent statutory body. The NHS Commissioning Board to announce (in the third quarter of 2012/13) the allocations that will be made directly to consortia for 2013/14.
2013/14	GP consortia to be fully operational with real budgets and holding contracts with providers.

Consultation Questions

1. In what practical ways can the NHS Commissioning Board most effectively engage GP consortia in influencing the commissioning of national and regional specialised services and the commissioning of maternity services?
2. How can the NHS Commissioning Board and GP consortia best work together to ensure effective commissioning of low volume services?
3. Are there any services currently commissioned as regional specialised services that could potentially be commissioned in the future by GP consortia?
4. How can other primary care contractors most effectively be involved in commissioning services to which they refer patients, e.g. the role of primary care dentists in commissioning hospital and specialist dental services and the role of primary ophthalmic providers in commissioning hospital eye services?
5. How can GP consortia most effectively take responsibility for improving the quality of the primary care provided by their constituent practices?
6. What arrangements will support the most effective relationship between the NHS Commissioning Board and GP consortia in relation to monitoring and managing primary care performance?
7. What safeguards are likely to be most effective in ensuring transparency and fairness in commissioning services from primary care and in promoting patient choice?
8. How can the NHS Commissioning Board develop effective relationships with GP consortia, so that the national framework of quality standards, model contracts, tariffs and commissioning networks best support local commissioning?
9. Are there other activities that could be undertaken by the NHS Commissioning Board to support efficient and effective local commissioning?
10. What features should be considered essential for the governance of the GP consortia?

11. How far should GP consortia have flexibility to include some practices that are not part of a geographically discrete area?
12. Should there be a minimum and/or maximum population size for GP consortia?
13. How can GP consortia best be supported in developing their own capacity and capability in commissioning?
14. What support will GP consortia need to access and evaluate external providers of commissioning support?
15. Are these the right criteria for an effective system of financial risk management? What support will GP consortia need to help them manage risk?
16. What safeguards are likely to be most effective in demonstrating transparency and fairness in investment decisions and in promoting choice and competition?
17. What are the key elements that you would expect to see reflected in a commissioning outcomes framework?
18. Should some part of GP practice income be linked to the outcomes that the practice achieves as part of its wider commissioning consortium?
19. What arrangements will best ensure that GP consortia operate in ways that are consistent with promoting equality and reducing avoidable inequalities in health?
20. How can GP consortia and the NHS Commissioning Board best involve patients in making commissioning decisions that are built on patient insight?
21. How can GP consortia best work alongside community partners (including seldom heard groups) to ensure that commissioning decisions are equitable, and reflect public voice and local priorities?
22. How can we build on and strengthen existing systems of engagement such as Local HealthWatch and GP practices' Patient Participation Groups?
23. What action needs to be taken to ensure that no-one is disadvantaged by the proposals, and how do you think they (the proposals) can promote equality of opportunity and outcome for all patients and, where appropriate, staff?
24. How can GP practices begin to make stronger links with local authorities and identify how best to prepare to work together on the issues identified above?
25. Where can we learn from current best practice in relation to joint working and partnership, for instance in relation to Care Trusts, Children's Trusts and pooled budgets? What aspects of current practice will need to be preserved in the transition to new arrangements?
26. How can multi-professional involvement in commissioning most effectively be promoted and sustained?