NHS

Liberating the NHS:

Commissioning for patients

A consultation on proposals

DH Department of Health

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Description	One of the central features in Liberating the NHS is to devolve commissioning responsibilities and budgets as far as possible to those who are best placed to act as patients' advocates and support them in their healthcare choices. This document sets out, and seeks views on, the intended arrangements for GP commissioning and the NHS Commissioning Board.
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1. Introduction

1.1 The White Paper *Equity and Excellence: Liberating the NHS* sets out the Government's strategy for the NHS. Our intention is to create an NHS which is much more responsive to patients, and achieves better outcomes, with increased autonomy and clear accountability at every level.

1.2 *Liberating the NHS* makes clear the Government's policy intentions and provides a coherent framework. Further work lies ahead to develop and implement detailed proposals. In progressing this work, the Department will be engaging with external organisations, seeking their help and wishing to benefit from their expertise. An analytical strategy published alongside *Liberating the NHS* sets out our plans to use the consultation and engagement activity to inform the development of Impact Assessments to be published later in the year. It also provides an initial indication of what benefits, costs and risks will be analysed.

1.3 This document, *Commissioning for patients,* provides further information on our intended arrangements for GP commissioning and the NHS Commissioning Board's role in supporting consortia and holding them to account. It seeks views on a number of specific consultation questions. Examples of existing practice and evidence that support respondents' views are encouraged.

1.4 This is part of a public consultation on specific aspects of the White Paper. The initial suite of supporting papers also includes:

- Regulating healthcare providers
- Local democratic legitimacy in health
- The review of Arm's-Length Bodies
- Transparency in outcomes: a framework for the NHS.

1.5 The Government will publish a response prior to the introduction of a Health Bill later this year.

Overview

1.6 When we think about the NHS, we often think of the individuals and organisations that provide care for patients, such as GPs, hospitals and community health professionals. But providers of NHS healthcare cannot exist in a vacuum. 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 that ensure high-quality outcomes, maximise patient choice and secure efficient use of NHS resources.

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

1.8 One of the central features of the proposals in *Liberating the NHS* is to devolve commissioning responsibilities and budgets as far as possible to those who are best placed to act as patients' advocates and support them in their healthcare choices. Through our world-renowned system of general practice, GPs, practice nurses and other primary care professionals are already supporting patients in managing their health, promoting continuity and co-ordination of care, and making referrals to more specialist services. In empowering GP practices to come together in wider groupings, or 'consortia', to commission care on their patients' behalf and manage NHS resources, we are building on these foundations. We are also empowering them to work more effectively alongside individual patients and alongside the full range of other health and care professionals.

1.9 As set out in the parallel document *Local democratic legitimacy in health*, we plan to put in place robust oversight arrangements for local democratic accountability with local authorities playing a key role. They will lead the statutory joint strategic needs assessment, which will inform the commissioning of health and care services and promote integration and partnership across areas, including through joined up commissioning plans across the NHS, social care and public health. They will support joint commissioning and pooled budget arrangements, where parties agree this makes sense, and will undertake a scrutiny role in relation to major service redesign. One option for doing this is through the creation of statutory health and wellbeing boards within local authorities.

1.10 *Liberating the NHS* also sets out proposals to establish an independent NHS Commissioning Board. The Board will provide national leadership on commissioning for quality improvement and promote and extend public and patient involvement and choice. It will be responsible for ensuring a comprehensive system of GP commissioning consortia across the NHS, for holding consortia to account and for commissioning some services itself. It will allocate and account for NHS resources.

1.11 The forthcoming consultation document on *Regulating healthcare providers* will also set out a proposed role for a new independent economic regulator of health and social care, to act as a champion for patients, setting prices where needed, protecting patient choice, and helping to ensure continuity of services.

1.12 This document sets out our intended arrangements for GP commissioning and the NHS Commissioning Board's role in supporting consortia and holding them to account. It serves as the starting point for a programme of consultation and engagement with patients and the public, GPs and other health and care professionals, local government, and voluntary sector, social enterprise and independent sector organisations. We would like your views on how to deliver the greatest possible benefits from these new commissioning arrangements, on how to develop the partnerships on which their success will depend, on how GP consortia can best work with the NHS Commissioning Board, and on the other specific questions identified below.

Current commissioning arrangements

1.13 For the past decade, commissioning responsibilities have largely rested with primary care trusts (PCTs) and to some extent the primary care groups that preceded them. The previous Government made belated attempts to strengthen PCT commissioning through its programme of 'world class commissioning'. But the weaknesses of the system have lain much deeper than the capacity of staff working in PCTs. Commissioning has been too remote from the patients it is intended to serve. It has been divorced from GPs' clinical responsibilities, such as referral, with efforts to create 'practice based commissioning' lacking reality and not sufficiently empowering. It has been beset by political interference and micro-management, with a rhetoric of PCTs being free to reflect local health priorities but the reality of having to pursue targets and Ministerial demands.

Proposed commissioning arrangements

1.14 Our proposals for GP commissioning and the NHS Commissioning Board mark a fundamental break with this past. Most commissioning decisions will now be made by consortia of GP practices, free from top-down managerial control and supported and held to account for the outcomes they achieve by the NHS Commissioning Board. This will push decision-making much closer to patients and local communities and ensure that commissioners are accountable to them. It will ensure that commissioning decisions are underpinned by clinical insight and knowledge of local healthcare needs. It will enable consortia 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.

1.15 Our proposed model will not mean all GPs, practice nurses and other practice staff having to be actively involved in every aspect of commissioning. Their predominant focus will continue to be on providing high-quality primary care to their patients. It is likely to be a smaller group of primary care practitioners who will lead the consortium and play an active role in the clinical design of local services, working with a range of other health and care professionals. All GP practices, however, will be able to ensure that commissioning decisions reflect their views of their patients' needs and their own referral intentions. It will be a requirement for every GP practice to be part of a consortium and to contribute to its goals, not least in ensuring that as a practice they provide services in ways that support high-quality outcomes and efficient use of NHS resources.

1.16 Nor will the practitioners who lead the consortia need to carry out all commissioning activities themselves. Whilst it is likely that they will 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, for instance to analyse population health needs, manage contracts with providers and monitor expenditure and outcomes. 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.

1.17 GP consortia will also be supported by the role of the NHS Commissioning Board in developing commissioning guidelines, model contracts and tariffs.

1.18 Transferring commissioning functions to consortia and, in some cases, the NHS Commissioning Board, alongside the potential role for local health and wellbeing boards, means that PCTs will no longer have a role. We expect that PCTs will cease to exist from April 2013, in light of the successful establishment of GP consortia. A number of PCTs have made important progress in developing commissioning experience. We will be looking to capitalise on that existing expertise and capability in the transitional period, where this is the wish of GP consortia.

1.19 PCTs will have an important task in the next two years in supporting practices to prepare for these new arrangements. We want implementation to be bottom-up, with GP consortia taking on their new responsibilities as rapidly as possible and early adopters promoting best practice.

Purpose of this document

1.20 This document sets out in more detail:

- **responsibilities (Section 3):** the scope of the services for which consortia and the NHS Commissioning Board will be responsible, their responsibilities as commissioners of these services, and the relationship between the responsibilities of the NHS Commissioning Board, GP consortia and individual GP practices

- **establishment of GP consortia (Section 4):** the statutory form that consortia will take, the bottom-up way in which we will invite GP practices to form consortia and arrangements for authorisation by the NHS Commissioning Board

- **freedoms, controls and accountabilities (Section 5):** the freedoms and flexibilities that consortia will have to decide how best to commission services and how they will be held accountable, both to the patients and local communities they serve and to the NHS Commissioning Board, for the outcomes they achieve and for control of resources

- **partnerships (Section 6):** how we envisage that consortia and the NHS Commissioning Board will work with patients and the public, with local government, and with other health and care professionals to secure more patient-centred and integrated delivery of care

- **implementation and next steps (Section 7):** the timetable for the transition to GP practice commissioning and the establishment of the NHS Commissioning Board, and the practical steps we propose that PCTs should take with GP practices and current practice-based commissioning

groups to begin this transition, including action to help ensure that consortia will be supported by excellent clinical leadership and excellent information.

2. Summary of key points

Responsibilities of GP consortia

2.1 In order to shift decision-making as close as possible to individual patients, the Department will devolve power and responsibility for commissioning most healthcare services to groups of GP practices.

2.2 Consortia of GP practices 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, and mental health and learning disability services.

2.3 Consortia will not be responsible for commissioning primary medical services, which will be the responsibility of the NHS Commissioning Board, but consortia will become increasingly influential in driving up the quality of general practice. The NHS Commissioning Board will also commission the other family health services of dentistry, community pharmacy and primary ophthalmic services, as well as national and regional specialised services, maternity services and prison health services, but with the influence and involvement of consortia.

2.4 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, and deciding how best to use resources to meet the healthcare needs of their patients. They will have a duty to ensure that expenditure does not exceed their allocated resources. They will enter into contracts with providers and hold providers to account for meeting their contractual duties, including required quality standards and patient outcomes.

2.5 Consortia will have a duty to promote equalities and to work in partnership with local authorities, for instance in relation to health and adult social care, early years services and public health.

2.6 Consortia will need to engage patients and the public on an ongoing basis as they undertake their commissioning responsibilities, and will have a duty of public and patient involvement.

Relationship between consortia and individual practices

2.7 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.

The role of the NHS Commissioning Board

2.8 To support consortia in their commissioning decisions we will create a statutory NHS Commissioning Board, which will:

- provide national leadership on commissioning for quality improvement, for instance by developing commissioning guidelines based on quality standards and by designing tariffs and model NHS contracts
- promote and extend public and patient involvement and choice
- ensure the development of consortia and hold them to account for outcomes and financial performance
- commission certain services that are not commissioned by consortia, such as the national and regional specialised services
- allocate and account for NHS resources.

2.9 The NHS Commissioning Board will be accountable to the Secretary of State for managing the overall commissioning revenue limit and for delivering improvements against a number of measures of health outcomes. The Board will in turn hold consortia to account for their performance.

Establishment of GP consortia

2.10 The intention is to put GP commissioning on a statutory basis, with powers and responsibilities set out through primary and secondary legislation.

2.11 Every GP practice will be a member of a consortium, as a corollary of holding a list of registered patients. Within the new legislative framework, practices will have flexibility to form consortia in ways that they think will secure the best healthcare and health outcomes for their patients and locality. The NHS Commissioning Board will have a duty to ensure comprehensive coverage of GP consortia, and we envisage a reserve power for the Board to assign practices to consortia if necessary.

2.12 Consortia will be formed on a bottom-up basis, but will need to have sufficient geographic focus to be able to agree and monitor contracts for locality-based services (such as urgent and emergency care), to have responsibility for commissioning services for people who are not registered with a GP practice, to commission services jointly with local authorities, and to fulfil effectively their duties in areas such as safeguarding of children. The consortia will also need to be of sufficient size to manage financial risk effectively, notwithstanding their ability to work with other consortia to manage financial risk.

Freedoms and accountabilities

2.13 We envisage that consortia will receive a maximum management allowance to reflect the costs associated with commissioning. 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.

2.14 Consortia will have the freedom to use resources in ways that achieve the best and most cost-efficient outcomes for patients. At the same time, 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 Department will discuss with the NHS the safeguards that will be needed to ensure these objectives, particularly with regard to consortia commissioning services from general practice (over and above the primary care services that they already have a duty to provide).

2.15 The NHS Commissioning Board will be responsible for holding consortia to account for the outcomes they achieve, for stewardship of NHS resources and for fulfilling duties such as public and patient involvement and partnership with local authorities. In turn, each consortium will develop its own arrangements to hold its constituent practices to account.

2.16 We propose that the NHS Commissioning Board, supported by NICE, will 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, and their management of NHS resources. The framework would also seek to capture progress in reducing health inequalities.

2.17 We propose, 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.

2.18 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. We propose working with the NHS to develop criteria or triggers for intervention.

Partnership

2.19 Consortia will need to work closely with the patients and local communities they serve, including through Local Involvement Networks (which will become local HealthWatch bodies) and patient participation groups, and with community partners.

2.20 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, including combined action on health improvement, more integrated delivery of adult health and social care, early years' services and safeguarding of children and vulnerable adults.

2.21 We will work with the NHS and the health and care professions to promote multi-professional involvement in commissioning.

Implementation

2.22 Our proposed implementation timetable is:

In 2010/11

- GP consortia to 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 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

In 2013/14

- GP consortia to be fully operational, with real budgets and holding contracts with providers.

3. Responsibilities

Scope of GP commissioning

3.1 The principle underpinning the scope of GP commissioning will be that commissioning responsibilities – and accompanying NHS resources – should be devolved as close to the patient as possible.

3.2 We intend that consortia will, therefore, be statutorily responsible for commissioning the great majority of NHS services, including elective hospital care and rehabilitative care, urgent and emergency care (including out-of-hours services), most community health services and mental health and learning disability services. Consortia will be responsible for meeting prescribing and associated costs. It will be for consortia to decide on a case-by-case basis whether to commission services themselves, or to make appropriate arrangements with another commissioning organisation (for instance a lead consortium).

3.3 There will, however, be some exceptions, where it makes sense for the NHS Commissioning Board to have responsibility – and the accompanying share of the NHS budget – for commissioning services. The proposed exceptions are:

- **primary medical care**: the Board will be responsible for holding contracts with individual GP practices in their role as providers of primary medical care, although we envisage a key role for consortia in driving up quality of general practice (see paras 3.14-3.22 below)

- **other family health services**: the Board will commission primary dental services, community pharmacy (and other dispensing services) and primary ophthalmic services. Consortia will, however, be able to commission services from primary care contractors, for instance if they wish to commission optometrists to help manage glaucoma

- **national and regional specialised commissioning**: the Board will have responsibility for commissioning certain highly specialised services, i.e. those covered by the Specialised Services National Definitions Set such as heart transplants, spinal injuries, burns and renal dialysis, which the Board will commission at the appropriate level. 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 of specialised commissioning. The Board will need to facilitate strong engagement of consortia in these arrangements and ensure a smooth interface between GP commissioners and specialised services

- **maternity services**: we propose that the Board plays the lead role in commissioning maternity and newborn care services, with a view to promoting choice across a range of settings and services

- **health services for those in prison or custody**: we propose that the Board works with criminal justice agencies and GP consortia to determine the most appropriate arrangements for prison health services.

3.4 There may of course 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. We propose that consortia, in accordance with their duties of partnership and engagement, should have the freedom and the responsibility to decide for themselves at what level (for instance through a lead consortium) these services are best commissioned.

Questions

- 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?

- How can the NHS Commissioning Board and GP consortia best work together to ensure effective commissioning of low volume services?

- Are there any services currently commissioned as regional specialised services that could potentially be commissioned in the future by GP consortia?

- 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?

Duties and responsibilities of GP consortia

3.5 The NHS Commissioning Board will calculate practice-level budgets and allocate these budgets directly to consortia. These budgets will need to reflect an appropriate share of healthcare resources to include both people registered with practices in the consortium and local residents who are not registered with any GP practice.

3.6 Consortia will be responsible for managing their combined budget and for deciding how best to use these resources to meet the healthcare needs of the patients for whom they are responsible. Just as PCTs are currently the responsible commissioner for people registered with a GP practice in their area (even if they live elsewhere), the consortium will be the responsible commissioner for any patients registered with its constituent practices. Cross-border arrangements with Scotland and Wales will be unaffected.

3.7 In addition to their responsibilities for registered patients, consortia will be responsible for ensuring the provision of comprehensive emergency services for any person in their area.

3.8 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
- providing oversight, with the NHS Commissioning Board, of healthcare providers' training and education plans.

3.9 The legislation will also set out a consortium's duties in relationship to financial management, including:

- ensuring that expenditure does not exceed its allocated resources
- requirements in relation to reporting, audit and accounts.

3.10 Consortia will have duties in relation to equality and human rights and in relation to data protection and freedom of information.

3.11 Consortia will have duties to work in partnership with local authorities, for instance in relation to health and adult social care, early years services, public health, safeguarding, services for carers, and to cooperate with local authorities and other agencies in relation to criminal justice.

3.12 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. Where this is likely to result in changes in the configuration of services, consortia will be expected to report on the likely impact of those changes and the impact of public involvement on their commissioning decisions.

3.13 Section 5 of this document sets out proposals for how consortia are held to account for how they carry out their responsibilities and duties.

Relationship between consortia and individual GP practices

3.14 The duties and responsibilities set out above will apply to the consortium. In turn, each consortium will develop its own arrangements to hold its constituent practices to account.

3.15 We 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 member of a consortium and supporting the consortium in ensuring efficient and effective use of NHS resources.

3.16 With the exception of a management allowance (see para 5.2 below), the consortium's commissioning budget will be used exclusively for commissioning of patient care. It will be distinct from the income that GP practices earn under their primary medical care contract, from which they both meet their practice expenses and derive their personal income. However, health outcomes for patients will of course depend both on the quality of the services that GP practices provide and on the quality of GP commissioning. We therefore propose (as set out in para 5.17 below) 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.

3.17 We also propose to work with the BMA and the profession to reform the Quality and Outcomes Framework (QOF) so that it better reflects individual practices' contribution to health outcomes. The QOF made an initial

contribution to improving patient care when introduced in 2004, but it is now failing to deliver any significant degree of continuous quality improvement for patients. A large number of QOF indicators reward GP practices for the processes they carry out, such as keeping registers of patients with long-term conditions or measuring blood pressure, and reflect standards of care that one would routinely expect from any GP practice. We want the QOF to focus more on the health outcomes that are achieved for patients and to provide incentives for continuous improvements in quality of care.

3.18 By the same token, the performance of consortia as commissioners will be closely bound up with the quality of services provided by their constituent practices. The effective identification and management of long-term conditions, the accessibility and responsiveness of GP services, and decisions on referrals and prescribing all have a major impact both on the overall quality of patient care and on the efficient use of NHS resources. We therefore propose that 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.

3.19 Whilst care will be needed to protect against conflicts of interest, the NHS Commissioning Board should have the power, where it judges it appropriate, to ask consortia to carry out on its behalf some aspects of the work involved in managing primary medical services contracts, for instance by promoting quality improvement, reviewing 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, for instance in relation to prescribing or the systems in place to support management of long-term conditions. The Board would retain overall responsibility for commissioning and contractual decisions.

3.20 The role of GP consortia in helping promote quality and review practice performance will also help ensure that action to ensure good financial management sits alongside and complements GPs' clinical responsibilities to patients and their role in supporting patient choice. This means promoting innovations that improve both quality and productivity, whilst challenging any behaviours that are inappropriate both for good clinical care and for efficient use of NHS resources.

3.21 The Government intends to work with the profession to move over time towards 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 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.

3.22 A consortium may need to arrange for some of its GP practices to provide primary care services over and above those that they already have a duty to provide, subject to safeguards (discussed in section 5) to ensure fairness, transparency and competition. We will take forward further work to identify the most suitable contractual framework for services of this kind.

Questions

- How can GP consortia most effectively take responsibility for improving the quality of the primary care provided by their constituent practices?
- 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?
- What safeguards are likely to be most effective in ensuring transparency and fairness in commissioning services from primary care and in promoting patient choice?

The role of the NHS Commissioning Board

3.23 To provide overall leadership on commissioning, we will create a NHS Commissioning Board with an appropriate infrastructure. The Board will be an independent statutory authority with a Chair, Chief Executive and both executive and non-executive board members and will be free to determine its own organisational shape, structure and ways of working. It will carry out some functions currently performed by the Department of Health, SHAs and PCTs, as set out below, but will be a lean organisation, performing those functions in a more streamlined way.

3.24 The NHS Commissioning Board will be accountable to the Secretary of State for managing the overall commissioning revenue limit and for delivering improvements against a number of measures of health outcomes. It will be responsible for reporting the consolidated financial position of consortia as part of its financial reporting obligations.

3.25 The Secretary of State will set the NHS Commissioning Board an annual mandate, based on a multi-year planning cycle, which will be subject to public

consultation and Parliamentary scrutiny. This will cover the totality of what the Government expects from the Board on behalf of the taxpayer, including progress against outcomes specified by the Secretary of State in the NHS Outcomes Framework, delivering improvements in choice and patient involvement and tackling inequalities in outcomes of healthcare. The Board will in turn hold consortia to account for their performance. The new system will be set out in primary and secondary legislation.

3.26 *Liberating the NHS* sets out five broad functions for the NHS Commissioning Board:

i) providing national leadership on commissioning for quality improvement

3.27 The NHS Commissioning Board will provide a framework to support GP consortia in commissioning services, including:

- setting commissioning guidelines on the basis of clinically approved quality standards developed with advice from NICE, in a way that promotes joint working across health, public health and social care. These will be used as the basis for developing the NHS Outcomes Framework into a more comprehensive set of indicators and making available accessible information on commissioner performance

- designing model NHS contracts for consortia to adapt and use with providers and setting standards for the quality of NHS commissioning and procurement

- designing the structure of tariff and other financial incentives whilst the economic regulator will set tariff levels

- having a role in determining technical and data standards to ensure there is consistency in the information that commissioners and providers are using, and compatibility between information systems

- where appropriate and by agreement with consortia, hosting some commissioning networks, for example for cancer, targeted health services for ill and disabled children, and coronary heart disease.

ii) promoting and extending public and patient involvement and choice

3.28 As well as involving patient and professional representative bodies in carrying out its work, the NHS Commissioning Board will take the lead in promoting and extending public and patient involvement and choice in the NHS by:

- championing effective patient and public involvement and engagement in commissioning decisions, and greater involvement of patients and carers in

decision-making and managing their own care, 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, in order to provide clarity for patients and providers alike

- 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

- commissioning information requirements for choice and for accountability, including patient-reported experience and outcome measures.

iii) ensuring the development of GP consortia and holding them to account

3.29 The NHS Commissioning Board will:

- support and develop the establishment and maintenance of an effective and comprehensive system of GP consortia; and

- hold consortia to account for delivering outcomes and financial performance.

iv) commissioning certain services that are not commissioned by consortia

3.30 The NHS Commissioning Board will have statutory responsibility for commissioning some services that it would be less appropriate for consortia to commission. These will include primary medical care, other family health services, maternity services, prison health services, and national and regional specialised services.

v) allocating and accounting for NHS resources

3.31 The NHS Commissioning Board will calculate practice-level budgets and allocate these budgets directly to consortia. The Board will allocate resources on the basis of seeking to secure equivalent access to NHS services for all, relative to the prospective burden of disease.

3.32 The Board will have overall responsibility for financial stability of commissioners and for accounting to the Secretary of State for NHS commissioning expenditure, underpinned by robust financial management measures at consortium level.

3.33 The Board will have limited powers, to be set out in legislation, to intervene where for example a consortium is failing to fulfil its statutory duties or there is a significant risk that a consortium will fail to do so.

Questions

- 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 supports local commissioning?
- Are there other activities that could be undertaken by the NHS Commissioning Board to support efficient and effective local commissioning?

4. Establishment of GP consortia

Organisational form

4.1 We intend that 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 officer potentially discharging this role for more than one consortium).

4.2 We believe that consortia should be held to account for the outcomes they achieve and for their fulfilment of appropriate duties, rather than for the way in which they constitute themselves. We do not intend to set out detailed or prescriptive requirements in relation to the internal governance of a consortium, beyond essential requirements for example in relation to areas such as financial probity and accountability (e.g. statutory accounting as determined by the NHS Commissioning Board), reporting (e.g. to publish a commissioning plan and report on expenditure) and audit.

Questions

- What features should be considered essential for the governance of GP consortia?

Forming consortia

4.3 We intend, subject to discussion with the BMA and the wider profession, that every practice, i.e. every holder of a primary medical care contract (whether it be a GP partnership, nurse-led partnership, voluntary organisation, social enterprise or independent sector organisation), should be required to be a member of a consortium, as a corollary of holding a list of registered patients.

4.4 Consortia will need to have sufficient geographic focus to be able to agree and monitor contracts for locality-based services (such as urgent care), to have responsibility for commissioning services for people who are not registered with a practice, to commission services jointly with local authorities, and to fulfil effectively their duties in areas such as safeguarding. For these purposes, they will need to have boundaries that interlock so that taken together they cover the entire country.

4.5 We do not, however, propose to issue a Whitehall blueprint for the geography of consortia. We believe that GP practices should have the flexibility within the legislative framework, subject to having the geographic focus described above, to form consortia in ways that they think will secure the best healthcare and health outcomes for their patients and locality. This might include preserving groupings used for practice-based commissioning, where they have been successful. The NHS Commissioning Board will have a duty to ensure comprehensive coverage of GP consortia across the country. We envisage a reserve power for the Board to assign practices to consortia, if necessary, but only as a last resort.

4.6 Nor do we wish to be unduly prescriptive about the size of consortia. There have been widespread variations in the size and population coverage of PCTs, and there is no evidence to suggest a single 'right' size. The NHS Commissioning Board will nonetheless need to satisfy itself that consortia are of sufficient size to manage financial risk and allow for accurate allocations.

4.7 We would encourage consortia to begin to form on a shadow basis in 2010/11 (building on practice-based commissioning consortia, where they wish), and, where they are ready to do so, begin to take on some responsibilities from PCTs, in line with the vision set out in this document.

Questions

- How far should GP consortia have flexibility to include some practices that are not part of a geographically discrete area?
- Should there be a minimum and/or maximum population size for GP consortia?

Authorisation

4.8 We propose that the NHS Commissioning Board will have the duty and powers to authorise consortia, once it is satisfied that they have the necessary arrangements and capacity to fulfil their statutory duties and accountabilities and that there is clarity about the geographical area that they cover for the purposes set out above. There will need to be a rigorous process to ensure that consortia are able to fulfil duties in relation to financial accountability and control. 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.

4.9 There will also 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 consortia.

5. Freedoms, controls and accountabilities

Freedoms

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

5.2 We propose that commissioning budgets will include a maximum allowance to cover management costs. Consortia will be free to decide how best to use this management allowance to carry out commissioning activities. Consortia are likely to carry out a number of commissioning activities themselves. In other cases, they may choose to act collectively, for instance by adopting a lead commissioner model to negotiate and monitor contacts with large hospital trusts or with urgent care providers. They may also choose to buy in support from external organisations, including local authorities and private and voluntary sector bodies. This could include, for instance, analytical activity to profile and stratify healthcare needs, procurement of services, and contract monitoring.

5.3 Consortia will also have the freedom to arrange for some commissioning activities to be undertaken at a sub-consortium or practice level, where that is appropriate and where the necessary internal controls are in place.

5.4 These freedoms are intended to 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, alongside their core duties of care for patients.

5.5 In the transition to consortia taking on statutory commissioning responsibilities, we envisage that PCTs will provide many of these functions in support of shadow consortia, alongside the many organisations that already exist to provide commissioning support. We envisage that over time a more competitive market will develop for supplying some of these services.

Questions

- How can GP consortia best be supported in developing their own capacity and capability in commissioning?
- What support will GP consortia need to access and evaluate external providers of commissioning support?

Managing financial risk

5.6 Consortia will need to have sufficient freedoms to invest resources in ways that achieve the best and most cost-efficient outcomes for patients.

5.7 At the same time, consortia will need to manage resources in ways that control financial risk and enable them to meet their responsibility for breaking even on their commissioning budget. A key issue will be managing volume risk in the new system. There are two broad categories of risk in the system:

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

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

5.9 We envisage that the NHS Commissioning Board will have a significant role in managing financial risk, for example through oversight of risk pooling within and between consortia. Consortia should have a level of flexibility in deciding how best to manage financial risk within the overall regime set by the NHS Commissioning Board to encourage good financial management. The principles for managing underspends and overspends, including whether any planned and managed underspends may be carried over to future years to invest in services and whether any actual overspends 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 direct 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
- ensuring sufficient incentives and disciplines to manage financial risk properly, and service risk in particular, at the local consortium level.

5.10 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 (see para 5.17). The NHS Commissioning Board will have intervention powers in the event of poor financial management (see paras 5.18-5.21).

Questions

- Are these the right criteria for an effective system of financial risk management? What support will GP consortia need to help them manage risk?

Transparency and fairness in investment decisions

5.11 It is essential that consortia have the freedom to make commissioning decisions that they judge will achieve the best outcomes within the financial resources available to them. At the same time, the economic regulator and NHS Commissioning Board will need to develop and maintain a framework that ensures transparency, fairness and patient choice. We propose that, wherever possible, services should be commissioned that enable patients to choose from any willing provider.

5.12 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 able to provide services in their own right. It is essential, however, that individual practices or groups of practices have the opportunity to provide new services (over and above the primary care services that they already have a duty to provide), where this will provide best value in terms of quality and cost. This will not happen if the muddled and over-bureaucratised approach that has too often characterised

'practice-based commissioning' is allowed to continue. Further work will be taken forward with the NHS to develop a framework that allows commissioning of new services whilst guarding against real or perceived conflicts of interest.

5.13 This will require transparency over how commissioning decisions are made and the value of services commissioned from GP practices. 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 from GP practices that are also themselves a provider or part of a provider consortium. We would also anticipate that, 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.

Questions

- What safeguards are likely to be most effective in demonstrating transparency and fairness in investment decisions and in promoting choice and competition?

Accountability to patients and the public

5.14 The NHS Commissioning Board will be responsible for developing an assurance process that enables consortia to be accountable for the outcomes they achieve, their stewardship of public resources, and their fulfilment of the duties placed upon them, for instance in relation to promoting equality and working in partnership.

5.15 We propose that the NHS Commissioning Board, supported by NICE and working with patient and professional groups, will develop a commissioning outcomes framework that measures the health outcomes and quality of care (including patient-reported outcome measures and patient experience) achieved by consortia, with an appropriate adjustment for patient mix. This would, for instance, assess the health outcomes achieved for people with long-term conditions, the quality of urgent care and acute hospital care, and health outcomes for people with long-term mental health conditions or a learning disability. It would include measures to reflect the consortium's duties to promote equality and to assess progress in reducing health inequalities.

5.16 This framework would allow the NHS Commissioning Board to identify the contribution of consortia to achieving the priorities for health improvement in

the NHS Outcomes Framework, against which the Secretary of State will hold the Board to account, whilst also being accountable to patients and local communities on a wider set of measures. It would also enable consortia to benchmark their performance and identify priorities for improvement.

5.17 GP practices already make a key contribution to the overall quality of patient care and to the effective use of NHS resources. Coming together in consortia to commission healthcare on behalf of patients will empower them to collaborate more effectively in pursuit of high-quality outcomes for patients. We therefore propose, 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 consortia and the effectiveness with which they manage financial resources. We propose that this 'quality premium' should be paid in the first instance to the consortium and that the consortium would be free to decide how best to apportion it between its member practices. This premium would need to be funded from within existing resources.

Questions

- What are the key elements that you would expect to see reflected in a commissioning outcomes framework?
- Should some part of GP practice income be linked to the outcomes that the practice achieves as part of its wider commissioning consortium?
- What arrangements will best ensure that GP consortia operate in ways that are consistent with promoting equality and reducing avoidable inequalities in health?

Accountability for the use of public resources

5.18 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, for instance in the event of financial failure or a systemic failure to meet the healthcare needs of patients, or where there is a significant risk of failure. This could include powers for the Board 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. a neighbouring consortium).

5.19 We propose working with the profession and the NHS to develop criteria or triggers for intervention, which could be reflected in the consortium's terms of authorisation, and to consult on these at a later date. We envisage that any intervention would typically be a staged process so that, wherever possible, a consortium has the opportunity to take remedial action itself rather than have commissioning responsibilities withdrawn. Any process would need to be in accordance with a transparent statutory framework of rules.

5.20 We consider that GP practices, like any other provider of NHS services, have a responsibility to use public resources responsibly and in the public interest. We anticipate that enabling GP practices to work alongside other health and care professionals through commissioning consortia will enhance their ability to fulfil this responsibility.

5.21 In any circumstances where there are concerns that an individual practice is causing ineffective or wasteful use of NHS resources, the consortium of which it is a part 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.

6. Partnership

Patients and the public

6.1 One of the principal aims of GP commissioning is to make decisions more sensitive and responsive to the needs and wishes of patients and the public. Good communication and engagement with the public will, therefore, be vital. Both GP consortia and the NHS Commissioning Board will need to find and evolve efficient and effective ways of harnessing public voice so that commissioning decisions are increasingly shaped by people's expressed needs and wants.

6.2 As part of the development of GP commissioning and the NHS Commissioning Board, we will promote:

- patient, carer and public involvement in decision-making
- responsiveness to the views and feedback of patients, carers and the public
- accountability to local people for the decisions about their health services made by consortia on their behalf.

6.3 We are not starting with a clean sheet. Commissioners will need to establish and nurture new relationships with:

- local HealthWatch (currently Local Involvement Networks) and the national body HealthWatch England, the new independent consumer champion that we propose to establish as part of the Care Quality Commission
- the Patient Participation Groups that GP practices are increasingly using to help make their own services more responsive to patient wishes
- local authorities, who will have a new enhanced role in promoting public involvement in decisions about service priorities and changes to local services and in responding to any public concerns about inadequate involvement
- local voluntary organisations and community groups, who often work with, and represent, the most disadvantaged and marginalised patients and carers.

6.4 The NHS Commissioning Board will be expected to ensure that practices provide accessible information to the public on the range of services they provide and that GP consortia provide information on performance against their commissioning plans.

6.5 We want to ensure that the prime focus is on developing the behaviours and cultures that will encourage and facilitate public participation and patient voice, rather than being over-reliant on the legal framework.

Questions

- How can GP consortia and the NHS Commissioning Board best involve patients in making commissioning decisions that are built on patient insight?
- 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?
- How can we build on and strengthen existing systems of engagement such as Local HealthWatch and GP practices' Patient Participation Groups?
- What action needs to be taken to ensure that no-one is disadvantaged by the proposals, and how do you think they can promote equality of opportunity and outcome for all patients and, where appropriate, staff?

Local government and public health

6.6 Under the proposals set out in the parallel document *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, public health and other services. One way in which this could occur is through health and wellbeing boards which would include representatives from GP consortia and, where relevant issues are being discussed, representation from the NHS Commissioning Board.

6.7 Local government will also 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, through areas such as reducing the incidence of smoking and alcohol misuse and promoting physical activity.

6.8 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, and relevant joint commissioning plans, reflect the health needs identified in these assessments
- draw on the advice and 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, for instance through pooled budgets or lead commissioning arrangements (e.g. a local authority becoming the lead commissioner for some older people services)
- support improvements in children's health and wellbeing
- play a systematic and effective part in arrangements for safeguarding of children and protection of vulnerable adults
- cooperate with the criminal justice system, for instance in relation to tackling misuse of drugs and alcohol, offender health services and assessment of violent offenders.

6.9 We envisage that bringing GP practices together into consortia for commissioning purposes will also help provide a more effective conduit for the involvement of individual practices in these areas of partnership working.

6.10 Where there are currently Care Trusts that bring together responsibility for commissioning health and social care services, their healthcare responsibilities will need to transfer to GP consortia in line with the proposals set out in this document. The framework described above is designed to enable GP consortia to work with local government to ensure that the benefits achieved through Care Trusts can be sustained and built upon.

Questions

- 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?
- 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 the new arrangements?

Other health and care professionals

6.11 Given their key role in co-ordinating care, GP practices are well placed to lead on commissioning care for patients. However, we expect consortia to involve 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, better patient experience and more efficient use of NHS resources.

6.12 Some of the most successful current examples of clinical commissioning have come when practice-based commissioning groups have engaged other health and care professionals in this way. This has often been driven by innovative use of data and information to throw a spotlight on the pattern of care received by patients with long-term conditions, particularly those with complex health problems. These types of analysis can show clinicians how the current system too often leads both to sub-optimal patient care and to inefficiency at the interfaces between primary care, community health services and specialist care. In time, we would expect to see this approach apply across the whole pathway, including health and social care.

6.13 We firmly believe that the GP practice and the registered patient list should form the essential building block of commissioning consortia, but successful commissioning will clearly also be dependent on the wider involvement of other health and care professionals. We will not fall into the trap of prescribing top-down processes or governance requirements to say how this should be achieved. We will, however, work with the NHS and professional bodies in the transition to the new arrangements to promote multi-professional involvement.

Questions

- How can multi-professional involvement in commissioning most effectively be promoted and sustained?

7. Implementation and next steps

7.1 PCTs will have an important task over the next two years in supporting GP practices to prepare for these new arrangements. Our indicative timetable is for:

2010/11

- GP consortia to 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 responsibilities from PCTs, supported by indicative budgets

2011/12

- a comprehensive system of shadow GP consortia in place, taking on increased responsibility from PCTs, including increased responsibility for the leadership of the existing Quality, Innovation, Productivity and Prevention (QIPP) initiative
- the NHS Commissioning Board to be 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 to be 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

Preparing for GP commissioning

7.2 There will be a number of practical next steps that PCTs will need to take with GP practices and existing practice-based commissioning groups during 2010/11, which we will discuss with the NHS and with the profession. This will include identifying the likely future shape of consortia and enabling them to start taking increasing responsibility for making commissioning decisions on behalf of 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.

7.3 PCTs will also need to work alongside shadow consortia to forge relationships with patient and public groups and with the range of external partners identified in Section 6 of this document.

7.4 In addition to these practical steps, we think there will be a number of areas where it is essential that early progress is made in preparing for the challenge of future commissioning arrangements. These include:

- **clinical leadership**: we will work with the National Leadership Council and professional representative groups to explore how best to provide support and development for GPs and other clinicians who would like to take on leadership roles within commissioning consortia

- **information**: we will work with the profession and the wider NHS to identify how best to support consortia in the significant challenge of accessing accurate, real-time data that can be translated into information to support efficient and effective care along the patient pathway and to understand the relationship between patient needs, service provision, health outcomes and financial expenditure

- **financial transactions**: we 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.

Engagement

7.5 Through *Liberating the NHS* and this document, we are setting out further detail on our plans for GP commissioning and the NHS Commissioning Board. We are inviting individuals and groups to engage with the policy design and are specifically asking for views on its implementation.

7.6 This engagement will be aligned with, and conducted in, close collaboration with the engagement activities for the broader White Paper to achieve a joined up and consistent approach.

7.7 Through this engagement, we will seek to build understanding, increase support, invite views, and prepare for the forthcoming changes in commissioning. Successful and effective engagement is an ongoing, two-way process and we will be using existing channels to take this forward.

7.8 Responses to the questions in this document should be sent to NHSWhitePaper@dh.gsi.gov.uk by 11 October.

Conclusion

7.9 Commissioning NHS services carries with it the responsibility to deploy public resources in ways that best improve health and healthcare for the public and local communities.

7.10 In future, people will have the confidence of knowing that their GP is not only their advocate in the healthcare system but part of a wider group of health and care professionals – a commissioning consortium – whose job it is to ensure that empowered patients have access to the right care, in the right place, at the right time.

7.11 The public will have the confidence that these commissioning decisions are being made within an overall framework that enshrines the principles and values of the National Health Service and promotes consistently high standards of quality.

7.12 Local communities will have the confidence that their locally elected representatives have the overarching responsibility for promoting joined-up health and social care services that are responsive to local patient and community voice.

7.13 We look forward to your active engagement in helping shape these new commissioning arrangements and helping deliver the maximum benefits for NHS patients.

Annex

Criteria for consultation

This consultation follows the 'Government Code of Practice'. In particular we aim to:

- formally consult at a stage where there is scope to influence the policy outcome;
- consult for at least 12 weeks - the policies in this document were included in the NHS White Paper, *Liberating the NHS*, which was launched on 12 July for a 12 week consultation period closing on 5 October;
- be clear about the consultations process in the consultation documents, what is being proposed, the scope to influence and the expected costs and benefits of the proposals;
- ensure the consultation exercise is designed to be accessible to, and clearly targeted at, those people it is intended to reach;
- keep the burden of consultation to a minimum to ensure consultations are effective and to obtain consultees' 'buy-in' to the process;
- analyse responses carefully and give clear feedback to participants following the consultation;
- ensure officials running consultations are guided in how to run an effective consultation exercise and share what they learn from the experience.

The full text of the Code of Practice and related guidance is on the Better Regulation website at www.bis.gov.uk/policies/better-regulation/consultation-guidance

Comments on the consultation process itself

If you have concerns or comments which you would like to make relating specifically to the consultation process itself please contact:

Consultations Coordinator

Department of Health

3E48, Quarry House

Leeds

LS2 7UE

e-mail: consultations.co-ordinator@dh.gsi.gov.uk

Please do not send consultation responses to this address.

Confidentiality of information

We manage the information you provide in response to this consultation in accordance with the Department of Health's Information Charter (available at www.dh.gov.uk).

Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

The Department will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.

Summary of the consultation

A response to this consultation will be made available on the Department of Health website by the end of this year.