Ara Darzi: what we have learnt from previous approaches to NHS reform?

Just to say, I’m going to give you an overview of my own experience, as a failed politician who lasted for about two years; also being an active clinician within the service. It is always, being an academic too, worthwhile certainly reading this report and in many ways having it at the perfect timing, because any post-mortem of anything you have done in the past I am sure would be of benefit, not just for the political leadership, but for many of those, or of us, who work within the health service.

To start off with, I think if you really want to understand the context, I would like to say a few things about the reforms of 10 years ago, the NHS Plan being the start of the reforms. I think it is important to acknowledge, and at least recognise the fact that these reforms, at the time they were done, were the right things to do. There has been a lot of talk here about – and I think you can read between the lines the negative tinge to some of them – but Chris, you were very much part of the leadership at the time. You know, the provider reforms, the Foundation Trusts have been a good story. There’s no question about that. We talked about the Commissioner Reforms and I think Stephen touched on that extremely well.

In many ways, certainly in my line of activities, competition, as Stephen said, is a very important part. The question is, I don’t compete with four-hour waits; I compete on clinical outputs. If I am really going to go as a patient seeking treatment, I would like to see what the outcomes and the experience is. In many ways, that is where competition should focus on, and choice should come in. I think there is plenty of evidence in the international literature and also in the UK that competition and choice works, but how do you make it work? Transactional reform – again, you know, giving the seal of a hospital, a brown envelope in April and say this is what you have; do your best – wasn’t the way of running a system.

Whichever way you look at it, at that time we had an NHS which was about 50 years old which actually wasn’t a system. It was a complete basket case and someone had to have the leadership of actually creating a system, but what went wrong, I think at the time, was the complete disregard to the business units who were delivering the care - the patient-focused care. That in many ways was really, despite those three reports, it was quite clear – I didn’t have to go to America to understand what is wrong with the system. You just had to talk to the patients; talk to the clinicians and talk to the leaders; talk to the Royal Colleges; talk to the different organisations as stakeholders and the message was very clear. The system might be reformed but there is a serious issue when it comes to service reform.
System reform is not necessarily symbiotic with service reform and I think that is the opportunity which was missed at the time, and it took more than eight years or so to start refocusing on what the NHS should be all about. Making quality the organising principle of the NHS was my motto at the time, bringing in the quality continuum; what engages clinicians is effectiveness; what engages clinicians is the matrix, the transparencies of measurements. Using Stephen’s, the most competitive thing, have you ever come across a doctor or a nurse who has ever told you, “Go to the hospital up the road. They do it better than me”? Never! Never! Even they are not able to do it. That is another challenge, but I will come back to that.

So it’s the clinical system, it’s the business unit, it’s the pathway design – they were the major challenges back in 1998 and I think in many ways we have sort of lost the focus again in 2010. I think with that there is no question comes the social mobilisation. Where is the energy? Where is the imagination? Where was the engagement? Where was the participation? The most irritating thing, although I had a huge admiration for Tony Blair as a leader, standing up there saying we have achieved this target, that target, that target, that target. That’s the sad thing, if I could just be critical from a political perspective – politicians have become technocrats. Politicians have become – someone told me in the Department when I started to use this civil service jargon – once you do that as a politician you should leave, because you know too much about the subject matter.

Obama did exactly the same mistake, if you really listen to his speeches. This is the most gifted orator standing up there and talking about the technical aspects of it, rather than mobilising the clinicians out there who were going to deliver this. This brings me back to the business units and we are going to hear a lot from Salford and there is more than Salford within the NHS; that is, where is the direction? Where is the leadership? Where is the co-ordination? Where is the motivation? What is the environment in which you are working? The capability within that organisation? These are the things that we missed and sadly none of these are sexy enough in Whitehall to make that happen. How do you come back to the business units and really drive that?

When you talk about leadership, there is plenty of leadership and not just in this room, who are the enthusiasts who are here and really want to learn what has happened before to improve the future. The problem in leadership within the NHS is not promoted. Leadership genes are not there and the balance between the promoters and suppressors needs to be re-balanced. That is a major challenge. Who are the role models in the organisation that I work in? Where are the skills for change? You know, I qualified from a medical school, not on this island, but I am and I do have a significantly senior role in a medical school here. We don’t produce the
new generation of clinicians, whether they are doctors and nurses, who
do actually have the skills for change. We take the most creative group of
people into our medical school. At the end of that pipeline they are
robots. In many ways we are doing something to these people in which
their creativity is not really translating or promoting their leadership skills.
The understanding of the system, the conviction that is required and that
– I’m sure David will tell us – is what he has achieved to do in the Royal
Salford. What are the reinforcement mechanisms in really promoting and
really encouraging that leadership at a local level?

The other issue you wanted me to talk about is innovation. Now in 1998,
1997 – is it 2007 when I went to the Department of Health, the word
‘innovation’ wasn’t in the taxonomy of the DH. There was some lady who
was recently appointed, her name was Sally Davies at the time, and she
was completely isolated. There was a ring-fenced budget given to her and
she had to manage these noisy people called ‘academics’. Brave lady,
who actually transformed the whole funding of research and created the
National Institute of Health Research, but as far as the DH, as far as the
rest of the DH, that was ‘innovation’, which was in many ways a complete
lack of understanding that she was actually funding research; she was
there funding new scientific discovery; she was out there trying to fund
and successfully did ten years down the line – in translating new
discovery into evidence.

But the challenge remained, despite Alan Milburn’s probably most creative
arm’s-length body created at the time which has been criticised this
morning by many, many doctors - the National Institute of Clinical and
Health Excellence. It again reinforces the mechanism; having an
organisation like that, out there, high up, will stimulate the clinical
community in translating that evidence, which was coming out of an NIHR
inter-clinical practice. That didn’t happen. Sadly, it happened in the wrong
places, which were technology assessment and all the rows in relation to
NICE.

So innovation was, how do we translate that hugely extensive evidence
that we have into clinical practice? That remains a challenge and may I
just say that remains a challenge in all health care systems across the
globe. In health, for all sorts of reasons, the uptake of innovation,
whatever it happens to be, may I just say, including the exemplars from
India, which could be a simple process innovation, is to create health or
economic value. We are not very good in doing that and we know that.
There are some system elements in that but there is also some business
units element in that and we need to work on that and need to find again,
like leadership, what are the promoters in which we will encourage
innovation?
I think in many ways, at a time of the economic climate we are living in, innovation is the only solution we have to survive in this new era in which we are not going to see the growth that we have seen before. I think innovation in that document, which clearly makes the case that hasn’t really helped the NHS in its reforms, is very important. So how do you make that happen? It is actually probably in itself a major scientific discovery that needs to happen here. I think we tried to address this – I think Greg Parsons is here. He designed an index called the ‘Global Diffusion of Healthcare Innovation’. He looked at the number of enablers, things like vision and strategy, and we have had a lot of visions and strategies in this place; we looked at the incentives and rewards. I think we have worked reasonably well with some of the incentives, but I think there is significantly more work that needs to be done.

To be fair to Andrew Lansley, one of the things he was pushing for was the alignment of incentives; funding; the transparency in evidence, again using the competitive nature of clinicians in driving the uptake of innovations. I think the bit that we don’t do well - and we have surveyed eight different countries to look at this and certainly the UK wasn’t on the top list – I think it was certainly one below the bottom, the biggest challenge we have had is what Greg described as the ‘cultural dynamics’. I think Stephen Dorrell was there at the panel discussion when this was presented in December of last year, are we harnessing the efforts of patients as co-producers of care? Are we addressing the concerns of the healthcare professionals? When it comes to outcomes, a safe sustainability, are we freeing up time for people to be creative and translating that? So there’s a lot to learn as well in this new world and how to drive innovation.

So to summarise, I would not be as negative as if you read between the lines in that report. I think what happened about 2000-2001 and the NHS Plan - you have to remember was the first attempt. You have to acknowledge Ken Clarke’s efforts here as well a few years before in getting a system in the NHS. I think it was the right thing to do in the right time, but I think we missed many, many other opportunities and the clear message here is another system reform is not going to address those. There are completely different sets of challenges that need different sets of solutions

Thanks again for having me.