

BODY POLITIC **Nigel Hawkes**

Keep GPs in the driving seat

Consultants may hate it, but commissioning consortiums need the minimum number of constraints

As it struggles to rescue its health reforms, the government is in danger of getting the worst of all worlds. By attempting to appease its critics and reconcile its internal differences, it risks retreating to a system of entrenched medical interests each doing their own thing and spending their spare time arguing over resources.

How best to get the highest quality healthcare at the lowest cost? For 20 years we have worried at this particular bone. Splitting purchasers from providers, introducing choice and competition, and elevating commissioning to a central role have been the levers of change. They have all proved weaker than their originators hoped but—if you squint—you can discern some evidence that in recent years the English NHS has performed better than those in the devolved administrations, which have followed a more collegiate organisational style.

Health secretary Andrew Lansley's aim was to make the levers stronger by increasing competition and improving commissioning. But every step in this 20 year evolutionary process has been fraught with difficulty. He therefore needed to do it in a way that did not animate its opponents or revive old arguments. His failure to do so risks setting back the clock—so much so that the architect of the Blair reforms on patient choice and provider competition, Professor Julian Le Grand, now argues that the best option for the government is to abandon the bill altogether.

What would be lost? Mr Lansley, perhaps. But of the actual contents of the bill, the move towards increased competition appears already to have been abandoned, or diluted to homoeopathic concentrations, while GPs who have volunteered to become commissioners have been left in the lurch, to their anger and frustration. They have stuck their necks out, or put them on the block, to use the words of Dr Michael Dixon, chairman of the NHS Alliance. “Suddenly now they are going to be told to go home . . . they are using words like betrayed.”

They are learning the hard lesson taught to generations of would-be reformers in the NHS: ministers propose, but do not dispose. Take the lead if you must, but watch your back. You may be doing exactly what the health secretary ordered, but if it causes too much fuss, you will be abandoned. The survivors will be those skulking in the back row, doing things the way they have always been done. They cannot sack you for that.

Since the purchaser-provider split, commissioning in England has been undertaken, in succession, by district health authorities, health authorities and GP fundholders, primary care groups, primary care trusts (halved in number in 2006), and practice based commissioners. All have, on mature reflection, been found wanting. So it is a triumph of hope over experience to believe that there is a model of commissioning yet untried that will unleash a mighty wave of innovation and change in the NHS.

The truth is we have no idea if GPs can give commissioning the backbone it has always lacked. The chances will be lessened if the advice of the Commons Health Select Committee is followed and commissioning becomes a cooperative enterprise, involving hospital consultants, nurses, a public health expert, a social care representative and a local councillor. The prime minister, David Cameron, has hinted he favours this prescription. Nick Clegg, in his speech on 26 May, made it clear that he does.

What's wrong with it? It would keep the royal colleges happy. Many consultants can't bear the idea of GPs in the driving seat. Take Dr Andrew Bamji, a feisty rheumatologist from Queen Mary's Hospital Sidcup, who responded to a recent article in *Pulse* by commenting: “I have (as a hospital consultant) long held the view that one of our roles is to tell GPs what services they should be buying—and why. If all healthcare planning is to exclude hospital doctors we might as well all resign.” He goes on to suggest that GPs have finally escaped the attribute



“
GPs are learning the hard lesson taught to generations of would-be reformers in the NHS: ministers propose, but do not dispose. Take the lead if you must, but watch your back
”

of being doctors “who have dropped off the hospital ladder, but it is foolish of them in the extreme to seek their revenge in their happiness at the destruction of consultants' power.”

Dr Bamji has the admirable quality of saying exactly what he thinks, but in this case it is also what a lot of other consultants think. The problem with this view is that you can't have a purchaser-provider split and be on both sides of it at once. Hospitals are unequivocally providers. GPs are too, but their interests are less bound up with the preservation of a particular service or hospital. Their focus is on patients, not specialisms.

Commissioning is worth the candle only if it can create change. In private industry, 60% of innovation is driven by providers falling out of the market and being replaced by others. Only 40% is internally generated. Commissioning needs to make possible this kind of disruptive innovation. But that means hard decisions, less likely to be taken if commissioning consortiums are not given the maximum freedom possible and the minimum number of constraints.

The NHS Confederation seems to agree. In its new paper *The Right Reform for Patients* it argues that while there should be effective input from specialist clinicians, clinical advice should not be confused with governance. “So there should not be a requirement to include representatives on the boards of the commissioning consortia from the acute sector or the royal colleges . . . there is merit in maintaining a strong primary care perspective in the commissioning process.”

Commissioning has so far proved a weak reed. Commissioning without effective competition will be weaker still. To believe that GPs are bloody minded enough to make it work is a long shot, but it is one part of Mr Lansley's plans that deserves to be preserved.

Nigel Hawkes is a freelance journalist, London
nigel.hawkes1@btinternet.com

Cite this as: *BMJ* 2011;342:d3382

bmj.com
Read other articles about the NHS reforms in England at bmj.com/nhsreforms

NHS REFORMS Jonathan Fielden, James Mountford

A chance to optimise “value” in the NHS

The financial squeeze and proposed reforms offer a chance to put value at the heart of the NHS

Meeting the financial challenge of the next three to four years is the subtext to the current NHS reforms in England. Although there is dispute about whether changes proposed in the Health and Social Care Bill¹ are evolution or revolution,² any changes must produce better results for patients in a climate of financial challenge.³ Amid the current debate, which often blends ideology with fact, opportunities may be created that could safeguard the NHS for the future and enable it to deliver more for those it serves within available resources.

One widely acknowledged positive change is the emphasis on delivering better outcomes.⁴ Evidence is mounting that specific elements are important to ensure this: transparent data linked to information systems; greater patient involvement; clinical leadership; more service integration; and, in certain circumstances, elements of competition—on quality, not on price.⁵

We think that an additional opportunity is created by the funding squeeze itself: a chance to bring outcomes and use of resources together as a unifying framework for improving results over time. “Value” is a simple concept to describe: useful outcomes divided by the cost of achieving those outcomes.⁶ Until now, cost and quality have existed in separate conversations, too often the responsibility of different professional groups. An era of rising demand, increased focus on outcomes, and resource constraint is the perfect time to bring cost and quality together: to put the pursuit of value for patients at the centre of our efforts, and to make this the shared responsibility of clinicians and managers.

“Quality” and quality improvement become sustainable when tied to resource use, especially as evidence grows that quality often comes at lower cost if care is well organised.⁷ A firm commitment from organisations and professionals to collecting, analysing, and acting on clinical data, paired to

resource use, is required if the NHS is to progressively improve value. Too often we have defined quality and performance through professional or managerial proxies: activity, admissions, episodes. Transparency and openness of outcome data, shaped and owned by clinicians, has been shown to produce substantial improvements in quality and safety. Improvements in cardiac surgery are one example of transparency’s benefits, and this must be extended to other specialties and patient pathways.⁸

Value emphasises the importance of doing whatever we do efficiently. It also highlights the importance of viewing health and disease along a continuum of prevention; of early diagnosis followed by proactive intervention in long term conditions; and of linking healthcare to social care and public health. Most of all it emphasises that what matters to patients and population is not healthcare in itself but health. Healthcare is often a means to health, but it is not the only means. This highlights the importance of establishing a quality numerator in the value equation that truly describes outcomes that matter to patients. We think that quality should encompass clinical outcomes, outcomes reported by patients, and patients’ experiences, measured along whole pathways of care. This enables measurement of quality to encourage prevention, effective long term management of conditions, and care organised around patients’ needs and preferences.

The reforms should aim to create conditions that maximise the potential for progressively improving value. Too much debate has focused on proxies rather than emphasising this overarching purpose—for example, should we emphasise competition or collaboration? Emphasising value gives primacy to patients’ needs rather than the needs of professionals or institutions. Organisational boundaries, incentives, funding flows, and the

“Patients will suffer if clinicians’ ethics and expertise are not leading the design and improvement of our system and maximising the health gain achieved for every pound spent”

structure of the workforce should be derived from what best serves the patient. In some circumstances value will most effectively be driven through competition on quality—for example, where existing providers fail to adapt. More often it will come through cross-sector collaboration, breaking down artificial barriers to patient benefit—for example, between primary and secondary care and between health and social care.

This change requires leadership that understands the complex adaptive nature of healthcare. The approaches required differ from standard management or business problems. Healthcare provision is a “wicked problem” and so will require iterative “clumsy” solutions to move forward.⁹ Clinicians must ask whether their professionalism takes them into this territory. We think it must: patients will suffer if clinicians’ ethics and expertise are not leading the design and improvement of our system and maximising the health gain achieved for every pound spent.

Many rightly see the current “perfect storm” of rising demand; quality and safety problems; and a need to limit costs as a crisis that risks the future of the NHS. However, lean times also bring a crucial opportunity almost inconceivable to achieve in times of plenty: the opportunity to unite throughout health and social care with a shared focus on improving value and the room to try many solutions to deliver. Optimising value puts patients first and can help ensure the NHS a sustainable future.

Jonathan Fielden is chief medical officer, Royal Berkshire NHS Foundation Trust, Reading
jonathan.fielden@royalberkshire.nhs.uk

James Mountford is director of clinical quality, UCL Partners, London

Competing interests: JF is a member of BMA Council. References are in the version on bmj.com.

Cite this as: *BMJ* 2011;342:d3244

bmj.com

Read other articles about the NHS reforms in England at bmj.com/nhsreforms

LIFE AND DEATH Iona Heath

Are policy makers really listening?

Distortion of words in the interests of those seeking to exercise power has a long history

The quality of healthcare has always depended on the quality of listening: intimate, attentive listening shared between the patient and the doctor or nurse. Now, suddenly, there is much talk of listening at the much less tangible level of policy making. The word “listen” is a beautiful and ancient one, thought to be first recorded in written English in the Lindisfarne Gospels of AD 950. The complementary verb “to hear” is equally ancient and makes its first appearance in the same exquisite text.

Words are precious and dictionaries the treasure chests within which the history of each word’s usage is stored. According to the complete *Oxford English Dictionary*, to listen means “to hear attentively; to give ear to; to pay attention to.” The marvellously idiosyncratic Samuel Johnson, in his great *Dictionary of the English Language*, published in 1755, defined to listen as “to hearken, to give attention.” The inclusion of the notion of giving in both definitions suggests the moral content of listening. Doctors have a grave responsibility to listen to their patients, politicians to their citizens. The BBC’s Skillswise website (www.bbc.co.uk/skillswise) is designed to help people wishing to improve their literacy and numeracy, but many of those already skilled in these areas might do well to consider the suggestions that are given in relation to listening: “Listening is a form of communication and is an active process. When you listen you must get meaning from what is being said before you can respond.” And: “Often, you may hear what you expect to hear, not what is actually said. Everyone brings past experience to a communication situation, even without intending to. Pressure of time and work increases the risk of doing so.”

All of us listen selectively and have to do so because of the intensity and complexity of auditory sensation. It is all too easy to listen without hearing, and, when preoccupied by other thoughts,

all of us have had the experience of losing the track of our listening. Music is perhaps the best test of true listening. How long can we listen and really hear the music before our brains begin to whirr again and the music recedes into the background of our more immediate and mundane thoughts?

Listening without hearing can also be a little more sinister. Somerville and colleagues have shown the extent to which doctors working in rapid access chest pain clinics allow themselves to hear only those parts of the patient’s account that can be used to confirm or refute a possible diagnosis of cardiac ischaemia, while ignoring aspects of the story that are clearly of great significance to the patient (*Social Science and Medicine* 2008;66:1497-508). Doctors working in this way are using listening instrumentally: not as an end in itself but as the means to a diagnosis. As the psychotherapist Paul Gordon puts it, in his book *The Hope of Therapy*: “The problem is not trying to make sense of things but that a search for understanding, for comprehension, can too often get in the way of a real attunement, a real listening. Instead, we end up hearing what we think we ought to hear . . . what fits into our preconceptions.” If it is easy for doctors and other healthcare professionals working in pressured clinical situations to fall into this trap, how much easier must it be for policy makers, who all too often have a predetermined agenda of their own and are listening at a distance far from the intimacy and immediacy of the clinical encounter?

George Steiner, in his book *Heidegger*, writes, “The vital relation of otherness is not, as for Cartesian and positivist rationalism, one of ‘grasping’ and pragmatic use. It is a relation of audition . . . It is, or ought to be, a relation of extreme responsibility, custodianship, answerability to and for.” It seems that far too much of what passes for listening at every level of the health service has this “grasping”



“It seems that far too much of what passes for listening at every level of the health service has a “grasping” instrumental quality”

bmj.com

Previous columns by Iona Heath are available on bmj.com.

instrumental quality and that we all need to test our own listening against these standards of responsibility, custodianship, and answerability to and for.

It is in all our interests to try to ensure that listening is genuine and is linked to both hearing and understanding. Words are precious—and, somehow, the more ancient they are, the more precious. But there is a long history of the distortion of words in the interests of those seeking to exercise power. There seems a definite possibility that listening will shortly be added to the ever lengthening list of words that have become corrupted in this way; recent additions already include words such as reform, quality, choice, and care.

The *Oxford English Dictionary* illustrates the use of the word “listening” with a quotation from John Milton’s essay, “The Reason of Church-Government Urged against Prelaty”: “It were a folly to commit any thing elaborately compos’d to the careless and interrupted listening of these tumultuous times.” This warning seems only too appropriate to our own tumultuous times, but we must continue to hope that this perception is mistaken. Samuel Johnson had chosen to exemplify the noun “listener” through an almost diametrically opposed figure. Roger L’Estrange (1616-1704) was a belligerent Tory, a staunch royalist, and a political pamphleteer and journalist. He attacked other writers who displayed any trace of dissension or radicalism, including John Milton. The quotation chosen by Johnson reads: “Listeners never hear well of themselves.” Perhaps the degree to which this is true makes genuine listening by those reliant on political power and popularity all but impossible.

Iona Heath is president, Royal College of General Practitioners, but writes in the *BMJ* in her personal capacity iona.heath22@yahoo.co.uk

Cite this as: *BMJ* 2011;342:d3218