

GP commissioning in England

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ABSTRACT – The NHS, yet again, is in transition with an emphasis on groups of general practitioners (GPs) (clinical commissioning groups) making decisions on which specialist services should be chosen for patients requiring referral from primary care. It is an area of new terminology with a new language and further change for all working in the NHS and the all-important interface between primary and secondary care, and its impact on teamwork. There are many drivers including choice, efficiency, franchising of services, coordination and leadership in an enormous organisation, but not least reducing costs and keeping to a budget. There are many logistical issues and ethical anxieties, and only time will inform patients, practitioners, stakeholders and politicians as to its success.

KEY WORDS: GP commissioning, clinical commissioning groups, primary care

General practitioner (GP) commissioning is not new. In 1991, GP fund holding was introduced, and since 2005, we have had practice-based commissioning (PBC) of services in the community, with care such as diabetes management, anticoagulation treatment, musculoskeletal therapies and the diagnosis of deep vein thromboses being provided closer to home. Both of these commissioning roles were voluntary activities undertaken within GP practices.

The new vision for GP commissioning

A new vision for, and scale of, GP commissioning in England was introduced by the Department of Health when the Health and Social Care Bill was published on 19 January 2011. In Scotland, Northern Ireland and Wales, devolved governments will continue to develop their own health services, which may or may not include GP commissioning.

Whereas GP practices were not obliged to take part in fund holding and PBC,¹ no GP practice in England will, in future, be able to operate outside of a commissioning group. There is no contractual obligation for any practice to do anything other than be in a commissioning group, but as it becomes very unusual for GP practices to work in isolation and as collaboration in federations is encouraged, a change in the role of the GP is inevitable.

Federations of GP practices will introduce policies and protocols for referrals to primary and secondary care, aiming to ensure that the most economic provider is available to patients and that duplication in both referral and follow-up is avoided. Ideally, commissioning should also be about the individual needs of the patient rather than about organisational constraints. Whether GPs like it or not, commissioning comes with considerable responsibility.

Like the constant change in the structure and responsibilities of Primary Care Trusts (PCTs) that has taken place over the past 10 years, the change in GP commissioning will take time; at least five years. Thus, objective short-term measurement of success, or otherwise, of GPs in effective commissioning will be difficult. In addition, as a result of the Health and Social Care Bill, further large and imminent changes in NHS structures lie ahead, with Strategic Health Authorities and Primary Care Trusts (PCTs) disappearing by April 2013.

Some of the proposed reasons for GP commissioning include: a desire to increase clinical leadership in the NHS, a reduction in bureaucracy, increased competition, ensuring patient-focused care that is appropriate to the locality, and a reduction in the workforce resulting in cost savings.

Organisation and authorisation of commissioning groups

To understand GP commissioning means understanding a new language of acronyms and a little of the preceding history. The resources that support commissioning will move out of PCTs into Clinical Commissioning Groups (CCGs), which are federations of GP practices that should receive training from larger Commissioning Support Units (CSUs). These CCGs and CSUs will be hosted by the NHS Commissioning Board (NCB or NHSCB).

The NCB named the CCGs that were likely to be authorised in four waves by November 2012. These CCGs had to send their constitutions to the NCB and needed to demonstrate engagement with the existing Local Medical Committees (LMCs). At present, the remaining Strategic Health Authorities (SHAs) can rule that a prospective CCG is too small to be authorised by the NCB and can determine whether or not they should be deemed an ‘unaffiliated practice’ instead.

In addition, groups called Local Area Teams (LATs), which will hold the budget for certain specialist services such as radiotherapy, chemotherapy and most vascular services under the umbrella of the NCB, will hopefully prevent ‘postcode lotteries’ from determining who gets what care and where. The LATs will

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also have responsibility for direct commissioning of GP, dental, pharmacy and some aspects of optical services. GPs will be responsible for commissioning nearly all other local health services, other than social services, for their patients. There will be 27 LATs, ironically one fewer than the number of strategic health authorities. A potential issue will be how CCGs and LATs will work together.

With the closure of the Strategic Health Authorities, workforce deaneries will fall under Local Education and Training Boards (LETBs). Health Education England (HEE) will be a special health authority responsible for developing and managing a robust system of authorisation for LETBs.

In total, 212 CCGs have been considered for authorisation, subject to having a constitution in place. They will carry the 'NHS' prefix and will cover populations ranging in size from 68,000 (NHS Corby CCG) to 901,000 (NHS North, East, West Devon CCG).² The number of CCGs is very close to the existing numbers of PCTs. Some leading charities have been selected by government as part of pilots that could lead to greater involvement from the voluntary sector in commissioning. The size of a CCG will determine its purchasing power.

Transition to GP commissioning

The introduction of GP commissioning is happening at a considerable pace and there is an aspiration that there will be a seamless transfer of services and responsibilities from PCTs to CCGs. Nevertheless, considerable amounts of information held by PCTs, many of the work functions carried out by PCTs, and the many clinical service contracts or agreements signed by PCTs (the latter estimated to be close to 100,000 in number in England) need to be identified before they can be transferred. When any big organisation, such as a PCT or Health Authorities, ceases to exist, there is the risk of losing vital corporate memory.

CCGs will need to consider and make difficult decisions as to whether current service contracts are required, and match what is needed in the locality, and whether they are being delivered efficiently and meeting defined clinical governance strategies. Bearing in mind the background of constant change leading to restructuring and changing responsibilities of PCTs and their predecessors, it has been very difficult logistically to evaluate objectively their role as commissioners of healthcare. Inevitably therefore, there must be some doubt as to whether CCGs will be ready to take over from PCTs in April 2013.

A further tier of complication for GP practices themselves, seen by many as more, not less, bureaucracy, is the requirement to register individual GP practices with the Care Quality Commission (CQC) by April 2013.

What do the changes mean for GPs?

The Health and Social Care Bill gained royal assent to become the Health and Social Care Act at the end of March 2012. Opponents of the Bill have argued that it will lead to the privatisation and fragmentation of the NHS. CCGs will make choices

in commissioning services locally from a NHS hospital or private provider, but they should also be able to look further afield to the best available providers if necessary. It could be argued that the Health Bill is about legislating for the development of joint commissioning strategies, reducing inequalities and raising quality by using the new Commissioning Outcomes Framework (COF) to drive clinical governance.

So what will CCGs actually do? In commissioning care, an objective assessment needs to be made about whether any service is providing the care that is actually needed. In addition, CCGs must determine whether there is a contract in place for that service and whether the service provider is meeting the terms of that contract. GP commissioners will be required to engage in the performance management of commissioned services. This will be completely different to the current role of a GP in managing their own GP practice. In commissioning, GPs will have to get involved, not just in contracts and in the procurement of services, but will also have to undertake difficult negotiations wherever a provider is underperforming. They will also need to enter the territory of identifying and working with stakeholders, which is something that PCTs have traditionally done. Most difficult of all will be the requirement to meet NHS financial constraints, which will inevitably involve some form of rationing challenges. In relation to ethics, it is vital that CCGs are open and disclose their activities with as much public engagement and involvement as possible.

The employment of private providers has been a concern raised by many, and commissioners must have open policies and documentation to confirm they have no conflicts of interest. Commissioning is not just about contracts, but is about improving clinical outcomes through effective collaboration in care planning between primary and secondary services (including private providers) and social services. Ultimately, it is about ensuring the provision of quality care to patients. It might, however, be difficult to achieve this without defined care pathways, adherence to guidelines and the setting of contracts. It should be stressed that for those working at the 'coalface' in general practice, there will be many patients whose individual needs cannot be defined in such a constraining context. Thus, CCGs must recognise a fine balance between practitioners' maintaining absolute compliance and common sense when some referrals and actions are outside agreed boundaries.

Some will argue that commissioning is all about money and contracts, and they may well have a point. Many GPs are not keen for the extra financial responsibility and do not wish to make clinical and financial decisions in parallel. They will voice the concern that they are not trained to make such decisions and do not wish to compromise the doctor–patient relationship. It could be said that the GPs who are already involved in commissioning are an enthusiastic minority, and it remains to be seen whether there will be grass-roots support. A further complication is that CCGs will not inherit legacy debt accrued before 31 March 2011, but any PCT or GP commissioning deficits that accumulate after that date will not be fully written off.

In relation to quality, the Department of Health is discussing the possibility of bonus payments for successful functioning of a

CCG. These are likely to be based on 44 indicators proposed by NICE. These indicators will form part of the COF and will also include mortality rates in under 75s, reductions in emergency admissions and re-admissions, improvements in the quality of life for patients with chronic disease (long-term conditions) including the concept of self management, and benchmarks of the quality of end-of-life care provision. The only direct remuneration to GPs or GP practices will be payments to CCG board members for their time, thus reducing potential conflicts of interest.

Ideally, CCG boards should have representatives from nursing and consultants in secondary care. There has, however, been a difficulty in recruiting consultants, as the regulations state that, although every CCG board must have one consultant as a member, they cannot be someone who provides a relevant service to a person for whom the CCG has responsibility. This regulation aims to reduce potential conflicts of interest but is making recruitment very challenging in practice. Unless the option of CCGs sharing consultant and nurse representatives across boards is promoted, consultant representatives may have to be retired consultants. GP commissioning will have a major impact in the management of long-term conditions. Much of this care is currently moving into the community and so out of hospital clinics. The ethos behind GP commissioning and the challenge is that services should be run more efficiently, reaching more patients but at a reduced cost. This may lead to the creation of so-called GP provider organisations (GPPOs), which may be NHS or private-sector providers.

As a result of commissioning, there will be greater competition between NHS trusts, foundation trusts and private organisations. An increasing emphasis is being placed on community care, relying on better coordination of primary and specialist care, as well as of health and social care. Examples in which the predecessor of commissioning, PBC, has had this effect can be found. In specialties such as ENT, a GP with special interest (GPSI) peer reviews referrals. As a result, that GP has been able to look at clinic outcomes and to produce recommendations regarding practice policy and the use of a community ENT clinic. The resultant clinic can be run by a consultant working in the community and also referring to the hospital, where more specialised procedures can be appropriately undertaken. This will reduce costs as the primary and secondary care clinics are being used more appropriately for targeted referrals. One ramification that has perhaps not been considered is that there will

need to be an increase in the number of GPs in the future to facilitate GPSIs in these community intermediate clinics in all specialties, not just ENT.

Conclusions

To coin a worrying phrase, 'we live in interesting times'. GP commissioning faces many challenges not least the requirements to prioritise patients' needs locally, manage very tight and potentially decreasing resources, and ensure close working relationships with colleagues in secondary care and social services. The gestation and birth of GP commissioning has been subject to considerable debate and this discussion will continue. It is important that we all work together; to quote the words of the President of the Royal College of General Practitioners (RCGP), Professor Clare Gerada, speaking about the new Health Bill at the annual RCGP October conference:

A bill qualified by a thousand amendments, longer than a Tolstoy novel, rushed through at breakneck speed and as a result, our NHS is in distress. Regrettably, our fight wasn't enough to prevent it getting passed into law. But we did succeed in getting our voices heard-loud and clear.

GP commissioning very much changes the role if not the job description of GPs and has considerable ramifications for colleagues working in secondary care. The leadership role it demands might be new for some GPs, but whatever happens, it should put patient care at the centre of commissioning decisions, potentially allowing their needs to be met when and where appropriate and creating better patient experiences and outcomes.

References

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