

**Briefing** December 2017

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# Making strategic commissioning work

Lessons from home and away



## Introduction

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Clinical commissioning is entering a new phase. Improving the health and care of our populations, both now and in the future, is a task that clinical commissioning groups (CCGs) are keen to embrace. Their clinical leadership, insight and readiness for change has meant they have already evolved into organisations that can work at scale and at pace.

Strategic commissioning is seen by CCGs as their future destination. It's acknowledged that the specific design and delivery of the function will vary by place, but at its core is the ambition to create a more person-centred and sustainable NHS. Our membership is therefore keen to shape the development of the strategic commissioner role to ensure the right enablers are in place at a local and national level to create a smooth transition towards it.

This briefing has been developed to better understand which enablers can support the transition toward strategic commissioning and some early lessons for its implementation going forward. It therefore builds on our publication *Steering towards strategic commissioning: Transforming the system*, which sought to define the function and highlight a number of national asks in relation to the changing commissioning landscape.

The content for this briefing has been developed from:

- interviews with a combination of our members, national stakeholders within health and social care and representatives from sites further ahead in the development of accountable care models.
- debate amongst our wider membership at our national event on 2 November 2017, which was themed on strategic commissioning. Around 120 CCG leaders attended, with speakers from across the national bodies, CCGs and the accountable care models.
- desk-based research on international examples of high performing place-based systems of care that have developed in New Zealand, Sweden, Spain and the United States, as well as a number of other countries reviewed on an individual basis. The full case studies are available for download on the NHSCC website.

## Five lessons from home and away

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Our work has identified several high-level lessons which we believe national bodies and clinical commissioners need to be aware of when transitioning towards strategic commissioning arrangements.

1. **It is right to evolve current systems.**

Experience in England and internationally shows that the gradual, locally-driven evolution of the healthcare system, rather than 'big bang' reforms, are more effective in developing sustainable systems that meet the needs of patients over the longer term. Where this is decoupled from national political cycles, local areas are given the certainty, freedom and flexibility to put patients at the centre of planning, transform services to meet local need and deliver long-term sustained quality improvement.

2. **National support for an evolved approach is essential.**

While local areas must lead and shape the development of the models for integrated health and care delivery, national clarity and governmental support on the 'end states' for areas to transition towards, will be essential. The nature of national work needs to be enabling and facilitative (in the form of a national framework) for local areas to plan and agree their directions of travel. Internationally, no system has been implemented without clear political consensus and a legislative framework to support it on an ongoing basis.

3. **Maintain clinical commissioning leadership and engagement.**

Having some continuity in clinical commissioning leadership is vital to retain at strategic and tactical commissioning levels when evolving the local health and care system to meet the needs of future populations. The success of population level planning will depend on the engagement of clinicians in primary, secondary and community care, as well as the wider workforce, in a unified vision for the future. Where systems have done this effectively overseas, we have seen increased quality of service delivery, innovation and improved outcomes for patients.

4. **Place the patient at the centre with a focus on quality.**

Targets, payment incentives and prescriptive regulation have proved largely unsuccessful in driving system improvement or in ensuring financial sustainability over the longer term. International evidence suggests that strategic approaches to planning and resource management offer an opportunity to refocus the local health and care system on the end user and ongoing quality improvement.

5. **Hold the delivery model to account on behalf of the local population.**

A strong strategic commissioning function will ensure a continued focus on quality and improvement within local areas. Competition does not preclude cooperation across systems or the integration of systems, and the development of a closed market has the potential to result in stagnation, with decreases in quality and innovation. The creation of a monopoly of providers who lack incentives to go beyond narrow contractual requirements must be avoided and therefore the strategic commissioner should hold the system to account for delivery. The health system in Israel shows how this can be retained (albeit at a smaller population level) while the lack of contestability is one of the key concerns in the development of accountable care models in the US.

## Defining strategic commissioning

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Clarification of the strategic commissioning role is essential for the evolution of place-based systems, as it is a function that has the potential to bring a more locally devolved and accountable approach to population health and care management.

Broadly speaking there are two levels of commissioning that are emerging within the sector:

- **Strategic commissioning** is system-wide leadership and service planning across a defined area, involving the development of an understanding of needs and requirements at a population level, monitoring system performance, redesigning the system architecture and repositioning services to better meet local need. This looks to deliver improvements over the longer term and across a wider area. Our publication *Steering towards strategic commissioning: Transforming the system* highlighted eight core strategic commissioner functions that our members felt must be retained for managing population healthcare.
- **Tactical commissioning** is focused on individual relationships with providers, the procurement of services, sub-contracting, and the management of the provider chain against specification and performance criteria. This would usually be focussed on the short-term and annual cycles. Connections with the population are based on a locality/neighbourhood approach. This would operate at an accountable care level.

Our national event highlighted that in the future the term 'commissioning' may become less visible in our vocabulary as local areas focus more on ensuring they have the right planning functions and accountability structures in place to undertake population level health and care.

Internationally, the strategic function is described in terms of planning and resource management, distinct from the more transactional functions that would usually be housed in the integrated provider delivery system. In New Zealand, strategic planning is undertaken by the local planning and funding team operating across district health boards (responsible for delivery of services), in the US it is undertaken by the health insurance fund, while in Spain, Sweden and other Scandinavian countries, these functions are delivered by local authorities who hold the responsibility for health service delivery in local areas.

## The current challenge when evolving to accountable care models

The bottom up evolution of accountable care models (ie, accountable care organisations (ACOs) and accountable care systems (ACSs)) and the devolution areas in England has meant that to date there have been differing approaches to local implementation. There have also been differing interpretations in relation to the level of engagement for partners, commissioner and provider roles, the activities and functions of existing and emerging local structures, leadership styles within emerging models and the approach of the national regulators, and the overall scale of the models themselves. This is to be expected at this current stage, but there appears to be some concern that this level of permissiveness going forward may be difficult to legislate for and may create inconsistencies in formal governance structures and accountabilities across local areas.

In *Steering towards strategic commissioning: Transforming the system*, some challenges are identified by CCGs as they plan their future journeys. Many of our members feel they are caught between the execution of their existing statutory functions and the immediate need to plan for new ones at a much broader scale. This is most recently demonstrated at our 2017 national event where, of those surveyed:

- 58 per cent identified that time, resource and capacity was the biggest need to deliver the evolution of the commissioning system (the next highest, an improved regulatory framework, was at 16 per cent)
- 44 per cent requested increased support and capacity to deliver a sustainable and transformed system (the next highest, money and collaboration of national organisations were both at 20 per cent).

We have also found there are some differing views on where the strategic commissioner function will reside going forward, some suggest the sustainability and transformation partnership (STP), others the ACS and some the ACO. However, in some areas there is more than one ACS in an STP footprint. This difference in views is in stark contrast to the consensus view that the tactical end of commissioning would reside in an accountable care organisation. Clarification around the movement of commissioning functions may require further national work and some increased engagement with all CCGs to understand it more fully.

## National enablers for strategic commissioning

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Through the research for this briefing we have identified several national enablers that were perceived to support the development of an effective strategic commissioner function both now and in the future. These are as follows:

### National clarity on the 'end states' and support for local directions of travel

CCGs are taking a lead role at a local level in the transformation of care delivery through the development of accountable care models. While there are benefits in allowing local variation, further clarity would be welcomed by CCGs on what the 'end states' of the commissioning landscape are likely to be, the anticipated roles and responsibilities of commissioners and providers and the role of national bodies, especially for assurance purposes.

This clarity would support areas to know which commissioner functions should transition to accountable care models, which are retained at a strategic level and where they sit in the broader architecture, that is at ACS level or STP level or both. Further, it should be accompanied by additional resources to enable the double running of systems and support those areas that are falling behind to catch up.

In international systems, such as the US, Estonia and New Zealand, while local areas have been able to develop healthcare delivery models to meet local challenges, this is within the framework of an overall direction of travel and priority setting from governmental organisations followed by subsequent empowering legislative change.

Our members are supportive of the development of guidance by way of a national framework. They are clear however that this must not be too prescriptive to limit local development, but should provide sufficient clarity to allow them to plan with certainty.

### A strategic role for clinical commissioning leadership

Our research suggests much of the early focus in transitioning the clinical commissioning leadership role has tended to be in relation to accountable care models or the tactical end of commissioning. However, there is a strong view in our membership that strategic commissioning must build on the progress that CCGs have made to create groups of primary care clinicians who also work as commissioning leaders. This means existing and future clinical commissioning leaders need bespoke support through the current transition. This will require some specific competency-based leadership skills, change management and GP development into commissioning roles.

Alongside this, there is a need to embed multidisciplinary clinical leadership across health and social care to take accountable care forward. This should be driven in the main by primary and community care which will be the focus of NHS service delivery in the future. In all the international models that we reviewed, including in Spain, the US, New Zealand and Sweden, clinician leadership at a local level has been central to the development of place-based systems of care.

On the broader theme of clinical leadership, our interviews identified several clinical leadership roles evolving at home. The first could reside at a strategic level, and the second and third in accountable care models as they mature. These roles are outlined as:

- **Medical director or shared leadership model.** Some areas in England are looking to explore the role of clinical leadership in the performance management of clinical colleagues in the accountable care models – underpinned with agreed clinical practice, protocols and expected standards of practice. This would be similar to medical director roles within hospitals. Others are looking to develop shared leadership approaches with the clinical leaders from across primary and secondary care coming together to form a joint leadership role.
- **Clinical network leadership.** This would entail leading networks within the multidisciplinary team on specific areas to: agree care priorities, determine how services should run to meet local needs, set clinical and patient experience standards, develop care pathways, monitor unwarranted variation (which can only be explained by differences in health system performance), and manage outliers. This will require subject specific experts.
- **Locality and representative clinical leadership.** Clinical locality leadership would provide a way for primary care practices to escalate issues and act as a conduit for local consultation and engagement. The principle, although most relevant to primary care, could be applicable to the wider multidisciplinary neighbourhood team. This will require skills in engagement and member representation.

## Strengthen local decision-making

Successful strategic commissioning requires more local decision-making with reduced oversight and intervention from arms-length bodies. As well as devolving budgetary control to local areas, those at the centre must take a permissive approach to both the development of systems and the management of those in local areas. We see most progress on this in some of the devolution deals in England. Internationally, local autonomy has been central to the development of effective health systems, usually at a local authority level as in Sweden, Spain and Denmark.

The move towards strategic commissioning offers the opportunity to successfully integrate social care to develop place-based approaches to health and care services. It was clear from our interviews that nationally supported devolved working must learn from the challenges in bringing different organisational cultures and accountabilities together. This has been most felt through health and wellbeing boards who have lacked the sufficient leverage to affect impactful changes in local areas. Internationally, the evidence suggests that where social insurance models are utilised, more comprehensive coverage is provided of health than social care needs, however, the gap between the two is less stark than in England.

Nationally, there must also be recognition that the development of effective relationships that will drive a local approach takes time and cannot be accomplished overnight. In New Zealand, the development of the current system began in 2007, in Sweden stability of leadership over 18 years locally allowed the Jönköping system to develop, in the Netherlands system development has taken over 20 years, and in South Korea the process has taken closer to 30 years.

## Develop strategic commissioning skills and capacity

New skills and increased capacity will be required to ensure the effectiveness of strategic commissioning in developing and monitoring service delivery and implementing an outcomes-based approach. These should enable an increased understanding of the needs of local populations and, most significantly, population level impact of interventions over time.

While some of this capacity can come from external organisations, such as Academic Health Science Networks (AHSNs), to be truly effective this must be developed in-house to allow for rapid monitoring and real-time interventions to be undertaken. Such skills include the data analysis of patient level information to develop clinical pathways, identification of developing long-term trends and assessment of impact based on both national and individual patient-level determinants of success to drive action. Additionally actuarial and contractual skills are needed to hold the system to account for delivery.

In New Zealand, secure medical records are shared across district health board areas and clinical and process guidance is developed centrally based on analysis of this data. In Spain, real-time data displays allow for monitoring of outcomes and the impacts of interventions.

## One approach to system assurance, regulation and governance

There needs to be some national work to develop a single assurance and regulatory framework which is coordinated at a system level to mirror the strategic commissioner and accountable care models locally. Our interviews identified there is a risk that without this single approach, there will be multiple layers of reporting for the strategic commissioner to undertake which will divert senior attention away from their population level roles. We have already seen this within the current landscape for CCGs.

Our national event highlighted an appetite for more integrated working between the national assurance and regulatory bodies (NHS England, NHS Improvement and the Care Quality Commission). NHSCC members also felt that without further clarity on the governance arrangements needed to support accountable care models, strategic commissioning will lack a robust framework for decision-making, which is required to establish it in the first place.

## Local enablers for strategic commissioning

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### Map the risks and challenges – mitigate them early on

To get a smoother transition to strategic commissioning, there needs to be some national work with CCGs to identify and map the risks and unintended consequences when developing accountable care models, as well as to take potential mitigating actions. These include the delegation of commissioning functions, governance, and the management of conflicts of interest, current and future statutory duties, and risk share approaches to handle provider fragility.

It is vital that we learn from international systems and the challenges that they have faced. These include the development of a robust allocation methodology that is flexible enough to respond to changes in demography, sophisticated enough to predict where these changes might occur and yet robust enough to allow for certainty and effective planning over several years, a challenge experienced in New Zealand and elsewhere.

The system should also take steps to minimise the risk of provider market capture that results in the decrease in quality and financial sustainability due to a lack of strength in the commissioning sector, as seen in provider-led models such as in Spain. In the US, evidence shows that consolidation of provider and local physicians can result in an increase in prices, therefore strong local levers must be retained to manage costs

### Share learning on the design and development of the accountable care models

Our national member event highlighted that evolving systems need to share knowledge in real time. It's clear there are some pioneer areas developing accountable care models that are defining the strategic and tactical commissioner functions. These areas are sharing their experiences and expertise as a community and to some extent are perceived as 'innovating in isolation'. It can be frustrating for areas not part of these communities to access the knowledge and intelligence they need to develop their approaches to accountable care and in effect kick start their journey in an informed way. This knowledge needs to be shared across the clinical commissioning community consistently and on a regular basis at a national level.

The international case studies and the interviews with those areas that have made most progress in developing strategic models in England revealed a number of local enablers that should be considered when developing strategic commissioning systems.

### Taking a person-centred approach

The strategic commissioner, although working at a population level, should maintain the primacy of the individual within commissioning decision-making. This approach is perhaps most advanced, although not uniquely, in Sweden where 'Esther' is a figurative representation of older people who have complex care needs that involve a variety of providers. The system collaborates and has designed services based on "What is best for Esther?" This person-centred approach ensures that commissioning decision-making is grounded in the perspective of the end-user and that the system prioritises the population it serves above other considerations.

In a public structure with one central source of funding and the requirement to remain in budget rather than deliver profits, this should be more easily achievable than when delivering care across competing commercial interests or through insurance-based payment methods. Involvement of community care, public health and social care within a local system, where considered appropriate, would enable a holistic approach to be developed.

### Being accountable to the local population and clinical community

The development of true accountability to local populations for decisions reached, through a formalised structure of engagement and involvement is essential to the effective development of both strategic commissioning structures and the transformation of health and care delivery that they are building. While existing patient and public engagement mechanisms are currently being embedded into accountable care models in England, international models suggest that this engagement could go further. In New Zealand, individuals are elected from the local population to sit as representatives on the local district health boards and plans for service redesign is undertaken with a patients' or public council.

By involving the local authority within accountable care systems, greater accountability can be achieved for the local population. However, this should not be a bolt-on style of working and must be a joint process of planning from the outset. It was not clear in our interviews if local authorities are fully embedded into the developing accountable care models.

As noted above, while CCGs are currently accountable to their local clinical community through their practice membership, as strategic commissioning develops, consideration will need to be given to how to achieve accountability to the wider clinical community (for example, primary and secondary care clinicians and nurses) and how to achieve mechanisms for representation.

## Finding the appropriate geography

To maximise the potential for strategic commissioning, the appropriate footprint for delivery must be identified. This will remove duplication across local systems, but also ensure that the principle of subsidiarity for service delivery is maintained. This will only be successful if clear lines of communication are developed and maintained across and between local areas, rather than taking an isolationist approach based on historic or current organisational boundaries. We have seen from international approaches that there is not a specific level at which all services can be delivered or commissioned, and local areas should decide what is appropriate based on the determination of local need.

Our interviewees felt that that strategic commissioning could be undertaken at a large population level, some suggested up to two million. Some CCGs are already collaborating to cover a larger geography due to the need to maintain their statutory functions and create scale, but are also developing the STP and ACS structures for some greater commissioning leverage and reconfiguration.

When commissioning at different geographical levels, our interviews found:<sup>1</sup>

- **Some care pathways are thought to be more effectively commissioned at a strategic level.** For example, learning disabilities (with social care), inpatient mental health, genetics hubs, some pathology services, and some specialist and secondary care services (ie cardiovascular and trauma services).
- **Some services were considered to fit a bigger regional footprint.** Examples included the commissioning of 111, population-based health protection, public health/prevention and ambulance services.
- **Some services needed integrated delivery.** Here services such as maternity, end of life and oncology were cited as those that required an integrated delivery and commissioning approach.

The strategic level was also considered to be useful to bringing coherence to local workforce planning and working with local Health Education England (HEE) teams to purchase training and education for the future clinical workforce at scale.

There are clear opportunities for carrying out some commissioning functions at a larger population base than a CCG, but as areas define which elements are tactical and which are strategic it seems the principle of subsidiarity and local assessment must be applied when planning where strategic commissioning functions reside.

## Involving the local clinical community

A key feature of successful international approaches to strategic commissioning, especially in New Zealand and the US, is the involvement of local clinicians across primary, secondary and community care in the development of whole-system patient care pathways, service improvement and system development. In Canterbury, New Zealand, for example, clinical leadership across the system is essential to the delivery model and the development of cross-organisational patient care processes. Clinicians can utilise their clinical skills and local knowledge to identify requirements ensuring that appropriate solutions are developed for defined populations in planning the contracting and implementation process.

Without the engagement of this community in the development of systems and processes which are imbedded in the reality of local service availability and need, strategic commissioning cannot be effective. We have heard about the establishment of clinical training programmes or academies in the developing NHS system that are encouraging clinicians within primary, secondary and community care to take ownership of system delivery and empowering them to redesign services based on clinical effectiveness.

In the US, Intermountain Healthcare has focussed on developing clinicians in leadership knowledge and improvement methodology through an advanced training programme, while in Sweden, there are regular cross-system clinical and managerial meetings to discuss challenges and propose solutions.

<sup>1</sup>Please note this will vary by place and is only indicative.



## Having a shared vision

In the most successful areas, including in New Zealand, the US and Sweden as well as in developing systems in England, a strong vision and its underlying principles has been agreed at an early stage. As strategic commissioning is at a larger scale and with longer-term ambitions than the annual tactical commissioning cycle, it is vital there is clarity about the system that accountable care models are expected to deliver and the challenges that will be addressed, built upon local understanding and experience of using services. The strength of this shared vision can then shape the conversation at a national level. The permissive approach currently adopted offers an opportunity to the system to develop processes where there is a clearly articulated vision that can then inform national guidance and legislation.

## Defining clear outcome measures

The outcomes against which system performance is measured must be linked a shared vision, agreed across the system and sufficiently responsive to identify problems in real time if not pre-emptively. However, they should also retain some flexibility to adapt to changing circumstances and population needs. Where these outcomes are too specific they can be unwieldy for the commissioner to utilise effectively, remove focus as it is dispersed across several competing priorities and function only as local performance management, rather than driving system improvement, as in the US where one network held four ACO-like contracts which contained 219 performance measures. Conversely, where outcome measures are too high level then the strategic commissioner may find it challenging to have effective oversight of service delivery and monitor service quality. A concern from observers of the provider-led Spanish system is the impact that a weak oversight function may have on the long-term quality of service delivery.

## Planning for effective data sharing

Clean, reliable and prospective data must be available for strategic commissioners to make effective decisions about the delivery of services in local areas, be assured that actions are being taken to address identified needs and that agreed interventions are influencing patient outcomes. This would require agreements to share information across organisational boundaries. Some of this may require national support to ensure the consistency of data sharing. Alongside clinical engagement, a common factor that we have seen across successful international systems of place-based care has been the development of integrated systems for data sharing, particularly medical records, between organisations. New Zealand and the US offer examples of where this been done effectively, but this has taken both time and tireless leadership focus to achieve it.

## Focusing on quality

The distinction between strategic commissioner and delivery organisation in terms of quality assurance is essential for services to improve, especially with the development of an integrated provider and reduced market access. Competition does not impede the integration of systems, and the development of a closed market has the potential to result in a decrease in quality and innovation. The creation of a monopoly of providers who lack incentives to go beyond narrow contractual requirements must be avoided and therefore the strategic commissioner should hold the system to account for delivery.

Internationally contractual agreements are fairly sophisticated. They extend for between ten to 15 years and have incentivised positive behaviours such as provision of additional funding for organisations or personal incentives for achieving quality outcomes for senior leaders or clinicians, as seen in Portugal, the US and Spain. This can be in both secondary and primary care.

Other areas, particularly Scandinavian countries, have adopted a national focus on quality improvement that permeates throughout the health system structures. In Israel, the central focus on quality, with the publication of comparative data on specific issues, along with a highly competitive system has driven considerable improvements at a national level. To exploit economies of scale and thereby improve quality on a larger footprint, competitive pressures can also force providers to cooperate more closely across disciplinary boundaries than they otherwise would.

## Conclusion

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We are experiencing a rapid period of change. The move to more strategic and population-based commissioning is the future destination for CCGs. This briefing shows there are a number of lessons in the form of national and local enablers for supporting the evolution of the current commissioning structures into the next phase. These are drawn from international evidence and the perspectives of those implementing and developing policy around the new care models.

The task of transitioning is not an easy one for CCGs, but our members know it is necessary in order to do what is right for the populations they serve and to ensure the NHS is as sustainable as it can be for future years. The evolution of current commissioning into more place-based systems of care offers the opportunity for CCGs to innovate both in the planning and resource management of health and care but also to drive quality to a scale never seen before in the English NHS.

It is important that national bodies and CCGs work together on the enablers outlined in this briefing to achieve the same end goal which is to create effective local systems that improve the health and wellbeing outcomes of populations, but also support people when they are at their most vulnerable and need it most.

## Acknowledgements

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If you would like to speak to NHS Clinical Commissioners about this briefing, or any of the case studies within it, please email [office@nhsc.org](mailto:office@nhsc.org)

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- Julie Wood, Chief Executive, NHS Clinical Commissioners

## Additional resources

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NHS Clinical Commissioners (2016), *The future of commissioning*.

NHS Clinical Commissioners (2017), *Steering towards strategic commissioning: Transforming the system*.

NHS Clinical Commissioners (2017), *Supporting strategic commissioning: Collaborative working between CCGs and AHSNs*.

NHS Clinical Commissioners webpage, *Sharing learning from new care models*.

The King's Fund (2015), *Place-based systems of care: A way forward for the NHS in England*.

The King's Fund (2017), *Accountable care organisations (ACOs) explained*.

The NHS England website has information on accountable care models, including case studies and contract service conditions: [www.england.nhs.uk](http://www.england.nhs.uk)

The full list of international sources can be found on the NHSCC website: [www.nhsc.org](http://www.nhsc.org)

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