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NHS REORGANISATION: CAN GPS DO IT?

NHS reorganisation is upon us again[1] with a change of philosophy and reversion to a strengthened, practice-based, commissioner–provider split. Since the announcement of this change and the subsequent White Paper, there has been a wealth of criticism.[2,3] The objections fall broadly into several themes: some of which are evidenced[4] and need little comment, but however, it is an observation that each new health secretary will make it clear that they intend to leave their personal organisational stamp on the NHS, regardless of any evaluation or estimate of transition costs. It is within these transitional periods though, that the high-minded, optimistic articulation of concepts become lost when translated into the reality of health service delivery.

Thus, there is a very real risk that existing services, in need of radical change, will remain in a stagnant state as local groups focus on a renaming process: for example, the re-labelling of community hospitals as polyclinics, because this is the simplest way to deliver the system changes demanded.[5] That change is imperative however, can not be understated. The NHS has been promised it will be spared reductions in income but this is against widely accepted predictions on the demand in growth over the next 5 years for which there will be no additional funding.[6] The changes of the past 10 years with successive creations of PCGs, PCTs, and practice-based commissioning have all been heralded with announcements that the organisational names reflect the importance of empowering general practice in decision making for configuration of local health services. All have failed to deliver this as the headline announcements have been superseded by processes and priorities dominated by managers' agendas and not those of the primary care practitioner.

To accuse GPs of being incapable of this work is a fallacy which must be dismissed. GPs are, quite frankly, some of the most intelligent people of their generation in the country. In addition, those GPs emerging from training over the past 10 years or so have been subject to assessment systems throughout their specialty training programmes which are by and large becoming incrementally tougher.

GPs will have to work with managers in this system. They must ensure they make it clear they retain the executive role and not allow themselves to become lost in management and operational issues. They must learn to discriminate between these two important large organisation functions of executive management and operational issues and be leaders of change rather than stalled in the change programmes of others. They must seize the initiative and use the time vacuum where Andrew Lansley is transmogrifying his ideas into practicalities, the opportune vacuum of the blank page, to identify their local needs, priorities, methods and structure before this is imposed on them.

Moreover, GPs must be realistic that there will be inadequate funding for the range of services aspired to or centrally required regardless of the processes and systems in place. They do not have to feel obliged to apologise for being unable to deliver a list of services and requirements when this is a result of inadequate resources, nor work themselves for inadequate remuneration in order to seek a financial balance. They must be prepared to stand up and declare that directions from others in the NHS, national or regional bodies, be it services or the governance processes to support processes deemed prerequisite, are unsustainable when the funding simply does not support this.

The current proposals[1] are exciting and invigorating but demand GPs show leadership, initiative and enthusiasm before the managers contrive to reassert their positions in the NHS, a position long associated with stagnation, inefficiency and complaint. It is vitally important that GPs are on the top table[7] in system redesign and do not fall into the systems once built by others without clinical experience or expertise.

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DOI: 10.3399/bjgp10X532468