

FEEDBACK



'The trick might be to tune indicators closely to what the public wants'

Dave West

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History repeating

We do not have to go across the pond for our lessons in GP budget-holding (news analysis, page 12, 10 June). Remember GP fundholding, initiated under a previous Conservative government in the mid 1990s?

Our experience, over a one million-plus urban population, was that fundholding exacerbated the inverse care law.

Per capita, money flowed towards fundholders, who tended to serve less needy areas, and away from non-fundholders, who tended to serve the needier. It was never on the cards that eventually all GPs would become fundholders. More recently, practice-based commissioning reinforced the point – commissioning was a minority interest among GPs.

At its best, GP-led commissioning can achieve extraordinary service change, often because clinical consensus enables real innovation. But GPs are not natural commissioners; nothing in their training equips them. Most are sole traders or in group practice businesses with a myriad of possible partnership agreements. Any GP consortium will be an uneasy alliance.

Also, 500-600 GP consortia contracting directly with a new independent NHS board will inevitably result in huge increases in management costs.

To plan on the basis that the GP consortium with hard budget will be a stable organisational form that will deliver effective commissioning of £60bn of NHS services, flies in the face of all the evidence.

Alan Torbet, healthcare consultant

Tips for success

Your leader provides both challenge and food for thought for clinicians (page 3, 17 June). As an established network for healthcare professionals engaged in commissioning (nurses, allied health professionals, pharmacists, dentists and optometrists), we agree entirely that any new



'The name "GP commissioning" could create a barrier to inclusive commissioning'

commissioning model should involve a wide range of professionals.

GP commissioning should build on "best in class" commissioning practice. Led by frontline clinicians, it needs to adopt a lean, pro-active approach that strikes a healthy balance between inclusivity, responsive decision making and action. "New commissioning" will be most effective when multidisciplinary clinical teams drive change at national, regional and local levels, using highly developed communication channels to create ownership and draw in ideas from across the health economy.

We believe that:

- Names matter – the name "GP commissioning" could create a barrier to integrated, inclusive commissioning.
- Local relationships are key – healthcare professionals need to share responsibility for NHS budgets. We need contractual frameworks that incentivise provider collaboration;
- Public health improvement is bigger than general practice or primary care – and those with the greatest health needs are often unregistered or low users of GP services. The new model must link with the joint strategic needs assessment to ensure local

commissioning retains a public health focus.

● Patients need to be fully involved in commissioning – finding more effective ways of doing this will be critical to the success of commissioning.

We are convinced that all healthcare professionals make a valuable contribution to commissioning. We look forward to debating the issues over the coming months so that whatever form commissioning takes, it quickly delivers meaningful improvements in care.

**National Health Care Professional Commissioning Network members
Stephen Foster, Debra Sprague and Paul Hitchcock**

Same again?

Farewell, then, world class commissioning. The Commons health select committee suggested that after 20 years we have had the disadvantages of an adversarial system for commissioning without as yet seeing many benefits.

We have had GP fundholding, then a break, then the internal market with primary care groups, then PCTs, then bigger PCTs and PBC groups, then some PCT sectors and clusters. Now we are to have GP budget-holding commissioners (again?). Some kind of mini-residual PCTs will commission those things GPs don't. Just maybe it is the whole idea that is wrong.

Still, we may as well have one more go. And we can spend all the savings from reduced management costs in PCTs and SHAs on all the new management costs.

Irwin Brown, Manchester