NHS Clinical Commissioners
NHS Confederation

Clinical commissioning groups

Transferring the legacy into learning

March 2022

About

This report reflects on the successes and learning from CCGs during their nine years of operation, and offers 11 recommendations for ICS leaders to help ICSs learn from this legacy.

The NHS Confederation is the membership body that brings together and speaks on behalf of organisations that plan, commission and provide NHS services in England, Northern Ireland and Wales. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities.

NHS Clinical Commissioners, which is part of the NHS Confederation, is the independent membership organisation for clinical commissioning groups. It provides clinical commissioning groups with a strong collective voice and represents them in the national debate on the future of healthcare in England.

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Key points

- As the health and care bill, which is expected to become the Health and Care Act (2022), is set to abolish clinical commissioning groups (CCGs) and establish statutory integrated care systems (ICSs) that will take over CCG commissioning functions, NHS Clinical Commissioners has worked with our members to consider the legacy of CCGs and offer reflections for the benefit of ICSs.

- During CCGs' nine years of operation, they have evolved from their initial founding principle of promoting competition, pivoting towards collaboration. However, their other founding idea of combining clinical and managerial leadership to make commissioning decisions that drive quality improvement, has been a successful legacy.

- While ICSs are an appropriate next step to further integrate delivery of care, important features of CCGs should be preserved to provide the bedrock for ICSs' success. In particular, CCGs' progress towards integration and clinical leadership at a place level, accelerated during the COVID-19 pandemic, has the potential to be a significant enabler of ICSs.

- CCGs have been largely effective at empowering clinical leadership and engagement, driving quality improvement, and facilitating integration at place level. This report sets out 11 recommendations for ICS leaders, to help ICSs learn from this legacy. These are set out on page 5.

Recommendations

Empowering clinical leadership and engagement

1. **Nurture and differentiate clinical, professional and operational leadership** and encourage individuals from underrepresented professional disciplines to take broader leaderships roles.
2. **Invest in comprehensive engagement of primary care clinicians**, enabling their direct influence of decision-making. Consider protecting a portion of primary care practitioners' time for continued input to strategic planning.
3. **Support a primary care leadership pipeline** from 'place' through to system and national roles, to encourage a strong voice from grass-roots practitioners.

Driving quality and improvement

4. **Embrace peer learning**, mutual support and system learning as key drivers of improving quality across wider areas of service delivery.
5. **Prioritise and 'systematise' medicines optimisation efforts**, building on CCGs' legacy, to improve health outcomes and deliver financial efficiencies.
6. **Develop clinically-led models of care at place level** to promote safety, efficacy and quality.
7. **Embed multidisciplinary commissioning skillsets** within ICS operations and safeguard institutional memory.

Facilitating place-based integration

8. **Delegate resources and decision-making powers** as near to the patient as possible at a neighbourhood and place level where the deeper understanding of the population sits.
9. **Support primary care leaders to collaborate with directors of public health at place** to reprioritise investment which best reduces health inequalities, drawing on their day-to-day experience of treating patients whose health is shaped by wider determinants.
10. **Learn from the most effective health and wellbeing boards** and best practice to support shared understanding and integrated working.
11. **Continue integrated local authority and NHS working at place** through use of new place-based arrangements, from joint committees to lead providers and provider collaboratives.

Foreword

Louise Patten
Chief Executive, NHS Clinical Commissioners
Director, NHS Confederation ICS Network

ICSs are set to become established as statutory organisations on 1 July 2022. This is a positive step on the journey towards a health and care system founded on local collaboration and partnership. While this will mark the conclusion of CCGs, they should be exceptionally proud of the part they have played in creating an environment that has allowed systems to take the first steps towards integrating healthcare services.

CCGs achieved this because of the advances they made in embedding clinical engagement, which gave them a better understanding of their population's health needs at a place level and stimulated a desire to look outside the walls of their own organisation for a solution. They demonstrated that clinicians and managers can work together in a way that enhances each other's expertise and that a focus on quality can deliver better outcomes for patients if the clinical community is on board. They were supported to do all of this by a fantastic team of staff whose skillset and dedication enabled them to drive improvements in population health and provide stewardship of limited budgets.

As we move towards another chapter, we wanted to reflect on the key ingredients that delivered success for CCGs, where improvements can be made, and what learning CCGs can offer

to ICSs as they take over the reins. NHS Clinical Commissioners brought together CCG leaders to discuss the legacy that CCGs will leave and to offer their thoughts on what ICSs should do to ensure that they are in the best position possible to build on the platform that CCGs have created for them.

CCGs have covered a vast range of roles – from evaluating population health needs and corresponding resource allocation, through to assessing unwarranted variation and quality assurance. This report is by no means a full account of everything that CCGs achieved or a comprehensive to-do list for an ICS. However, we hope it pays credit to CCGs and their staff and captures the key learnings for the health leaders of the future.

Introduction

The CCGs were formed in 2013 after the Conservative and Liberal Democrat coalition government legislated for a programme of radical reforms in the Health and Care Act (2012). These reforms aimed to make the NHS more accountable to patients, to empower local healthcare professionals and to improve clinical outcomes.[1] At the core of the reforms was a structural reorganisation of the NHS, which involved the creation of 211 CCGs.

The establishment of CCGs aimed to engage clinicians in the commissioning process, with all general practices (GP practices) as members and involved in redesigning services on behalf of their patients.[2] The premise was that GPs, as the public's main initial contact with the NHS, were best placed to understand the needs of their practice population and redesign services accordingly. Having GPs as commissioners also sought to establish an accountability link between those doing the spending through referrals and prescriptions and responsibility for managing the budget.

The Act delivered a clear division between the commissioning and provision of NHS services which, combined with the introduction of mandatory tendering, aimed to build competitive internal and external markets that would drive quality and safety, operating as a key improvement mechanism.

Over time, smaller CCGs recognised the need for increased at-scale working and since 2016 there has been a steady stream of mergers of CCGs as they have taken on an increasingly strategic role across larger populations.[3] Furthermore, as commissioning expertise matured, there was an increasing preference to work more collaboratively within their local health and care system, with many finding the requirement for frequent retendering relatively burdensome.

The NHS Five Year Forward View, sustainability and transformation partnerships (STPs) and the NHS Long Term Plan offered opportunity for greater integration of primary, secondary, specialist, physical and mental health services and social care, with more shared responsibility across the system to improve population health.[4] This was the development of a significant policy shift in the organising principle of the NHS, away from competition towards collaboration and integrated care.

The health and care bill going through parliament at the time of writing, which is likely to become the Health and Care Act (2022), seeks to remove legislative barriers to integration, with the replacement of CCGs by statutory ICSs that will take over CCG commissioning functions in 2022.[5]

NHS Clinical Commissioners (NHSCC) has been the membership organisation providing a national voice for CCGs, bringing together clinicians, managers and lay members and enabling them to share best practice and influence the wider NHS, government, parliament and the media. As CCGs draw to a close, NHSCC has sought to highlight the key aspects of the CCG legacy.

Methodology

Our methodology for this report included roundtables with clinical and managerial leaders and interviews with senior national leaders, capturing their reflections of CCGs. As a result, our report is neither a comprehensive analysis of everything CCGs have delivered nor a purely objective, impartial analysis. Instead, it seeks to acknowledge CCGs' contribution to healthcare and offer learnings for the benefit of ICSs as they seek to build on this legacy.

Empowering clinical engagement and leadership

Evidence shows that good engagement with clinicians and other health professionals in leadership drives high-quality improvement in health services. The CCG membership model brought together ownership and understanding of the challenges associated with improving outcomes, with the responsibility and means for resolution.

Why clinical engagement and leadership worked

A leadership of equals enabled effective joint working between managers and clinicians. It realised the benefits of both skillsets, which was embedded throughout CCGs with the statutory relationship between the clinical chair and accountable officer setting the overall tone.* Clinical leaders described how being exposed to and responsible for managerial issues had enhanced their ability to be effective in the commissioning process. For example, a knowledge of governance and finance had enabled them to remain motivated and adapt their clinical input, feeling ownership of the change process. This close working relationship also led to managerial leaders and lay members developing an increased understanding of the clinical case for change.

*Also see NHS Confederation, What Makes a Top Clinical Commissioning Leader? https://www.nhsconfed.org/publications/what-makes-top-clinical-commissioning-leader and Collaboration in Clinical Leadership: the Role of Secondary Care Doctors on CCG Governing Bodies https://www.nhsconfed.org/publications/collaboration-clinical-leadership

> "The power of a clinician and a good manager working together, that's a powerhouse, and in that process, you turn the managers into clinicians and the clinicians into managers. How more powerful is that … when you see a manager stand up and argue a clinical case?"
>
> Prof Sir Sam Everington, Clinical Chair, Tower Hamlets CCG

Participants at the roundtable described the development of effective two-way communication links between clinical leaders on the governing body and the clinical membership. This gave a real voice to the wider primary care team and maintained the feedback loop, which in turn supported the motivation for continued engagement of those working full time at the front line in primary care.

This 'front line to board' messaging meant that the decision-makers at the CCG were GPs with ongoing frontline experience of patients' issues. This fostered a diverse leadership triumvirate of managers, clinicians and lay members, building multi-professional governing bodies with a diversity of skill sets and expertise to more effectively address local health needs.[6]

However, there was reflection from CCG leaders that the clinical leadership model was initially too GP-centric and there have been missed opportunities for wider clinician engagement. This does, however, takes time to do properly so that clinicians feel they have not been marginalised.

Examples of delivery through strong clinical engagement and leadership

Transforming end-to-end patient pathways

GP commissioners approached service transformation from primary care through secondary care and back into out-of-hospital care services. They were well placed to recognise gaps or weaknesses in service provision that had a negative impact on patient outcomes. This contributed to the development of improved services in previously under-emphasised areas such as mental health and out-of-hospital care.

Pathway transformation was supported by clinical networks and the Academic Health Science Networks (AHSNs). These data-driven partnerships had impacts across the country: improving patient outcomes while reducing anti-coagulation treatment costs by £1 million in Newcastle; reducing referral admission times by six days for patients with acquired brain injuries in London; and developing a platform to predict patient presentations at hospital in Somerset.[7]

Strong clinical engagement mechanisms were put in place throughout the CCG membership, which enabled clinical messages to local communities that supported the implementation of pathway and strategic service change. Because the clinicians making decisions about service change would also experience the impact at the front line, it legitimised the proposals.

Most CCGs were co-terminous with local government and worked closely with elected members and local scrutiny committees, often presenting the clinical case for change as trusted GPs and explaining the merits of proposed service change in terms of patient outcomes.

Laying the foundations for primary care networks

CCGs put in place different mechanisms for clinical engagement with its membership depending upon their size. In the main, they involved grouping member practices together, usually on geographical groupings, often at place-level through GP federations or neighbourhoods as the footprint. These groups and relationships have provided the foundations for developing primary care networks (PCNs). ICSs will often have several PCNs within their footprints and so renewed engagement will be needed to ensure PCNs have a voice at a system level.

Enhancing the primary care voice in national NHS leadership

CCG investment in clinical engagement and the development of primary care clinical leaders at a local level, backed up by representation through NHSCC, has significantly enhanced the primary care voice in national policy discussions. This included a pipeline of primary care leaders who have risen to national roles. This has provided an important balance between hospital and primary care clinical leadership, helping to ensure NHS resources are focused on evidence-based interventions which demonstrably improve people's health.[8] The loss of GP membership and the incentives it carried to ensure GP involvement in system commissioning, means there is a real risk that ICSs will lose the engagement and goodwill of primary care. A single statutory position at ICB level will not suffice and ICSs should strive to ensure effective primary care engagement.

Case study: Mental health crisis services – mental health commissioners influencing national and international policy

NHSCC's Mental Health Commissioners Network (MHCN) co-hosted a two-day event on mental health crisis services at the 2018 International Initiative for Mental Health Leadership conference with RE International. The event brought together over 50 leaders in urgent and emergency behavioural healthcare and included commissioners, providers of mental health services, people with lived experience, representatives from ambulance services and the police, MPs, and civil servants, mainly from the UK and USA. Collectively, this group developed ten clear recommendations to transform mental health crisis care services, covering alternatives to crisis care services, postvention support for people bereaved by suicide, and 24/7 crisis lines such as NHS 111 for mental health.[9]

The evidence and recommendations influenced the commitments for mental health crisis care in the NHS Long Term Plan.[10] For example, the NHS Long Term Plan subsequently included a commitment to roll out mental health crisis lines to all areas as well as postvention support; a highly effective service for people bereaved by suicide and which helps prevent further suicides. Since then, MHCN representatives at the second crisis global conference also contributed to the International Declaration on Mental Health Crisis Care.[11]

Recommendations for ICSs

1. **Nurture and differentiate clinical, professional and operational leadership** and encourage individuals from underrepresented professional disciplines to take broader leaderships roles.

2. **Invest in comprehensive engagement of primary care clinicians**, enabling their direct influence of decision-making. Consider protecting a portion of primary care practitioners' time for continued input into strategic planning.

3. **Support a primary care leadership pipeline** from place through to system and national roles, to encourage a strong voice from grassroots practitioners.

Driving quality improvement

From their establishment, CCGs have prioritised their statutory function to secure continuous improvements in service quality and patient outcomes, particularly by improving clinical effectiveness, safety and patient experience.

CCG quality assurance has incorporated patients' perspective of their experience across pathways and multiple care providers across the geographical footprint. Oversight of the whole local health system has enabled CCGs to identify best practice, with a focus on pathways in and between service providers. With no provider organisation conflicts, CCG clinicians have been well placed to offer a degree of independence to oversee key quality and safety functions.

Key areas of quality improvement

Establishing peer review to drive improvement in primary care

As GP member organisations, CCGs were able to establish support to primary care for improvement and transformation through peer-to-peer learning, rather than instigating a top-down 'must do' approach. The peer review process was led by a programme of comprehensive data sharing, enabling GP practices to compare themselves to similar practices and have a constructive dialogue with CCG clinical leaders about opportunities for improvement. CCG practice visits supported ongoing learning, offering tailored support. This approach has been successfully used to tackle unexplained variation in a range of areas including referral management and prescribing and procedures of limited

clinical value, as well as for the nationally set CCG clinical quality improvement measures, such as dementia and learning difficulties health checks.

Case study: Blackpool CCG – peer review of unwarranted variation in referrals and procedures

Blackpool CCG asked local GP practices to review both referrals to secondary and specialist services and the procedures they deliver, to reduce unwarranted variation. Peer reviews were included into GP contracts and supported by oversight from the CCG e-referrals team to ensure compliance with the CCG's referral policies. All practices now check each other's referrals data, regularly discuss how they manage referrals and seek to identify any outliers. This has led to a general reduction in inappropriate referrals and a reduction in variation between practices, moving towards greater standardisation.[12]

> "I believe that [GP] practices have (by and large) improved in quality as commissioning has been brought much closer to them."
>
> Dr Phil Moore, Deputy Chair (Clinical), Kingston CCG

Evolving medicines optimisation

As part of the approach to improving quality, ensuring patient safety and value for money, CCGs have evolved medicines optimisation functions which have improved healthcare outcomes while enabling significant efficiencies.[13] For example, the development of co-produced CCG-wide drugs formularies, supporting equitable access to the most appropriate medicines.

The skills for the thorough appraisal of medicines – critical appraisal, data analysis, assessment of clinical and cost-effectiveness and value for money – have been developed as part of the wider commissioning skillset, often along patient pathways between secondary and primary care.

Using a peer review approach, CCGs have facilitated structured reviews of primary care medicines prescribing, to support the reduction of unexplained variation and to increase compliance with best practice guidelines. This has helped patients to get the most appropriate and effective medicines while reducing inappropriate polypharmacy.

At a national level, NHSCC has given CCG leaders a platform to shape the medicines agenda through national bodies such NHS England's medicines optimisation oversight group, as well as through regional medicines optimisation committees.

The development of the CCG executive nurse role

Driving the quality agenda at supra-provider level, CCG chief nurses have largely been responsible for leading the assurance of service quality, through highlighting the reality of patient experience of service delivery, which often involves multiple providers along the care pathway.

This executive nurse role has brought together nursing and other leaders to co-create and implement quality improvement systems and shared learning along care pathways and across multiple provider organisations. This has laid the foundations of system-level quality assurance across multiple stakeholders. For example, in delivering their statutory oversight of safeguarding, CCGs have developed effective partnership working with local authorities, the police and third sector organisations.

CCG executive nurses work closely with stakeholders to develop ongoing quality assurance and surveillance, complementing the work of the Care Quality Commission (CQC) and triangulating intelligence and performance data to inform where funding and resources are to be focused within systems to drive quality improvement. Because of the relative independence of the chief nurse from individual provider organisations, this role is highly trusted by stakeholders in developing a fully co-operative approach to ensure lessons are learned.

Development of commissioning expertise

CCGs have made a broad contribution to local health systems. This has helped to improve the quality of services and health outcomes not just delivering contracting and performance management functions, but also through analytical skills and relationship management that are critical to developing a population health management approach. Over time, CCG staff have developed a clear understanding of effective clinical engagement and a profound understanding of primary care. The skillset of a mature commissioner nurtures health and care collaboration to drive positive behaviours, support innovation and promote contributions from the wider clinical system, all of which will be required at the top level within ICSs to continue the collaborative and distributive leadership approach to improving quality of services. Safeguarding commissioning expertise and institutional memory will help to build on the past work of CCGs, particularly given changes in senior leadership in some systems.

Case study: Identifying and optimising the care of respiratory patients in Oxfordshire – developing an enhanced integrated multidisciplinary team

Through joint working, Oxfordshire Clinical Commissioning Group (OCCG) and Boehringer Ingelheim (BI) piloted an enhanced NHS multidisciplinary integrated respiratory team (IRT) to improve service quality. The pilot aimed to improve accurate and timely respiratory disease diagnosis, optimise clinical management, enhance holistic and end-of-life care, identify patients at risk of respiratory admissions, and integrate patient care across primary, secondary care and community settings.

The integrated team enhanced existing community, hospital-based and primary care by providing a community consultant who worked alongside additional respiratory nurses and physiotherapists, a dedicated psychologist, pharmacist, public health smoke-free advisers and specialists in palliative care. Awareness and links to third sector organisations, including Better Housing Better Health, were also improved.

This led to timely, coordinated care closer to home for respiratory patients, and the development of a proactive and preventative approach that showed potential to reduce system costs and improve individual patient outcomes. Outpatient referrals were reduced, as was prescribing of non-formulary inhalers and high-dose inhaled corticosteroids. Small patient sample analysis indicated reductions in annual healthcare resources through patient improvement scores, medicine optimisation and proactive case finding.[14]

Recommendations for ICSs

4. **Embrace peer learning**, mutual support and system learning as key drivers of improving quality across wider areas of service delivery.

5. **Prioritise and 'systematise' medicines optimisation efforts**, building on CCGs' legacy, to improve health outcomes and deliver financial efficiencies.

6. **Develop clinically led models of care at place level** to promote safety, efficacy and quality.

7. **Embed multidisciplinary commissioning skillsets** within ICS operations and safeguard institutional memory.

Facilitating integration at place level

Addressing health inequalities through partnership working – CCG leaders have described strong partnerships at place level between multiple organisations from and beyond the NHS, as a key factor in CCGs' contributions to tackling health inequalities. For example, CCGs have been able to support the improvement of health outcomes for mental health service users through co-ordination of the different NHS and local authority public services available.

Most CCGs have close working relationships with local authority commissioners, often beyond the joint duty to produce a joint health and wellbeing strategy to improve health and reduce inequalities. Co-terminosity between CCG and local authority boundaries helped to build partnerships outside of the NHS to improve population health. Through membership of health and wellbeing boards – which bring together CCG leaders, local authority officials, elected councillors, directors of public health and NHS provider leaders – local NHS partners have increased their understanding of local authority community assets-based approaches and place-based care.

CCG leaders referenced their role as a system convenor who is trusted by all partners to act in the interests of the local population, to manage competing provider interests, particularly at times of competing funding requests. Acting as the 'glue' within local systems, and as, what one roundtable participant described, 'a shock absorber' for the system. The impact of this has often been less visible, for example with CCG leaders working behind the scenes to ensure the sustainability of occasionally vulnerable but

critical providers, or manage the impact on patients when there were quality concerns that required commissioner intervention (often in collaboration with the CQC).

> "We have been able to look outside the NHS... and build fantastic links with wider stakeholders whether that be local government, local employers, with the DWP, with local schools and colleges, looking at housing and so on. I'd worked for about 25 years in the provider side before I went into commissioning... and how much we [the NHS] could achieve in helping address the wider determinants of health was a revelation."
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> Idris Griffiths, Chief Officer, Bassetlaw CCG

Case study: Partnership working in Doncaster to support children and young people's mental health

Following an increase in children and young people accessing the emergency department after a suicide attempt or due to self-harm, Doncaster CCG helped to form the Social and Emotional Mental Health (SEMH) Group. Mental health issues in children and young people are complex by their very nature and in how they present, so they are often picked up by different agencies, who may not always know how best to support them. Prior to the setting up of the SEMH group, interventions were often delayed by debates around whose responsibility they are and who is best placed to plan care and treatment.

The multi-agency forum includes representatives from the CCG, local authority, CAMHS services, police, education, and other partners across the Doncaster area to consider the

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holistic needs of children and young people experiencing social, emotional and/or mental health issues. The CCG's designated nurse for children's safeguarding and looked after children, brings a system-wide perspective and impartiality to the group to pursue a shared agenda and, where necessary, escalate any enduring issues that cannot be resolved as a group. Such collaborative working has helped the different agencies work together more effectively and to deliver joint assessments, planning and service delivery for vulnerable young people in need of care without delay. By fostering collaborative working at a place level, the CCG has helped ensure that children and young people receive the support they need, when they need it.

Developing joint commissioning opportunities

Integrated CCG and local authority commissioning, drawing on the insights of health and wellbeing boards,* has offered many opportunities for commissioners to work together to ensure that gaps in services are addressed and improved experiences and outcomes for service users are promoted.

Despite the very different legislative frameworks, accountability structures and expectations, many CCG and local authorities have been successful in delivering integrated commissioning and provision of health and social care, using innovative approaches to section 75 agreements, structural integration through formal arrangements such as joint posts and committees, and virtual integration with organisations agreeing to work closely together.[15]

*NHSCC and the Local Government Association have co-run a development programme for health and wellbeing boards – for further information, please see: LGA, Leadership Development, https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/health-and-wellbeing-systems/leadership-development, accessed 24 November 2021.

In some areas, joint CCG/local authority commissioner roles have ensured dual accountability for funding commitments and aligned or pooled budgets. The Department of Health and Social Care's integration white paper seeks further advancement of the use of delegation to place-level and pooled budgets.[16]

Case study: Jointly commissioned senior mental health and community psychiatric nurse service – Kernow CCG

The Council of the Isles of Scilly and NHS Kernow CCG jointly funded Cornwall Partnership NHS Foundation Trust (CFPT) and Outlook South West to employ a senior mental health and community psychiatric nurse to support patients' health in the community and reduce hospital admissions. The nurse provides a one-stop shop for people experiencing poor mental health or at risk of hitting crisis point, including adults with wellbeing concerns such as dementia, anxiety and depression. The nurse has worked with colleagues in the health centre, hospital, social care, police and ambulance service, along with key employers, to improve people's emotional wellbeing. The service reduces patients' need to travel to the mainland, only now necessary when they need specialist acute mental health support.[17]

Learning from COVID-19

The NHS response to the COVID-19 pandemic accelerated CCGs' investment in collaborative and partnership working, effective clinical engagement and experienced managers. CCGs worked with system partners to manage pressure from extraordinary demand and, using their relationships with primary care and local government, supported the roll out of COVID-19 vaccines. Knowledge of local populations at a place level helped to identify communities with the lowest rates of vaccine uptake and to develop targeted interventions to overcome vaccine hesitancy.

> "The most important thing that's happened is the focus on inequalities, the data-driven approach we've taken - the vaccine being the best example through the partnership that the CCG has led to drive the vaccine programme where the CCG has taken the leadership role and has brought our trusts together, has brought our local authority and DPH colleagues together... I have never been prouder of anything in my whole life and I just think what a fabulous, fabulous legacy we have to hand over... the CCG in covid found its place in the system; it's recognised as an absolutely equal partner with as much skin in the game as any other statutory organisation. I just think [the CCG] has got a fantastic legacy and I am sure that many areas have got similar stories to tell about the vaccine, but it wouldn't have happened without us."

Frances O'Callaghan, Accountable Officer and Joint ICS Lead, North Central London CCG/ICS

Case study: Increasing COVID-19 vaccine uptake in Camden

The Camden Disproportionality Communications BAME Working Group was formed to encourage a high take up of the flu and COVID-19 vaccines. In collaboration with local authority, public health and local community leaders, the CCG developed communication materials to meet the needs of local communities, demystifying messages to improve the uptake of the flu and COVID-19 vaccinations. Ambassadors champion the vaccine in their own local communities. To support the work, address concerns and improve uptake, the Camden team has hosted public meetings with several local groups such as the LGBTQ + forum, Camden Carers BAME Carers,

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Healthy Minds (a sub-group of members of MIND Camden), and Parents Advisory Board, to answer questions that people have about primary care recovery and the roll out of the vaccine. In collaboration with partners, the CCG assisted with a film of the deputy leader of Camden Council and a local BAME GP, discussing issues that were important to local BAME residents around the COVID-19 vaccines.[18]

Recommendations for ICSs

8. **Delegate resources and decision-making powers** as near to the patient as possible at a neighbourhood and place level, where the deeper understanding of the population sits.

9. **Support primary care leaders to collaborate with directors of public health at place** to reprioritise investment that best reduces health inequalities, drawing on their day-to-day experience of treating patients whose health is shaped by wider determinants.

10. **Learn from the most effective health and wellbeing boards** and best practice to support shared understanding and integrated working.

11. **Continue integrated local authority and NHS working at place** through use of new place-based arrangements, from joint committees to lead providers and provider collaboratives.

Conclusion

CCGs were established nine years ago and each of those original 211 organisations will leave their own individual legacy for the communities they served. However, many CCG leaders acknowledged ICSs as the logical next step to go further on integration, bringing together a wider partnership for system governance and using collective resources to do more to address health inequalities and advance a population health management approach. Indeed, CCGs themselves have laid the groundwork and pioneered the change that the health and care bill is now legislating to catch up with. Doing implementation before legislation is a novel approach not just in healthcare, but in wider public policy.

As ICSs pick up the reins in July 2022, they should learn from the factors that have influenced CCG successes, what is at risk in the new arrangements and what are the opportunities to build on the legacy. To live up to their expectations, ICSs will rely on the positive legacy of CCGs: empowering clinical engagement and leadership, driving quality improvement, and facilitating integration (inside and beyond the NHS) at place level.

Clinical leadership should not be lost from a world without clinical commissioning groups. Clinical, professional and operational leadership – distinct skillsets but working in unison – can be the driver of the change ICSs seek. ICSs can ensure that partners from different parts of each system have greater involvement in decisions and resource allocation, bringing in leaders from outside of primary care, but primary care must still have meaningful input. Taking decisions at the most local level possible – often at place – will help to do this, as will comprehensive engagement with PCN clinicians and protection of a portion of primary care time for strategic engagement. These place structures will also provide a

pipeline for the clinical leaders of the future, as CCGs did, so that the NHS makes the most of all the talent at its disposal.

Quality improvement has been driven by clinical and managerial collaborative leadership, facilitating the spread of peer learning and developing mature medicines optimisations functions that have both improved health outcomes and delivered financial efficiencies. ICS leaders should continue to nurture the multidisciplinary commissioning skillsets once found in CCGs as essential tools to achieve their ambitious goals to improve population health.

Place-level partnership and insights will remain key to reducing health inequalities. In many areas, GP leaders have worked effectively with local authority directors of public health to shape priorities for investment, drawing on their day-to-day interaction with patients in their communities. Meanwhile health and wellbeing boards have often been vehicles for collaborative working and sharing best practice. ICSs should continue to harness and develop these boards' potential as part of their wider integration of NHS and local authority decision-making and resource planning.

The health and care system has seen what CCGs could deliver at a time of crisis, along with the extent of health inequalities that still needs to be tackled, which the population health management approach has thrown into stark relief. Their expertise and innovation will be key to realising the ambitions of ICSs. It is at the place-level where the clinical, quality and collaborative legacy of CCGs is best preserved and built upon.

As CCGs hand over the baton, this is our challenge to the next generation of ICS leaders.

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