GP commissioning: Dream or nightmare?

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So now GPs are to take on the challenge of making the NHS work. The coalition Government White Paper *Equity and Excellence: Liberating the NHS* (Department of Health, 2010) brings to England another huge change in NHS leadership and organisation. For now, the other UK nations may just watch with interest. How will this affect diabetes services, and should we be excited or filled with trepidation?

Details of just how the White Paper will change practice remain to be revealed but the headlines will be familiar to most of you. Primary care trusts (PCTs) will disappear from 2013 and their commissioning functions will be taken over by consortia of GP practices, which are likely to be somewhat smaller than PCTs but will have to be large enough to avoid the chaos of large numbers of small commissioners, each asking local providers to work to differing specifications. Primary care services will be commissioned separately by an NHS Commissioning Board, and the GP consortia held to account for the success or failure of their commissioning efforts. All NHS trusts will become foundation trusts, public health departments will be integrated with local authorities, and strategic health authorities will be abolished in 2013. The timetable of the proposed changes is hugely ambitious, with the new GP practice consortia assuming full financial responsibility for their local healthcare budgets from April 2013.

Efforts to move the responsibility – and therefore planning – of overall healthcare provision towards GP practice groups date back 20 years to the last Conservative government. "Practice fundholding", as it was then termed, achieved some popularity largely on account of the generosity of its funding, but was perceived as increasing rather than reducing inequalities of provision. Commissioning then became the responsibility of the perhaps oddly named primary care trusts, whose perceived failure to meet that challenge resulted in the next idea, practice-based commissioning (PBC). PBC involves groups of GP practices taking responsibility for notional healthcare budgets in their communities. Described in a memorable phrase by the Government's own primary care czar, David Colin-Thomé, as "a corpse not fit for resuscitation" (Ireland, 2009), the voluntary scheme of PBC is now to give way to the compulsory development of GP consortium commissioning. This will have to find and fund its necessary management structures among the debris of PCTs viewing their own dissolution with less than wholehearted enthusiasm.

Fortunately, however, the Secretary of State for Health Andrew Lansley assures us that "this is not going to lead to a big upheaval" and that "my expectation is that many GPs do not see it impacting on them very much" (O'Dowd, 2010).

Apart from GPs, you may have noted that I have made no mention of other professionals in primary care. Neither does the White Paper. It talks only of GPs as carrying the responsibilities of commissioning. One might therefore worry that it will be only they who make the decisions. Of course, we all realise that proper planning and commissioning of services will depend on the constructive involvement and influence of a wider group including patients, all professionals in primary care, and our colleagues in intermediate and specialist care, together with the necessary management and financial input.

So how do we carry forward our ambitions for better diabetes care within the new framework? In some areas, the creation of Diabetes Networks, as envisioned in the National Service Framework (Department of Health, 2003), has brought together primary care, specialist care, patient groups and commissioners to plan or influence local services. Both models emphasise the importance of bringing together users and providers of services to assess need and plan provision.

There will be opportunities but also grave potential pitfalls as we get to grips with a new system at a time of unprecedented financial stringency, but also in the face of the continuing inexorable rise in the number of people with diabetes. I hope and trust that Primary Care Diabetes Society will play a full and constructive part in striving for equity and excellence in diabetes care throughout the UK. ■