GP commissioning: the first year

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The aspiration of a medical teacher should be to train better doctors than their own generation. Similarly, commissioners should aspire to facilitate an improvement in healthcare. I am a doctor who falls into both groups, as both a medical teacher and a general practitioner (GP).

In April 2013, GP commissioning in England was introduced with the new Health and Social Care Bill. Primary care trusts (PCTs) were replaced by clinical commissioning groups (CCGs): groups of GP practices that became responsible for most of the budget relating to patient care. One of their strategies was to introduce policies and protocols for referrals to primary and secondary care, trying to ensure that the most economic provider is available to patients, whether that means community care, intermediate care or a hospital clinic. The aim was to increase clinical leadership in the NHS, increase competition by allowing the franchising of services to private providers, reduce bureaucracy, reduce the workforce, achieve cost savings and maintain quality.[1] Are we anywhere near to achieving this?

I made my enquiries starting at the 'coal face'. My patient participation group had not heard of commissioning, suggesting that it had had no major impact on their lives. I regularly ask groups of undergraduates, some of whom have heard the word commissioning but have no idea what it means. Postgraduate trainees in general practice have definitely heard of commissioning, but know little more than that. Going back to the 'coal face', most colleagues are not interested in being involved but are exasperated by the almost weekly changes in referral policies and protocols. The increasing demands of referral management and the complexity of computer referral programmes such as the Map of Medicine add to their frustrations. The need for data collection has seen an exponential rise, and the available administrative support in the new CCGs is a fraction of that available in the former PCTs. So yes, the workforce has decreased, but the bureaucracy has not. More worrying still is that some of the most experienced GPs have taken themselves out of the front line of patient care to lead CCGs.

Three positives, however, can be recorded. For the first time doctors are having to consider and reflect on the many costs associated with healthcare other than medication, whether that be hospital admission, an outpatient appointment or an investigation. Second, there has been poor recording of data in some areas and this is being tightened up. (Nevertheless, there remain considerable challenges with the sharing of patient records using the NHS data spine, including the need to ensure patient confidentiality and the current lack of uniformity with the software used in primary care, which impedes efficient interfacing with secondary care.) Third, improvement of care pathways in some CCGs has facilitated care becoming better integrated between community and specialist services.

The area that needs to be addressed most urgently by GP commissioning is the reduction of emergency admissions, and thus the frequent users of unscheduled care – an almost daily media issue. One answer has been to provide 'community matrons' who might pre-empt possible hospital admission of identified patients who are on 'virtual wards' and have multiple long-term conditions. However, the wider issue, which is not being addressed, is the need to continue to provide adequate GP access with a diminishing workforce and a lack of recruitment of new GPs to vocational training schemes. One result according to the media is that more patients are going to accident and emergency (A&E) departments with primary care problems, despite the creation of NHS walk-in centres. This has been accelerated by the 2004 GP contract, which allowed GPs to opt out of providing out of hours (OOH) care. Many of the then PCTs decided to ensure OOH care provision by using commercial providers. This reduced the costs of OOH care provision instead of the benefit to A&E departments of the more expensive OOH GP cooperatives run by local GPs with considerable local knowledge and patient experience. But, more than this, the valuable triage services which they also provided were replaced, first by NHS Direct and now by 111, with well-documented consequences.

One wonders how GP commissioning can work in the long term, as there is still a 'top down' approach. Although CCGs can consider local priorities, they are accountable to keep to their budgets. Overall, they are being told to cut funds with quite profound consequences. Take the example of *in vitro* fertilisation (IVF). Research by the National Infertility Awareness Campaign indicates that nearly three-quarters of CCGs now ration IVF treatment. It found that 73% of 198 CCGs funding facility services do not routinely offer three cycles of IVF, as recommended by NICE. A further six CCGs do not fund IVF routinely.[2] Perhaps this is also an example of GPs commissioning secondary care but having no skill in the area.

'The government has set up conflicting incentives. On the one hand, you must identify all disease groups and all risks, and be judged on how well you do that. On the other hand if

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you refer patients to hospital, you are going to be financially penalised.'[3] Take the potential example of a GP overestimating their knowledge of diabetes and providing pre-conception advice for women with diabetes in order to cut costs rather than refer. The structure that GPs were familiar with has ended (PCTs and strategic health authorities [SHAs]) and a new system, namely NHS England, based in Leeds, has been put in place, leaving them uncertain as to where to seek guidance. It is challenging, to say the least, to navigate a new system with the loss of the corporate knowledge that PCTs and SHAs possessed. This situation is not something GPs requested and is one with which many do not feel comfortable, but nevertheless have to work in. This is further complicated by the stasis of GP practice income, the threat of the possible loss of enhanced services and the minimum practice income guarantee (MPIG) factor. As a result GPs not directly involved in commissioning are starting to form federations outside of the CCGs. This is to create provider arms as separate legal limited companies in which to move core services, in particular enhanced services, from GP general medical services, in an attempt to ring fence and avoid losing this funding to prevent them being franchised to private providers by the CCGs.

It could be argued that nothing has changed, or at least nothing has changed for the better. It seems appropriate to ask what impact commissioning has had on healthcare, other than the changes of 'headed note paper'. The Kings Fund video 'An alternative guide to the new NHS in England' illustrates the situation, stating that GP commissioning is the most wide-ranging reform of the NHS since its formation in 1948 and highlighting this as a further complexity of the NHS in both England and the UK.[4] It details how GPs' limited experience in commissioning means that the almost 200 CCGs need to be supported by 20 clinical support units, while their lack of expertise in managing the extremely complex needs of some hospital patients necessitates support from clinical senates. Furthermore, to avoid conflicts of interest, CCGs cannot commission GP services themselves and so this is done by what is now called NHS England. The future of the new NHS in England and how it will work – let alone in the devolved nations, who have their own departments of health – is unknown. One certainty is that it has to reduce expenditure and yet meet defined clinical governance targets, which is a tall order. ■

References

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