



Response to Lord Darzi Interview

Dr Deborah Colvin

As one of three GPs on the Clinical Advisory Group (CAG) for Healthcare for London, I read this interview with interest. The CAG has, to a certain extent, had to deal with the ‘fallout’ from the original ‘Framework for Action’ document and my experience of talking to many clinicians about the report has been illuminating.

Let me first lay my cards on the table. I believe that there are many very exciting ideas in the framework and in particular about the future shape of primary care. There is no reason that we should continue to practice in the same style as we have done for the first sixty years of the NHS. There are many weaknesses in the service and, as Lord Darzi points out, we are here to ‘improve the care of the patients we look after’. For example, it is not good that patients have to spend half a day travelling to and from hospital for blood tests. So improving access to diagnostics and other services closer to home can be beneficial. Lord Darzi makes it clear that the word ‘polyclinic’, (in my view still terribly inadequate) is about an idea of community care rather than a building. Furthermore if his vision of the proposed services in the polyclinics became a reality, the quality of care patients receive would be transformed.

I am very heartened by his insistence that he recognises the value of general practice and the work we do, and that change means improving care and building on what is best. This view did not come across in the original ‘framework for action’ document and this was a pity. It caused considerable antagonism from the general practice community, so I commend him for highlighting this view now.

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His vision of integrated working both horizontally and vertically is immensely appealing. We can improve care if we are able to communicate easily with social services, mental health teams and secondary care colleagues. We can improve the health of our patients if we can offer them truly local services. Many of these changes started happening with the advent of practice based commissioning but are only occurring on a patchy basis.

Reading this interview, a couple of points strike me immediately. Lord Darzi reiterates on several occasions his belief that having set out the broad framework, change needs to be bottom up. This is laudable. However, this will require the Department of Health to change its heavy handed approach to the PCTs. Their diktats lead to poor decisions on the ground, like the Oxford eye service debacle when the Oxfordshire health authority was instructed that they ‘had to’ provide independent treatment centre

provision for eye conditions when their existing service already had extremely low waiting times and was very efficient. 'Choose and Book' makes it very difficult for GPs to work closely with secondary care colleagues because we cannot ask for a particular consultant to see a patient. It is increasingly difficult to pick up the phone to discuss a patient. 'Payment by results' causes perverse incentives which militate against integrated working.

Similarly Lord Darzi mentions 'virtual boundaries' that exist in our minds only when we think about care pathways. That is true to a certain extent, but there are very real fears, concerns and again financial drivers adding to these boundaries and unless we address these, we are unlikely to succeed in building a better future.

Lord Darzi discusses his lack of experience in primary care but feels that somebody had to do the review and implores us to 'look outside the box'. However, I feel his lack of understanding of primary care (not his commitment to primary care) has meant that the framework has been poorly received in its initial form by primary care and we are having to struggle very hard to undo some of that initial harm.

Lord Darzi says he believes that the biggest opportunities to improving health care in the future will be in primary care and the community. Again, I commend him for this. We know that health promotion (un-sexy as it is) is more productive in health finance terms than some complicated secondary care procedures. We know that if we could improve healthy living, pound for pound this would be a better way to spend. We still don't really know the best ways of doing this but there is mounting evidence that we can look at and build on. GPs are highly valued by patients and are in a powerful position, together with other primary care colleagues, to help people to alter their lifestyles.

Some of the discussion talks about the role of nursing. My experience of working in primary care is that this is an area where the whole concept of the polyclinic could fall down. It is very hard to find nurses who want to come and work in primary care. Every nurse we have employed, we have had to train from scratch. This process takes

time. If we want this vision to succeed it is important that this enthusiastic discussion of the enormous value of appropriately trained nurses is translated urgently into action or we will be very short of staff to do this work.

On the subject of working more closely with social care, again I agree with him that this is crucial. Are there any general practitioners who are able to easily liaise with their social care colleagues? Given how crucial they are to caring for many patients, I would welcome with open arms an attempt for the services to work together in a truly integrated way.

Finally I would also like to bring to the reader's attention his challenge to the academic institutions to provide programs to enable true clinical leadership in primary care. In my view, if the polyclinic concept is to succeed it will need to be run by general practitioners. There is a very real threat to general practice because if we don't step up to the challenge, private health companies will step in. I truly don't believe that these companies are the best people to be making decisions about the shape of health care provision. There is no evidence that 'private is better'. The reason that I think the private/public institution of general practice has worked so well is because GPs have committed themselves long term to their practices and it is this commitment that provides continuity to the patient and pride of achievement that keeps standards high. Critics could argue that this system has also enabled some examples of truly appalling practice to go unchallenged for too long and I would absolutely agree with this. So, built into the 'brave new world' needs to be good quality assurance.

Finally, this interview would make me truly excited if I thought Lord Darzi was fully supported in his statements by the Department of Health. My fear is that an idea which could lead to a renaissance in primary care and make Britain the envy of the world in terms of health care systems again will be put in jeopardy by interference from above.