

# GPC guide to the NHS White Paper

GP consortia commissioning:  
initial observations

September 2010

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## Introduction

**All GPs are involved in commissioning. Every time a GP sees a patient, they decide whether to prescribe medication, refer them to another part of the NHS or admit them to hospital. These decisions are based on the GP's training, experience and knowledge of hospitals, services and secondary care clinicians, and all of these elements are considered in consultation with the patient.**

In determining what the patient needs, GPs direct how NHS resources are to be spent, what care pathway a patient will take, which drugs they will use and which services they will access. GPs have always been the coordinator of NHS care, and they should also be seen as an intrinsic part of the commissioning machinery within the NHS. It is important to everyone, patients and clinicians alike, that the right services are commissioned for the NHS and at a price that the NHS can afford.

The Department of Health published in July 2010 the NHS White Paper for England, '*Equality and excellence: Liberating the NHS*'<sup>1</sup> and a supporting consultation '*Liberating the NHS: commissioning for patients*'.<sup>2</sup> These stated that:

*"The Government will devolve power and responsibility for commissioning services to the healthcare professionals closest to patients: GPs and their practice teams working in consortia."*

This GPC paper is not a response to the proposals contained within the White Paper. Rather, it is a set of principles and practical observations that GPs and LMCs should consider when beginning to explore how these ideas will be put into practice. There is little detail in many of the White Paper proposals and their development remains fluid. As such, it is likely that this document will be superseded in the near future once more information is available. The BMA is responding specifically to all of the White Paper consultations, and these responses will be published in due course. The GPC will provide all GPs and LMCs with regular updates; these will be available on the BMA's White Paper hub page along with the consultation responses once they are available:

[http://www.bma.org.uk/healthcare\\_policy/nhs\\_white\\_paper/index.jsp](http://www.bma.org.uk/healthcare_policy/nhs_white_paper/index.jsp)

### ***Effective commissioning is effective general practice***

Effective commissioning will improve the care that patients receive through general practice. The work of a GP is to manage their patients. Where a GP has a full range of efficient and effective services available to them, then their working life becomes less complex and more rewarding and their patients have better outcomes. But if services are not available or they are ineffective and inefficient then their working life becomes more difficult and time-consuming and patient outcomes are not as good. The majority of GPs have at some point experienced the frustration of chasing

out-patient letters, discharge summaries or X-ray results, wished their district nursing services were better integrated within the practice or been forced to prescribe medication for depression when cognitive behavioural therapy services would have been more appropriate but were not available.

Clinically-led commissioning, as outlined in the White Paper, will provide GPs with the opportunity to redevelop services and remove these frustrations, so that the patient journey is more streamlined. This will allow GPs to spend more time focussing on patient care, rather than tackling the bureaucracy around the management of that care. Effective commissioning may involve the movement of services and resources into primary care, and thus enable GPs to provide a wider range of services to patients if they so choose. Efficient GP-led commissioning may also release resources back into the NHS to be reinvested in new patient services.

Effective, cost-efficient, health services and care pathways are vital for patients, and essential for the long term sustainability of a National Health Service that is free to all at the point of delivery. All GPs, as clinical decision makers, have an important role to play in this. Consequently, the commissioning proposals set out in the White Paper will affect **all** GPs. The change will be challenging, and it is important that all GPs are fully aware of them and understand them. However, good commissioning will make the most of general practice.

## How commissioning can be made to work

LMCs should read this document alongside the GPC guidance note *'The role of LMCs in supporting the development of GP consortia'*<sup>3</sup> to ensure that LMCs are a key part of local discussions regarding the White Paper proposals.

### ***The formation of commissioning consortia***

The success of GP-led commissioning will be based upon the effective operation of GP-led commissioning consortia. In theory, these will shadow PCTs until they are formally established in 2012/13, although some may become operational sooner if PCTs disband earlier than expected. Nonetheless, until new legislation has been passed by Parliament and regulations have been published following negotiation with the GPC, there will be no legal change in statutory function or responsibility.

It is essential that the formation, governance and management of consortia is appropriate for the responsibilities they are to be granted. Under the proposals, every holder of a primary medical services contract with a registered list of patients will be required to be a member of a commissioning consortium. To operate effectively and to provide



individual members of a consortium with a stake in the decision making process, each consortium must have a formal mandate from its members. It is also important that the board of the consortium and the consortium leadership has the respect of its members – it would be inappropriate for early adopters (such as existing PBC leads) to declare themselves the consortium leaders for an area without proper reference to the practices in the area. Nor would it be appropriate for a PCT or SHA to select a consortium leadership team.

Before a consortium can agree a mandate for its leaders, it will be necessary to determine the extent of the consortium so that all practices within its boundaries have an opportunity to express their preferences. As such, it would be improper for a small group of practices to establish a consortium and then seek to add further practices without offering them a say in the leadership and management of that consortium.

It is unlikely that the Department of Health will provide specific guidance on the formation of consortia, or interim shadow consortia.

*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.<sup>4</sup>*

However, loose details of the statutory responsibilities that consortia are to undertake have been made available. Consortia will be able to decide locally how they are formed, but the GPC advises that this process is flexible, to account for the interim nature of the shadow consortia and the paucity of information regarding their responsibilities.

The leaders of the commissioning consortium must not only have good leadership skills and be competent managers who genuinely understand the needs of local patients, with well-developed commissioning capabilities, but also have the respect of, and a mandate from, the consortium members. We suggest that to achieve this, the practices within an agreed consortium area could elect a 'board of appointment'. The board would need to have a definite mandate from all the GPs within the consortium and would be empowered to recruit and appoint the key executive positions within the consortium (such as the accountable officer and chief financial officer, etc.) by assessing the abilities of potential candidates against required competencies. There would need to be an external scrutiny mechanism to ensure the probity of this process: it may be appropriate for LMCs to perform this role in some areas. This process would avoid the difficulty of having popular elected leaders who were incompetent, or appointed leaders with no mandate from the practices within the consortium. Whilst recruiting, the board of appointment should consider whether they would want to see the consortium leaders retain their practical experience of general practice, and thus offer positions that allowed the post-holders to continue to work in their practice for a session or two each week. Where all consortia are in agreement, it may be possible for a chief financial officer to perform the same role for a number of consortia.

It is likely that some groups of practices will be ready to begin this process and develop shadow consortia with appropriate appointment and governance mechanisms before others. The success of these proposals relies on all practices being able to form consortia successfully. The GPC would therefore expect to see early adopters sharing their experiences of forming a consortium with their colleagues and LMCs.

### ***Natural health communities – determining commissioning population size***

The Department of Health does not intend to be prescriptive about the size of GP commissioning consortia. However, getting the size of the commissioning population right will be essential for effective commissioning. There can be no one-size-fits-all approach. The focus of a commissioning consortium is to design effective care pathways which cross between GPs, local hospitals, local authorities and community services. The commissioning population therefore depends primarily on the natural clinical community of the local hospitals and local health economy. The population must also be sensitive to social communities – unusual urban boundaries and local transport problems can create groups of patients more likely to seek healthcare in an area other than that which they live. Dispersed rural populations must also be considered. The commissioning population must thus reflect the natural health community of the locality, both clinical and social. It would be inappropriate to dictate specific boundaries for the size of the population but it is likely that an individual community-facing consortium would serve a population in the range of 100,000 to 750,000 people, which reflects the size of most large cities in England. Local engagement and the application of a local understanding of the health community will be central elements in determining this variable.

All consortia should consider the benefits of working in partnership with their neighbouring groups, but where practices choose to form a consortium that is at the lower end of the suggested population range, they should consider joining with other consortia and either appoint a lead consortium for their federation, or develop a shared service agency that works on behalf of all members of the federation. It is unlikely that consortia with populations of less than 500,000 will find it easy to manage financial risk, while they may not have sufficient management resources to function effectively nor take advantage of the economies of scale necessary to ensure that commissioning is efficient. Moreover, larger consortia (or a lead consortium) will find it easier to engage in credible interaction with acute care trusts and local authorities and to attract high calibre medical and managerial leaders

The Department of Health expects to see comprehensive coverage of GP consortia across England. When forming a consortium around an agreed health community, the consortium should include all practices that are integral to that community. It would be inappropriate for a consortium to cherry-pick only those practices considered low referrers, for example, and equally unacceptable for a consortium to seek to exclude a practice that was a known high prescriber from being part of the grouping that encompassed their health community.



### ***The responsibilities and governance of consortia***

The coalition government has set out the broad responsibilities of commissioning consortia in the White Paper; however there are few specific details.

*“We intend that consortia will 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.”<sup>5</sup>*

Consortia will be able to decide whether they commission a service themselves by employing existing NHS managers or by engaging support from an external organisation, or alternatively by making arrangements for a neighbouring consortium or lead consortium to do this. Subject to the consultation process, consortia will be exempt from commissioning primary medical care services, other family health services, national and regional specialised services, maternity services and health services for those in custody.

As a commissioning consortium is being formed, consideration will need to be given to the governance and decision-making structures within the consortium. While the responsibilities of consortia remain ill-defined, these structures must be flexible so they can adapt to suit their commissioning role in due course. This role is likely to involve the determining of local health care needs and what services are required to meet those needs (which will require good public health advice and support), the entering into and management of contracts with providers and the monitoring and improvement of the care provided under those contracts. To do this, a consortium will require a governance structure that makes decisions in line with its responsibilities, aims and objectives, and on the basis of clear evidence and advice; that implements the decisions that are made; where the decision-making process is transparent; and that has internal controls to direct and account for the use of resources in implementing these decisions. Consortia will also need to consider the implications of managing their own staff. Beyond these local governance mechanisms, the new National Commissioning Board will hold all consortia to final account. The GPC has provided guidance in this area in the document *‘GPC guide to the White Paper – a legal overview of commissioning proposals’*.<sup>6</sup>

It is quite likely that some consortia, particularly smaller groups, will not wish (or not have the capability) to carry out all of these functions themselves. Instead, they may choose to subcontract some of the specific tasks such as strategic planning, contracting, HR, etc., to a lead consortium, or shared agency working on behalf of a federation of consortia. Nonetheless, where this is done, the responsibility for these functions, where they are tied to the responsibility to commission services for their registered list of patients, will ultimately fall to the original consortium.

### ***Funding for commissioning consortia***

Commissioning consortia will receive the full budget for all of the health care services which they are to commission. It is also likely that consortia will receive a management allowance that will be capped in reference to the size of the consortium. This will fund the actual process of commissioning: redesigning and procuring services, as well as key roles such as the accountable officer and chief financial officer. The actual amount allocated to consortia will be much less than that currently given to PCTs and this will reflect the understanding that consortia are to have fewer responsibilities than PCTs, as well as the coalition government's desire to reduce health care bureaucracy.

Consortia should be aware that while it is expected that they will shadow PCTs until 2012/13, it is not clear whether they will be given a management allowance during this period. Until the transition arrangements between consortia and PCTs have been determined, consortia should avoid making plans for the management of the consortium which they are unable to fund.

Consortia will have the freedom to decide how their management allowance is spent, and may choose to employ experienced NHS managers rather than buy in external commissioning support. The BMA continues to believe that it is generally in the best interests of the NHS if commissioning advice comes from those who work in the NHS, where this is possible. Where consortia wish to commission external providers to support them with their commissioning functions, this must be carefully considered and weighed against any benefit to the NHS in the short and long term, particularly the requirement to procure fairly. Consortia will also need to be able to manage the support they receive. Alternatively, some consortia may choose not to employ experienced commissioning staff and may instead find it easier to join with other consortia and allow a lead consortium or shared service agency to employ management staff.

With the replacement of PCTs by commissioning consortia, it is likely that there will be many capable and highly experienced former PCT managers whom consortia may wish to consider employing as part of their management staff. It is vital though that all consortia understand and follow employment legislation and the Transfer of Undertakings (Protection of Employment) Regulations (TUPE) where they apply. Information on the TUPE regulations is widely available, but specific advice for GPs and consortia on this area will follow in separate employment and HR guidance.





The White Paper proposes 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”<sup>7</sup>*

This will only be agreed in negotiation with the GPC and the profession. Such discussions have not taken place, and any consortia that are beginning to form should make no calculations based on these proposals.

### **Consortia commissioning budget setting**

Commissioning consortia must have commissioning budgets at their disposal that are appropriate for their commissioning population. This does not mean an immediate move to a ‘fair share’ budget. Historic NHS funding is entrenched in local health economies and any sudden move away from this would destabilise health systems that are vulnerable to small shifts in funding. Moreover, where ‘fair share’ budgets have been used in the past, many have failed to take account of the wide variety of factors that can cause prevalence variations across even a small number of practices within a defined area. The previous government had implicitly recognised these difficulties by slowing the move from historic indicative PBC budgets to ‘fair share’ indicative PBC budgets, which were supposed to more fairly reflect the health needs of a locality.<sup>8</sup> If ‘fair share’ budgets are to be used, there must be a gradual transition towards this approach and in full consultation with the profession.

Developing a commissioning budget that realistically reflects the existing and likely health needs of a local population and enables consortia to commission all of their patients’ care will be very difficult. Any budget formula must be highly sensitive, or else consortia could be held responsible for overspends which have more to do with an inadequate budget than ineffective commissioning. Accurate commissioning budgets will also require accurate and timely data and analysis: information on expenditure, referrals, prescribing and clinical performance across secondary and community care. It is widely acknowledged that the provision of such information to practice-based commissioners by PCTs has been poor in the past. Commissioning groups will only be able to commission effectively when the relevant information is to hand. It therefore likely that practices will be expected to provide detailed activity data to assist with this process.

Further to the commissioning budget allocation, there must be a risk pooling and insurance mechanism to ensure the stability and viability of these budgets against planned and unplanned debt. For example, unexpected major incidents may consume considerable healthcare resources and set a well-planned commissioning framework into financial turmoil. Similarly, it will need to be determined what budget areas GPs have no control over, such as funding for tertiary or continuing care, existing PCT debt, or PCT agreed contracts (such as PFI, ISTC or GP-led health centres) as it would be inappropriate for future consortia to be held to account for these.

There should be no expectation that an effective commissioning process will generate freed-up resources on a regular basis. Although services must be commissioned with reference to available NHS resources, patient demand can vary year-on-year and an expectation of any budget surplus is unrealistic. Where commissioning groups are able to release resources these should be reinvested into the NHS, for example in infrastructure to enable the provision of better services to patients. This should not be limited solely to investment in primary care – rather, a more integrated approach should be taken so that released resources are re-deployed where they will benefit patients most.

It would be prudent for commissioning budgets to be allocated for three-year periods, or longer. It is unlikely that such a model will be permitted, but if it were, this would smooth out annual variations in health care demand, while also removing the constant push to achieve savings or balance the budget over a single year. Successful commissioning is much more likely to become apparent over a number of years. In particular, where a consortium invests in service re-design in one year, that may cause a temporary overspend that only realises a saving at a later date. Strict in-year accounting also encourages spending towards the end of the year to ensure that a budget is fully utilised. Such perversities are wasteful of time and resources that could be better spent on patient care and must end. Whatever accounting period is eventually agreed, practices should be aware that the White Paper states that the Department of Health will not 'bail out' those consortia that fall into significant deficit.

It is imperative that there is a clear divide between the commissioning budget allocated to consortia, and the individual practice budgets held by GPs. Any change to this situation would be completely unacceptable.

### ***Ensuring commissioning probity – a service design/contracting split***

Many GPs already contend with and address conflicts of interest that arise from their existing dual role as providers and practice-based commissioners. There are established mechanisms and principles, set out by the Department of Health and General Medical Council (GMC), to ensure that conflicts of interest are declared at the appropriate points in time, and that the probity of clinicians is maintained. The GPC has previously produced detailed guidance on how these apply as part of PBC.<sup>9</sup> This will be updated once more details on the consortia commissioning process are available.

However, the new commissioning proposals mean that GPs will have the primary role in the commissioning and redesign of services and consequently the awarding and managing of provider contracts. All GPs have a responsibility not to abuse this new role. The commissioning process will require appropriate clinical and corporate governance structures to be in place and there must be a proper audit process of the commissioning decisions that are made. Clinicians involved in the commissioning process should declare a conflict of interest where appropriate, and remove themselves from the process if this is too great.



The GMC has produced guidance on probity and declaring a financial interest that may need to be revised to account for the changes in commissioning structures. Nonetheless, the key principles still apply. For example, Good Medical Practice, published in 2006, states that:

*"5. If you have a financial interest in an institution and are working under an NHS or employers' policy, you should satisfy yourself, or seek assurances from your employing or contracting body, that systems are in place to ensure transparency and to avoid, or minimise the effects of, conflicts of interest. You must follow the procedures governing the schemes"*

and

*"76. If you have a financial or commercial interest in an organisation to which you plan to refer a patient for treatment or investigation, you must tell the patient about your interest. When treating NHS patients you must also tell the healthcare purchaser".*

The commissioning of specialist services – those which not all practices will be able to offer and where a formal procurement process will be necessary – may require special arrangements. The GPC believes it may be appropriate to establish a split in the commissioning functions of the consortia between the designing of a care pathway and the contracting and procurement of services that will fulfil that pathway. The designing of the care pathway would naturally be clinician-led. However, the procurement function could be carried out by appropriately skilled and experienced managers employed by consortia or by a consortia-managed service agency or external experts with capability in this field. They would procure the service from the most appropriate provider, in line with the consortium governance and decision-making protocols and with no bias towards (or against) any members of the consortia who were also potential providers. A 'Chinese wall' would thus exist between the two key functions within the commissioning process. This split would ensure that clinicians involved in commissioning decisions had no influence over the actual procurement of services and as such would avoid conflicts of interest.

The GPC believes that this model would provide the best method for commissioning specialist services for patients, in a manner that maintains the integrity of the commissioning process.

### ***Collaboration with specialists***

Effective, successful, commissioning must put the healthcare needs of patients at the centre of the commissioning process and take account of the implications on the wider health economy. Consequently, commissioning must be founded on the principle of meaningful collaboration between primary and secondary care clinicians. The relationship between these groups has long

been considered an obstacle to commissioning in the past. It is important that these commissioning proposals seek to remove the barriers between primary care and secondary care in the NHS. Where it occurs, 'gaming' as a result of the purchaser/provider split and the Payment by Results mechanism must end while there should be no 'turf wars' between consortia and NHS Trusts. Rather, clinicians from both sectors will have to work together to develop and commission integrated care services that provide the best services for patients. To achieve this, it is likely that secondary care clinicians will need to work closely with commissioning consortia and consortia must seek to build these relationships from an early stage. This applies equally to public health clinicians and social care workers.

Individual consortia should consider how best to achieve collaboration. It may be appropriate to co-opt secondary care clinicians onto specific subgroups of the consortium when exploring service redesign. However it is achieved, consortia should have in place a collaborative framework to promote multi-professional involvement in commissioning.

### ***Maintaining patient confidence***

Once implemented, the current commissioning proposals may lead to significant changes in local NHS structures as services and care pathways are redesigned. Patients will need reassurance that when in the consulting room, GPs remain their independent advocate and organise their care with appropriate regard to the conditions with which each patient presents. There must be no conflict with the role of GPs as commissioners making clinical decisions with regard to the local health economy. In particular, GPs should not personally profit from any surplus in a commissioning budget – this must be reinvested in patient services. It is also important that patients do not perceive that their GP or practice has any vested financial motive for making rationing decisions. Although this issue may raise little concern amongst the majority of patients, it is important that the integrity of GPs in this respect is restated so that there is no opportunity for concerns to develop. Practices may feel it is appropriate to engage with their Patient Participation Group, where these exist, to ensure that practices are aware of patient views, and that patients have confidence in their GPs. Consortia may wish to consider holding open commissioning meetings so that patients and members of the public can observe the work of the consortium, with perhaps a facility for patients to submit their views on the commissioning process.

### ***Healthcare variations***

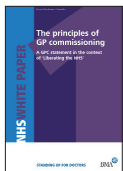
The current commissioning proposals are an England-only initiative. The devolved administrations are unlikely to undergo the structural changes that this model of commissioning entails, although they may adopt some elements of the commissioning proposals. It is therefore quite possible that variations in healthcare will develop between the home nations. These will be more noticeable for consortia, practices and patients in the border regions, and consortia in these areas will need to consider how best to respond to this situation.

It is possible that there will be variations in healthcare across England as a result of the choices consortia make in redesigning local health economies to meet local need. Effectively commissioned services should reflect the needs of the local population, but it would be useful if there were a set of national minimum criteria for NHS services to ensure consistency in what patients are offered across the country.

## Further information

This document forms part of a series of GPC guides to the profession on the NHS White Paper. Further advice on the White Paper and its proposals can be found in the publications listed below. The GPC will continue to provide information and advice to GPs and LMCs on these issues, and new publications will be available on the BMA's White Paper hub page:

[http://www.bma.org.uk/healthcare\\_policy/nhs\\_white\\_paper/index.jsp](http://www.bma.org.uk/healthcare_policy/nhs_white_paper/index.jsp)



### The principles of GP commissioning

A GPC statement in the context of 'Liberating the NHS'. This statement identifies a set of fundamental principles with regard to GP commissioning which will define policy, inform debate and negotiations, and ensure that good medical practice is enshrined within these enhanced responsibilities.

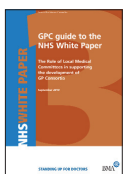
[http://www.bma.org.uk/images/whitepapergpcguidance1aug2010\\_tcm41-199488.pdf](http://www.bma.org.uk/images/whitepapergpcguidance1aug2010_tcm41-199488.pdf)



### Legal overview and guidance on the commissioning proposals

This guidance is an introduction to the legal issues relating to the commissioning proposals that GPs may have to consider in preparation for the outcome of the current consultation on the White Paper.

[http://www.bma.org.uk/images/whitepapergpcguidance2sept2010\\_tcm41-199669.pdf](http://www.bma.org.uk/images/whitepapergpcguidance2sept2010_tcm41-199669.pdf)



### The role of LMCs in supporting the development of GP consortia

This guidance identifies a number of specific actions that the GPC believes LMCs can and should take over the next few months. It provides advice to LMCs on communicating with GPs and practices, supporting practices in planning future consortia and in building wider relationships.

[http://www.bma.org.uk/images/whitepapergpcguidance3sept2010\\_tcm41-199670.pdf](http://www.bma.org.uk/images/whitepapergpcguidance3sept2010_tcm41-199670.pdf)

## Endnotes

- 1 Department of Health (2010), *Equality and excellence: Liberating the NHS*  
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- 2 Department of Health (2010), *Liberating the NHS: Commissioning for patients*  
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- 3 British Medical Association (2010), *The role of LMCs in supporting the development of GP consortia*  
[http://www.bma.org.uk/images/whitepapergpcguidance3sept2010\\_tcm41-199670.pdf](http://www.bma.org.uk/images/whitepapergpcguidance3sept2010_tcm41-199670.pdf)
- 4 Department of Health (2010), *Liberating the NHS: commissioning for patients*, paragraph 4.2
- 5 Department of Health (2010), *Liberating the NHS: commissioning for patients*, paragraph 3.2
- 6 British Medical Association (2010), *Legal overview and guidance on the commissioning proposals*  
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- 7 Department of Health (2010), *Liberating the NHS: commissioning for patients*, paragraph 5.17
- 8 Department of Health (2009), *Practice-based commissioning: budget guidance for 2010/11*  
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- 9 British Medical Association (2008), *The dual role of practice based commissioner and GP provider: avoiding conflicts of interest and ensuring probity*  
[www.bma.org.uk/employmentandcontracts/independent\\_contractors/commissioning/PBCdualrolejan2008.jsp](http://www.bma.org.uk/employmentandcontracts/independent_contractors/commissioning/PBCdualrolejan2008.jsp)