The role of specialist physicians in the commissioning of clinical services

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The NHS in England has adapted to the concept of the purchaser–provider split. Over the last 25 years this has undergone several reincarnations, the latest of which is practice-based commissioning (PBC).[1] After general practitioner (GP) fundholding was abolished, this alternative model, developed by the Labour government in 2006, set out to engage primary care physicians alongside primary care trusts (PCTs) in the commissioning of services.

Practice-based commissioning complemented the explicit recommendations of the 2002 white paper to enable 'plurality of provision',[2] whereby traditional models of care might change in order that not all services would be provided by acute NHS or community trusts.[3] In addition to fulfilling the government mantra of patient choice, it was explicitly stated that PBC would be an appropriate mechanism to ensure a cost-effective and innovative basis for providing more scheduled care in settings other than hospital outpatient departments or day case care environments. In addition, the principles of effective clinical governance and quality, as well as probity, were integral to the scheme. It was stated that GPs were best placed to make greatest use of the public purse health costs.[1,4]

To date, 60% of general practices have engaged with PBC, with an expectation that by April 2009 all practices will take part.[5] The Audit Commission has reported problems with budget settings, poor engagement with practices, inaccurate financial information, and inherited deficits as a basis for indicative baseline PBC budgets.[6] A separate survey of GP practices, carried out by the Department of Health (DH) and published in October 2007, stated real uncertainty as to the benefit of PBC, with less than 60% supportive of the process, and less than 50% of practices yet to agree a commissioning plan.[5] This is despite financial incentives of £98 million in 2006–7 to enable take up of PBC by family practitioners.[6] The evolution of managed chronic disease programmes, as in the USA, has been a further stimulus to commissioning services in house or through alternative models such as intermediate care services operated by community specialist nurses or GPs with specialist interests.

It is undoubtedly possible that in this headlong rush to strip hospitals of 'unnecessary' chronic disease activity and create models commissioned by and potentially provided by GPs, a conflict of interest may arise. In addition this could leave a large gap in the specialist component of such services. Any such issues could potentially have been resolved by managed clinical networks established to enable integrated care with all key clinical stakeholders engaged in the planning of service reconfiguration. There are national DH documents, for example in diabetes, which favour such an approach.[7,8] Unfortunately, some of the alternative developments may encourage fragmentation of complex services operated by multidisciplinary teams (MDTs).

To date, there is a dearth of examples of service reconfiguration that have fully engaged specialists in the process of commissioning in respect of service planning and delivery. A recent survey from the Association of British Clinical Diabetologists (ABCD) showed that very few consultants had been included in discussions regarding service commissioning for diabetes.[9]

Apart from the risks of service fragmentation there are real concerns that individuals best placed to inform discussions on service reconfiguration and commissioning of specialist services are being denied the opportunity to inform the process, namely specialist physicians and their MDTs. No other individuals are as aware of the levels of input and skill requirement for specialist services either in the hospital setting or in a reconfigured community-focused system.

The reconfigured embryonic PCTs are still less than three years old and many GPs have been given a major responsibility alongside them to commission services. There are real concerns that protecting trust incomes and developing community services through asset stripping are mutually incompatible. This is likely to inhibit these sectors from collaboration, not least since the community sector has a role as both 'poacher and gamekeeper'.

The lack of skills of PCTs and primary care in commissioning has been recognised.[5,6] Organisations with experience of managed clinical networks and chronic disease programmes in other countries could potentially be employed by PCTs for the purpose of commissioning. In recognition of this, the PBC Academy was launched by the NHS Alliance with support from

Humana Europe, an external commercial health provider.[10] The ethos of the NHS since its inception has been collaboration between different sectors, yet the consequences of current government policy is more towards competition. Engaging consultants in service commissioning is almost intuitively vital and as necessary as relying on GPs and PCT managers.

There is a danger that without a change in emphasis of healthcare provision, commissioning will not achieve the cost-effective integration of care, which is especially necessary for the management of chronic disease. This concept has the general support of many organisations involved in diabetes care, and no doubt in other complex chronic disease areas.[11] In part, it requires input of skilled and fully trained specialist physicians, working in new service models in different environments. To achieve this they need to be fully engaged in the process. It is also vital from the perspective of training to ensure that the commissioned service models introduce doctors to these new ways of working and afford them the opportunity to learn how to be included in service commissioning.

Documents from the DH explicitly state that 'PBC places GPs working alongside secondary care clinicians at the heart of decision making to commission services for their local population',[1] but to date the reality is different.[5,6] This may have, in part, reflected the great financial pressure in both acute trusts and PCTs to balance budgets in 2005–7, which may have ensured commissioning gridlock.

There may be less resistance than first thought to the concept of specialists working in different more cost-effective settings outside of acute hospitals, especially for long-term conditions. Some PCTs have unfortunately interpreted this as a view that non-specialist community-based clinicians can therefore manage the vast majority of chronic clinic-based disease. A change in such services would include much work of the medical specialties, including diabetes, endocrinology, respiratory and rheumatology, dermatology, and some gastroenterology, neurology and cardiology.

If this revolution of care is to be successful, physicians in these specialties have to be fully engaged. There will be issues regarding future training, as well as the need to ensure that employment and pension rights are secured if new employers take on the management of these posts. As yet, there has been very little dialogue between primary care, specialist associations and the royal colleges, and the process to date has been rather piecemeal through some PCT provider units. The model may conceptually have been better suited to Payment by Results but the majority of specialist services can be provided 'out of tariff' in a more economical way.

The breakdown of barriers between primary and secondary care through integrated services has worked for some areas, for example in diabetes.[8] The key to success has been collaboration and not competition. Specialists are needed to see patients in the right place at the right time. This will be in community and acute settings at different stages of the patient pathway. Patients' circumstances change from chronic disease to acute exacerbations so links with acute aspects of care are necessary. The solution lies in a commissioning strategy that overcomes the administrative barriers in the system and fully engages specialist physicians as key stakeholders in the process.

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