Kent Local Medical Committee

Supporting list based personalised care, the partnership model and meaningful collaboration

8 Roebuck Business Park, Ashford Rd, Harrietsham, Kent ME17 1AB
Tel. 01622 851197 Fax. 01622851198

Medical Secretaries **Dr M Parks**
Dr J Allingham
Clerk **Mrs Liz Mears**
Deputy Clerk **Mr Carlo Caruso**

Highlights from the Full Kent Local Medical Committee Meeting August 2015

Dr Julian Spinks welcomed members to the Committee meeting and thanked them for accommodating the change of date (previously scheduled for October) to facilitate a debate on co-commissioning and to enable members to re-visit the stance taken at the LMC meeting on 24th November 2014.

Dr Grzonka stepped down as a representative and was thanked for her valuable contribution to the LMC. The LMC will run an election for a contract holding GP in Medway in September 2015.

JS informed members that part one of the meeting would be condensed usual business, and part two would consist of deliberations on the proposed options for co-commissioning. Guest speakers from NHS England South (South East) and CCGs have been invited to offer their views on co-commissioning, and participate in an open debate. Members will be given an opportunity to revisit the stance taken in November 2014 which stated "The LMC strongly opposes Model C (Delegated Commissioning), and cannot recommend Model B (Joint Commissioning)".

Part One
Flu (Housebound)
With the exception of Medway CCG, flu for housebound patients now forms part of the KCHT contract moving forward.

There were discussions around the issue that from September 2015 patients will be able to access seasonal flu vaccinations in participating community pharmacies, for which the pharmacy will be paid £7.64 per vaccination administered (with an additional £1.50 payment in recognition of costs incurred such as training, revalidation and disposal of clinical waste). The importance of equitable payments in local schemes was highlighted.

Concerns were raised around pharmacies offering vaccines to at risk patients and the need for robust mechanisms to be in place for pharmacies to notify practices that they have vaccinated patients. It was agreed that the scheme could potentially reduce coverage and lead to difficulties with call/recall.

It was noted that the fine detail of the scheme has yet to be determined, including the responsibility/process of pharmacies to inform practices. The GPC has reopened negotiations around the level of payment for GPs, however in the meantime practices should review their own programmes. The LMC recently circulated an advice sheet (click here) which suggests how practices can compete with Community Pharmacists and encourage at risk and over 65 population to be vaccinated by practices.

Premises
Primary Care Infrastructure Fund
The due diligence process at NHSE is still ongoing and not likely to be finished until at least October, so schemes are currently on hold. Concerns were raised around the practicalities of completing projects within the proposed 6 month timescale (October – March). It was noted that practices could move forward at risk but this is not something that the LMC would recommend. The LMC agreed to forward concerns to the GPC Premises Leads, Dr Brian Balmer and Dr Ian Hume.

There is no news yet about phase/year 2 (2016/17) of the fund.

Premises/Business Rates
Approximately £700k Improvement Grant monies have been secured for Kent, Surrey and Sussex. NHS England will write to practices imminently to outline the process for practices to apply for this funding.

All practices are now responsible for paying and recouping business rates. (Those received before 31st May 2015 would have been paid in full by the KPCA). Practices were reminded to ensure they recoup this cost from NHS England.

The LMC are aware that some practices have received a letter from their local authority regarding an application for a rebate on business rates. There is uncertainty that the rebate, which will be returned to NHS England, will be reinvested in primary care. Practices are therefore advised that, if they haven't already applied for a rebate, they refrain from doing so until this is clarified.

NHSPS Lease/Service Charge
National lease negotiations have not yet concluded and the LMC understand there are two areas outstanding.

NHSPS are trying to recoup all their costs and have been sending some practices service charge details which are very high, variable and unreliable.

The LMC are working with the 38 practices that are effected across Kent, and are utilising a legal firm and a surveyor who are able to provide appropriate advice to practices. The LMC are of the view that practices working together across Kent & Medway will provide a much stronger negotiating position moving forward. Practices are advised not to pay these service charges but to acknowledge receipt and indicate professional advice is being sought.

Concerns were raised around NHSPS, particularly relating to their engagement with Primary Care. It was suggested that practices copy the LMC into any concerns relating to NHSPS that they raise with their CCG.

Premises Cost Directions 2015
The Premises Cost Directions are still being negotiated. It is anticipated they will be published in Autumn 2015 along with the GPC Principles of Best Practice (which will include an abatement policy).

Collaborative Fees
This issue has been raised as a potential patient safety and particularly child safeguarding risk at the NHS England Quality Hub meeting. NHS England have agreed they will put together a proposal to seek funding. The LMC recommends that practices continue to claim for collaborative fees, and will seek a further update from NHS England.

Appraisal Standards
At a recent LMC Regional Liaison meeting some standards within the appraisal process were identified that go beyond GMC, RCGP & RO guidance, making it more onerous. Despite the LMC raising concerns at a subsequent meeting between the LMCs, Alison Milroy and Alison Taylor from NHS England South (South East) only subtle changes were incorporated and the document has now been circulated. It was noted that the GMC guidance is seen by NHS England South (South East) as the bare minimum that is acceptable. Discussions are ongoing with NHS England and the GMC.

KPCA – Capita working with Anglian Community Enterprise (ACE)
Capita, working with Anglian Community Enterprise, have been selected by NHSE as the preferred supplier to establish a single provider framework for administrative support functions for primary care across the UK.

KPCA staff will transfer to Capita in September, and the office in Maidstone will close in 2016. Anxieties were expressed at the lack of local presence and the impact this will have on practices. It was noted that a call centre will be established in Preston/Darlington, and medical records will be administered centrally. We understand that practices may no longer have to pay for the courier service from later this year.

The KPCA have been tremendous servants to practices and GPs, and have always been supportive of primary care.

LARC
There were discussions the bureaucracy and extensive list of requirements to provide certificates of training undertaken just to register for LARC. The LMC agreed to outline the scope of practice requirements with regard to GPs registering on the performers list, and forward appraisal/CQC training requirements to Public Health to determine whether these would provide sufficient evidence to alleviate the need for practitioners to provide further information before enrolling on training courses.

Buff Forms
(Community Nurse Administration Charts)
There remain ongoing issues around the use of Buff forms in East Kent in addition to FP10s. The recent GPC Guidance on PGDs/PSDs states that "Some employers of Community Nurses ask GPs to fill in administration charts before allowing a nurse to give a drug, although this must be viewed as discretionary as it is not a legal requirement if a prescription providing detailed instructions has been provided". It was suggested that this stance should be adopted for Buff Forms. Hazel Carpenter has agreed to address this issue on behalf of East Kent practices with Marion Dinwoodie at KCHT. It is hoped that a definitive solution will be reported shortly.

Joint Statement Duty of Care
A Joint Statement on Duty of Care for hospital test results and drugs recommended from outpatient clinics has been published by the BMA, setting out expectations on how this relationship should be managed. The document sits alongside the Quality First publication, highlighting that effective working across the interface between primary and secondary care is of vital importance to both clinicians and patients. The LMC has circulated the statement to practices and Kent & Medway Trust Medical Directors for them to share within their organisations. Practices are encouraged to utilise the letter to push back unfunded work to secondary care.

Community Education Provider Network (CEPN)
CEPNs are in varying stages of development across Kent. The CEPNs in East and North Kent are in the early stages of development, whilst in West Kent they are moving forward with the support of their CCG. The CEPN in Medway is established, and may well emerge with forerunner/vanguard status.

PMS
NHS England will be reviewing PMS contracts imminently. There are 33 PMS contractors across Kent & Medway (and considerably more across Surrey & Sussex). The review process is being led by Richard Woolterton. It is anticipated that NHS England South (South East) are considering several options moving forward.

NHS England/LMC are setting up a meeting for all PMS practices to discuss the options in due course. NHSE South (South East) will write to practices early September, and practices will have to make a decision by mid November 2015. The LMC are keen to discuss individual concerns with practices.

Concerns were raised that the time constraints do not allow for practices to be assessed on an individual basis (as stated in the NAPC Guidance). The LMC agreed to raise this concern with them.

LMC liaison meetings/Engagement with LMC Representatives – Phase Two
Following the circulation of a questionnaire to all LMC representatives, 68% of representatives felt that the liaison meetings are effective and that quarterly meetings were considered the right frequency. It was suggested that pre-meetings be utilised to plan and improve negotiations/outcomes and that the LMC should highlight the importance of key CCG personnel attending the liaison meetings. The consensus from representatives is that the liaison meetings do work, but that the repetitive nature of meetings is a concern and illustrates issues that remain ongoing.

The LMC currently have regular meetings with NHSE South (South East), EKHUFT, MTW and KMPT, and are hoping to secure dates with CEPNs, MFT and Community Trusts in the near future.

It was suggested that representative roles could be assisted with a little admin support, and that an e-mail list of constituents/PMs would be useful. Circulating LMC rep details was also suggested as a way of increasing communication. Different ways to seek issues/ideas from constituents were discussed.

Members were encouraged to actively seek the views of their constituents to bring forward to liaison/interface meetings.

Kent LMC Annual Conference – 11th November 2015
GPs and Practice Managers are encouraged to attend the Kent LMC Annual Conference on Wednesday 11th November 2015 at the Ashford International Hotel. Speakers include Richard Murray, Director of Policy, The Kings Fund, Neil Goulbourne, Deputy Director of Strategy, NHS England, Dr John Ribchester, Vanguard site, Invicta Health & SECAM (Prime Minister's Challenge), Dr Gary Calver & Kim Horsford, Invicta Health, Paul Gordon, Financial Advisor and Dr Brian Balmer, GP Executive, GPC. Ashford and Canterbury CCGs have agreed to incorporate the LMC Conference as their PLT for November.

Part Two
Primary Care Co-Commissioning (Open Session)
JS welcomed guest speakers to the meeting and invited them to deliver their views on co-commissioning.

Sarah Macdonald, Director of Commissioning & Stephen Ingram, Director of Primary Care, NHS England South (South East)
Sarah Macdonald provided an aide memoire to help navigate through the headlines of Primary Care Co-Commissioning (attached).
Sarah Macdonald outlined the three models of co-commissioning, provided an overview of considerations for the CCGs, highlighting the need to manage conflicts of interest, and noted that the consideration is contingent on 75% of individual named GPs on the contract voting for one model. Sarah Macdonald commented that there is a need to radically consider the

provision of general practice. NHS England are committed to the agenda set out in 5 year forward view and fully support the development of new models of care, vanguards, PM Challenge fund initiatives etc). They have 604 contracts (GMS/PMS/APMS) across the South East, and unless a CCG has a serious governance issue or is in 'special measures' they are supporting them in moving towards implementing co-commissioning arrangements.

Fiona Armstrong, Chair, Swale CCG, Liz Lunt, Chair, DGS CCG and Patricia Davies, Accountable Officer, Swale & DGS CCGs
Fiona Armstrong presented the view of co-commissioning for Swale/DGS CCGs (attached).The CCGs believe delegated commissioning will provide better protection of primary care funding, opportunities to develop GMS plus type models, greater opportunities for collaboration and joint working between practices and other providers and a greater focus on commissioning of primary care and enhancing quality rather than just 'contracting'. It was noted that NHSE will retain individual performance management, the administration of payments, performers' list management and the terms of the contract (along with any nationally determined elements of PMS/APMS contracts).

The risks to mitigate and the need to ensure joint working with the LMC were highlighted, and the CCGs believe delegated commissioning will facilitate the development of better care and adequate funding for patients locally.

Dr Bob Bowes, Chair & Mr Ian Ayres, Accountable Officer, West Kent CCG.
West Kent CCG shared the view of Swale/DGS CCGs, and delivered their vision of Co-Commissioning (attached). Ian Ayres spoke about the development of MCPs, involving federations, networks and super partnerships to enable general practices to operate on the scale required to deliver a wider range of services. Ian Ayres outlined the potential benefits of co-commissioning and noted the precautions of managing conflicts of interest, ensuring transparency and preserving the national contract.

Bob Bowes outlined the two options for consideration moving forward: Delegated commissioning – GPs influence increases, population has greater benefit from wider GP advocacy and independent contractor status remains contributory. Greater Involvement (status-quo) – practices become increasingly vulnerable, independent contractor status and contribution marginalised. Bob Bowes commented that it is West Kent members' choice moving forward, and that other CCGs will make their decisions locally.

Bill Millar, Chief Operating Officer, Ashford/Canterbury & Coastal CCGs
Bill Millar shared the views delivered by his neighbouring CCGs. Emerging views from Ashford and Canterbury & Coastal are seeing more practices building relationships and engaging with the CCGs, and the CCG are aware of the need to implement changes to support primary care. Ashford and Canterbury & Coastal CCGs will be writing to members ahead of discussions planned for September.

Co-Commissioning Open Debate
Julian Spinks opened the debate and welcomed questions and comments from Members. Members deliberated the views delivered by the speakers at length. Anxieties were expressed around the potential eroding of primary care budgets, and that ring fencing the GMS budget alone would not be enough and should include extra funding (ie. DES/LES, Premises etc). It was noted that the budget within NHS England is not ring-fenced, but that due diligence will be undertaken to ensure the total budgets are transferred. It was suggested that ring fencing the budget would be enshrined in the CCG constitution and could be increased (GMS plus) but not decreased.

It was suggested that general practice may flourish better through delegation rather than remaining with NHS England. The importance of managing conflicts of interest was reiterated.

The need to take a view on a wider horizon, for future of general practice (not just individual CCGs) was noted. There were discussions around the investment needed to develop and strengthen primary care, and it was suggested a Kent-wide system may provide an opportunity to harness skills whilst sharing resources behind the scenes.

Members were urged to seek views from practices in CCGs outside of Kent & Medway where they have opted to move to delegated commissioning to help inform their decision.

Julian Spinks thanked the guest speakers for their views and contribution to the debate and requested members remain to debate the LMC policy to help inform/influence members in making decisions at forthcoming CCG meetings.

LMC Policy Debate
Members were reminded of the motion agreed in November and engaged in an interesting and

wide-ranging debate about the proposed options for co-commissioning.

Members reiterated serious concerns around adequate funding to facilitate co-commissioning, and it was stressed that the total ring-fenced budget should include all GMS/PMS/APMS, DES/LES, Premises and IT funding.

There were discussions around the option of federations/integrated care organisations moving forward, and it was suggested that members be offered this as an alternative to co-commissioning across the whole of Kent & Medway. Julian Spinks urged caution in making recommendations for the whole of Kent due to the variation across the patch in terms of the development of federations.

It was agreed that following the debate the LMC Secretariat, Chair and Vice-Chairs would formalise a position statement on behalf of Kent LMC. The statement has since been shared with LMC membership and the wider health care community in an endeavour to help reach a decision about the next steps:

Kent LMC feels Joint Commissioning does not offer any benefits to primary care and Delegated Commissioning can only be supported if the following issues have been addressed:-

- ***As a minimum the totality of the general practice funding is ring fenced.****
- ***There is a transfer of those financial/human resources that are associated with primary care from NHSE to CCGs.***
- ***Contractual management of practices is properly resourced, equitable and transparent and must include early discussion with the LMC.***
- ***That conflicts of interest are recognised and managed appropriately and transparently.***
- ***CCG constitutions are changed to address these and any other issues that arise in discussions with CCG membership.***

Kent LMC believes the future of primary care is in the promotion of collaborative working via GP federations which deliver integrated care at locality level and any commissioning model should support this.

****By totality of general practice funding we mean at least, all GMS/PMS/APMS funding, all enhanced service funding, IT funding, Premises funding.***

Date of next meeting:
Full LMC:
Thursday 11th February 2016 at 2.15pm at the Village Hotel, Maidstone.
LMC Executive Sub-Committee:
Thursday 8th October 2015 at Len Valley Community Centre
Thursday 10th December 2015
LMC Finance Sub-Committee:
Thursday 10th December 2015
Further details of LMC meetings are available on our website (Meeting Dates 2015/16)

Kelly Brown
Liaison Support Officer

Kent Local Medical Committee

Primary Care Co-commissioning – discussion points

Introduction

The overall aim of primary care co-commissioning is to harness the energy of CCGs to create a joined up, clinically-led commissioning system which delivers seamless, integrated out-of-hospital services based around the needs of local populations.

Intention is to empower and enable CCGs to:

- Take a fully integrated approach to commissioning on a 'placed based' basis (based on local assets).
- Improve primary care by taking a more collaborative approach to designing local solutions for workforce, premises and IM&T solutions.
- Integrate (particularly) primary and community based services.
- Achieve greater consistency between outcome measures and incentives used in primary care services and wider out-of-hospital services by developing alternative schemes to QOF and DESs.

CCG considerations

- Critical to both know and be able to articulate the CCGs vision for co-commissioning and how it fits the CCGs broader strategy for integrated service provision (what do you want to 'do with it'; how and why?).
- Management of conflicts of interest – nothing new to CCGs but vitally important from a probity and public confidence perspective. Primary Care Commissioning Committees Lay Chair and majority; HealthWatch representative and Local Authority representative from the HWB as non-voting members.
- Member vote (75% and for which model)
- Budget and allocation
- Running costs and staffing from NHS England (alignment / secondment / direct recruitment)

Background

- Current and potential CCG responsibilities:

CCG responsibilities 2014/15

- Legal duty to promote quality improvement in primary care.
- Delegated responsibility for design of LESs
- Commissioning of GP out-of-hours services.

CCG optional additional joint or delegated co-commissioning responsibilities in 2015/16

- General practice commissioning: review or renew existing GP contracts, award new ones

including ability to design Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS) contracts, establish new practices in an area and approve practice mergers.
- General practice contract performance management (e.g. breach notice administration)
- General practice budget management.
- Complaints management.
- Design and implementation of local incentive schemes (e.g. new local incentives to replace Quality and Outcomes Framework (QOF) payments, LES and directly enhanced services (DES)).
- Making decisions on discretionary payments such as returner/retainer schemes for GPs seeking to return to general practice after a break.

Primary care responsibilities retained by NHS England

- Dental, eye health and community pharmacy commissioning (although CCGs can be involved in discussions).
- Performance management of individual GPs: medical performers' list, appraisal and revalidation.

(NHS England and NHS Clinical Commissioners, 2014)

- Models:

Model 1 – Greater involvement

- CCGs collaborate closely with NHS England particularly around CCGs duty to improve the quality of primary care
- No new governance arrangements required
- No formal approvals process

Model 2 – Joint commissioning

- A Legislative Reform Order (LRO) has been passed through parliament to enable CCGs to create joint committees with each other and with NHS England from 1st October 2014
- Joint committees would require CCGs to amend their constitutions.
- Model TORs and schemes of delegation are being developed nationally. Pooled budgets can be developed and arrangements would need to comply with SFIs.

Model 3 – Delegated arrangements

- Full responsibility for commissioning of primary care services (however for legal reasons, the liability for primary care commissioning remains with NHS England, therefore NHS England will require assurance that its statutory duties and being discharged effectively)

- National Context / Support:

  * A National Primary Care co-commissioning Programme Oversight Group has been established (Co-Chaired by Dr. Amanda Doyle (Chief Clinical Officer, NHS Blackpool CCG) and Ian Dodge (National Director: Commissioning Startegy, NHS England)

* National position – 149 CCGs co-commissioning (63 fully delegated; 86 Joint)
* National methodology for determining delegated budget and move to ensure all CCGs have access to 'shadow' budgets for Primary Care during 2015/16.
* Delegation agreements.
* Suite of FAQs and exemplar governance documents available

Next steps

Unless a CCG has a serious governance issue or is in a state akin to "special measures", NHS England will support CCGs to move towards implementing co-commissioning arrangements.

- Timetable

    * Greater Involvement – anytime (largely the position today – NHS England will rarely take a decision about a practice which the CCG does not agree with)
    * Joint Commissioning – anytime – all governance arrangements need to be agreed and in place before the agreed 'go live' date
    * Fully delegation –'go live' only at the beginning of a financial year. Application by 2nd October 2015.

- Submission proforma

    * Proforma may change
    * Heavy focus on conflicts of interest management

- South East Context

    * Commitment to the vision articulated in the Five Year Forward View (supporting the development of new models of care, Vanguards, Prime Ministers Challenge Fund initiatives etc.)
    * 2 CCGs in Full Delegation (High Weald Lewes and Havens CCG and Eastbourne Hailsham and Seaford CCG). NHS England role becomes one of assurance.
    * 604 contracts; working out of well over 700 sites
    * Emerging impact of CQC regulatory regime (currently 1 CQC registration cancelation; 1 CQC registration suspension and 4 practices in special measures)
    * 25% staff vacancy rate

Sarah Macdonald
Director of Commissioning
NHS England South (South East)
6th August 2015

LMC presentation

Fiona Armstrong
Patricia Davies

Introduction

- In May 2014, NHS England invited (CCGs) to take on an increased role in the commissioning of GP services.
- Three Options:
  - **Fully delegated** responsibility for commissioning the majority of GP services
  - **Joint commissioning** responsibility with NHS England
  - **Greater involvement** in GP commissioning decisions with NHS England (current CCG position)

Things have moved on in 2015/16

- Over 70% of CCGs opted to take an increased role primary care commissioning
- 64 CCGs approved for full delegated commissioning of GP services
- Many CCGs now considering full delegated commissioning as want to better support primary care

Early days but key learning (from HWLH, Eastbourne and Tower Hamlet CCGs)

- Delegated commissioning presented a good fit with the CCGs long term plans
- They felt that 'doing nothing' is not an option – Current NHSE team is small and remote;
- Faster and clearer decision making on local primary care issues, for example: workforce, contracts, GP access, premises, etc;
- A greater degree of protection for the primary care budget

Early days but key learning (from HWLH, Eastbourne and Tower Hamlet CCGS) :

- Locally designed incentive schemes without the need for NHS Eng. Permission (GMS Plus models)
- Peer led Quality review at locality level focused on improving outcomes
- More collaborative approach to designing local solutions for care;
- Greater potential to move resources within the local health economy/across care pathways

Benefits we believe are…

- Better protection of primary care funding
- Opportunities to develop **GMS plus** type models
- Greater opportunities for collaboration and joint working between practices and other providers
- Greater focus on commissioning of primary care and enhancing quality rather than just 'contracting'

NHS England will retain?

- Individual GP performance management
- Administration of payments and performer list management.
- The terms of GMS contracts – and any nationally determined elements of PMS and APMS contracts

Risks we need to mitigate with support and joint working with LMC

- Primary Care funding protection – ring fenced budget with the right amount of money coming across
- Insufficient CCG resource to take on primary care commissioning, may need to look at shared arrangements across CCGs;
- Negative impact on CCGs relationship with GP members – open and transparent approach around conflicts of interest

We Don't have all the answers but…

- We agree that 'do nothing' is not an option – train in motion;
- Has to be better than status quo and we believe this could and should support federations
- Enables us to develop better care locally for our patients with funding actually following the patient
- Offers the opportunity to fully utilise the knowledge of GPs and build on the relationships that CCGs have developed.

NHS
West Kent
Clinical Commissioning Group

Co-commissioning: Kent LMC August 6th 2015

NHS E is no longer acting as a supportive environment for G/PMS, only interested in performance management and reporting compliance. It's got harder to run a practice under the present arrangements

There are no signs that this is going to get better (apart from additional 5000 GPs!)

If the future is like the recent past, G/PMS contracts are not a sustainable platform for practices and independent contractor status

Meanwhile national (5YFV) and local policy (MTF) envision enhancements to out of hospital care, which will require management and clinical leadership. The CCGs are responsible for the implementation of the 5YFV, GPs are crucial to this; the CCG can't deliver its strategy without GPs and their practices

5YFV describes new models of care, in particular Multisystem community providers

MCPs This involves the development of federations, networks and super partnerships to enable general practices to operate on the scale required to deliver a wider range of services. These services would include those provided by some specialists alongside other professionals such as nurses, therapists, pharmacists, social workers and psychologists. The purpose being to deliver holistic care closer to home, not in secondary care where spend has inexorably increased over the last 8 years

The CCG needs strong Practices in order to deliver this vision; the alternatives will be worse for commissioners, the public, and practices

Benefits of Co-commissioning

Making it easier to run a practice; simpler reporting, better business support

Integrated provision of out of hospital care, led by GP federations

Restoring partnership between practices and commissioners to foster public engagement, strategic planning, federated working and the development of MCPs; reviewing primary care services and investments in primary care

Precautions

Managing conflicts of interest and ensuring transparency

Preservation of national contract

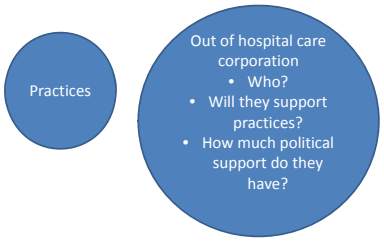
Clarity about what will and won't be in scope

Possible Futures 1

GPs influence increases, population has greater benefit from wider GP advocacy, independent contractor status remains contributory

NHS West Kent Clinical Commissioning Group

Possible Futures 2



Practices done to and increasingly vulnerable, independent contractor status and contribution marginalised

NHS West Kent Clinical Commissioning Group

It is the West Kent members choice whether West Kent does this , what we do and what we seek to achieve by doing it, and for other CCGs to make local decisions.

NHS West Kent Clinical Commissioning Group