Systems and Organisations – Interview

Lord Howe interview

Interviewed by Hamed Khan (Associate Trainees Corner Editor)

On 27 July 2010, Health Minister Lord Howe (LH), who leads on Primary Care at the Department of Health, was interviewed by Hamed Khan (HK) on behalf of the *London Journal of Primary Care*. The interview focused on the Government's plans for GP Commissioning and other imminent issues affecting primary care.

HK First and foremost, the Government intends for GPs to cluster around together to commission care pathways for diseases, and to monitor the performance of these care pathways. Dealing with many different diseases and powerful hospitals is quite a task, how do you expect this to be practically managed by GPs?

LH I think the key to this is to fix in our minds that this is not about GPs being on their own. Effective GP commissioning will come about when there is the full range of professional input going on alongside that of GPs. Now GPs clearly have clinical expertise, they also have the power of referral, and they are very trusted individuals. But I hope that all GPs would agree that to design services and deliver services that meet the needs of the local population requires an effective dialogue and partnerships with other health care professionals including nurses, allied health professionals and hospital doctors, as all of them have a role to play.

Now we're not going to tell consortia how to configure themselves, although they will have the freedom to take commissioning decisions collectively if they wish to. For instance adopting a lead commissioner model could be a good route for large hospital trusts and urgent care providers. Also consortia will decide what commissioning activities they undertake themselves, and what activities they choose to buy in support for from outside. Local authorities, private sector bodies and voluntary sector bodies are all in a position to help them commission effectively.

The monitoring of care pathways will depend on who is in charge of the commissioning. But also it will depend on the information systems that are put in place by the commissioning organisation. These information systems are

key and the NHS commissioning board will have a role here.

The engagement document that we've put out on commissioning raises all these sorts of questions, and we will look forward to the responses we get.

HK You spoke about how it is not expected that GPs will be able to do all this on their own, both in terms of the design and the delivery. Commissioning obviously requires a whole range of new skills that many GPs may not necessarily possess. How will you train GPs to do these tasks effectively?

LH Well, we are already seeing in certain parts of the country this kind of activity going on extremely encouragingly, and the pattern that is emerging is for clinical leaders in the consortia to set the path on which others follow.

You're right about training, but GP's needn't worry that we're asking them to turn themselves into managers that is not the idea. Many GPs will be able to continue serving their patients in much the same way as they have done up to now. The difference will be that the way they act and the way that they serve their patients will be much more transparent.

They will be assessed and monitored on the basis of outcome measures that are to be devised, so the basis on which their success will be judged will change. But good GPs, those who are already doing a good job, have nothing to fear from this, and I think they have everything to be excited about. Any professional wants to deliver good outcomes and I think it will matter as much to GPs as it will to patients how those outcomes are measured, and what their performance looks like.

HK You said that GPs will be able to decide which commissioning activities they take on and which they buy support for from outside organisations. This appears to be a high risk activity in terms of the management costs. Do you have evidence that the end management costs will actually be less than what they are with PCTs and Strategic Health Authorities?

LH I think the whole question about what the management costs are will emerge. I don't think I'm yet in a position to give you a clear steer on that. But GPs are only going to buy in activities such as negotiating contracts and monitoring performance if they think it's going to be cost effective for them to do so. GPs may judge that over several consortia it is cost effective to buy in that kind of support and that'll soon become apparent.

There will be economies of scale, but with regard to saying what the management costs will be for a consortium, it's too soon for me to tell you, quite honestly. I think we will judge that when we know how big these consortia are going to be, because we don't know yet and we're not dictating either.

HK OK, now the government also intends for GP clusters to lead local communities for health, working in partnership with the local authorities and communities. Making sense of such multiple voices and a constantly evolving agenda is unfamiliar to some GPs. How do you expect this aspect of commissioning to be practically managed?

LH Right, this is all about having services that are both appropriate for the population in a local area and joined up. We envisage GPs working alongside local authorities, as local authorities are going to have a lead role in ensuring that NHS services, social care services and public health services are genuinely joined up.

They [GP's] are in an ideal position to do that. We have, as you know, two consultation documents out at the moment especially for commissioning patients' and increasing democratic legitimacy. Increasing democratic legitimacy lies at the centre of this question and the consultation papers look at how best GPs and local authorities can be supported in those roles over the months ahead.

We in the Department of Health want to work with those in the NHS, professional bodies, and local authorities to make sure there is the right support available to enable them to undertake this role. This is a challenge as local authorities are being asked to perform a role that they haven't done for 40 years. But we think it is the right place to put this activity and we're convinced that GPs, other primary care professionals and local authorities are the people who are best placed to work with local communities, to achieve integrated services and deliver high quality care with more efficient use of resources.

GPs, because they are closest to the patients, and local authorities because they are

democratically elected to represent the people in the area. They currently lead on social care, and they will also lead on public health. And I shouldn't forget Healthwatch either because patient input is absolutely key to the design of local services and to the maintenance of quality. So Healthwatch and other patient organisations will feed in to all of this, and it is also terribly important that we take on board the responses of the consultation documents that are going to flow in.

It seems to me that good commissioning is in part about understanding the needs of the patient population in a particular area, and making sure that the right services are there to meet those needs. The overview of service need that will be provided by local authorities, with input from Healthwatch, will be absolutely key to enabling the consortia to commission the right services. Commissioning isn't just about buying services, it is about assessing the needs of a population and how best to meet those needs.

HK You answered to some extent how the Government will be investing in technology to help GPs gather the relevant data to facilitate the commissioning process. How else could GPs influence it's specifications of data so that the data truly helps primary care to innovate?

LH This is key to the vision set out in the White Paper. Over the months ahead we will be working with the profession and the wider NHS to identify how best consortia can be supported in the whole business of accessing accurate data and information. Data that is real-time can be translated into information that patients understand and value and that supports effective care, information that takes on board and reflects the relationship between patient needs, service provision and health outcomes, and indeed the money that is needed to support those services.

We don't want to dictate what systems there should be, so over the months ahead we will work up an information strategy with input from GPs. Again we welcome any comments that flow from the consultation. But I can't stress enough that I think this is extremely important, because without information you don't have patient choice, and without information you cannot deliver on the outcomes framework in the fullest sense.

HK With respect to accessing accurate data, it's extremely important that we have research approaches that are attuned to such complex systems of care. Does the Government intend to modify the criteria for research funding to cater for such dynamic situations?

LH I think the short answer is that there is no need to modify the criteria for research funding. We have, as I'm sure you know, robust mechanisms for commissioning research as it is, and this is clearly an area where we will want to commission research. The proposals that come forward will stand on their merits. We are clear that we want to fund research projects in this area, and the best proposals will receive funding.

So I don't think that the criteria for funding needs to change. But again I welcome the question because this is absolutely key to looking at how to develop, in quite short order, some pretty complex care pathways and everything that goes with them. It is a priority and we need to define what we mean by these care pathways, to work through the impact of our policy, and to provide transparency. Amongst other things we have the National Institute for Health Research who are skilled in doing this kind of thing. The expertise is already there and I think the challenge for them and for us is to make sure that best practice that is already out there is shared.

We set out our strategy for commissioning in the White Paper and the supporting documents. And once again I think that there will be much that we can learn from the responses that we get, that point us in the right direction as regards the kind of research that we need to prioritise.

HK Providing a better standard of care is something which is in all our interests as healthcare professionals. There's been talk of financial incentives [for GP's]. What other incentives do you intend to give GPs who plan to take a lead in the commissioning process?

LH I'd like to believe that this is the moment that many GPs have been waiting for. What our proposals amount to is the bringing together of clinical decision making, with decision making about how money is spent. I think that putting those together provides an extremely exciting prospect for GPs.

Many doctors that I've spoken to have, in one way or another, described their frustration at how the system sometimes gets in their way. They want to act in the best way for their patients but in one way or another they can't. We hope that the system of GP commissioning and consortia that we are putting in place will support them. The end result should be not only more cost effective commissioning and care of patients, but also better quality of care. That's what all this is about how do we raise our game as a health service.

We see GPs as central to this; they're in pole position to deliver better care all round and commission better care. So that's the excitement factor of all this and the incentive, an intangible incentive, but it should play well throughout the NHS. Yes there need to be financial drivers as well and we will be talking to the BMA and others over the months ahead about the GP contract but that's perhaps for a future interview.

HK It probably is. That's been very helpful Lord Howe, thank you very much for being interviewed by the *London Journal of Primary Care*.

LH Great pleasure, I hope it will be helpful and interesting to your readers.