

HEALTHCARE
LEADER



A POST-MORTEM

EVALUATION | REFLECTION | PREDICTION



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Dr Ethie Kong , former Brent CCG chair for two terms. Currently a GP partner and a clinical lead in Central London (Westminster) CCG	Dr Neel Gupta , governing body member and finance committee chair, North Central London CCG, 2020. Before that, chair of Camden CCG from 2017 to 2020
Dr Stewart Findlay , Chief Officer for County Durham CCG. Before that, accountable officer for Durham Dales Easington and Sedgefield (DDES) CCG	Dr Joanne Watt , chair of Northamptonshire CCG .
Dr Jagan John , chair of North East London CCG since 2019. Before that, chair for Barking and Dagenham CCG	Dr Agnelo Fernandes , South West London CCG borough lead for Croydon. Before that, chair of Croydon CCG from 2017 to 2020

About Healthcare Leader

Healthcare Leader is an online media platform dedicated to informing, engaging and supporting decision-makers in NHS primary care services.

As the architecture of the NHS shifts from clinical commissioning groups to integrated care boards and integrated care partnerships, Healthcare Leader gives primary care leaders in the three emerging tiers of the NHS – system, place and neighbourhoods – the opportunity to share innovative ideas on how to address the challenges they face politically, structurally and financially.

Our team produces daily news, thought leadership, roundtables, insight and reports to champion primary care services.

We work to seek out case studies, profiles and interviews covering innovative projects and pilots to help spread best practice and support the ICBs' triple aim – a duty of better health for everyone, better care for all patients and sustainable NHS services.

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Introduction

A decade ago, there was a party at Number 10 Downing Street. It was a different time, though still a controversial time. As guests mingled, shaking hands, the then Prime Minister, David Cameron, welcomed the bright new GP leaders who would head the 2012 reorganisation of the NHS – a reorganisation that would put GPs front and centre of commissioning the majority of healthcare, holding £65bn of the £95bn NHS commissioning budget.

Jump forward to 2022 and CCGs are consigned to history like primary care trusts and primary care groups before them. So before those clinical leaders are dispersed to core practice work, the private sector, retirement, primary care networks (PCNs) or the newly minted integrated care systems (ICSs) we've captured their thoughts and feelings.

Through eight interviews with CCG chairs past and present and a poll of 143 clinical commissioning leaders and staff, we've pulled together a snapshot of the past decade's successes and current concerns to evaluate and reflect what CCGs achieved and predict what ICBs need to be wary of and build on for future success. The report records some of the work done by CCGs and gauges opinions on what the future could look like after GP-led commissioning.

It also seeks to recognise a decade of dedication from the GPs who put their heads above the parapet and became commissioners. It's a role that, at times, brought them into conflict with colleagues, but always with the aim to create a clinically led service with better outcomes for patients.

1

EVALUATE

Background:
The evolution of CCGs

A decade ago, Andrew Lansley, the then health secretary and Conservative MP for South Cambridgeshire, embarked on a controversial set of healthcare reforms to place clinical decision-making at the heart of care planning and increase competition in the NHS by creating an internal market to drive efficiency.

A key facet of these reforms was CCGs. Clinical commissioning groups (CCGs) were to receive the lion's share of the NHS budget, about 60%, and would use it to commission care from NHS, private and voluntary sector providers. They were responsible for commissioning community and mental health services, urgent and emergency care, including

NHS 111, and planned hospital care. They also commissioned GP services through co-commissioning. Lansley aimed to put clinicians, usually GPs, in the driving seat as chairs and accountable officers of these bodies and also to get every GP in every consultation room to think about the financial implications of each interaction – every referral and every prescription. All GP practices had to be members of a CCG and the chair was elected by the members. The reforms were not plain sailing. Lansley was not able to steer the ship. The bill floundered and the tide turned against it – particularly the promotion of competition by hospital regulator Monitor, now part of NHS Improvement.

The waters had to be calmed by the then Prime Minister David Cameron, who rebranded the reforms as 'evolution not a revolution'. There was an unprecedented pause in the passage of the bill. A new body, the NHS Future Forum, was created, which embarked on an eight-week 'listening exercise' to gather the views of everyone. Then the bill proceeded largely as planned but with a few changes.

One change was the name of the commissioning organisations. They were to have been called GP consortia. This was changed to CCGs, to be more inclusive. Monitor's role to promote competition was retracted.

The primary care trusts and strategic health authorities were consigned to history as CCGs were established by the Act in 2012 and took over on 1 April 2013. Originally, 211 CCGs progressed through an authorisation process with the NHS Commissioning Board, which is now NHS England. Since 2015 there have been 37 mergers of CCGs as they realised the merits of working at scale. The final number stood at 106.

In 2013 CCGs began the work of commissioning care for their populations. The internal market was set up. There was a commissioner-provider split – there were conflicts of interest between GPs who provided care and those who were commissioning care.

CCGs have lasted nine years, which is probably longer than most expected. We now sit on the precipice of another restructuring cycle. The Health and Care Bill 2022 received Royal Assent on 28 April and ICSs became statutory bodies – integrated care boards (ICBs) – and officially took the reins from CCGs on 1 July, although many will continue in shadow form into the autumn.

ICSs have had a long run-up. They started in 2016 as sustainability and transformation plans (STPs), which were voluntary collaborations. Now they will be run by ICBs in collaboration with integrated care partnerships, which bring in wider health stakeholders. They will manage care across vast areas of England, covering populations of between one to three million people.

It is both timely and important to look back at CCGs – their successes and failures, and especially what those GP commissioners with little initial support or training, have been able to achieve.

2

EVALUATE

CCG successes and failures

CCGs were set up with the dual aim of bringing clinically led decisions to the fore when commissioning and planning care and to incentivise every GP to think about the cost of their consultation decisions when prescribing or referring. Did they succeed?

CCG leaders pointed to several common areas of success: creating a unified voice for primary care; improving pathways and patient care; and developing primary care, including establishing primary care networks (PCNs) in 2019.

A unified voice and primary care development Our Healthcare Leader CCG evaluation survey, answered by 143 CCG leads and staff, found that 67% think CCGs were successful in making clinically led decisions, 71% think they were successful in increasing the primary care perspective and voice within the NHS and 66% think they generated clinical leadership. See box 1, below. CCGs were given the lion's share of the NHS budget with which they were to commission care for their local areas. This helped to adjust the playing field between small primary care providers and large acute providers, even if it did not level it. Having leadership from GPs was 'wonderful', said the chair of West Leicestershire CCG, Dr Mayur Lakhani. 'We've never had it before. It was official, so that was really good.'

'I think when we look back, CCGs will be seen as the crucial element underpinning a clinically led NHS. I've just been in an ICS meeting, and it's all about supporting the transition of clinical leads. About five or 10 years ago, that would have been managers sitting in a room – not because they didn't want to [engage with clinicians] but because they didn't know how to connect,' adds Dr Lakhani, who has recently been appointed chair designate of the clinical executive of Leicester, Leicestershire and Rutland ICB.

Another powerful achievement of CCGs is the idea of general practice as a corporate entity. Leaders point to the establishment of PCNs and GP provider alliances, or a network of networks, as good examples of the creation of primary care as a more cohesive tranche of healthcare architecture.

Dr Lakhani explains that in Leicestershire there is a provider alliance of GP practices that have come together as one unit – which would have been 'unheard of without CCGs and other enablers'.

'GPs are now working together as practices and saying, "we're a force to be reckoned with", he says, and highlights that instead of 7,500 disparate practice voices there are now 1,200 PCNs.

'Just imagine our power and might if we spoke coherently, which I think we're getting to, because we've got a way of speaking, a common language – population health.'

Dr Joanne Watt, chair of Northamptonshire CCG, agrees that CCGs have been the 'glue in the system' through co-ordinating the Covid response, the vaccination programme, the development of PCNs and the GP board that was formed during Covid.

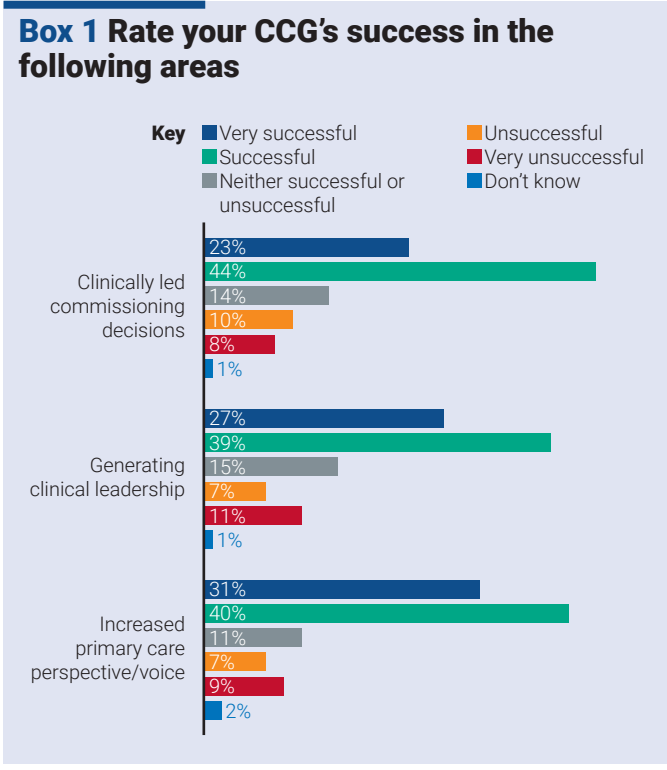
Speaking about the board, Dr Watt says: 'It's supported by the LMC and chaired by the LMC chair, but it's so much more than the LMC. It incorporates three federations and the CD16 – which is what our PCN clinical directors (CDs) call themselves. It is going to be taking on the support of our localities as well,' she says, and adds that this organisation will feed into the primary care representatives.

Of course, there are huge tensions in some areas between practices and CCGs. This highlights the division created by the commissioner-provider split, which we will explore later. But Dr Watt says her CCG worked hard to engage and advocate for practices.

'It used to be that when hospitals got busy, an email arrived telling GPs to work harder and faster. I have changed that and I hope it sticks. Now, when hospitals are hot I phone the medical directors and ask "What are you hot with? What can we do? What could be different?" That's one of the areas I'm most proud of. We've got a clinically sensible approach to surge. I hope that it continues [in the new system].'

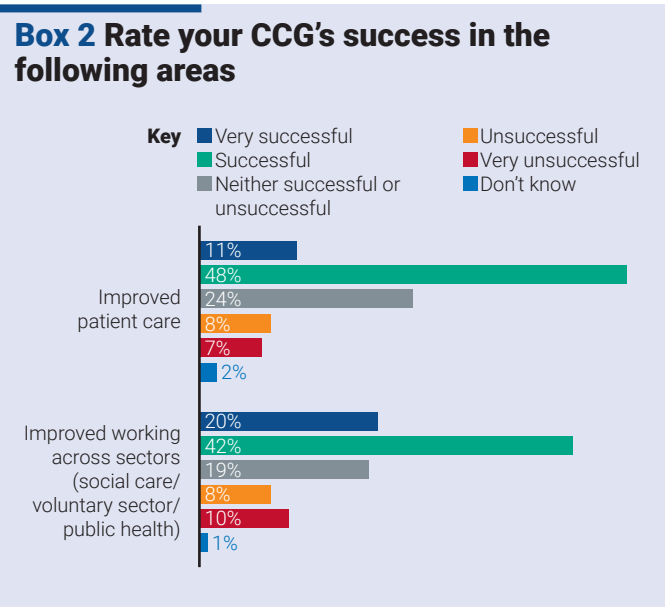
Dr Agnelo Fernandes, clinical chair for Croydon CCG in south-west London, also says close working with the area's key trusts has been a huge positive.

His CCG appointed a place-based leader across the CCG and the trust in 2018 with a memorandum of understanding that



I particularly think CCGs enabled clinical leadership in primary care to develop as they gave influence to primary care in commissioning and improving services

Survey participant: Dr Annabel Crowe, chair of North-West London CCG until March 2022



established joint board and committee meetings and joined their finances ‘at the hip’.

‘Before, either the CCG or the trust did well financially, but not both. The system was in deficit and commissioners and providers were not working together. Once we started working together, we had huge improvements in terms of quality, transformation, efficiencies and finance.’

In Croydon, investment was funneled into primary care for integrating general practice with the wider primary care and transforming pathways. Planned care was part of this, where there was a single point of referral to the local hospital, because ‘finance follows the patient’.

Referrals were reviewed before they were sent, and advice and guidance were available before they became mainstream policy.

‘In my practice we still have a peer review meeting every day, for all referrals that go into secondary care. We had a financial challenge, but we had a quality challenge as well. So all our other trusts have long waiting lists for client care, but ours is the shortest,’ he says.

Dr Neel Gupta, former chair of Camden CCG in north London, explains they worked on bringing GP practices together before PCNs.

‘We have taken an innovative approach to primary care commissioning in Camden. Ahead of PCNs, we brought together neighbourhoods and we set outcomes at neighbourhood level. It embedded joint working because we were collectively responsible for the outcomes of that population rather than just our own practice.’

Improved care

CCGs set about designing new care pathways and leaders say that this work has ‘definitely’ improved care. See box 2, left.

Some 59% of our survey respondents thought CCGs had been successful or very successful at improving patient care, while just 15% felt they had not.

North East London CCG covers seven boroughs with very different populations. Its chair, Dr John Jagen, has numerous examples of his CCG’s successful innovations in primary care.

‘We’ve done really impressive stuff over the years, built on hardworking, professional clinical and care staff, looking at population-based health. We’ve also done a huge amount of work on social prescribing and holistic care plans, which is something North East London’s really leading on, the personalisation agenda,’ he says.

He highlights the diabetes care and treatment in Barking and Dagenham, which reduced the number of undiagnosed cases by more than 1,000, produced patient information on foot care in numerous languages and, during the lockdowns, carried out patient reviews in local parks.

In Redbridge, he says, there was award-winning work on atrial fibrillation. ‘This saw improvements in detection of heart conditions. We were recognised as the most improved London borough in terms of preventing strokes, and working collaboratively with our local hospital – Barking, Havering and Redbridge University Hospitals Trust. And as a result of this, the pilot was adopted by three of the boroughs.

‘Also we’re leading on a big piece of work for a new health and wellbeing hub on the former site of St George’s Hospital in Hornchurch, which is a massive win. We also aim to get a dialysis centre there,’ he adds.

Dr Stewart Findlay, chief officer for County Durham CCG, says CCGs have supported care closer to home and community services. They have also led on integration with mental health teams, the voluntary sector, local authorities and social care. He also says the CCG has improved access and ‘done a lot of work to support the urgent and emergency care system’ – something CCGs are often criticised for.

‘We have a liaison scheme in Durham. It’s like an enhanced service scheme, an incentive scheme, that moves a lot of testing out into primary care. It makes sure GPs do things like 24-hour ECG monitoring, ECGs, manage DVTs. We’ll do bloods on behalf of hospitals’ remote clinics in the community, a whole load of things. We’ve done so much to help and support secondary care as well as develop primary care as CCGs.’

Our survey found that 62% of respondents felt integration across social care, the voluntary sector and public health had been successful. See box 2, above left.

Dr Watt says the fact that CCG clinical leads are also jobbing GPs helps smooth the path of patients as they can report back directly on problems as they move through the system.

She says her CCG has a better relationship with care homes through its frailty work and the PCN care home service.

‘Our relationship with care homes is different. They were left out of the system but they are where a significant proportion of our patients live. I am pleased with how they’ve developed. As a CCG we’ve done lots of education and upskilling, and I’m hoping care homes have become much better places for people to live,’ she says.

Dr Lakhani cites the end-of-life care in his West Leicestershire CCG as a success, demonstrated by the fact it was adopted by all 133 practices. Another success was improvements in management of long-term conditions.

Dr Neel Gupta, chair of the North Central London CCG finance committee, says: ‘We’ve done genuinely ground-breaking things in Camden. In particular, we took an early move towards value-based commissioning and outcomes-based commissioning. Now, a decade on, people are still talking about these things as novel concepts.’

Camden developed a diabetes integrated practice unit using an alliance contract with a lead provider, the Royal Free London NHS Foundation Trust and University College London Hospital NHS Foundation Trust (UCLH), with an outcomes component making up 20% of the contract, with the aim of getting everyone to work together. A similar outcomes-based contract musculoskeletal service still exists, with UCLH as the lead provider.

‘We were able to invest in that contract and get people’s interest. We needed money to get the Royal Free and UCLH to the table, but we also needed lots of engaged clinicians for the clinical relationships. Over the years, we’ve built a lot of relationships between GP leads and hospital consultants – a real success that allowed us to develop pathways and commissioning models that I don’t think would have happened in a previous era,’ he says.

Dr Gupta says Camden was ‘the highest performing area in the country’ when assessed against the NICE diabetes triple target, for blood pressure, sugar control and cholesterol management – an illustration of the CCG’s success in getting people to work together.

‘Even if your practice was doing well, you had to think about what your neighbouring practice was doing – so it drove up the overall quality,’ he says.

Finances

Of course, the opportunity to innovate and improve care depended on the financial picture of a CCG. Some CCGs started life with huge deficits – something that Dr Gupta is very aware of.

‘People’s experience of this will have varied massively depending on the financial picture they inherited. When we took over as a CCG from a primary care trust (PCT), we had a large surplus.

‘We were in the perfect position, where we brought clinical leaders to the forefront who had great ideas about what was working well, what wasn’t working well, how things might look different and how we might transform the system. And we had the money to invest to deliver that.

‘Of the five CCGs, [in North London] Camden and Islington had more money and the outer boroughs didn’t. So the GPs in Barnet or Enfield who were CCG governing body members had very different experiences from me in Camden.’

South of London, in Croydon, Dr Fernandes inherited a deficit of ‘around £46m’.

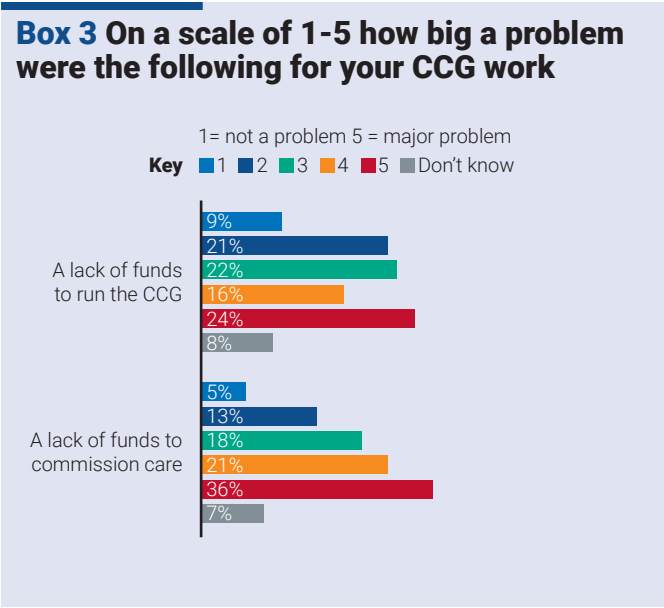
‘It was seen as a poisoned chalice and we could hardly get any GPs involved in the governing body, or anything really. But we turned the tide. We wanted to do something different. We wanted to focus on quality, to improve quality and services as a way of addressing the financial challenge.

‘We started off on a really bad platform, but that was a driver for change. By the time we finished the Croydon CCG we had an efficiency saving of more than £122m, with transformational quality improvements as well as financial efficiency.’ See box 3, below.

The evaluation survey highlights lack of funding as one of the major obstacles. Some 57% of respondents said a lack of funds to commission care was a major barrier to success, although respondents were evenly spread on whether they thought there was a lack of funds to run the CCG.

Dr Lakhani says the financial levers set up in the CCG system did not work. He says CCGs got into a lot of debt, because they ‘essentially ended up growing the acute sector’ while there were no levers to grow primary and community care.

‘Hospitals had incentives to increase activity. Primary care had incentives to reduce activity – and this is for the same group of patients. One finance team was saying: “Let’s do more, let’s admit more people, see more people”. The other side was saying: “Let’s reduce activity.” That wasn’t deliberate, but the commissioning wasn’t aligned. Basically we had a system that was broken and wasn’t working in a joined-up way for patients. I think there was a need for change.’

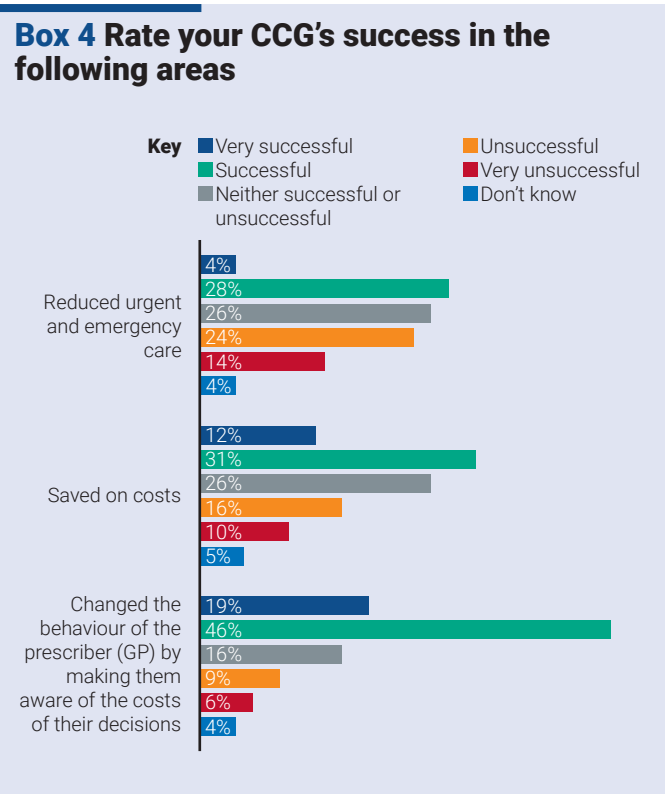


“The CCG never had powerful enough levers to change the behaviour of the trusts, which spun the financial roulette wheel for all they were worth

Survey participant from North Central London CCG who wished not to be named

CCGs are totally focussed on looking good among other paper shufflers and bean counters

Survey participant who wished not to be named



The majority (43%) of those surveyed agree that CCGs were successful in saving on costs. See box 4, above.

CCG leaders feel there has been an impact on the behaviour of GPs, making them aware of the cost of their referrals and prescriptions. Some 65% rated CCGs as successful in this area in our survey. See box 4, above.

Dr Findlay says that in Durham behaviours in the consultation room changed.

‘For a while our incentive scheme was partly based on each practice showing a balanced budget at the end of the year. That was their share of the budget for everything, so if they managed services in the community rather than referring to secondary care they would be incentivised for the reduction in hospital referrals and in the cost of our services into secondary care. That drove a real change in referral patterns. GPs saw many more people in their own surgeries. When PCNs and the Investment and Impact Fund (IIF) came in, we thought they were going to replace our service so we stopped. We also had contracts in place by then rather than payment by results.’

Dr Findlay says that Covid makes it difficult to tell if referrals have gone up since the end of the incentive scheme.

‘We’ve tried to put similar incentives into a block arrangement

with primary care but my feeling is that the incentive has been taken away. I’ve heard GPs say they’re now not incentivised to stop referrals – so maybe we stopped it too soon.’

However, if CCGs had been an unmitigated success, there wouldn’t be a move to shake things up again. Our interviewees point to several common failures of the CCG structure – the commissioner-provider split, the failure to ‘move the dial’ on urgent and emergency care, and perverse incentives.

Internal market

This biggest of these failures is the commissioner-provider split. This divided the GP workforce into two camps. The commissioners had the power and the budget and pushed the incentive schemes to drive efficiencies at practice level. But some GPs who focused on providing care felt that CCG GPs went into new shiny buildings and forgot their roots.

The commissioner-provider split was the clearest tension in the CCG structure. The Covid pandemic shone a light on the fact that much more can be achieved through collaboration.

Dr Findlay says: ‘We were encouraged by the system to work against each other. In the early days we were pretty tough with our providers, particularly our acute provider.

‘I think we went to arbitration twice with them and obviously that’s seen as a failure. But if you wanted to invest in primary care and community services, the money had to come from somewhere. It was a couple years until we got into a more balanced position with our providers and realised we should think win-win, not competition.’

Our survey showed a spread of opinion on the relationships between CCGs and GP practices and trusts. Most respondents (44%) said the relationship with GPs did not pose a barrier to success. There was a spread of opinion on whether relationships with acute providers were a barrier to success – 33% ranked this a big problem and 29% ranked it as no problem, which perhaps reflects the varied relationships around the country. See box 5, right.

Former chair of Brent CCG Dr Ethie Kong says the division CCGs created in primary care led to mistrust between commissioning GPs and providing GPs, and became a barrier to improvement. She is concerned that these tensions will not dissipate.

‘If only the commissioners in primary care had worked better with the providers, we could have worked better with our community and secondary care colleagues. At the moment, there are PCNs, which do not have the same voice as CCG GP leaders. But we’re all GPs. We’re all caring for our patients, wanting to commission good services for our patients, wanting to provide good service for our patients. We are all on the same side for our patients. Why is there this divide?’

Dr Watt says it’s been difficult to develop a sense of shared outcomes, things that everyone feels are important for their populations. She also points to difficulties in translating the public health data into innovation for clinical services.

‘The way the finances have worked, it’s been about counting

the number of procedures one does, even though they’re not necessarily the procedures that will produce the most health for our population.

‘If we look at an area like frailty, we should make sure people have the best lives possible, not that we do the most hip operations. We should be focusing on mobility, independence, satisfaction and happiness, rather than operations, which may or may not have improved people’s mobility, but are necessary in order to fund hospitals.

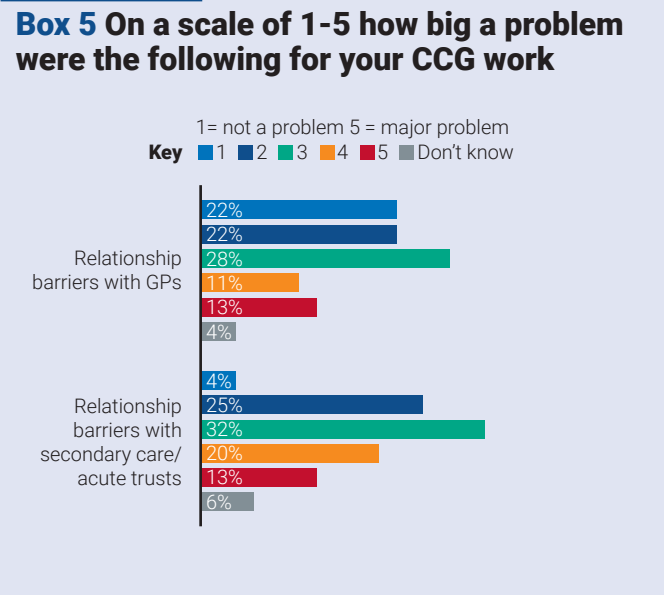
‘We’re now hopefully going to take a much more holistic approach to what our population actually needs for a dignified and appropriate old age.

‘I am optimistic about that focus on health inequalities, looking at Core20PLUS5, a national approach to tackling health inequalities. I hope we’ll start to get more of a focus on what is important from an outcome point of view, the shared proxy measures. And that, hopefully, this will allow finances to be moved more flexibly around systems.’

The impact of Covid on CCGs

Covid brought many things into sharp focus – who the key workers were, who the people in most need were, the disparities in society. It also showed that the way forward for the NHS was collaboration, not division, competition and financial penalties.

The internal market, which was lauded as the key driver for saving money in the NHS, worked in giving primary care leverage with large acute providers and in incentivising practices to refer less. But collaboration has won out as more beneficial to both the system and patients.



Dr Lakhani says: ‘The internal market is going because particularly in Covid, we found that the providers got together and said: “These are the services we need for the Covid emergency – set up these pathways.” We created hot hubs, and hot and cold wards in the hospital.’

Much of the leadership in the pandemic came from providers. But CCGs had a role to play providing clinical leadership and supporting PCNs as hot hubs were established and resources were shared.

Urgent and emergency care

Urgent and emergency care is often seen as a particular area of failure for CCGs.

Our survey showed a spread of opinions – with 32 % rating urgent and emergency care as successful, 26% neither successful or unsuccessful and 38% as unsuccessful. See box 4, far left.

Dr Lakhani says: ‘I think we were overwhelmed with demand and weren’t able to really reshape the healthcare system. It wasn’t through lack of trying. But remember these are worldwide problems, and we didn’t have the powers to really change things.

‘We had payment by results, and there wasn’t an aligned financial framework and strategy. There is a new framework now for thinking about things. It’s detailed and complex, but basically, it rewards collaborative working.

‘I think we didn’t really move the dial on the big issues that would worry the Government and people – waiting lists, cancer diagnoses, urgent and emergency care, and A&E. But was it realistic to expect CCGs to do that? I think hopes were very high.’

However, our interviewees had a spread of opinions. Dr Findlay did not see issues with urgent and emergency care.

‘In North Cumbria we had an emergency care network. All our trusts, CCGs and ambulance service worked together to make sure urgent care worked across the region. How will an ICS create anything different from that? I think we were one of the most successful urgent emergency care networks,’ he says.

Urgent care remains a challenge for the system. The latest thinking comes from the *Next steps for integrating primary care: Fuller stocktake* report published by NHS England in May. It calls for an urgent care pathway in primary care to link all aspects of the service from 111 and urgent treatment centres to GP practices and pharmacies.

The report states the NHS should: ‘Develop a single system-wide approach to managing integrated urgent care to guarantee same-day care for patients and a more sustainable model for practices. This should be for all patients clinically assessed as requiring urgent care, where continuity from the same team is not a priority. Same-day access for urgent care would involve care from the most clinically appropriate local service and professional and the most appropriate modality, whether a remote consultation or face to face.’

Perhaps this latest idea will be the one that gets a handle on the issue of managing urgent care in the community.

3

REFLECT

Should CCGs be scrapped?

The Health and Care Act 2022 sets in motion the next reorganisation of the NHS. CCGs will be replaced by 42 ICBs – which will have one, two or three primary care representatives, not necessarily GPs. ICSs will work alongside integrated care partnerships, which will bring together the NHS and local councils.

These IBCs officially kicked off on 1 July but have been gestating as STPs since 2016 . Now they have statutory status and will receive much of the NHS budget, currently about £151.8bn.

These ICBs will be judged on how well they foster integration. Each area is still working out its structure but broadly speaking ICBs will delegate their budgets to places – usually based on council footprints – and neighbourhoods at PCN levels.

But many have questioned whether this is the right thing to do and if, after a pandemic, it is the right time. Many of the CCG leaders understandably feel annoyed that CCGs are coming to an end and regard it as a general failure of governance of the NHS. Changes take a long time to work through an organisation as big as the NHS. There is a feeling that rather than reconfigure the service more efforts should have been made to raise all CCGs to the best standards.

The majority of respondents (49%) say CCGs should not come to an end but a quarter believe they should. See box 6, below right.

Dr Hasan Chowhan, chair of North East Essex CCG, doesn't think legislation was needed to develop integrated working.

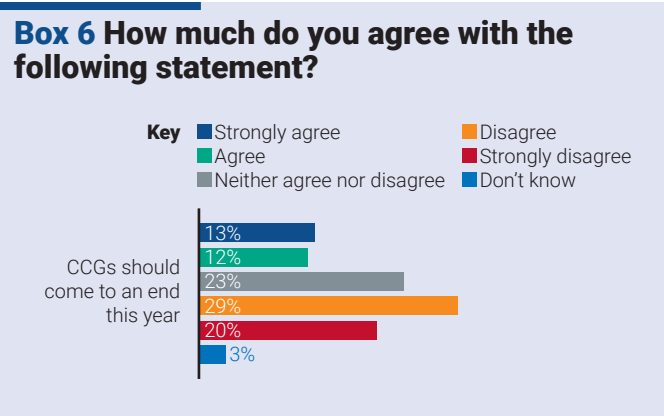
'CCGs have been working in the system for quite some time, so although there wasn't formal integration, many of us have been working in that way. For us in North East Essex, using this model of alliance contracting, we've transformed urgent care. We've been living it. It's nice to get the formal sign-off for integrating health and social care, but I don't think it's so apparent how that will work. I'm not sure a great deal will change under that integration badge.'

Dr Fernandes echoes this sentiment. 'Everything that the ICS is trying to achieve, we achieved in Croydon because we developed an alliance with the local authority, the mental health trust, the GP collaborative and the voluntary sector. The voluntary sector came in to its own during the pandemic and we built on that. So, we had an integrated system already developing.'

Dr Findlay, who has worked in CCGs since they began, is emphatically against getting rid of CCGs.

'The problem is that not all CCGs were good; but instead of making all CCGs good we have another reorganisation. What they should have done was try to make all CCGs as good as the best.

'I'm a great fan of CCGs. I think they've done a lot to develop community services. Durham was doing primary care home (a programme from the National Association of Primary Care) before we had PCNs. We've invested in community services and developed integrated services. We're closely integrated with our council, voluntary sector and acute trust. We've set up joint partnership boards with mental health trusts, the acute sector, local authorities, CCGs and GPs. CDs of PCNs are on them already. So, from a place point of view, we have done everything but set up



a formal joint committee and we're in the process of doing that at the moment,' he explains.

He says the move to ICBs is political. 'It's hard to understand why [they are getting rid of CCGs]. It's not going to help integration. If anything, it will make integration more difficult. If they're not going to make staff redundant, which they've said they won't do, it's not going to save money. How will it help? I don't understand,' he says.

Croydon's Dr Fernandes agrees. 'If we hadn't had CCGs I don't think we'd have got through the pandemic as we did because it required a lot of clinical input, clinical leadership and management support. I can't see how the pre-CCG era could have done that – or a system that is further removed from the front line,' he says.

Dr Lakhani says he has 'mixed views'. 'I agree with the policy direction, but I feel sad that CCGs themselves are coming to an end.' He says CCGs weren't able to create the change needed as

“Unlike a CCG, which had a clinical majority on its governing body, the ICB will have clinicians in the minority. Primary care influence will be eroded

Survey participant: Dr David Spraggett, chair of NHS South Warwickshire CCG

providers captured the market. People needed to be 'brought together in accountable care organisations – which is what ICSs are'.

'Now there is a statutory responsibility for hospitals, GPs and community trusts to work together in a partnership that's legally defined, for patients. So this is the big change. There's no procurement, or there shouldn't be, and there's no competition.

'Forget all the policy. The change we need is this – when somebody's ill or thinks they're ill, there's a local solution to their needs, and 90% of that should be done [out of hospital].'

Dr Lakhani is worried about what the 'big change' will mean for GP engagement. He feels CCGs provided a voice for general practice. 'I don't think it's black and white. I think the policy direction is clear because we needed the mechanisms to change services, and the financial packages, but I'm worried the clinical voice that CCGs gave might be diluted,' he says.

Dr John says CCGs are not ending; rather, they are 'evolving'. 'This is the next stage of CCGs. We've got this clinical leadership, we've got that historical learning. We're building on what we've learned and trying to improve outcomes even further.' He adds that the change is also about looking at resources in terms of finances, workforce and estates in a collective way to make long-term plans for population growth and infrastructure changes.

Dr Gupta is also in favour of the move to ICBs. 'Yes [CCGs should come to an end] but there's a lot of good stuff we mustn't lose. I'm probably biased when I say this, but the single biggest success of this has been bringing clinical leadership through from primary care specifically.'

Dr Gupta fears that while CCGs spent the last decade investing in people who are now skilled and experienced 'there is no retention and succession planning going on'.

'There's a huge risk that, having invested in these people and proved they add value, we then lose a lot of primary care clinical leadership.'

He says that in North Central London, the five CCGs had around 40 GPs in strategic leadership roles. This number fell to 10 GPs on the North Central London board. The ICB has plans for just one or two.

'That's a huge reduction – and what's become of those 40 leaders? What efforts are being made to retain them in some form? While I don't think you need 40 strategic leaders, you don't want to lose them. You want to retain the skills and experience,' he says.

Crudely, if that figure of 10 clinical leads per CCG is extrapolated, that would be around 1,000 clinical leaders who have worked at a strategic level. The new system has space at ICB board level for 61, according to the recently published 42 ICB constitutions.

'It's not the clinically led commissioning element that needs to end,' he says. 'It's the commissioning set-up in general that needed to be overhauled. CCGs, as they were constituted, have run their course – because some of the commissioner-provider split has run its course. Putting clinicians into directly adversarial positions is not a good idea.'

4

REFLECT

Clinical leadership:
where will it go?

While assurances have been made that CCG staff will not lose their jobs and will transfer across the ICB there are no such provisions for the clinical leadership chairs. So where will they go? Some have moved to PCN roles, or are looking towards the ICS or private sector. Others are seeing it as an opportunity to retire. As much as everyone agrees that a key success of CCGs was giving voice to primary care clinical leaders, there is now a unifying concern over a loss of that leadership.

Our survey showed that 68% of respondents felt there will be a loss of clinical leadership. See box 7, below.

Loss of leadership

Our survey also found that just over a quarter (27%) of respondents were looking to continue in leadership roles with the ICS while the majority (36%) were not. See box 8, right.

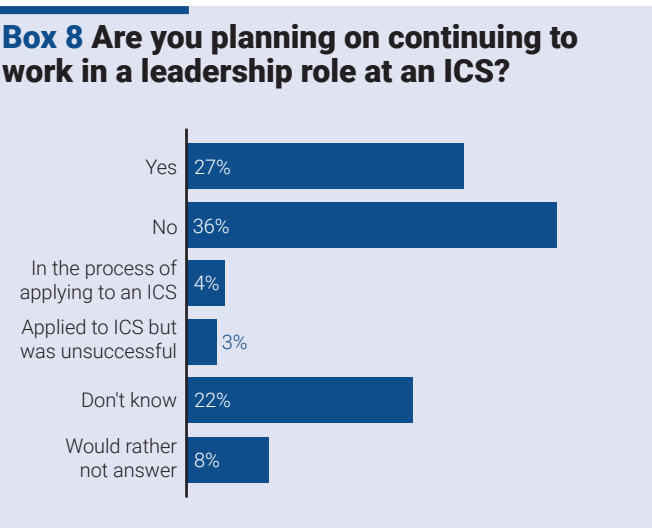
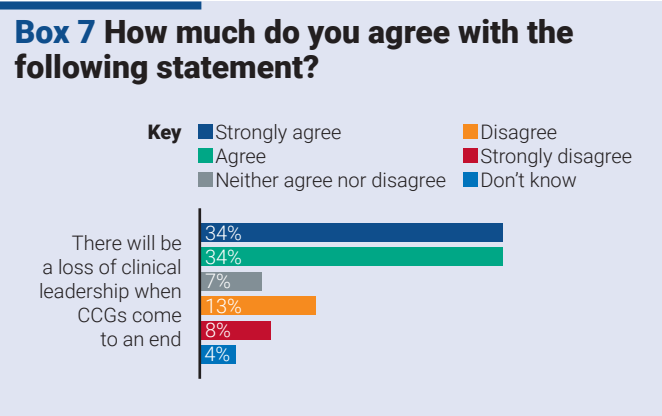
The CCG leaders interviewed were concerned about the loss of experienced leaders.

North East Essex chair Dr Chowhan says: ‘Whenever you have an organisation change from one form to another, you have to think who are the people who will take that change forwards? There isn’t a mass of people with this level of experience, be it clinical or non-clinical.

‘I fear for clinical leadership, and I’m biased because obviously I’m a clinical chair and a GP, but I don’t think there was ever any thought about what happens to those experienced clinical leaders. If I speak to my colleagues, many of them have no pre-set notions of where they’re going to next,’ he says.

Dr Kong says you need ‘very knowledgeable, very skilled leaders’ at the ICB who can balance the competing needs of different places along with the needs of the system as ‘every borough might be fighting for its own inequalities, its own needs’.

‘We have eight boroughs in North West London ICS, and there’s only one [primary care board] place at the ICB. I think the anxiety among GPs, and borough-based people including residents, is “are our interests, in our boroughs, well represented and listened to?” ‘



Dr Lakhani recognises this concern about the loss of influence at system level. ‘In CCG land, we ran the show. Nothing happened without GPs’ agreement. It was a rare power; a rare first in NHS history and it was used carefully and ably. But now, we’re not a membership organisation, we are one person on the board. I think people are genuinely worried about the loss of the general practice voice at system level. I don’t get a sense that people don’t want it to be clinically led, it’s how you exercise the powers and influence in the complex governance of an ICS. Time will tell whether it will remain strongly clinically led.’

He highlights the clinical and care professional leadership framework (CCPL), a policy that requires each ICS to develop a framework for clinical leadership and engagement that is signed off nationally.

‘They can’t become an ICS by just saying they’ll involve GPs. They have to say how. CCPL is going to replace the clinical leadership membership model, but ICSs are not membership organisations, they won’t be made up of GP practices. It’s a shame.’

Dr Gupta says that everything about the formation of ICB is ‘entirely silent on the non-executive side of things’.

‘It’s not just GPs. There are lay members who have been part of the system going back to the PCTs and bring a huge wealth of experience, skills and knowledge. Again, there’s nothing about the retention of the non-executive. I’ll include GPs in the non-executives.’

Dr Fernandes says there will be a loss of clinical leadership to the system as there isn’t a directly transferrable role for a CCG chair on the ICB.

‘There are only two groups of people that meet the public on a daily or weekly basis. One is GPs and the other is local authority counsellors. When we came together on the health and wellbeing

board, and I’ve been vice-chair since 2012, it brought these two groups together to challenge the system. That primary care input will be less because the trusts will have a bigger say in everything and be given a bigger budget,’ he says.

In South West London, the outgoing clinical chair has set up a clinical leadership structure at borough level and at South West London level. There are clinical leads across programmes of work. But Dr Fernandes thinks they will be supporting managerial decision-making, not leading the work.

‘We’ll have to see what impact they have. But their roles will be totally different. They’re termed clinical leaders but actually they will be providing clinical advice.’ Dr Fernandes adds that this dilution of the clinical role will ‘diminish’ clinical leadership.

The survey also found that 24% of respondents face a loss of income when CCGs come to an end. See box 9, below.

Where next?

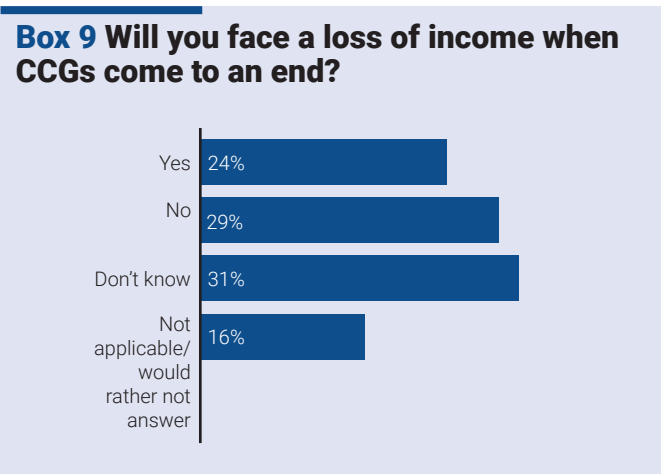
The top three places survey respondents said they would look to work in were an ICS role at board, place or neighbourhood level (28%), a PCN role (19%) and a GP practice role (21%). See box 10, above right.

For Dr Fernandes it’s an opportune time to think about work-life balance as well – particularly with the challenges faced by the profession in the peaks of the pandemic.

‘People gave an awful lot in the last two years, and the clinical leaders disproportionately, because they knew what the reality was – especially where we lost GPs. That really brought it home.’

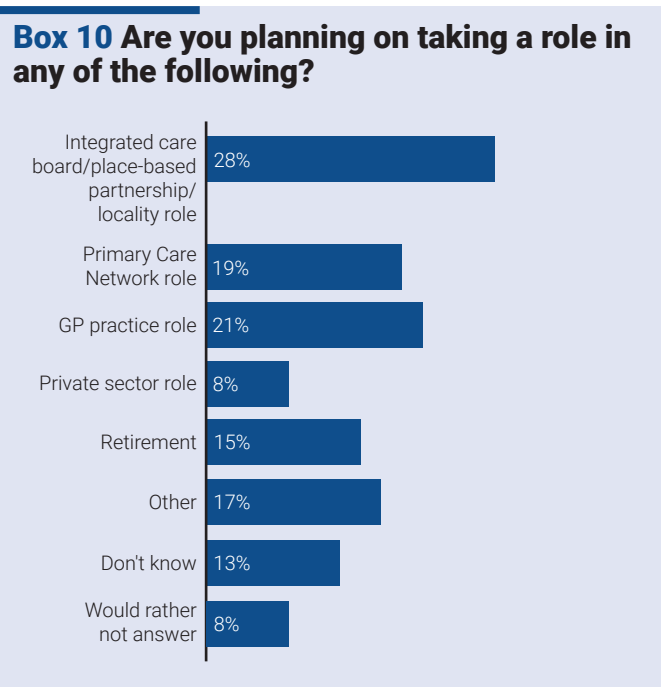
North East Essex chair Dr Chowhan says colleagues are using the time to reflect on their career and life. Some are retiring or moving to other organisations.

‘People are doing different things. Some are forming alliances or place-based groups and committees. They’re chairing those to maintain their leadership. I’m not sure if anybody is taking on ICB



ICS roles are few and far between for primary care clinicians. There may be roles at ICP level in boroughs or networks but this remains unclear at present

Survey participant from London who wished not to be named



roles or which ICBs are taking on experienced clinical leaders, but, actually, the roles aren’t plentiful.

‘That whole concept of clinical leadership – which we spent ages embedding in CCGs – feels now like a bolt-on. If you think back to the STPs, before ICSs, it was almost done in secret. It was: “Leave the clinical leaders out, we’ll figure it out and we’ll come back to them.” I think there could be a significant loss [of clinical leadership] to the system and then to the population.’

He adds that some CCG-elected members are moving into PCN CD roles but he feels they have been ‘flung in the deep end’ without the necessary experience.

‘There was an expectation from NHS England that they were going to jump in and be the CCG leaders of the future, but many of them didn’t have the experience. It’s one thing being a CD for your PCN, but answering to those outside your PCN is a different concept,’ he says. He adds that it takes one or two years to get to grips with working in a CCG and that’s with the benefit of experienced people around you – something PCN CDs did not immediately have,’ he says.

At the moment, North East London’s Dr John is supporting the newly appointed ICB chief medical officer and chief nurse but he and his colleagues are also taking time to reflect. He points out that while some colleagues will retire or go for roles in the new system, place is where there will be most opportunity.

‘Most CCG leads have always been involved with place anyway,

“CCGs were a great idea but weak clinical leadership has meant they’ve largely failed to deliver on their promise. PCNs could be a fantastic platform for a more effective primary care-led system – but only if NHS England and ICSs put significant organisational development investment in, and allow two to three years for that to take effect

Survey participant from Manchester a GP who wished not to be named

so I don’t think it’s a major change. I think the difference will be that we will be working with a much bigger group of people.’

Dr Kong has stepped down from her CCG role in Brent, north-west London, to make way for ‘the future generation, who should step up and carry on’. She says she knows colleagues that are doing the same.

‘People like us, the older generations, should pass on our knowledge and step back and be supportive. That’s my belief; supporting the younger generations to be leaders. Although some of us have reapplied for higher roles,’ she says.

In West Leicestershire, Dr Lakhani says a substantial number of CCG GPs have chosen not to have a role and a minority have looked for continuation by leading on certain pathways.

He agrees with Dr Kong that new leaders are ‘not a bad thing’.

‘Change is good; new people are coming in, some people are staying on. There are plenty of opportunities for everyone. I would urge everybody who was involved in CCGs in any role to think about how they can contribute to the new framework.’

‘I know of at least four people who’ve become PCN CDs. Before,

we had a rule that you couldn’t be a CCG lead and a PCN lead because of conflict of interest and the purchaser-provider split. So we banned them from being CDs; they had to choose.’

Although Dr Findlay says he is ‘well past retirement age’ he would be keen to be involved at county Durham level. But he admits that having been an accountable officer and then a chief officer it would be ‘difficult to work in an organisation where he didn’t have a degree of autonomy’.

Dr Gupta is heading to the private sector and is pursuing his passion for lifestyle and prevention with Oviva, which delivers behaviour change programmes for people with diabetes and obesity.

‘I am leaving the CCG commissioning space. I made that decision a long time ago. No effort was made to try to retain people like me. I don’t think any other sector would do that. It’s crazy really.’

Dr Gupta says his career path is a good example of how much experience is being lost to the NHS by this organisation upheaval. ‘My leadership training was in the NHS and then I became a CCG clinical lead and governing body member. I’m essentially going largely to the private sector. [I know of] five or six CCG governing body members who are now employed part-time by private healthcare operators. I suspect we’ll see more of that because people have skills that are available off the shelf for some of these companies. That cohort of GPs probably didn’t exist 10 or 15 years ago.’

He adds that CCG leaders may not be a natural fit for PCNs because of the adversarial nature of the commissioner-provider split.

‘[The PCN CD] is a provider role and this is a commissioner role. It is quite adversarial. Some of the hardest conversations I’ve had over the last 10 years have been commissioning primary care. They have been the most difficult and bruising.’

Dr Watt also finds it encouraging to see new clinical leaders coming through and is more optimistic about PCNs.

‘Looking at the PCN CDs, quite a lot are absolutely new to leadership, and that’s really exciting – new people wanting to do these roles, not just in general practice but across secondary care as well.’

Dr Watt is ‘exploring options’ in the new system. ‘Most of us will continue to be GPs in the systems that we are emotionally, intellectually and financially invested in. It matters to me that this works, because regardless of what role I’m in, I am still going to be working in the system. One of the reasons I went into commissioning was to deal with a sense of impotent rage. I could see the service my patients were getting was not great at times. Much of it was fantastic, but there were times where it seemed cumbersome, illogical, and not evidence-based,’ she says.

‘I want to make things better and I want a better experience for the population that I serve. One of the things that’s been really helpful as a commissioner is to be able to bring that experience into high-level meetings,’ she says. She gives an example of a patient who can’t access GP services because of fuel poverty.

5 PREDICT

What does the future hold for primary care?

The outgoing cohort of leaders has major misgivings about the new system. Our survey found that about two-thirds thought it would not be positive or improve primary care. Half thought it would not improve patient care. See box 11, right.

Even more damning, just under three-quarters of those surveyed (74%) did not have confidence in the way the Government was running the NHS.

Just 9% thought the move to ICSs would improve primary care and 14% thought it would improve patient care.

PCNs

For CCG clinical leaders thinking about the future of primary care, all roads lead to PCNs. The funding going into the Network DES via the IIF and the additional roles reimbursement scheme (ARRS) makes it clear that the Department for Health and Social Care and NHS England is putting its weight behind PCNs as the change-makers for locally driven, population-based primary care.

Dr Chowhan says it’s PCNs that will change things for primary care, not the ICBs, if they are supported to reach their potential. ‘If PCNs develop and mature in the way they could, a lot will change for primary care. [But they might] fall by the wayside and become a wallpaper title.’

‘We are starting to embrace PCNs. Locally, three years in, we’ve got to a steady state. We’re starting to see the ARRS movement take effect. I think we are transitioning to a point where primary care will change.’

Dr Lakhani echoes that ‘the centre of gravity will be with PCNs for primary care’.

‘We had too many GPs who were either commissioners or providers, and there were conflicts of interest. Now, everybody is sitting round a table and saying: “Our population need is diabetes, obesity, mental health, how do we sort that out?” I think PCNs will be doing that. Instead of having the purchaser-provider split, we now say “It’s all our job to do it”.’

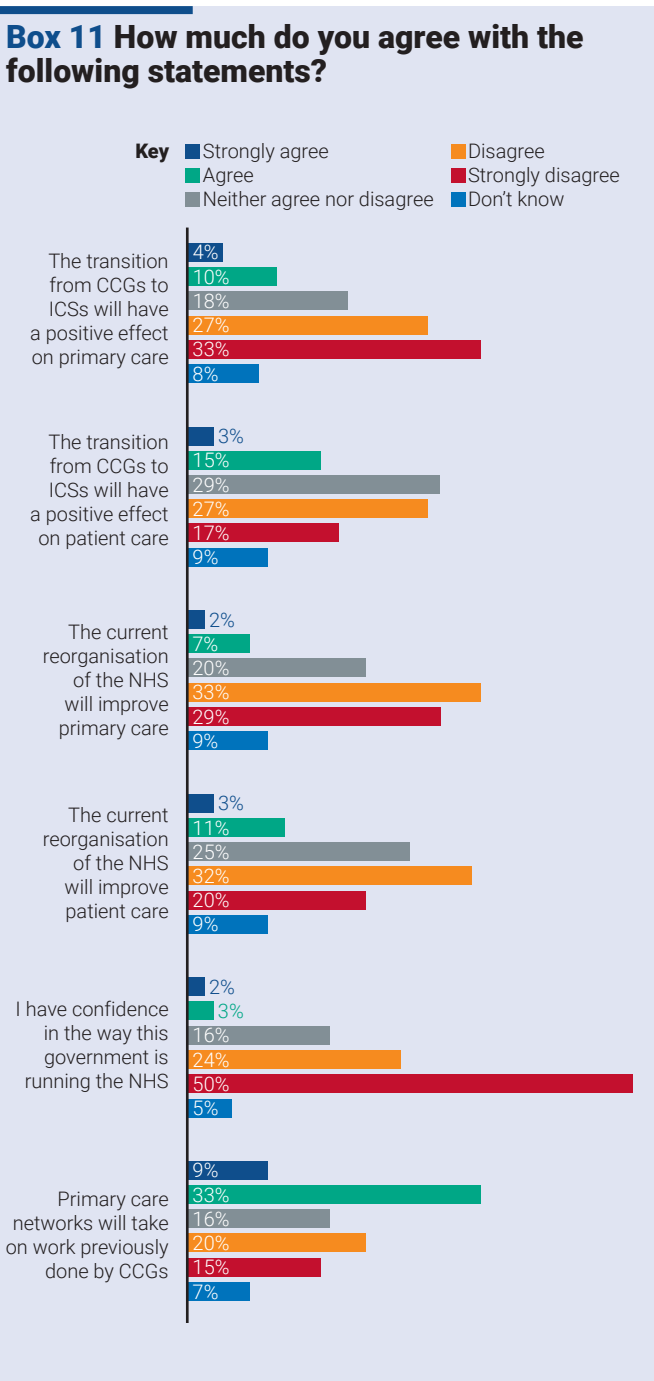
Dr Findlay agrees that PCNs are the future. ‘We’re seeing more services being created at a PCN level. They have to lead their practices into this new world and include other professions and services in their PCNs,’ he says, and adds that multidisciplinary working will be a key feature of the new NHS system.

But PCNs have challenges. Practices are by no means all on the same page in each of the 1,200 or so PCNs. They have issues with sharing data and IT, the sheer workload of meeting the DES and recruiting ARRS positions. And those new recruits need training and support.

Our CCG evaluation survey found that while most (42%) thought PCNs would take on work previously done by CCGs, 35% did not think they would. See box 11, right.

Dr Fernandes points out that while PCNs have been well funded for new staff they have nowhere to put them and managing them has created more work.

‘You’re spending more time supervising these roles, which



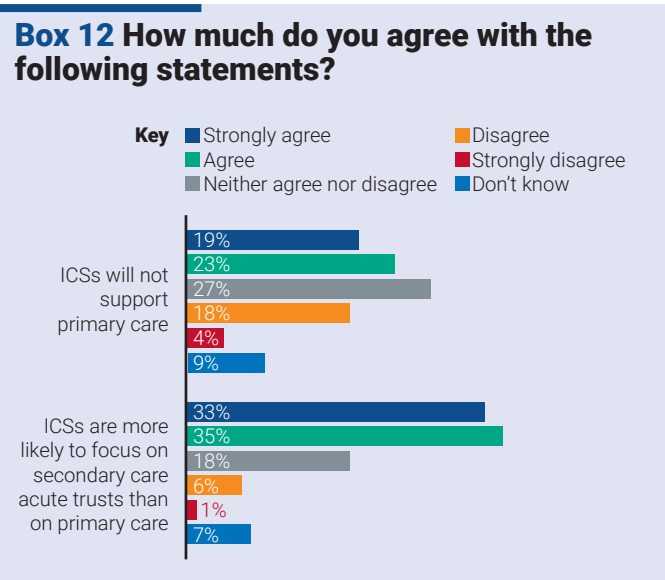
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“The politics of the system are toxic and change takes too long to happen. All decisions are financially driven and the organisations involved are parochial and self-serving rather than truly integrating

Survey participant who wished not to be named

“We are 100% behind the concept of ICSs. [But] the devil is always in the detail [and] there are concerns about subsidiarity and delegation to places and provider collaboratives that themselves aren’t legal entities yet

Survey participant: Dr Sarah Whiteman, clinical chair NHS Bedfordshire, Luton & Milton Keynes CCG



is adding to pressure. GP partners are getting fed up of people knocking on the door all the time, as they can’t do their own work.’

Dr Fernandes says that the pharmacists, first-contact physios and home-visit paramedics add value. ‘We’ve got so many attached staff who are off sick so often it’s unbelievable’.

He added that the set-up of PCNs means there isn’t a defined structure in PCNs to manage ARRS staff because they’re all employed by practices.

Dr Lakhani says he thinks the big thing people will need from PCNs is a local solution for patients who need same-day care. Certainly this is highlighted in the Fuller Stocktake.

While CCG leaders are pleased there are new leaders coming up via PCNs they have concerns about these leaders’ relative inexperience and what will be expected of them.

Dr Chowhan says: ‘A lot of CDs will have to sign in and out of meetings in the middle of busy clinics so I don’t think they have the protected time or opportunity to develop as the next tranche of clinical leaders.’

As PCN development has not been uniform, Dr Kong feels some PCN CDs may lack the gravitas and experience to negotiate with and challenge the more established partners in the ICS as some stakeholders do not view PCNs as equal partners on the platform.

ICSs

A clear three-tier structure is emerging for the ICSs – the ICB, places and neighbourhoods (the latter two refer to council areas or boroughs and PCNs). But there are nuances. Each ICS area has different terms and groupings, which are still emerging. Some have an intermediate level between the ICS and the place. Added

to that is the development of ways to represent GPs – a network of networks, an alliance, a collaboration or a board are some of the terms being mentioned. But whatever the structure, a crucial element is the finances and getting that to the front lines so local changes can be made.

Dr Lakhani says the financial framework for system working – with aligned goals of quality, stopping repeat tests and treatments and agreeing where people are best treated – ‘will be good’ and should support the hoped-for changes.

Dr Chowhan hopes that the money from the ICB will be delegated to PCN level.

‘We should try to delegate as much as we can. Unless we go down beyond place to the level of PCNs, people don’t feel empowered or impassioned. And if they’re not passionate about what they’re doing, nothing will change. I hope money and decision-making delegate as far down as they can go.’

Dr Kong thinks the worst-case scenario of infighting between the places and boroughs for the ICS resources will be over issues of deprivation. Having worked in different London boroughs she knows that even those that are perceived as affluent have significant challenges.

Much of the work of CCGs is contracted and will therefore transfer to the ICB, but Dr Gupta points out that when new people come in they revert to the contract so anything that is ‘a loose agreement’ will fall apart as there is no continuity of staff.

‘My worry is, that even with a contract, if you lose the organisational memory and the relationships, the contracts will not be sustained because people forget the rationale. And the relationships that help you to troubleshoot are lost. We are going to see a reduction in the number of GPs on the commissioning side. There will be clinical leads still. But the ability to build and maintain those relationships between the commissioner and, let’s say, a secondary care consultant, is going to be diminished.’

Dr Gupta is concerned that the provider-commissioner split, the ICB commissioning the providers, will still be heavily weighted towards reactive acute care in terms of how money is spent.

‘Our outcomes will go nowhere or get worse. That’s the worst-case scenario for me, that nothing changes other than the personnel. We’ve still got a commissioner-provider split. This idea that we’ll have an ICS focused on population health, which is the holy grail, will not come to pass.’

For Dr Watt, the biggest concern is the tension between national and local priorities. ‘There may be national initiatives that have nothing to do with what we’ve identified for our population. We will have to divert our staff and teams to whatever the national initiative is, which may or may not be a local problem for our system,’ she says.

However, CCG leaders do feel that the changes brought about by the Health and Care Act 2022 will benefit the acute sector. More than two-thirds of our survey respondents felt the new system would benefit hospital trusts (68%) – and 42% felt ICSs would not support primary care. See box 12, above left.

Dr Lakhani acknowledges the concerns about renewed dominance of the acute sector, but says it’s not something he’s seeing in his area. ‘There is a real concern that the ICS will be dominated by issues with acute providers. I’m not seeing this, because one of the requirements of ICSs is collaborative leadership. To use a football analogy, you think about “what’s best for the country, rather than the club”.’

Reality check

As mentioned, three-quarters of those surveyed do not have confidence in the way the NHS is being run by the Government. CCG leaders interviewed were also critical about the reality versus the rhetoric.

Dr Kong says: ‘Needs and wants are different things. It is in our Hippocratic oath not to ignore clinical needs. So we must have honest, mature conversations with everyone involved. With the current workforce crisis and limited funding and resources, we have to contain the “wants” realistically, to deliver the clinical needs and outcomes, working with our residents, our patients and carers. Otherwise, GPs face bad press as they do now.’

Dr Watt agrees. ‘We are still dealing with Covid and are likely to be for the next two years. It is a really difficult patient message, because they’re being asked to pay more money in their taxes. They have been told: “It’s over, it’ll be better”. That’s what the politicians want people to hear, but given the workforce we have, the demand, the capacity and the challenges, it’s not that realistic.’

‘CCGs and ICBs are being asked to save money. In real terms this means budget cuts, despite the public feeling as though they’re paying more, and the cost of living going up. In many respects, because of the unmasked demand, I don’t think it can feel better,’ she says.

The pandemic gave people time to reflect and identify previously undiagnosed conditions such as autism or ADHD, which means the demand has increased. Also, there is the increased complexity of patients presenting later, especially those with cancer.

NHS England figures from January 2022 show a record 6.1 million people waiting to start treatment, with more than 300,000 having waited for a year and nearly 24,000 people having waited for more than two years. While patients wait for hospital care it is the GPs and primary care services that hold the risk and take the calls from patients following up about their condition, in turn adding to the demand.

Workforce

And of course, we need people to meet this demand. Anyone who works with or in the NHS is united on this issue – there is a lack of available workforce to meet the current demands, let alone the demands in the future. Time and again, lobby groups, clinicians, the House of Lords and the health select committee urged the Government to set out a workforce development plan in the new Health and Care Bill. The Lords passed an amendment, backed by around 100 organisations, that would have ensured the

Government published independent reports on workforce numbers every two years. The reports would have been accompanied by an ‘independently verified assessment’ of current workforce numbers and ‘the projected workforce supply for the following five, 10 and 20 years’. But this was rejected by the Government and the bill was passed without it.

Following the devastation of the global pandemic, where NHS staff put themselves in harm’s way, some losing their lives, the Government has piled on the pressure to clear the backlog and increase access to meet patient demand. But many feel it has failed to address the shrinking numbers of health professionals available to do that work.

Our survey found more than half (57%) cited lack of workforce and lack of time (53%) to carry out the work as major barriers to the success of CCGs. See box 13, below and box 14 on page 20.

Dr Kong says: ‘They want PCNs to do the extended hours – 8am to 8pm Mondays to Fridays and whole-day Saturdays. Where are we going to get the workforce? It’s the same people doing the same jobs two or three times over. People working in 111 are sometimes GPs locuming. You get the nurses to do it, the nurses come from somewhere else. Nobody is saying “let’s be real”. Extending access points is not the solution.’

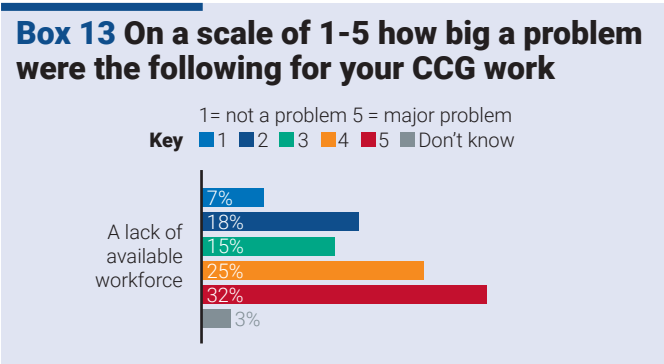
The negative media about GPs only compounds the issue, making recruitment all the more difficult, says Dr Watt.

‘There are fewer GP partners this year than last year and the numbers keep going down. With the media bashing, why would anyone want to go into general practice?’

‘We need to be loved. As a GP we are strongly identified with our practice, and it matters to us deeply,’ she says, and adds that it feels personally insulting when there is negativity towards general practice.

Board-level representation

The ICSs are required to have one primary care representative on the board. This worries some people. Others are creating systems to feed up to that person.



“I would love to believe ICSs would improve patient care and primary care but unfortunately they are so dominated by secondary care that I fear the opportunity will be lost and, as usual, all the money will be poured into secondary care which will complain that primary, community and social care cannot support it properly

Survey participant a staff member of a commissioning support unit who wished not to be named

The 42 ICSs published their constitutions at the start of June, detailing how they would appoint people to the board. ICBs are required to have one primary care representative on the board, but a Healthcare Leader investigation found that two, NHS Bedfordshire, Luton and Milton Keynes ICB and NHS Hertfordshire and West Essex ICB are appointing three, while 12 have stated they want two primary care reps on the board. Five have gone further and mentioned experience as a PCN CD will be a requirement or desired.

Dr Watt says that while it is essential that general practice has a presence at strategic level, it's equally important to have 'appropriate provider representation every level of the system'.

It's not one person on the board. It's about general practice being everywhere that providers should be, and linking general practice into communities of practice education.

'One of my hopes is that the generalist approach GPs have been able to bring to commissioning continues in the future, because obviously when we're in commissioning roles we're not speaking on behalf of our practices. But we are able to give that generalist view because our patients will tell us what their journey has been like.'

Dr Fernandes questions whether there will be any GP representation on the ICB.

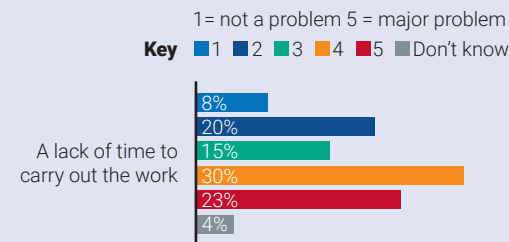
'They say it's going to be a GP, but actually might be a primary care representative. At place level we've got a primary care provider representative, but they will be representing GPs as providers, and also dentists and ophthalmology and pharmacy. Then we've got a primary care development lead, which again is about primary care in the wider sense – not only general practice but also pharmacy and the other primary care providers, community services and PCNs.'

Multidisciplinary leadership

Dr John says the biggest change the move to ICSs will bring is the push for multidisciplinary leadership.

'We are moving to a much wider multidisciplinary leadership than we've ever done before. If you look at some of the evidence

Box 14 On a scale of 1-5 how big a problem were the following for your CCG work



we've seen in other streams, like personalisation, there are huge assets in our communities that we probably haven't explored enough.'

Dr John also feels that the ICSs are well placed to 'get hold of the population health and health inequalities agenda that we've struggled with'.

He highlights the Covid vaccination campaign, which showed that traditional ways of advertising the vaccine didn't work in North East London.

'We needed to work with faith groups and communities, support people's concerns about vaccination and target things in a different way,' he says.

'That's one of the big advantages of the ICS looking at this, in a very reflective way, to address problems through the lens of voluntary sector groups, the local authority, the councillors and the wider stakeholder group.

'It's a much more integrated approach. But I think that's where, in some respects, the pandemic has given me confidence that this is the approach we need to take, going forward. Building on the successes of the CCG.'

Next generation of leaders

As well as concerns about the ending of the clinical influence and commissioning-level CCGs, leaders are also concerned about developing future leaders.

Dr Lakhani says he hopes the importance of training in medical leadership will be recognised in the new system and called for 'everybody to have a mentor'.

'It's crucial, because how can GPs suddenly run a billion-pound organisation? How does that happen? We need credentials. I like new blood. One of the things I've seen in the transition from CCGs to ICS is that new blood has come in. We've done a recruitment process that's been very open. People are interested, particularly under-represented groups such as female GPs, and they've come forward in the hundreds saying: "We want a role, tell us how we do it", he says.



This report and the accompanying CCG evaluation survey highlight deep concerns about a loss of clinical leadership and a diminishing influence from primary care.

The timing and the need for this reorganisation have all been questioned. Many CCGs had already begun working in an integrated way and following the extreme and ongoing pressures of the pandemic, system shift of this size does not seem wise. But efforts should be focussed on the future and retaining what's good.

The nine years that CCGs held the commissioning budget will probably be seen as a halcyon time by primary care leaders in terms of making changes for their populations and raising primary care as a corporate entity, a force to be reckoned with.

There is acknowledgement in some quarters that CCGs have run their course – certainly, where the purchaser-provider split led to conflict and division and the financial incentives were misaligned, which led to a reduction in primary care and an increase in acute care. The pandemic highlighted that collaboration is the way forward – something the best CCGs were already implementing.

ICSs are a continuation of this idea that requires a cultural leap from NHS trusts and community providers to come together for the greater good of the system rather than individual organisations.

However, there are significant concerns that ICBs will see a lurch back to the dominance of the acute sector. The recently published constitutions largely show that representation is skewed towards

the acutes. GPs will not be leading the commissioning of local services and while PCNs show great promise, they are not placed to negotiate with large acutes. To mitigate against this, groups of GPs are getting together as boards, alliances or collaboratives working with local medical committees and PCNs to ensure primary care is present as the majority of patient interactions are in primary care.

ICSs have huge potential to build on relationships and support changes at place and neighbourhood level. But national priorities will need to run alongside, rather than eclipse the local ones and funding must be delegated to the front lines for local innovations.

PCNs are the jewel in the crown for primary care and if they can keep practices on side, cope with the demands of the network contract and access good data they can effect change for their populations. This comes with caveats, though – of being supported as leaders and having workforce, finances, estates and time.

And the skills of outgoing clinical leads should be captured. Outgoing CCG leaders could be invited to mentor and advise new leaders. While in many areas tensions may make this unpalatable, the skills of CCG clinical leaders could be harnessed in other ways – perhaps through online coaching or mentoring to other areas of the country.

Succession planning should be continuous to mitigate against the loss of clinical leadership in the future – because nothing is as certain in the NHS as change.



Postscript: Farewell

While there is optimism about the future, there is a good degree of sadness about the ending of CCGs. Teams around the country will be marking the occasion.

Dr Findlay says: ‘I feel very sad about [the end of CCGs]. Obviously, I have now been through umpteen reorganisations, but I believe CCGs were one of the best I’ve seen. When we had small PCTs or small PCGs they were almost as good but didn’t have the level of clinical leadership we’ve had with CCGs.’ Durham CCG is planning to have a commemorative lunch on the last day the CCG is operating.

Dr John says: ‘We certainly thought of doing a brochure of the achievements of the CCG. City and Hackney did that before merging with North East London and it was fantastic. We’ve also thought about creating awards, to say “We really appreciated what you did and what you’ve been doing”.’

“These last three years have been tough, with the pandemic. So part of me says “Phew, I’m glad I’m handing over to someone else”. The only thing I’m sad about is if people move on. I love our staff. I think our staff, from our management teams, to our clinicians across the system, have been brilliant, in all our boroughs. But I’m also excited about formulating new [teams]. So, there’s a mix of elation and sadness.’

Dr Watt says: ‘It was inevitable that it would be this way. I’m not so naïve to think this three-letter abbreviation was going to last

much longer. It’s important that we take what has worked, and I think the clinical leadership and involvement, particularly from general practice, has been really helpful.

‘It’s allowed general practice to be the big provider that it is, or that it can be. The trick will be not to lose that and to make sure we support our GP board locally, because I’m optimistic that that will be the way to make sure general practice continues to be involved. It is about working together as a true system. I know there are going to be pressures, particularly demand capacity and staffing, which will be huge across the system. Workload transfer is a really big risk for the system.’ Her CCG had a day of celebration for the CCG to ‘reflect on the achievements we have made together’.

The three CCGs in Dr Lakhani’s area, Leicester, Leicestershire, and Rutland, have put together a showreel collecting people’s memories and achievements during the last nine years.

Resources

- kingsfund.org.uk/publications/integrated-care-systems-explained
- nhsconfed.org/publications/clinical-commissioning-groups
- england.nhs.uk/statistics/wp-content/uploads/sites/2/2022/03/Jan22-RTT-SPN-publication-v2.pdf
- england.nhs.uk/wp-content/uploads/2012/04/ccg-auth-app-guide.pdf
- england.nhs.uk/publication/the-constitutions-of-integrated-care-boards/
- england.nhs.uk/ccg-details/
- england.nhs.uk/wp-content/uploads/2022/05/next-steps-for-integrating-primary-care-fuller-stocktake-report.pdf

ABOUT THE SURVEY

The CCG evaluation survey asked those involved in CCGs about the successes and failures of GP-led commissioning.

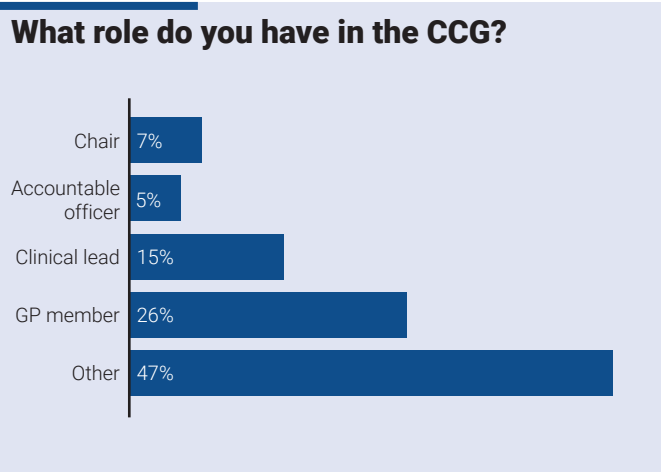
The majority of the 143 respondents were GPs (26%), 15% were clinical leads, 7% were CCG chairs and 5% were accountable officers.

Of the 47% that described their role as ‘other’, the majority had managerial or leading positions in the CCG ranging from CCG chair, head of quality, chief nurse and chief financial officer.

The other respondents included: one interim integrated care system chief medical officer, five pharmacists, three practice managers, three nurses, six GPs, two PCN CDs, four CCG governing body members, one retired hospital consultant, one 111 provider and one social care representative.

The survey ran from 28 March 2022 to 30 May 2022 and was promoted by Healthcare Leader newsletters and on the website.

Participants were offered the chance to win £100 John Lewis voucher.





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