EDITOR'S CHOICE

INSIDE COMMISSIONING
The latest thinking on redesigning healthcare

Reform will have little impact until there is greater primary care representation in NHS En gland

Dr Kosta Manis
Cardiology lead for Bexley CCG and senior GP partner in south London.
16 September 2013

There is an elephant in the waiting room of GP commissioning. It is a large somewhat cantankerous beast used to throwing its weight around and getting its own way.

Hospitals have always played big brother to primary care but the opportunity to put that relationship on a level footing through the NHS reforms has been conveniently sidestepped.

There is nothing Machiavellian about it. One officer-led hierarchy has simply replaced another in the shape of NHS England which, like its predecessor, still dictates what primary care can and can't do.

Primary care and commissioning are linked and must be developed in tandem

It makes mockery of the claim that GP commissioners call the shots when you realise that the senior ranks of NHS England are dominated by secondary care representatives with a stranglehold over the national decision-making processes that really count.

The bias towards preserving secondary care is imprinted so deeply in these senior

decision-makers' DNA that I genuinely don't think they can see the wood for the trees.

This leaning towards all things secondary care means the organisation fails to understand a simple truth: primary care and commissioning are inextricably linked and must be developed in tandem with one another.

In reality, we are moving further away from this as NHS England dismantles important parts of primary care's infrastructure aided and abetted by political interference.

CCGs told they will be given tools but have had axes replaced with toothpicks

CCGs know what needs to be done, have been told we will be given the tools to do it and then had our pick-axes and shovels replaced with toothpicks and spoons.

A good example is Bexley CCG in Kent which attracted great attention for its multi award-winning community cardiology project and included the use of a cardiac scanner for patients with chest pains which removed the need for invasive, expensive and often unnecessary angiograms.

To date, the project has saved £1.3m over three years, improved patient satisfaction 100% and reduced waiting times from 18 to two weeks. An independent Matrix report also concluded that the national adoption of this model would save the NHS at least £126m a year.

The great and the good came to visit us and it was cited as a model of excellence by the prime minister and the mayor of London as an example of GP-led commissioning at its best.

So why has this model not been applied widely when some of the top echelons of the NHS have visited and inspected the service and acknowledged its high quality cost effective values?

We need to upset the local health economy by challenging hospitals

The answer came from a senior DH director who stated that the model could not be implemented, because it would 'upset the local health economy' by challenging the hegemony of district general hospitals.

In reality, this is exactly what needs to be done.

What GP commissioners want is accountability and transparency from their hospitals. However, this is being blocked through a combination of political expediency and providers' unwillingness to examine their own working practices and often questionable interaction with primary care such as the artificial activity generated by payment by results.

This has been compounded by legislation that effectively denies GP commissioners access to certain patient information on the grounds of patient privacy.

In reality, secondary care doesn't want us to have access to this data because it will reveal the true picture of what is happening with regards to patients' activity and expenditure.

We are now being asked to play a guessing game on hospital contracts worth millions

As a result, GPs have lost access to a system for checking hospital bills worth millions of pounds a year along with risk stratification analysis of patients with complex health needs which present a huge financial challenge for commissioners.

Contract management has been an area of weakness within the NHS for many years because of the lack of clinical involvement in the decision-making process.

A key part of this process is access to all the relevant primary and secondary data so we can make well informed decisions. Data doesn't lie and is one of the keystones of effective contracting, especially in these times of financial austerity where every penny is meant to count.

In reality, we are now being asked to play a guessing game when putting pen to paper on hospital contracts worth tens of millions of pounds.

GP commissioners are not interested in a witch hunt or finger-pointing but neither do we want the status quo maintained which is financially bringing the health service to its knees and artificially propping up hospitals.

The NHS under-uses and under-estimates the value of the community and voluntary sectors

I don’t believe the NHS can survive much longer in its current state and an example we should be moving towards is a model which combines the public, private and, importantly, voluntary sectors.

Our health service woefully under-uses and under-estimates the value of the community and voluntary sectors in helping create a sustainable healthcare system, especially in light of a population that is living longer and affected by a variety of long-term conditions in the community.

This is where the majority of our services need to be focused and that requires primary and secondary care to genuinely work alongside one another or we risk losing one of this country’s most prized assets