CCGs and GP practices within the health economy

CCGs are an easy target for criticism; however, not all of it is justified. There are some very good examples of CCGs working with their local General Practices, GP Federations/Networks, Super Practices and New Models of Care - Multispecialty Community Provider (MCP) or Primary and Acute Care System (PACS).

The backdrop of austerity has made it tougher for CCGs to meet their statutory duty of financial balance, and the fear of overspend often makes it challenging to effect change. Add in governance, safeguarding, subcommittees, conflict of interest, sustainability and transformation plans, which risk disempowering CCGs, along with overly complex bureaucracy, and it's easy to see why many have failed to deliver the changes expected post authorisation.

However, it's not all doom and gloom. There are a small number within my work that have commissioned services directly, mostly around extending access to General Practice services, in one way or another, but not always that service. I have seen them accept gain share proposals with their local GP federation, where the federation's "share" of the "gain" has to be reinvested in patient services. In these instances, agreed services can then be delivered as pilots by the federation, which provides a significant opportunity for both CCG and federation - there are many basic services that can safely be transferred.

Additionally, I have examples of pilots where services are moved from in hospital to out of hospital, under the banner of transferring and then transforming care delivery. In short, we don't move the service and retain the same delivery; this becomes about how we rethink the care provision as part of the shift and start to work at scale across the total population, rather than just the registered list of an individual practice.

When successfully implemented, even the most basic service changes offer significant benefits, including for example:

- improved patient outcomes
- less waste
- quicker results
- fewer repeat diagnostics
- shared results
- care closer to home
- avoiding unnecessary referral to hospital
- avoiding unnecessary hospital procedures
- prescribing more efficiently and effectively
- reducing the levels of unfunded work
- cost effectiveness and value for money

This way of working makes the goal of achieving one, high quality and standardised approach without unwarranted variation, deliverable. Consequently, these projects provide a platform for the larger and more complex system-wide changes that the NHS needs.

If CCGs cannot quickly get basic services shifted from in hospital to out of hospital care as part of the development of a local MCP or PACS, I hold out little hope for delivering the large scale, complex changes that will ultimately be required in those models.

If you cannot get all the stakeholders engaged in the development of the MCP or PACS, right at the start, and quickly get them working to transfer and then transform basic services, why would anyone buy in to the concept of large scale, wholesale change?

You are likely to need an evidence base of basic straightforward changes that provide confidence and underpin larger scale projects/changes.

Too often, before CCGs attempt anything, I see them hesitating on the premise they are waiting until "everything is perfect", which of course it never will be. The time is here and now to take a low risk approach to shifting basic services, that should sit in General Practice (with proper resourcing) and start to build the local PACS or MCP model from the font line, through formal engagement at the start.

What I know from my work is that where people own both the problem and the solution, you will see change being delivered. Where change often doesn't work, is when it comes top down, leaving the frontline providers to implement an idea they would never have created had they been engaged right at the start. In this instance, what often happens is that no matter how good the idea, people simply don't/won't engage and the attempted change fails.

There is nothing to fear in engaging everyone affected by the proposed change, right at the start, and indeed, everything to gain. Whilst challenging, this ensures that the vision created is one that has been developed by all those who have a role to play, whatever that role, leading to buy-in and ownership of what you create as a "community for change", bringing about a critical mass for driving successful change.

Given the current financial position within the NHS, and the significant challenges it faces in the next few years, the emerging PACS and MCP models, underpinned by General Practice operated at scale through a GP federation or Super Practice, offer significant opportunity for CCGs willing to engage in commissioning services directly from them. It also creates an opportunity to build resilience and stability, particularly in to General Practice.

That opportunity can only be realised where all involved in implementing change are genuinely engaged, willing to take a small risk and a bit of a leap of faith that working in collaboration with each other and across providers is going to be to their advantage. This means engaging everyone right at the start and developing one organisation, with one vision that everyone involved then works to deliver. There are great examples out there but CCGs need to be willing to first look at the examples and then act upon them. You cannot keep doing what you are doing now and expect a different outcome.

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