GP Commissioning
What's beneath the surface?

Will we get value for money under the Coalition Government's Plans for the NHS?

"Can GP power cure the NHS?" [The Mirror, July 2010]

Commissioning health services is not something which typically makes headlines in the popular press, but during the summer, the Sun found space amongst its World Cup coverage for a column describing the ground-breaking structural changes the new Government is initiating in the NHS.

So what is the big news? We know that the NHS is the UK's biggest employer with a headcount of 1.4 million and a total budget in excess of £100 billion. Every year there are an estimated 10 million GP appointments. We also know that Britain has an ageing population, meaning a rising incidence of orthopaedic surgery, dementia and long-term conditions such as diabetes and bronchitis. And that as a population we expect to benefit from new medical technologies, high cost drugs, to wait less time for care and to find our surgeries and hospitals clean and well appointed.

At least overall NHS budgets are expected to remain flat, rather than suffer the cuts anticipated elsewhere. Nonetheless an initial £20bn of savings is required to pay for increased demand from older people in the short term, and strong medicine is required to make the NHS we want a viable long-term proposition.

The Government's prescription is to undertake a radical reform of commissioning. Commissioning is the job of getting best value from the NHS budget – understanding the population's health and healthcare needs, procuring the mix of health improvement and healthcare services from providers (surgeries, hospitals, helplines etc.) to best meet those needs, and making sure those services deliver. The Government is scrapping the 130 primary care trusts currently tasked with commissioning and handing the whole job to GPs, working in consortia. The idea is to save in two ways – first by cutting a layer of bureaucracy, second by placing purchasing decisions directly in the hands of clinicians who best understand patients' needs and see the quality of services delivered day-to-day.

This of course was not the job the present generation of GPs signed up to do, and GPs are not NHS employees – they are small business people working in partnerships. Will they want to become "part of the system" and to do so just at the time when there will be huge pressure to cut expenditure? As recent press has said, the proposed reforms are not just "distinctive" and "radical", but also "brave" and "highly risky"!

Berkeley has been active in NHS commissioning for over six years. In our experience concrete change only happens with GP involvement and where there is real collaboration in a local area between GPs and their clinician colleagues in, for instance, hospitals and community nursing teams. So conceptually it is right to give GPs a pivotal role in commissioning. But we see three big challenges:

First, GPs "know best" for individual patients, but working in consortia, they will be commissioning for populations of over 250,000 people and accountable for the prioritisation – or rationing – of public money across all health needs. This is a new role with legal implications, if not moral challenges, requiring both a different mindset and certainly staff to do the legwork.

Second, GPs are independent practitioners and not corporate animals. Working in consortia will require investment in relationship building and the taking of cabinet responsibility for difficult decisions, meaning a partial loss of autonomy at the same time as an increase in responsibility without direct control.

Third, there is the question of transition. The organisational development of GP commissioning consortia will be time consuming. Put this alongside GPs' day jobs of seeing patients – and add in their role in the pressing delivery of £20bn savings and improved quality of services – and you ask whether this can really all be done in parallel.

All in all, this is a change management exercise of equivalent scale to those Berkeley helps its private sector clients tackle, and we have been asking ourselves what this experience should teach us in helping GP commissioning consortia move forward.

Our early conclusions are:

The top-down prescription of solutions for independent GP practices in very different geographies will not work, but the sharing of ideas across practices and the use of common inputs to local thinking will be beneficial.

Consortia should have a good idea of their destination, but progress should be made steadily and taken step-by-step, with allowance for evolution and mid-journey innovation.

The intended benefit locally of GP commissioning – to deliver better health outcomes locally and make savings – should be quantified and actively tracked over time, ensuring that the organisational change does not become an end in itself.

So, when all is said and done, will the Government's changes lead to better healthcare, and will the taxpayer benefit? A definitive diagnosis could be some time coming, but it will certainly be an eventful ride.

Find out more about Berkeley's NHS experience, or how we could support your GP Commissioning journey. Visit our website at www.berkeleypartnership.com