

Reflections on the Darzi Interview

Charles Easmon

The interview with Ara Darzi was timely. NHS London is about to report on its consultation over *Healthcare for London: A Framework for Action*. The first of the reports from the other nine regions on *Our NHS Our Future* have just been published and the remainder will follow in the next few weeks. It will be interesting to see how much they differ from the London recommendations.

Healthcare for London is the third report on the NHS London since the introduction of the internal market in the early nineteen nineties. However, it differs significantly from its predecessors Tomlinson and Turnberg. They were both very much top down exercises, commissioned by Secretaries of State for Health and imposed on London. Healthcare for London was commissioned by NHS London, not the Department of Health. Ara Darzi used a new approach, led by clinicians, rooted in clinically defined categories and sites of delivery. He and his team also gave some thought to the key enablers, such as workforce, education, information and commissioning, necessary for the practical implementation.

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Ara Darzi is a thoughtful and subtle man. He appreciates the complexity of modern healthcare systems and I thought him correct in firmly rejecting the criticism that because he is a surgeon he is not qualified to comment on primary care. The basis of the approach was that he used panels of clinicians from a wide range of backgrounds to come up with the proposals. Greater vertical and horizontal integration of care is the future; the real question is how this is going to be achieved. Having worked in the NHS as a clinician for much of my adult life, I now encounter it increasingly as a patient with chronic conditions. This has brought home to me the importance of smooth integration of care across the professionally or organisationally defined silos.

It is regrettable, but understandable how much the debate on *Healthcare for London* and its national follow up has focused on polyclinics. As Lord Darzi restated in the interview, for him the polyclinic is a concept and not a building. However, the polyclinic idea comes at a time when the level of trust between the government and the medical profession has sunk to a new low. The profession is worried by suspicions of a privatisation agenda in primary care and that the government is trying to claw back some of the financial ground lost to GPs through the pay reforms. The government is concerned that generous pay deals have not brought about desired improvements in productivity and access. If this atmosphere of mutual suspicion is not bad enough, there is a real concern that, notwithstanding Ara Darzi's views on polyclinics, PCTs may be encouraged to take a simplistic approach to primary care provision and seek to impose solutions based on the polyclinic as a building, rather than a concept for improving the quality and range of care outside the traditional hospital setting.

I hope cool heads prevail. Resolution requires good medical leadership that avoids knee-jerk reaction, strong PCTs that respond to local clinical need, not current dogma and SHAs that facilitate some bottom-up planning and do not emulate the Department of Health's penchant for "one size fits all" solutions. My greatest concern for London is the number of PCTs and the depth of quality of their commissioning strength.

I was pleased to see Ara Darzi recognising the importance of nursing and nurse leadership. I must confess that when I read the original report, particularly the sections on clinical leadership, I was concerned that there was too much emphasis on medical leadership and too little on nursing and the other clinical professions. I also welcome his comments on the need to integrate health and social care, but achieving this in practice is done in spite of, rather than helped by existing systems. The current national proposals don't change this situation.

One final reflection. Earlier I mentioned that some thought had been given to enablers, such as workforce and education. Primary care workforce planning systems are relatively weak. Clinical education systems, particularly outside medicine and dentistry, are very much focused on the secondary care sector. The existing primary healthcare workforce in London has a significantly older age profile than the overall workforce. If there is to be a shift to more community based care, then, given the inevitable time lag in both workforce and educational response, these factors may become a key impediment to rapid change. Will we then have yesterday's workforce for tomorrow's world?