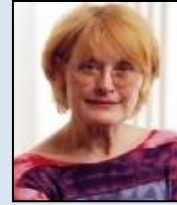


Andrew Craig is a partner in the Moore Adamson Craig Partnership LLP, a specialist user involvement consultancy, and a PEC Member for NHS Wandsworth. His views are his own.

Two regular contributors go Head-to-Head on GP Commissioning Consortia



Lynn Young is the Primary Healthcare Adviser for the RCN. She was a district nurse in West London.

Lynn ‘speaks’ in Black and Andrew in Blue

Lynn

1. GPs are the great spenders of NHS cash. They make the referrals to specialist services, which cost.

Andrew

They are commissioning all the time in the sense of committing NHS resources, most of which is sucked up by acute hospitals, but most of them don't understand this. They are not natural proactive commissioners and do not see health inequalities between groups and areas. Many make unnecessary specialist referrals and are not competent to deal with problems in lower-cost primary/community care. That's the problem. The FTs will end up getting all the work and then just swallow up the GP

We PCT people are up (down?) there with estate agents and purveyors of cold sick. But what we need is informed trust, not blind faith, and certainly not deference to “doctor knows best”.

providers anyway – vertical integration with a vengeance. I don't want to pay GPs to do (badly) what specialist nurses and therapists and primary care NPs could do better. I don't think the future is rosy for people with long term

neurological conditions, for example, as GPs are not well versed and for the rarer conditions, see few people.

2. The one part of the NHS which takes continuity of care to its heart is that of General Practice.

Hard to argue with this because there aren't any competitors for the title! But that doesn't mean they do it very well in many places. If they

commission the right mix of specialist nurses and other community services and social care they just might have a chance. Someone has to have oversight of complex cases – community matrons are sinking. How will individual budget holders (patients and carers) who are likely to be hyped in the White Paper going to fit into this?

3. OK, now we are into choice. Statute deems that the public have the right to choose their own GP, though few people choose to exercise this option.

Go the final mile and abolish practice boundaries/catchment areas if the government is serious about choice and then let market forces prevail.

EMIS web is the way to link things together and we are not making enough

progress there. Publish comparative scorecards about GP performance and offerings in a way like school league tables that consumers can access and understand and make all of this very easily available on websites and in the local media.

Collectively we are tainted because we have been too slow to deliver change

4. 99% of the population is registered with the GP of their choice (theoretically), whose practice holds the most valuable data and health and social information within the system.

That figure (source?) is rather high I believe when applied to urban areas like inner London (we have a 30% population churn annually in parts of Wandsworth which plays havoc with registrations, hence list cleansing to save £1m a year). The practice may not be the patient's choice because of geography and lack of knowledge and they need to be empowered to make better choices.

5. The public trusts nurses and their GPs beyond any other professional group.

So it seems from surveys; we PCT people are up (down?) there with estate agents and purveyors of cold sick. But what we need is informed trust, not blind faith, and certainly not deference to "doctor knows best".

6. The easiest way of redesigning services is to gain agreement between GPs and local consultants. Commissioning can never succeed without achieving this successful dialogue.

This is a rather health-centric and doctor-focused view of what is needed.

Dialogue is all fine, but where is the power and leverage across commissioning sectors: including care, housing, education, leisure and environment? GPs, bless 'em, haven't a clue about any of that. Real life extends beyond the NHS remember.

7. Alright, GPs are a funny lot and come in many different shapes, sizes and various levels of talent and integrity, but the key to success is to engage with those who have a passion for improving services – and they are out there.

There are simply not enough of the good ones, and when they focus on commissioning who is providing the services back in the practices?

8. PCTs have failed to successfully commission and they have cost the nation huge amounts of cash.

I dispute that Wandsworth PCT is a failure, though I acknowledge that many PCTs are seriously underperforming in both financial and service reconfiguration terms. But collectively we are tainted because we have been too slow to deliver change – mainly because GPs are not strong enough to decide on and deliver shifts of care outside of hospitals. There is no evidence that 600+ commissioning consortia will cost any less.

9. GP fund holders were brilliant at investing in community nursing (yes, I am biased), whereas the Health Authorities of the time failed to.

Specialist nurses will disappear unless they embed their cost effective and clinical quality contributions into the new arrangements ASAP

Were they? Where is the evidence? I agree the HAs were not good at this though some of us on HA Boards did continually bang the drum about it.

10. The potential is for the RCN to argue the case for commissioning

ing to take place around clusters of general practices, with others, such as nurses, social care personnel, members of the public and public health folk being involved and influential. In the past, this has been called locality commissioning and commissioning primary care groups.

GP commissioning is not the same as primary care commissioning and that is what is needed. Local commissioning boards with GPs, local authority people, lay members (NOT patient representatives for god's sake) and public health and business advisers are already being created. As Chris Ham argued, let's see what some of them can do first before we plunge into everyone trying it for themselves.

11. So, here we go again.....

Yes and no. It should not be Fundholding mark 2 and it won't be PCGs redivivus. Something that combines best of both and public health intelligence, business management acumen and real customer involvement might be a good objective. But who will do the clinical work if the GPs are

all doing the commissioning? Oh wait, that's what consultants are for isn't it?

12. There is a suspicion that commissioning GPs will pocket NHS cash. Such action is fraudulent and criminal and we need to ensure that systems are in place to prevent this from happening. PCTs with Local Government should be the joint accounting bodies and sign off the contracts.

Trousering the lolly is a danger, as are sweetheart insider deals. The NHS Board and its regional outposts (when? where? who?) will hold the new GP contract and performance manage them (so much for reducing management costs).

13. Finally, there is more potential for nurses to be involved in commissioning at general practice level, then from within the PCT.

Yes, yes and yes, so why haven't they done it before? Specialist nurses will disappear unless they embed their cost effective and clinical quality contributions into the new arrangements ASAP.

