What do NHS managers really think?

GP Commissioning Consortia

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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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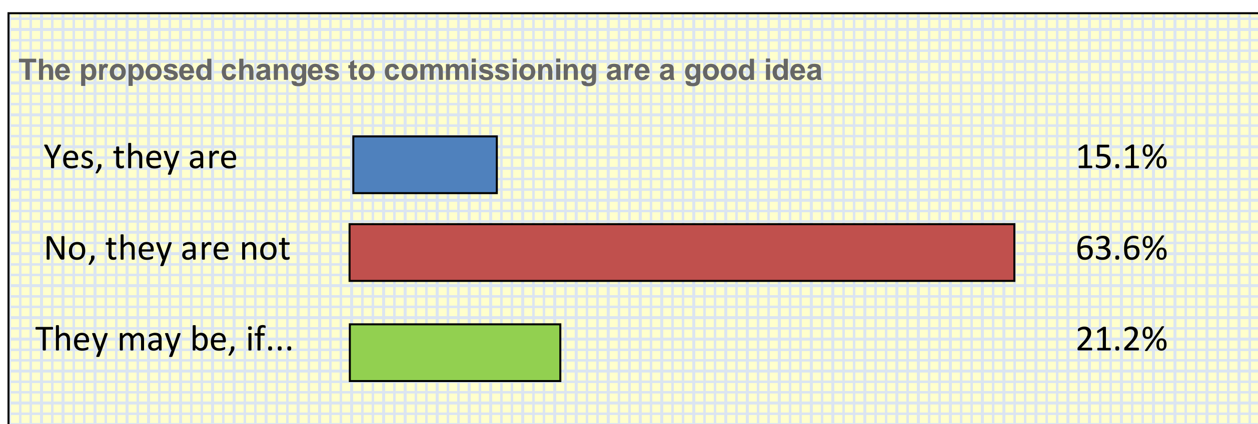
THE QUESTION



This is not a winner. Even, taking together, the ‘yes’ votes and the ‘may be’ votes (36.3%), it’s still a 3:1 ‘no’.

As usual it is the comments that tell the real story. There is a ‘feeling’ coming through. More of sorrow than anger. It says; ‘we just don’t think the GPs can do, or even want to do it.’ That’s probably right. The enthusiasts in the BMA, NAPC and Alliance will be gung-ho and good luck. However, handing over the whole budget and the complete responsibility without any pilot, trial and effort to see what’s scale-able is almost reckless. And then, of course, there is the cost of making it work.

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YOUR COMMENTS

- It looks like a very confusing and expensive reorganisation. We trained GP's to deliver Patient Care not management. Very Expensive and untrained managers will not help the health service.

- It eliminates the high number of commissioners we currently have. They're on high bands and cost a lot of money. I still truly believe services should be commissioned centrally with only a very small amount of money left for some specialist services. This would ensure equity, remove 'postcode lotteries' and eliminate the high cost (and time) to commission everything locally.

- GP practices simply do not have the time, expertise or interest in commissioning beyond basic add-ons to GMS work.

- I'd love to know the total cost to dismantle Fundholding, and then reinstate it under a new name 13 years later, with all the other changes/reorganisations in between.

- Most GPs lack the competencies for strategic commissioning and do not know how to address health outcomes or inequalities. Other PbC would have been a success, which is clearly is not. The patients they see may not be typical of the larger area and many health needs will be overlooked or subject to prejudice. And, if GPs do the commissioning, then who will commission primary care if PCTs bite the dust.

- Commissioning existed in the first place

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- Why doesn't the government concentrate more on getting the front-line services right and worry less about commissioning and paying for bureaucracy

- The interests/skills of GP's within a practice are hugely variable. To think that a 'group' of GP's will redesign services from end to end is not going to happen. Local hospitals will be supported by local GP's and inertia will follow.

- .....we eliminate some of the daft things we have spent money on over the last few years, and focus on achieving the things we urgently need to do (like directing people to the right care first time)

- If it does NOT become bitty like Fundholding did, which also created inequalities in health care and destabilised parts of secondary care. I have worked in secondary care prior, during and after Fundholding, in financial management, now I work as a Practice Manager with PBC experience and feel I have a rounded view on the subject. I think the GP Commissioning Consortia will have the knowledge and respect in their colleagues providing services to review and make changes for good clinical reasons.

- GPs should be concentrating on providing patient care! Certainly their voices should be heard but so should the voice of other health professionals. Too much power with GPs is not necessarily good for patients or for the development of the NHS. Given the financial restrictions we are all going to have to live and work with what is needed is radical thinking on how best to provide optimum care at optimum cost and that's unlikely to be achieved by a GP focus.

- The DoH actually allows devolved commissioning from the PCTs. Our experience is that whenever true commissioning is proposed, the PCT opposes it due to 'destabilisation'. What they (PCTs) don't ‘get’ is that destabilisation is the last thing that GPs want - they want to work WITH hospitals to effect meaningful change.

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- There is no question that commissioning needs to be improved but how you do that and reduce management costs; and is it really cost-effective to do it at GP Practice consortium level - unless they are about the same size as PCTs. What about joint commissioning with Local Authorities if the boundaries stop being coterminous? [*Reference to Boundary Commission changes as a result of Coalition Agreement on voting mechanism changes – Ed*] What does that do for the other aim of bringing health and social care closer if you just break local ties?

- 300 GPs agreeing on anything sounds unlikely. How on earth will they be held to account? Would Lansley send the naughty ones to prison?

- GPs have the opportunity to be involved in commissioning through PBC, but PBC has not been successful. GP Fundholding created a two-tier system where Fund-holders could queue jump to access services for their patients, rather than focusing on improving services for all. Build on the strengths of the NHS to address the weaknesses, instead of losing them in the chaos of restructuring. Enable clinicians to do what they are trained to do and employ competent managers to manage in partnership with them.

- Once again there will be management (by any other name) revisiting the same old territory with no money left to deliver quality services to patients. "Cinderella" probably will become even more threadbare or more likely starve to death.

- It gets rid of the dinosaurs at PCT / SHA level although in the past they managed to pop up again somewhere else, with a different job title. At GP level, we need to have the most appropriate skills to support their clinical care. These skills are the enthusiastic, experienced and qualified managers that can take on the non-clinical leadership with both arms. It will work when GPs and managers work TOGETHER and when information, e.g. data, is available in a speedy and appropriate manner.

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- GPs have proved themselves time and time again to be far too arrogant, ignorant and self interested to be allowed to commission community and secondary care services for their patients. What is amazing is that politicians of all hues seem to fall for it over and over. Where Alan Milburn (who?) went in 1999, Andrew Lansley seems hell-bent on following in 2010. Those who don't know history are destined to repeat it.

- ..... specialised pathways, e.g. forensic M.H. including health care in prisons, could be expressed as public health commissioning along with substance misuse and blood borne infections; and commissioning partnerships between consortia & Local Authorities established for generic CAMHS and adult mental health, substance misuse, learning & physical disability and older person pathways, and predictable high-price single arrangements e.g. transplants commissioned between consortia, using a few, agreed, KPI's.

- It's rebranding and would be more effectively done by working in partnership! Once redundancies have occurred, collectively between the combined organisations they may employ less staff, but during the transition there will be chaos and the need to employ more administrators to see the change through, thus actually costing more as there will be redundancy costs as well as re hiring (advertising) costs etc.   On paper the Gov will state that they have made redundant x number of people and saved 1,000s!

- It gets rid of some top heavy non clinical senior manages and the costs associated with the mess they have made of the NHS and its constant changes over the last seven years?

- This is the worst concept since Bevan thought the NHS would improve health. PBC does not work now with far smaller groups of GP practices not able to work together, not able to separate their provider interests from the commissioning process and having too narrow a focus on small scale health care services. I cannot see how this will save money as overheads will multiply exponentially. Rubbish idea.

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- It would work if; GPs were employees only and not looking for personal gain.

- As you point out, a massively expensive merry to round. GPs want to be doctors not managers and certainly from the experience of my PBC group there is not the expertise to do the work required. PCTs are not perfect but at least they are staffed with administrators, some of whom know their stuff

- All reorganisations cost more than they save. If politicians stopped messing with the structure and concentrated on developing real expertise and bringing in data, IT and commissioning systems that have been shown to work in other countries, the NHS, patients and taxpayers would all be much better off. Lord save us from shiny new politicians with the same old ideas repackaged a new!

- Fundholding worked well for us; there was a point to it. PBC is dead in the water in its present form and has now become a mechanism for demand management only. All commissioning by GPs has stopped. Give us the budget and the go ahead and we will make it work

- Unfortunately, whilst GPs often have good ideas in terms of patient care they have demonstrated that they struggle to make sense of the strategic 'whole' and population need, including prevention.

- It will work if; there is proper governance that prevents the previous abuses of GP Fundholding and the Cinderella services are properly commissioned.

- Can't see how any savings will be made. Commissioners from PCT's will just be recycled and turn up and one of the new PBC Super Consortia, as you rightly point out! Just sounds like yet another excuse for Commissioning to create yet another "industry".

- Ii might work if they do, in fact, lead to the re-establishment of Primary Care Groups - which included not only GPs but other partners and were able to provide a genuine focus on local

needs. But I guess the effective support they would need is not now affordable.

- But will GPs want the hassle? Instead of referring willy-nilly, they will now have to think about the cost. Good. The old guard will take their huge NHS pensions and the new guard will outsource to ... who? Maybe the outsourced commissioner would like to buy the practices. Will Sec' of St' allow that?

- Is this just another way of extending PBC Commissioning Groups - these tend to be dominated by a few large practices and have problems engaging with many practices.
  What about the DoH performance management agenda - who will deal with that or will it, hopefully, be reduced

- Crazy!

- This is Fundholding dressed up and today's fashion.
  Unless Practices know what they are doing few will benefit.
  we all know that what is today's fashion is tomorrow's duster

- GPs are allowed to restart all the services lost thro' PBC. Easier and cheaper to buy services direct. Savings generated (and there will be lots) would need to be used to improve local care in the community, i.e. restarting home help etc. Sort out budgets for GPs to buy direct services inc OOH care with PCT/PCG *et-al* responsible for PH and other core services (maternity etc). Keep it simple.

- More pointless and expensive change & rebranding already tried and failed as generally unviable. (See PCGs, Fundholding GPs, practice-based-commissioning etc). Just reinventing same old tired ideas. May have a core of a good idea but history tells us it will be implemented too hastily, ideologically driven without proper thought for the possible damaging consequences. Will allow the *chancers* to skim-off profits and give power to GPs that simply shout loudest.

- It may work if......the consequences are thought through properly. There is danger as you say of a round of unsettling expensive redundancies and recruitment processes which will

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hold up the essential work of getting new pathways in to keep people out of hospital by using different services and new technology. Just when we get to a period of stability it is all change again - which is why nothing ever gets done.

- The resources and expertise are made available, but I have serious doubt about the ability of GPs to be able to do this work, or even WANT to do this work.

- This may work if......you are a GP with no conscience; fed up with seeing patients who are unemployed and stressed and want to trade the salary of the middle manager. Perverse incentive though - you'll be too bogged down with paperwork, patients demanding you find the money for their expensive treatment and meetings to enjoy it!

- Why not scrap commissioning altogether or in other words the internal market. What is the point of one government agency charging another and all the administration that involves across the country? In our local PCT there are dozens of people just processing paper. Billions could be saved or spent on hospitals, A/E, cancer drugs, diagnostics, community nursing, medical staff, equipment etc. Paying off the PFI schemes otherwise will be there for 30 years. Get rid of PCT's they are only a talking shop.

- And when exactly are doctors going to fit in some actual doctoring?

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