



Commissioning primary care

Transforming healthcare in the community

Primary care is at the heart of the vision for a 21st century NHS. It has a critical role in the delivery of a high-quality, financially sustainable health service. The Health and Social Care Act (2012) brought a number of changes to the way primary care is commissioned, with NHS England managing the contractual elements and local clinical commissioners having a duty to improve the quality of services.

Our members told us that the reforms to primary care commissioning were not supporting more transformational ambitions at a local level and that clinical commissioners must be enabled to jointly commission services across whole pathways with NHS England. In late 2013, we held a roundtable meeting with members, our leadership group and national stakeholders, to explore the challenges and identify practical solutions. This briefing outlines the key messages from the discussion, alongside case studies where clinical commissioners are already making a difference.

NHS Clinical
Commissioners

The independent collective voice
of clinical commissioning groups

Introduction

Primary care is the bedrock of the NHS. As we reap the benefits of longer lives, general practice is key to helping us stay as healthy as possible, managing our own healthcare and living independently in our communities. It also holds the key to ensuring that the NHS remains free at the point of use and does not become an unsustainable burden on the taxpayer.

According to NHS England's recent *Call to Action*, GPs and nurses in general practice see over 800,000 people a day. It is through the GP and wider primary healthcare teams that patients will access both hospital and community care, with many seeing their GPs as champions in the healthcare system.

Professor Barbara Starfield, in her paper *The primary solution: put doctors where they count* (2005), summarised the central role of primary care in an affordable, effective, patient-centred health system:

"A good relationship with a freely chosen primary care doctor, preferably over several years, is associated with better care, more appropriate care, better health, and much lower health costs. We also know that when specialists care for problems outside their main area of expertise, the results are not as good as with primary care. Since most people with health problems have more than one ailment, it makes sense to have a primary care practitioner who can help decide when specialist care is appropriate."

Since the recent health and social care reforms, medical general practice is commissioned by NHS England, as part of its responsibility to commission primary care. This role is increasingly being complemented by local clinical commissioners, who are able to provide primary care expertise as well as an understanding of their area's health needs in the commissioning and development of the primary care service.

As the membership body of clinical commissioning groups (CCGs), we decided to collaborate with partners across the healthcare system to understand the role that clinical commissioning could play in relation to the commissioning of primary care, and more specifically the relationship between CCGs, NHS England and general practice.

In late 2013, we brought our members together with representatives from NHS England, British Medical Association, Association of Medical Royal Colleges, Royal College of Nursing, Royal College of General Practitioners, Family Doctor Association and the NHS Confederation for a roundtable discussion to explore what the commissioning landscape could look like in order to build a sustainable approach to primary care commissioning.

Overall there was a strong consensus among participants that everything possible should be done to enable primary care to fulfil its potential, and that there was a critical role for clinical commissioners in working alongside NHS England and primary care services to achieve that. In particular, there needs to be a clearer focus on commissioning across whole pathways of care.

The ideas put forward during the discussion were developed in further consultations and form the basis of this briefing.

Fulfilling the potential of primary care through commissioning

Key messages for the system

- Excellence in primary care commissioning is essential to the delivery of a person-centred health service, and ensure the clinical and financial sustainability of the NHS.
- To provide patients with integrated services, clinical commissioners need to be able to develop and implement a 'whole-system' commissioning strategy that brings together primary, community and acute services.
- A whole-system commissioning strategy needs to think about the investment needed for primary care in the round, so investment that is relative to the needs of a population and strategies to support out-of-hospital care.
- The development of primary care is most effective where there is close collaboration between clinical commissioners and NHS England's area teams.
- A legislative reform order due to be introduced this year allowing CCGs to form joint committees with NHS England to exercise a CCG's functions could be extended to allow a joint committee to exercise an area team's functions.
- NHS England could strengthen the effectiveness of its area teams by giving them greater freedom to decide the best ways to work with their CCGs.
- There are a range of tested and effective mechanisms to ensure that CCGs' decision-making around primary care is open and accountable.
- Area teams and CCGs need to ensure there is timely, effective action to address any underperformance in primary care services.

Key messages for CCGs

- CCGs need to develop close, collaborative relationships with NHS England's area teams, as part of a whole-system, joint approach to commissioning that breaks down the artificial barriers between acute, primary and community services.
- CCGs must ensure high standards of governance and transparency in their decision-making, notably around commissioning additional or enhanced services from their member practices.

Key messages for general practice

- General practice needs to build public and political confidence in primary care investment by being open and transparent in the management of funds. The public and Government need to see evidence that additional funding is being used to develop primary care services, to avoid accusations that it is being used to increase remuneration.
- General practice should work with NHS England and CCGs to ensure all communities have good access to primary care.

Why primary care commissioning must evolve

Under the Health and Social Care Act 2012, NHS England took over the commissioning of all the primary care services previously commissioned by primary care trusts (PCTs). It holds around 35,000 primary care contracts.

The commissioning is handled by NHS England's 27 area teams, based on a national framework and a range of mechanisms including General Medical Services, Personal Medical Services and Alternative Provider Medical Services (GMS, PMS and APMS) contracts. As well as commissioning the services, area teams undertake quality assurance, contract monitoring and performance management.

Meanwhile, the 211 local CCGs focus on commissioning services, including elective hospital care, urgent and emergency care, community health and mental health. CCGs do, however, have a statutory responsibility to support area teams in improving the quality of primary care services, such as by sharing benchmarking data and providing peer reviews. They do not have the statutory authority to actually commission those services, even though a CCG is able to commission additional community-based services from its member practices.

Under the NHS reforms it was decided to place primary care commissioning with NHS England because it was perceived that there was an insurmountable conflict of interest for GPs, as clinical commissioners, in making decisions about primary care contracts that could directly or indirectly affect them and their colleagues.

There are, however, growing difficulties with sustaining the current arrangements, as:

- area teams are struggling to give primary care the focus it needs – in terms of resource and expertise
- CCGs are prevented from taking a whole-system approach to the local health economy by the artificial division between primary care commissioning – undertaken by NHS England – and their own commissioning of services such as community health, elective hospital care and urgent and emergency care. This means they find it difficult to ensure a whole pathway of care can be commissioned and delivered

- creativity in primary care services, which has flourished under PMS contracts, risks being lost as the area teams adopt a standardised approach to commissioning
- it is critical for the future of the NHS that there is a joined-up approach to developing primary and secondary care. But at present CCGs, who commission much of the acute care and know most about primary care, are being sidelined in key decisions about primary care development.

The work of the area teams

As well as commissioning GP services, the area teams' responsibilities include commissioning all other primary care services such as community pharmacy, dentistry and optometry.

The ambition of the teams – set out in NHS England's single operating model for primary care commissioning – has many strengths, with a focus on quality, patients' experiences, partnership working and outcomes.

But, in the face of an overwhelming workload, the teams are unable to make all this happen. In many areas, CCGs have been waiting for area teams to come up with comprehensive primary care strategies that have, largely, either not been forthcoming or been drawn up with little CCG involvement.

Local area teams have limited capacity to expand and reform primary care because they are being forced to spend most of their time on contracting process. It falls on them to sort out a huge array of contractual issues created by the turbulence of reforming the NHS and the complexity of the new system.

While this work is essential, it is preventing area teams from giving the intense focus to primary care that is needed. With some exceptions, CCGs often experience the commissioning of primary care by area teams as distant and transactional – they are contracting rather than commissioning. The teams' intention to work closely with CCGs is being lost under the pressure of day-to-day administrative demands. Clinical commissioners often find their local team's approach inflexible, and collaboration tends to be weak. In some cases, CCGs



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feel the area teams risk reinventing the controlling behaviour associated with strategic health authorities rather than working with clinical commissioners to develop local solutions.

The use of a single operating model for area teams means they are being inhibited from giving clinical commissioners a greater role in primary care commissioning by the need to constantly check with NHS England's national team whether they are allowed to make a particular decision. This causes delays and frustration.

The work of NHS England's area teams is inevitably influenced by the national political debates about the health service. For example, their hands-on approach to A&E services – which they do not commission – contrasts sharply with the attention they give to the primary care services they do commission. They have been far closer to the emergency services than general practice – spending time watching them in operation, looking at staffing numbers and examining the patient experience.

The urgent care boards that have been set up around the country in response to the political and service pressure around A&E exemplify how the default response of the system is to focus on hospitals, even when the long-term answers lie elsewhere. CCG expertise around the primary and community care end of urgent and emergency care is being sidelined.

Managing Personal Medical Services contracts

Around 40 per cent of GP services are funded through Personal Medical Services (PMS) contracts. These contracts were introduced as locally agreed alternatives to General Medical Services (GMS) contracts to promote innovation and local service improvement, and provide local commissioners with flexibility. But now these locally flexible contracts are being overseen by NHS England, which is insisting that all such contracts are consistent with a central set of guidelines.

There is a significant risk that, if PMS contracts remain under NHS England's sole control, the local variations will gradually be eradicated in the name of consistency. If that happens, important innovations in primary care in response to local needs will be lost.



“The development of primary care is most effective where there is close collaboration between clinical commissioners and NHS England’s area teams”

A whole-system approach to commissioning primary care

It is commonly accepted across the NHS that the solutions to its many pressures lie in taking a clinically-led approach that addresses all the services and connections within the system, rather than pursuing disjointed, piecemeal reforms. But the separation of primary care commissioning from that for acute and community services is stopping clinical commissioners taking a system-wide approach to their local health economy.

This is one of the core reasons why the much discussed need to move care out of hospitals is proving so difficult to achieve. The clinical commissioners who are closest to the needs of their local populations are unable to pull one of the principal levers needed to secure reforms such as better disease prevention, early intervention and patient self-management of long-term conditions.

The current system repeatedly reinforces the focus on hospitals. Many CCG ‘levels of ambition’ are set around hospital care, and most of their regular review meetings with the area team concentrate on that theme.

This focus has also been reflected in spend. During the years of sharp growth in NHS spending, increases in funding for secondary care far outstripped that for primary services. According to the Nuffield Trust report *The anatomy of health spending* (2013), real terms spending by PCTs on primary care rose by 22 per cent between 2003/04 and 2011/12, from £17.7 billion to £21.6 billion, while PCT spending on secondary care jumped 40.1 per cent, from £49.1 billion to £68.8 billion.

The report also says: “Despite the overall increase in spending on health since 2003/04, spending on GP services has been static since 2005.” According to Department of Health data (*HSJ*, 9 September 2013), within the primary care total (which includes prescribing costs and dentistry, ophthalmic and pharmaceutical services), £7.8 billion was spent on GP services in 2012/13 out of a total budget of around £106 billion.

The roundtable discussion highlighted that there are also a number of challenges in primary care itself, arising from the lack of investment in community services. One example cited at the roundtable was that the district nursing workforce is at a low, which impacts on the performance of primary care as a whole. Some CCGs are finding that even modest plans to expand community-based services are being undermined by pressures from overspent trusts. The payment by results system further exacerbates the problem by driving hospital activity rather than encouraging preventative and patient-centred care in the community.

CCGs are frustrated that too often their work ends up exacerbating rather than challenging the excessive dependence on hospital care. Yet they have a passion for, and expertise in, developing primary care, and know that if they are going to change both the pattern of care and the public's understanding of what constitutes effective healthcare then

Case study: NHS Tower Hamlets CCG

Jane Milligan, chief officer at NHS Tower Hamlets CCG, describes their relationship with the area team as “open and honest”.

“We work hard to try to ensure there are no surprises on both sides, and they are helpful when there are blockages in other parts of the system.”

The CCG’s involvement in developing the strategy for primary care “is starting to evolve”, Jane says.

“We are not as far forward on that as we would like. As a CCG we recognise there are some key areas we need to work on more closely.”

A particular priority for Tower Hamlets is investing in GP premises. Some surgeries are inadequate and the borough’s population is growing rapidly. Making progress on this involves numerous meetings with NHS England, the local authority and NHS Property Services Ltd, which took over the landlord and estates services from PCTs: “We have been quite dogged in getting people to the table.”

The CCG invests about £8 million in GP services beyond the core contract – commissioning networks of practices to meet the needs of patients with long-term conditions. These have played a central role in keeping primary care needs out of A&E departments, and are “very much the cornerstone of our integrated care work”.

“What we are now exploring with our area team is how we can take that further forward – what would it make sense for them to keep commissioning separately and what could be done more in conjunction with us,” says Jane.

they need to spend far more time and resource on primary and community services. It is perverse that the people who know most and care most about primary care are largely excluded from commissioning it.

To make care outside hospital work, primary care needs to sit at the centre of the range of services that patients use – out of hours, NHS 111, walk-in centres, minor injuries units, community nurses, ambulance services, social care, hospital emergency services, elective care and pharmacy. CCGs, in collaboration with the area teams, need to make all that happen, while primary care needs to champion the patient in the system and ensure that the services wrap around the user. Commissioning primary care services such as general practice and community pharmacy needs to be a joint CCG/ NHS England enterprise.

As such, a whole-system commissioning strategy needs to think about the investment needed for primary care, community care and hospital care in the round – as opposed to investment that is based on specific sectors. Investment must be relative to the needs of a given population and the CCG’s strategy to support out-of-hospital care.

Developing excellence in primary care services

In *Improving General Practice – a call to action*, published in August 2013, NHS England identified three main challenges facing primary care in addition to the financial and demographic pressures affecting the whole health service. They are:

- growing dissatisfaction with access to services – the

GP patient survey in December 2013 shows a further reduction in satisfaction with access, both for in-hours and out-of-hours services. A total of 75 per cent of patients rate the overall experience of making a GP appointment as very or fairly good, compared with 79 per cent in June 2012. The proportion of out-of-hours callers who said it took too long to receive care rose from 30 to 34 per cent over the same period

- persistent inequalities in access to, and the quality of, primary care, including a twofold variation in GPs and nurses per head of population between affluent and deprived areas
- growing reports of primary care workforce pressures, including recruitment and retention problems.

It sees a transformed primary care service playing a much bigger role in:

- coordinating care, particularly for people with long-term conditions and more complex health and care problems
- holistic care – addressing people’s physical health, mental health and social care needs in the round
- ensuring fast, responsive access to care and preventing avoidable emergency admissions and A&E attendances
- preventing ill health, ensuring more timely diagnosis of ill health, and supporting wider action to improve community health and wellbeing
- involving patients and carers more fully in managing their own health and care
- ensuring consistently high care quality, including a good patient experience.

In the wake of the Francis Inquiry into Mid Staffordshire NHS

Foundation Trust, there has been an understandable focus on regulation as a means to improve services. But while inspection and regulation have their role, they can never deliver first-class healthcare. Achieving the objectives for primary care set out by NHS England requires highly effective commissioning that integrates care across primary, acute and community services. This will not happen while different people are commissioning different parts of that system.

Giving CCGs the lead role in commissioning primary care alongside acute and community services provides the foundations for achieving NHS England's objectives. This collaboration with the area teams would enable an integrated approach to strategy and funding across the commissioning system, including joint commissioning of any new primary services.

Joint strategies for change

A year after the launch of the coalition Government's health reforms, both the opportunities for developing primary care services and the limitations of the current commissioning system are becoming clear.

NHS England recognises the need for it to collaborate more closely with CCGs, notably on determining strategic issues such as the optimal distribution of resources across acute, primary and community services. Meanwhile, health secretary Jeremy Hunt, in his speech to the NHS Alliance conference in November 2013, highlighted the potential for joint commissioning between CCGs and NHS England.

CCGs want to work with NHS England to develop a new approach to primary care commissioning that moves care from hospitals to communities. More needs to happen faster.

In our discussions for this report, we identified four key areas where clinical commissioners want to drive improvement in primary care.



“NHS England could strengthen the effectiveness of its area teams by giving them greater freedom to decide the best ways to work with their CCGs”

1. Putting primary care at the heart of integrated services

We need to build integrated care around the patient and practice, bringing secondary care clinicians into the community to work with general practice in developing integrated care pathways. GPs are the patients' champions in the system. This is the most effective way to manage long-term conditions, helping people such as the frail elderly to maintain their health and independence for as long as possible while significantly reducing emergency hospital admissions.

Investing in primary care is not about general practice taking more resource but rather being the centre of resource. It should be the place where community, primary and secondary care meet and integrate around the needs of the patient.

2. Improving access

General practice needs to commit to working with NHS England and CCGs to resolve the problem of poor access. It is unfair on patients and politically damaging to primary care to have to wait days or even weeks for an appointment.

Many surgeries are already improving access by introducing changes such as triage systems and carrying out many consultations by telephone, email and online, but much more needs to be done. CCGs, working with their GP practice memberships, need to champion this issue on behalf of patients.

3. Decommissioning poor primary care

Over the last decade there have been tremendous improvements in the quality of primary care. Commissioners have been far more robust in identifying GPs who are providing poor care and in taking steps to either improve or remove them.

Poor practice persists, however, and the contractual rules make it hard for commissioners to take robust and timely action against underperforming GPs. Waiting for the chief inspector of general practice to take action is not enough. The rules need to be changed to enable commissioners to decommission GPs who are not up to standard; CCGs need to be robust in identifying individuals and practices who are failing, with NHS England supporting that action with the appropriate contracting levers.

4. Bringing hospital services into the community

Having primary and acute care commissioned by different organisations reinforces artificial divisions between the two sectors that impedes the delivery of an integrated service. Acute services – and particularly hospital consultants – need to be part of the discussions that secure a new approach to primary care.

Case study: NHS Sheffield CCG

Sheffield's commissioners are developing a relationship with the South Yorkshire and Bassetlaw area team that "recognises independence and interdependence", says programme director for primary care Katrina Cleary.

The area team and its five CCGs are jointly developing a primary care strategy that supports CCGs in playing a leading role in commissioning and improving primary care. The area team provides practical support to commissioners in taking on more responsibility.

The two sides are focused on developing strong, trusting relationships. They try to be open and frank, and try not to spring surprises. They do their best to coordinate their work with GPs to minimise duplication and ensure consistent messages. The area team's head of primary care already spends a day a month at Sheffield CCG, and Katrina hopes that will be expanded.

She believes the biggest impediment to the CCGs and area team collaborating over primary care commissioning is the constant need for the team to ask NHS England for permission to change the way they work.

"They say they will have to take that away and check that; it leads to inherent delays," Katrina says.

"I do feel for them because there is a blockage in the system. I would very much welcome NHS England giving more autonomy to our area team."

The Royal College of Physicians, in its report *Future hospital: caring for medical patients* in September 2013, stresses the importance of extending hospital services into the community, working alongside primary and social care services seven days a week. It says the "default will be to provide integrated, patient-centred care at home or at a community setting" rather than in hospital.

There is a pressing need for hospital consultants to play a leading role in moving care into the community. The development of primary and community services needs to embrace a new future for hospital consultants and junior doctors. This needs to include closer working with GPs and a physical and virtual presence in the community.

Medical training needs to break down the rigid barriers between hospital doctors and those working in the community.

A role for CCGs in commissioning primary care

Maximising the potential of primary care involves defining an effective way for CCGs, area teams and GPs to work together, while ensuring accountability to the public through governance, openness and transparency.

At present the money and staff for managing primary care commissioning are in the area teams. Without some of that capacity, CCGs – run on tight management costs – will not be able to take on important parts of that work.

Ideally, therefore, if many primary care responsibilities were to move to CCGs, people and administrative resources would move too. But after the upheaval of establishing the existing structure there is vanishingly little appetite for yet another substantial transfer of staff between organisations.

So the solution is far closer collaboration between CCGs and area teams, including sharing staff time. One approach would be for CCGs to use their primary care expertise and local knowledge to determine the strategy and be responsible for implementation and primary care improvement, while the area team is responsible for leading the commissioning process and ensuring effective oversight.

A current legislative change shows how this might be formalised. In November 2013, the Department of Health consulted on a legislative reform order that will allow CCGs to form joint committees with NHS England to exercise a CCG's functions. It is expected to come into force this October. If this was taken to the next stage – allowing a joint committee to exercise an area team's functions – it would greatly assist NHS England and CCGs in their goal of developing primary care.

Effective governance and assurance

If CCGs are to take on a major role in primary care commissioning, governance has to be in place that ensures openness, transparency and accountability. In particular, local people need to be confident there are systems in place to deal with any potential conflicts of interest in the way decisions are taken or money spent.

The conflict of interest issue is not the block to closer CCG involvement that is often assumed. Within the existing structures there are numerous governance arrangements that can be used to ensure spending and financial oversight is rigorous and transparent. These include vesting powers in the lay members of CCG boards, giving a stronger oversight and accountability role to the council-led health and wellbeing board, strengthening audit, having oversight from neighbouring CCGs, and of course the monitoring and performance management provided by the area teams.

Investing in primary care does not mean more money going into individual GPs' income; it means investing in new and better services. To win political and public support for moving funds from hospitals to primary and community services, and to overcome concerns about conflicts of interest if CCGs play a bigger role in primary care commissioning, GP practices need to be far more transparent and accountable about how money is used.

NHS England has been concerned that, where services have been funded through PMS agreements, it has often been unclear how the money has been spent. This cannot continue.

The Government has been promoting more transparency in primary care. The new GP contract promotes openness through GPs having to publish net NHS earnings relating to the contract (probably an average of drawings and salaries across each practice rather than individual pay) from April 2015. There has been considerable resistance to this move, but GPs need to accept that in the current climate of austerity and growing transparency of public spending, the price of moving money from hospitals to primary care will include greater openness and public accountability.

GPs have nothing to hide, so they should not hide it. This is key to GPs demonstrating the value they provide to the NHS.

Case study: NHS Bristol CCG

Jill Shepherd, chief officer at NHS Bristol CCG, says their relationship with the area team has a good balance between oversight and support.

“They are very clear that they know we have a difficult job to do and they are there to support us in doing it,” she says.

They are working through how they could collaborate more on commissioning primary care: “We are having a good debate about what co-commissioning means. Their view is slightly different from ours, and we are trying to work that through.

“They don’t have the capacity to do everything that needs to be done, but we’re being clear that neither do we, because this was something that wasn’t in our original remit. So it’s not just an opportunity to dump work on us, it has to be proper partnership working.”

The area team has demonstrated its willingness to argue the case for a particular local policy with NHS England, but the need to refer back can still cause delays.

“They can’t move certain things themselves, but they have been proactive in putting the case forward,” says CCG chair Dr Martin Jones.

Like other parts of the country, Bristol has found that negotiating changes to the Quality and Outcomes Framework (QOF) is one area where the division of responsibility between the clinical commissioners and the area team causes difficulties.

Jill says GPs are still confused as to which body is responsible for what: “We keep trying to explain it but it’s hardly surprising they’re confused.”

Ideally the CCG would like to lead on strategy, improvement and developing enhanced GP services, but it does not want its core business to be managing contracts.

Case study: NHS England Derbyshire and Nottinghamshire Area Team

NHS England Derbyshire and Nottinghamshire Area Team and its ten CCGs are working hard on building a collaborative approach to primary care commissioning.

“(The area team) approach is that we are co-commissioners with them. We are one and the same,” says Tracy Madge, assistant director for clinical strategy.

“When I go and work with the CCG director of commissioning I say ‘see me as your director of primary care. If I was in the office next door what would you want me to do?’”

Since the CCGs have the relationships with the GP practices, the area team expects them to lead on quality assurance “and talk to us when they want us to get involved. Equally if there is something happening on their patch we will tell them. So it is mutual dependency.”

The team has agreed a development plan with each CCG looking at issues such as workforce, patient flows and premises. Payments is one area where they have been trying to innovate – within the limits of the rules.

The area team and the CCGs all meet together four times a year to share ideas.

The toughest part of the collaboration is finding the staff capacity on both sides. “(Teams are) small and developing trust and relationships takes time. It feels quite tight,” says Tracy.

NHSCC viewpoint: Moving forward

Over the coming months, NHSCC will be working closely with our CCG members to identify and spread good practice in collaborative working between clinical commissioners and area teams that enables the healthcare system to benefit fully from the primary care expertise which the commissioners hold.

Meanwhile, we want to continue discussions with NHS England and CCGs on developing a new, joint approach to primary care commissioning, in which CCGs take the lead in strategy, improvement and developing enhanced services.

We believe one change that NHS England could implement quickly, and that would greatly enhance collaboration between area teams and CCGs, would be to give the teams greater autonomy in deciding their local approach to primary care commissioning, rather than adhering to a single operating framework.

Political support, both for reforming primary care commissioning and for expanding primary care to reduce hospital demand, is crucial. We will be discussing the ideas in this briefing with ministers and the major parties to secure backing for a more effective relationship between NHS England's area teams and CCGs, in the interests of patients and the long-term sustainability of the NHS.

Share your views with us

As a member-driven organisation, we are keen to hear the views of members on the issues we have raised in this briefing. For more information on it, or to speak with its commissioners, please contact either Julie Wood, director, or Julie Das-Thompson, senior policy manager at NHSCC, at office@nhsc.org

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Notes

NHS Clinical Commissioners is the only independent membership organisation exclusively of clinical commissioning groups.

Our job is to help CCGs get the best healthcare and health outcomes for their communities and patients. We're giving them a strong influencing voice from the front line to the wider NHS, national bodies, Government, Parliament and the media. We're building new networks where they can share experience and expertise; and providing information, support, tools and resources to help CCGs do their job better.

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