Our current commissioning system will utterly eliminate the personally known family doctor

David Zigmond

Can commercially modelled commissioning bodies provide the kind of doctors we want and need? This explains why not.

Early in February there were several news reports of the possible/probable replacement of a well-liked, highly reputed Family Doctor practice (the Whitnell Health Centre) by an entrepreneurial commercial health conglomerate (SSP Health). All the reports concur in the following: this established practice had excellent long-term stability, high levels of patient and staff satisfaction, and very satisfactory measurable outcome indices.

Nevertheless, the Integrated Care Board (the commissioning body that decides and awards NHS GP contracts) has initially favoured SSP via a points-based decision: SSP scored higher in plans for IT and HR, despite its far less favourable record – over many sites – surveying patients' experience and satisfaction. The decision has now been challenged.

Some media reports talk optimistically of a 'watershed moment' where we might retrieve and freshly assure GP services that are smaller-scale and staffed by familiar people – where we can again get to know, and matter to, one another. This optimism harks back. In previous decades the traditional moniker of 'family doctor' was very apt in a number of ways: those erstwhile practices did, indeed, know and understand not just individuals-within-families, but their other embedding connections and neighbourhoods. Such family doctors' responses were, therefore, more readily sensitive, holistic, bespoke and healing because of those relationships.

Those previous, smaller practices themselves were like well-functioning families, too. Their staffing scale and stability encouraged (mostly) relationships of personal understanding, trust, natural synergy and care. Family doctors could be, and were,

communities-within-communities.

For all its unevenness the era of the family doctor was, generally, far more trusted, popular and efficiently responsive than our current regimes of competitively commissioned Primary Care Service Providers selected and refereed by Integrated Care Boards (sic) – the often clumsy, if not nepotistic, behemoths we have now.

SSP Health and its kindred commercialised enterprises burgeon and play well on this slanted pitch: their size, business-seasoned savvy and mindsets mean sharp negotiating skills and glossy promises.

But what such corporatised and commercial health providers actually 'deliver' to individuals is so often alienating, frustrating and worse. Such commissioned services are now almost all devoid of the sterling community-within-community qualities that nourished and sustained previous generations of GPs, their staff, and patients. Instead we are 'serviced' by increasingly large and remote conglomerates. These are staffed by unfamiliar, often anonymised teams that are usually rotaed by managerial decree and must adjust to gig-economy working conditions. Engaging with such cybernated and gigantised health providers has become more and more like attempting to get personal attention and understanding from any utility provider – the electricity or digital network service, for example. Even if you are fortunate enough to encounter a kindly and (relatively) unstressed practitioner it is unlikely to be anyone with whom you will ever develop a trusting familiarity and understanding – both you and they will probably be limited to a Kwikfit-fitter experience. Personal continuity of care – a good index of a stable, vocationally-spirited GP workforce – becomes here very rare indeed.

Does this matter? And if so, why?

Well, it matters deeply and extensively. Not only to the quality of experience to the givers and receivers of our healthcare, but also to the very measurable costs and outcomes. Repeated research has shown how greater personal continuity of care is related not only to greater consultation satisfaction shared between practitioners and patients but also to the following: better control of chronic diseases and risk factors; less use of emergency services, A&E and acute hospital admissions; fewer specialist referrals and investigations; better patient compliance to fewer prescribed medications; and – remarkably – significantly longer longevity. So the losses and damage that ensue from our jettisoning personal continuity of care are considerable. (Metastudies and original research clearly demonstrating all this can be found in many years of publications from a team at the University of Exeter, headed by Denis Pereira Gray.)

Apart from the subtle and deep losses here to people, the cumulative wastage to our national economy is massive. The specious reforming belief has, for three decades, been that by scaling-up, marketising and corporatising our general practice it would become better value and safer. The folly of such beliefs is now very evident in our unravelling, depopulated and demoralised services. Everyone is unhappy: GPs cannot practise as they would best judge or choose, patients cannot get the personal care they need (or even an appointment), and managers know they cannot manage to manage all this…

The suggestions that this challenge to the Integrated Care Board heralds a

'watershed moment' may, sadly, be more heartening than realistic. For the past three decades of reforming tides have swept away almost all that once existed of our communities-within-communities – our familiar healthcarers working in smaller, very local premises with gentler and more sustainable work satisfactions.

The systematic destruction of such 'therapeutic communities' is not now easily reversed. As town planners found several decades ago, newly tower-blocked residents could never restore the neighbourly kinship that had sustained and nourished them previously in their then-demolished old streets of terraced houses. Those relationships depended on a smallness of scale and accessibility that was horizontal; scale these up and stack them vertically, and such relationships all but disappear. They cannot be simply designed back.

Such are human eco-systems, and we have largely lost our perception of the NHS being an eco-system needing our sensitive and imaginative stewardship; instead we are treating it as an engineering or business project – to be specified, competed for, tendered, chivvied, bribed or threatened into its desired form…

'You can't turn the clock back' – an oft-used retort. A truism, yet often unnecessarily and unwisely limiting because it may discourage us from looking back and seeing what we may now learn. So here, with our healthcare, is the discouraged and discounted option: we can survey the past and ask: what used to work better? Why and how was that? What from this could we now restore and reconfigure? And how?

Liberating watershed or darker denouement? That depends on whether we embrace

or avoid such questions.

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