Soap Box

The past neglect and future promise of general practice, or why my PCT Chief Executive never saw GPs.

Dr Michael Taylor September 2011

The past neglect.
My last PCT Chief Executive has now been promoted to a bigger better job in Wales; Trevor never saw his GPs. I did an audit of the number of GPs who had signed the visitors book at the PCT over a three month period and there were 13, 14 if you count the Medical Director who didn't need to sign and 10 if you also exclude the three GPs who were clinical directors 6 if you discount the four who attended meetings to do with GP Commissioning. That works out at one every other week and some of these may have nipped in to use the staff loo! Most GPs had never seen him other than fleetingly at some large event. That same ethos permeated the whole of the PCT Directors and upper management. Emotionally PCTs had moved away from GPs.

I later understood when I became the clinical director for mental health that GPs had similarly moved away from the PCT; a yawning chasm had opened where there was but a small ditch before.

It is my opinion that this chasm was an unintended consequence of the PCT becoming a provider as well as a commissioner, and unintended consequence of Kenneth Clarke's reforms of 1990. Until April 2011 the provider arm of my PCT employed more staff and had a greater budget than the whole of local General Practice. Though there are almost no metrics/measurements of this provision, there are so many top down tick boxes that the PCT was forced to concentrate upon these targets that is upon the provider arm. The commissioning of secondary care services and that of GP has been quite secondary, in fact neglected.

Faced with the choice of investing "scarce resources" in General Practice or in the PCTs provider arm the managers would choose to invest the time, attention and money in their own service. This well-known human, managerial trait is recognised as the Headquarters Effect, the "periphery" is in consequence neglected.

Both GPs and managers are so inured that they may not recognise this neglect so how about a little reminiscence therapy? Annual reports have been a contractual obligation since 1990. My practice has submitted one for 20 years; never a question, never a comment, not even a thank you. I know for a fact that for in the early '90s they were bemusedly retained; now I doubt that they are even submitted. Clinical engagement to demonstrate compliance with the "Gold Standard Framework"? Following an initial visit, nothing. The PMS contract? No mention, no monitoring, nothing until a recent visit by a managerial colleague focusing intently on minor surgery for reasons unknown but imagined, i.e. to save a bob or two.

The future promise and supportership.
Commissioning is now to be GP led. This causes great anxiety in many quarters but not here at the FDA where we believe that this will be seen in the future as one of the factors resulting in the salvation or the sparing of the NHS it from the Charnel House of failed good intentions.

One question frequently asked, when admitting that there will be an interested and competent 5% who will want to lead, is how to get the other 95% to support. So let's look at what motivates GPs now

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To my mind there are three extremes of practice:
1. Clinical Excellence
2. Bottom line
3. Work life balance.

This tells me that there are three major motivators.
1. Doing the job well and being recognised for it.
2. Take home pay and or greater recognition.
3. Working shorter or more controllable hours.

Some practices are extreme but most have motivations that are a mixture of the above; these therefore are the three GP motivators, these are the three drivers for "supportership."

UK GPs are the best paid in Europe if not the world and should recognise this; so no financial whingeing please. However small amounts of money will continue to provide powerful incentive especially in time of cuts. Greed remains is a wonderful motivator but in the same way that bankers need regulation so should GPs. No additional finance should be given to the 95% of GPs for involvement in commissioning but a little leaching of finance in return for excellence will be essential.

I may demonstrate limited imagination but I cannot think of any job which is more complex than that of the General Practice in 2011. Also I cannot think of one that is observed and validated by more external agencies. GPs almost to each individual are heroes already. Some self recognition of this fact by the 5% leaders to their colleagues will undo many of the ills from previous corporate neglect.

With regard to the work life balance those commissioning groups working to understand better the behaviour of the 20% of patients who generate 80% of practice work. Putting thoughtful, compassionate, downward pressure on frequent attendance would send a powerful message to GP colleagues about understanding and support. This is but one of a myriad of ways to sow and harvest supportership.

There is no circle to be squared. Though the matter for GP commissioners is composed of a thousand problems each is linear and manageable. But there remains the seminal question concerning cost efficiency. Which is the best way to increase the capacity of primary care? For if the above are the values by which the NHS will be saved, increased capacity is surely the mechanism. My answers to this question dear reader, are for another article, another day.

Please tell me what you think michael@family-doctor.org.uk

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