

GAMBLING with the NHS

Politicians tinker with the NHS at their peril. But, says **Rob McCargow**, taking risks with commissioning still poses a serious threat to reforms

The NHS represents much of what the public holds valuable in society and politicians must tread carefully to avoid undermining its fundamental values. Even in the current economic environment, where the need for public sector spending cuts is real and pressing, it is a gamble to mess with the NHS.

The coalition government's solution to the economic dilemma is radical – and may create the most challenging period in the NHS's long history.

On the face of it, there's a lot that makes sense in the Health and Social Care Bill 2011 – its call for the reduction of top-down targets; the removal of unnecessary red tape; a focus on clinical outcomes rather than outputs; more streamlined national and regional structures; putting the patient at the centre of the service. All these measures instinctively feel right.

As likely costs of delay and restructuring look set to nudge £2bn, it is GPs, working in clinical commissioning groups (CCG), who will be at the forefront of reform and entrusted with the bulk of the UK's £105bn health budget. They will be in control of decisions that influence the quality and efficiency of care, against a backdrop of £20bn cost improvements to be realised over the lifetime of this government.

There has been widespread resistance from all corners of the sector including the unions, hospital consultants, senior NHS management and the BMA, leading to significant amendments to the proposed reforms. Empowering clinicians, particularly GPs, may hold appeal for those within the service, but they are already worried about how successfully they can sustain quality standards, productivity and morale while pushing through major reforms and cutting costs.

The new NHS Commissioning Board – a body described by Labour as the biggest quango in the world – has been tasked with developing a process that will hold CCGs (in conjunction with clinical senates and local authority health and wellbeing boards) to account and creating a commissioning outcomes framework to monitor their performance against a national outcomes framework.

But this has only added to the existing tensions between government and some GPs. The BMA has expressed its opinion that GPs must not allow themselves to become the "whipping boys" of the new board.

There will be considerable scope for each CCG to lead decisions regarding local governance and organisation. This will require them to assess the skills needs of the CCG and where those skills will come from – a potentially serious threat to the reforms.

GP involvement in commissioning has been patchy thus far and it's hardly surprising observers see this as something of a leap of faith. The likely outcome is that it will fall to a smaller group of enthusiastic GPs to lead CCG strategies and clinical engagement, and to maintain good relationships among their own community.

Meanwhile, where will they source the senior management skills needed to ensure effective commissioning? There's a broad expectation that this should cost less in future, and that better, cheaper means of commissioning within a leaner system can become effective more quickly.

There is a need for greater clarity at national and local level about just what CCGs can and cannot do – and what this means for their workforce. But they must ensure this clarity within the constraints of a reduced management allowance, funded out of savings from the abolition of strategic health authorities and primary care trusts. Denying CCGs access to much-needed management skills in the interest of austerity is misguided and risks jeopardising the whole reform process. Some of what they need is already present (and improving, according to world-class commissioning scores) in the doomed PCTs, but they must be allowed freedom to recruit much needed new skill sets from other industry sectors.

Enlightened GPs already recognise the value of drawing on existing commissioners' experience, talent and management capacity, but a systematic approach to identifying the dynamics of the current commissioning workforce is urgent. A coordinated effort will be needed across

the NHS to relocate commissioning talent and to challenge less engaged GPs' lack of enthusiasm.

It is crucial that talented people are focused on their contribution to the NHS, as opposed to their own livelihoods. This is at least as important as driving down commissioning costs. Leaving it to chance or treating it as an unnecessary expense would be to risk wrecking the reforms before they even take root.

There is political allure to the prospect of being the government that successfully improved the NHS. But the ambitious scope and timescale (albeit now "relaxed" following the listening exercise) of the current reforms, coupled with traditional failure to factor in passive resistance to change, narrows the current government's chances of success considerably.

For reforms to be successful, we'll need strong leadership, accurate resource and talent management, and recognition that such fundamental changes require a unified approach to workforce engagement.

Where there is change, there is opportunity as well as risk. There must remain a relentless focus on genuinely delivering better services to the public and, if the politicians, senior management, and clinicians all work together with this target in mind then the reforms have a fighting chance of succeeding. But that's a big "if".

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