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Conversation with a ...

Commissioning conference

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This week has seen several headlines about 'the state of the health service', which have centred on the financial position of the service, and the reorganisation of primary care trusts (PCTs) into much larger organisations; it is tempting to see this as a time of lost opportunity, with 'everyone' being far too busy moving offices and relocating admin teams to think about patient services. It is tempting to think that there is no point in trying to improve services clinically, because 'everyone' is too busy doing other things.

I think that this would be a very big mistake, and would argue that now is the time for clinicians to get more involved than ever – for now presents an opportunity that will not present itself again for a few years, if ever again, unless we have the courage to grasp it.

Last week I attended a conference on commissioning; after the conference it was clear that all the attendees had a much clearer understanding of the future of the NHS, and how action now can change the outcome. Inaction now will tend to favour a poor outcome. Yet it sometimes feels like inaction is the most likely result, unless we can all shake off our change fatigue.

The growth in NHS finance is planned to sharply reduce in 2008. Much of the extra investment has gone to partially reverse decades of under-investment, and also in increasing clinical staff salaries. The increased growth in total spend of about 10% per annum has only translated into a 2% per annum increase in productivity. The cut in growth that is in the pipeline makes it certain that, unless we change our behaviour, there will be a financial crisis every year, and each year will feel worse than the last.

The changes introduced by 'payment by results', foundation hospitals and practice-based commissioning have the potential to energise healthcare in the UK, and make it a truly dynamic, stimulating, successful, place to work.

The least favourable outcome of all would be obtained if few people embrace the changes, resulting in rising costs, unmanaged demand, poor productivity, and a downward spiral of recrimination, blame and failure.

The most favourable outcome comes from wholesale embrace of the reforms, with 'a multitude of providers and commissioners', competition on quality and patient experience. This is achievable if the costs can be contained in the future, and we can increase efficiency. If this is managed it will actually feel as if there is more money, and waiting lists will become a faded memory. The key to this is 'demand management', by keeping more care in intermediate and primary care. In order to achieve this, money will have to be invested in primary and intermediate care, at the expense of secondary care. A few foundation trusts will fail, as they are unable to change fast enough and succumb to bankruptcy.

Clinicians in primary care should find working in this sort of system more enjoyable than at present, as they will be helping to give patients the care that they need, and are constantly learning and applying new clinical skills. Patients will notice barriers to effective care dropping away. Clinicians in secondary care will also have to change their ways of working, and will be doing much more advising and consulting, along stepped care principles, rather than taking over care entirely as they do at present. Done well this will be very enjoyable.[1]

The rub is that often commissioners only have experience of commissioning secondary care. Instead of allowing this to continue, the primary care organisations (PCOs) of the future (or whatever they finally are called) are going to have to trust in practice-based commissioning, and stop commissioning traditional services, which is often all they know. Do they have the courage to change? Will PCOs support this change in commissioning, or will we still have 'same old, same old'.

The changes need bold leadership from the front of every trust, with full embracing of the principles. The main change in attitude is going to have to be one of adopting a 'solution-focused approach', at a senior level. As I was told Alan Yentob put it, 'We went to the States and looked at what some of the

most financially successful companies were doing. Valuing people and building on successes – acknowledging and valuing what they did well was without question a critical variable for success in every single company we talked to'.[2] This means an end forever to blame cultures, and instead celebration of those prepared to try new ideas, with support for when they work, and support when they fail. It also means giving patients what they ask for, because if you don't they will go and see someone who will. Look what Jack Welch achieved with General Electric (GE).

In mental health this means more support than ever for primary care, deployment of intermediate care teams as the main vehicle to deliver talking therapies, lots of training for GPs and nurses with special interest, call centres to deliver telephone support in the community, bibliotherapy agreements with local council libraries, mental health promotion, exercise in community facilities, web-based directories of services that actually work, and many other innovations.

I hope that we all have the nerve to roll out sleeves up and give it a go. To make it work we need to begin changing tomorrow; you could start by looking at your educational needs and booking on some courses tomorrow.

REFERENCES

1 Gask L. Role of specialists in common chronic diseases *British Medical Journal* 2005;330:651–3.
2 Iveson C. Solution Focused Leadership – course at Brief Consultancy, www.briefconsultancy.com (accessed 1 November 2005).

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