

# What do NHS managers really think?

It's time to call-time on  
commissioning



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It features NHS news, guidance and discussion topics and features regular polling and surveys of manager's personal thinking and attitudes.



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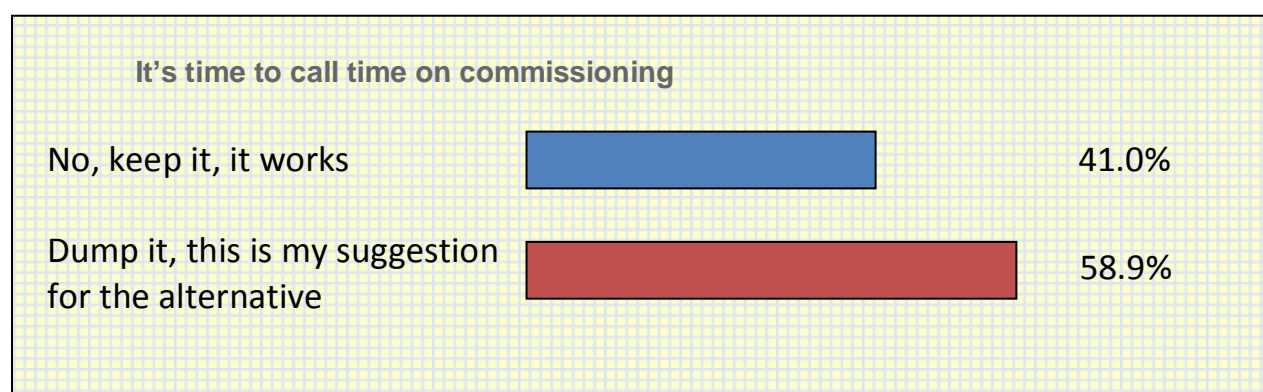
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## THE QUESTION



A lot of time and money has gone into developing NHS commissioning. World Class Commissioning has become a business in its own right. Conference organisers and consultants have prospered but, it is probably true to say, commissioning has not much improved. PCT managers have struggled with the power of the Trusts and the indifference of GPs to PbC. Do managers need a clinical background to commission, is there a real driver for improvement, would collaborative commissioning give a better result? Have a look at Wales said one respondent, they manage without it and look what is happening there! Just some of the interesting questions to come out of your comments.

On balance it looks like most NHS managers would like to call time on commissioning.

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## YOUR COMMENTS

- Collaborative commissioning is way forward - not clinical led commissioning, and not a function separate from provision but equally informed by each
- Go down the Welsh route and join up all services in one provider organisation - including the GPs. The financial situation will force us to work together despite the internal tensions. Whether there will be any staff left at the end (especially doctors), is another matter.....
- Get back to a proper planning and providing system with planners having experience of the provider end (unlike commissioners) and managers working with clinicians and other staff.
- There can be no more expensive way of getting money from DoH to the front line. The continual 'politically correct' emphasis by everyone on Public Health is misguided, as it is currently measured by the number of public health staff rather than what they have achieved. The best public health initiatives have nothing to do with local public health staff, who are generally overpaid and ineffective. The focus of Public Health should be on the 'traditional' areas of dealing with diseases.
- Commissioning in my area is not patient oriented with no patient input into service specs for stroke/TIA. Until that happens the key driver will always be money not improvements in quality/outcomes.
- You need a clear driver for improvement. It's not brilliant but is good enough and might get better slowly. Without PCTs will hospitals and Trusts really improve? PCTs are a lot better than their press. Nevertheless, the role for GPs is working within PCTs, they will never lead commissioning! Barmy. Watch Wales to see the result of having no commissioners!
- The real "on the ground" problem with commissioning is that the majority of commissioners do not have a clinical background so do not the knowledge to make the best decisions for patient care - so they dawdle,

wasting time and money. Clinical quality needs to be monitored, but not in a wasteful way. Stop all the commissioning and invest a much smaller amount in monitoring quality of outcomes - such that only effective providers get the work – that is ‘get commissioned’, but cut out the middle man.

- It works well in the United States so why not here? If they just stopped with the top-down reorganisations and let commissioners get on with the work and develop the competencies required then we'd have seen a significantly different picture!
- Central budget allocation but with extremely stringent outcome & performance management against clearly defined standards.
- BUT it is still spending precious money - it seems to be the dumping ground for ex PCT staff. So get rid of the PCTs or SHA and give the money to these PbC groups to manage it. They can.
- Absolutely, strengthen the formal role of primary care clinicians in supporting commissioning processes, but don't hand the whole system over to them. They are doctors and nurses, not managers and strategists.
- It's too unwieldy in its present format and doesn't allow quick reaction/redesign/innovation - as with most (sorry, all) NHS initiatives. Time to red card bureaucracy and cut by 90% the number of meetings, committees, focus groups etc and start actually doing something.
- Don't let GPs do it either, they are not even employed by the NHS!
- Dumping commissioning is like saying dumping accountability. Unless financial incentives are aligned with operational incentives then management goes out the window. Imagine what clinical note taking and clinical coding would be like if it wasn't linked to price. Why should the UK be different to the rest of the world?.
- Keep it, as somebody needs to work out the bigger game plan (strategy) and then gear up for providers to deliver it. Unfortunately, the strategy is the part that is missing. Biggest danger is that we are moving to completely new types of organisation and service delivery without the means (apart from fax, email and telephone) to transfer the patient across from one organisation to the next which will capture the data for financial, quality and performance purposes.

- Commissioning's taken too long to become a useful lever and PCT's can only blame themselves and government reorganisation that sapped capacity as FTs ran rampant. However, where it is working it is working well, providers are being held to account on quality, activity and costs to the absolute benefit of patients, their carers and the tax payer. Learn from what works well. Apply this to evidence based policy rather than self interested financially driven individuals that lobby so effectively
- Part of the privatisation agenda. Market forces will increase at this time of cash constraint and the invoicing system will become real as providers emerge. It is time for chambers/medical consortia to be formed and compete!
- Look at Scotland and Wales.....
- It's time to go back to good old service planning based on demography with a few adjustments for need. This worked 40 years ago. And also what happened to health economics? That made sense. We could save the NHS billions! (By the way, I am a retired service planner)
- Why one Gov't agency charges another and all the processes that involves. I would take it further and abolish PCT's. Are just talking shops? In our local PCT must be 100 desks, doing what? And, at ever increasing cost. Our local CEO would have received £80/90k now 3/4 years later £140k. Also all other directors and other senior PCT staff saw massive increases in same period. Also abolish purchaser/provider split. Have one organisation for geographical area. Divert resources to front line.
- Service Level Agreements should be enough - but I think some sort of penalty clauses would still be required for non-compliance (particularly if some targets go by the wayside)
- If politicians decide that provision in England should stay mainly in the public sector, then we could develop strategic commissioning combining LA, Public Protection with NHS Public Health for the macro, designed and delivered by Trusts, L.M.C.'s & L.A partnerships. The partnerships would also purchase social care and contracted out healthcare for the micro and pricey; all monitored using nationally agreed K.P.I.s by a forum of elected members, exec managers, and user and carer representatives.
- What we have now works (well sort of!) it keeps most people happy including GP's. Major upheaval may well lead to GP's and practice staff looking for the escape hatch. Patients don't care what happens so long as they see a GP, get their prescription, or have a referral to a consultant.

- As someone who has been involved in the tender process on two occasions I would suggest that the time spent by senior clinicians, usually measured in days if not weeks, in completing the tender is a waste of time, which would be better spent on patient care. With the improvement in data collection and robust SLA's there in ample provision to ensure quality services.
- The political and service power still lays with the providers. Give them the money that is available and some outcomes and let them manage it all
- Though I do think you are barmy [Referring to Roy Lilley] on some issues (!) you are spot on here when you ask: "Why does the NHS have to raise an invoice to pay itself for something it's going to have, anyway?" Speaking not only as a clinician, but also as a tax payer I would abolish the entire internal market if the EU permits (sic) It has simply created expensive and unnecessary bureaucracy.
- Allow GPs to talk to individual patients about where would be the best person/place/service to meet their needs, and to refer accordingly. Fund providers' activity to reflect the demand this creates. Analyse relative costs of different providers fairly crudely - i.e. without spending a fortune on doing so; analyse total expenditure per capita of patient lists by individual GPs also crudely. Devote resources to investigating reasons for outliers' expenditure (both GPs & Trusts/provider services).
- The NHS has a long history of a 'free service' which, of course, it isn't. Tell everyone what their treatment costs, i.e. your hip operation cost £12,000. Costs must be budgeted and PBC has been the biggest waste of money ever. In Fundholding we tracked every patient and our data matched the hospitals (if it didn't, it got sorted before payment), it was quite simple really. Something along those lines with local accountability.
- I don't think your barmy, [reference to Roy Lilley] but it needs reform. Two main aspects; we should stop commissioning interventions and start commissioning whole pathways. The patient experience. This stops commissioners wasting time trying to knit together pathways which currently are mostly broken. Commissioned Pathway managers then provide:
  1. Control over intervention outcomes
  2. Ensure that the 'hand off' between intervention work &
  3. Manage the pathway change processI've done this and it works.

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