Will co-commissioning liberate primary care?

Just under five years from the publication of Andrew Lansley's blueprint for health service reform, a wall at the heart of his vision for the NHS is about to be torn down.

The 2010 white paper *Liberating the NHS* set out plans for clinical commissioning groups (CCGs) – unveiled at the time as 'GP consortia' – to commission the bulk of NHS services.

However, the document was clear that these groups 'will not be directly responsible for commissioning services that GPs themselves provide'.

Keeping CCGs out of controlling primary care contracts was among the few parts of Lansley's reforms that won support from the British Medical Association.

But influential groups that helped develop Lansley's plans – such as the NHS Alliance and the National Association of Primary Care – continued to argue that dividing commissioning functions in this way made no sense.

They believed that commissioners need control over both secondary and primary care budgets to drive through plans to integrate NHS care and move it increasingly into community and primary care settings.

The five-year plan for the health service published in October by NHS England chief executive Simon Stevens suggests this group have at last won the argument.

Stevens' *Five Year Forward View* acknowledged that primary care is currently under 'severe strain'.

He promised a 'new deal' for general practice, with plans for a significant rise in the proportion of NHS funding targeted at primary care.

At the core of his proposal was a plan to give GP-led CCGs 'more influence over the wider NHS budget, enabling a shift in investment from acute to primary and community services'.

The *Forward View* document is explicit that over the next five years, the NHS will 'expand funding to upgrade primary care infrastructure and scope of services'.

Across England, CCGs are currently submitting proposals to embark on a new age of 'co-commissioning' – taking on full or partial control over primary care contracts.

In a foreword to *Next steps to primary care co-commissioning*, published this November, NHS England officials Dr Amanda Doyle and Ian Dodge explain this as 'an essential step towards expanding and strengthening primary care'.

CCGs are being given greater power and influence over commissioning primary care because NHS England believes this will give them the freedom to take a more 'holistic and integrated approach to improving healthcare' and remove a barrier that holds them back from improving

local primary care in tandem with hospital services.

In July 2014, NHS England's chief operating officer Dame Barbara Hakin said a third of England's 211 CCGs were ready or nearly ready to assume full control of commissioning primary care.

All but around 20 had expressed an interest in either joint commissioning – sharing the role with NHS England's area teams – or the fully-delegated model.

Formal applications for co-commissioning powers must be submitted by January, and from 1 April 2015 it is likely that the vast majority of CCGs will play a significant role in commissioning local primary care.

Some GPs are confident that the new era will kick-start a dramatic change in primary care, liberating CCGs to invest in new services and better premises.

NHS Alliance chairman Dr Michael Dixon, a GP in Devon, says: 'I think the walls are coming down and things are going to move fairly quickly.

'I think an awful lot of people will move fast to completely devolved primary care commissioning. I think it will become the norm very quickly over the next 18 months for CCGs to do fully fledged primary care commissioning.

'People will have devolved capital and decision making fairly fast - and then I think things will move fast.'

Dr Dixon says it is 'inevitable' that control of decision-making over primary care premises development will move from NHS England's area teams to CCGs as co-commissioning takes off.

The benefits this could bring – innovative thinking on developments that span primary and secondary care or bring them together, and unjamming primary care development that has been 'completely constipated' – should outweigh any concerns about conflicts of interest, he says.

Conflict of interest concerns have dogged GP-led CCGs from the start, but the organisations have become relatively adept at handling them – often asking potentially conflicted board members to step out while committees handle sensitive decisions.

NHS England believes the transfer of primary care commissioning control to CCGs can be handled in a similar way – the groups will be expected to set up decision-making committees with a lay majority to handle decisions that relate to GP contracts and other primary care funding.

Dr Dixon adds: 'I think practices and CCGs will become incredibly close. Everyone will have their eye on the ball – GPs will notice if funding is being shared out fairly.

'But the whole thing is becoming more transparent. I think the dangers are small - people would be quickly found out if they try to influence a committee to provide funding for their own premises unfairly.'

By the end of 2015, Dr Dixon believes, 'we will begin to see movement' on GP premises.

Forward-thinking CCGs will demand control of budgets and begin to invest, in part from existing premises funding, but also with funding shifted from other NHS funding streams, such as hospital funding, he believes.

Some CCGs' development plans and initial expressions of interest in co-commissioning suggest Dr Dixon's assessment is correct.

Wiltshire CCG, for example, plans to work closely with practices in its patch to help them shape business plans for premises development.

The CCG is clear about the case for greater involvement in primary care commissioning, and that freedom to influence premises development is key: 'Given the central role that primary care plays in the successful implementation of our strategic plans, we feel that an inability to shape the local primary care strategies including workforce development and premises would represent significant barriers to the implementation of our CCG strategy.'

Some GPs, however, remain sceptical.

GPC deputy chairman Dr Richard Vautrey warned that if the key to unlocking primary care premises spending was simply to join up commissioning of primary and secondary care, it 'would have happened under PCTs'.

'That is where we are heading back to,' he says. 'And the resources are still not there to properly fund the primary care development we want.'

Dr Vautrey said CCGs needed to 'do what PCTs did not', by moving money from hospitals to primary care.

He pointed out that the difficulties in doing so were highlighted by foundation trusts pouring cold water on Mr Stevens' suggestion that their financial surpluses could be used to build primary care.

'Everyone agrees, we have to do something about premises for practices. We agree with NHS England. The challenge is funding – it's very difficult to get money out of the Treasury or elsewhere and then to use it for practices when there are other competing, complex interests.'

Dr Vautrey pointed to a recent report that suggested London's primary care premises alone needed a £1bn overhaul. 'That means £5bn across the country.'

If that kind of money is needed, many CCGs may find it difficult to think beyond funding minor alterations and additions to buildings, rather than thinking bigger.

So will co-commissioning work – could it revitalise primary care and liberate funding for infrastructure and premises?

The answer is that in some parts of the country it may well do just that. But everywhere? Probably not. Perhaps more crucially, if a Labour government is elected next May, it plans to rethink the role of CCGs anyway – potentially

making them subcommittees of health and wellbeing boards.

If that happens, Lansley's reforms won't just have had a cosmetic rethink as is currently the position – it could be back to the drawing board.