Interview

Dr Hilton Dixon, Clinical Director of the Darlington PCT and County Durham PCT was interviewed in October by the Editor.

Ed – Thank you very much for agreeing to be interviewed. Can I start by asking you to tell us a bit about yourself and where your roots are?

HD – I was born in Carlisle in 1951 and went to the local grammar school. I wanted to be a doctor from quite a young age and I think my local GP Patt Honeyman was a significant influence - and always has been - on my professional career. He was a patient-centred GP and had a significant influence on my choice of career as a GP.

Ed – Was there anything else that you ever seriously considered doing?

HD – Well I suppose if had any other alternative it was classics. I never seriously considered or wanted do anything else but if I had a choice that would be the area - I did classics at school in my early years.

Ed – So you would know that the plural of meatus is not meati!

HD - I went to Newcastle University which I enjoyed and had a great time. I did a BSc degree in anatomy. That involved a bit of research and I thought when I finished my research that was the end of that. I went back to Carlisle to do my vocational training on the East Cumbria scheme and my training as a GP in Keswick where we really had a lot of responsibility with the cottage hospital. I was very fortunate to work with a lot of the senior doctors and consultants who were interested in people - I had a wonderful time as a trainee GP. I worked then with two enthusiastic GP trainees Roger James and Trevor Birniewho were a couple of years ahead of me. I wanted to find a practice that was progressive and innovative and wanting to make a difference, so at the end of my vocational training I found there was a job advertised in their practice in Darlington - I applied and was appointed and that is how I started in Darlington. The practice soon became a training practice.

Ed – Can we go back a bit? You said that you never seriously considered anything other than medicine - would you say that you never seriously considered anything other than general practice?

HD – I had an interest in neuro anatomy and neurology and that was part of my BSc. I suppose one of the options would have been to do neurology but at that time there was what was called "Walton's muscle mill" which you had to go through at Newcastle to become a consultant. I had already made my mind up that I wanted to be a GP, but neurology was interesting as I was interested in the structure of the brain.

Ed – Do you want to tell us a bit about the research that you did during your BSc?

HD – It was neuro-anatomical research - looking actually at brains in monkeys and cats and experimental neuro-anatomy with a chap called Geoffrey Pearce. It was interesting stuff. So neuro-anatomical research is what I was doing - which was interesting. I had to write a thesis and I was very glad to see the back of that at the end of the year, but I enjoyed doing it.

Ed – So you changed that into a PhD?

HD – No the BSc was a taught module plus a research dissertation that was for a year.

Ed – How important is it in medical training that students should be given some real science rather than just the technical training of being a doctor?

HD – I think its horses for courses. I think that there were not that many of us who did a BSc - perhaps about ten in our year, I did it specifically because it was neuro-anatomy. I think people need to have an understanding of research methodology as part of the under graduate process. I do think that people need to understand the basics of scientific method so they can critique evidence to make an informed decision as part of our professional practice. There are implications sometimes where, for example in an individual patient NICE guidance is not necessarily followed, but you have been able to justify why that isn't followed. Therefore understanding and ability to interpret research findings I think are important. Whether you have to do research as part of that I think is a different question but understanding it is important.

Ed – So you found yourself doing General Practice in Darlington and you were one of the early fund-holding practices?

HD – Yes, I saw fund-holding as an opportunity to improve quality of care. I was conscious that we wanted to get open access for physiotherapy and ultrasound etc, which fund-holding did allow us to do. It also helped other practices across the patch, so we actually had a catalytic effect although fund-holding wasn't popular in Darlington. We did actually come out of that with open access cystoscopy because our savings contributed to the purchase of a cystoscope for urology and a hysteroscope for gynaecology. So there was a difference made for the patients in Darlington as a result of that. Obviously, that transformational change was difficult for the Trust and we changed some referral pathways for investigations locally where it was clear we were not going to be able to get the access we wanted. But our local Trust did actually come on board very quickly and recognised the fact that we were interested in improving quality of care for patients.

Ed – And does the current arrangement with PCTs and so on, owe rather more to the experience of fund-holding than one might like to admit?

HD – I think that's a political question! But the benefits of fund-holding were not lost completely. It was on a relatively small scale but there was very strong evidence base on fund-holding actually driving improvements in care, and I believe that was recognised by the government. Obviously for a whole variety of reasons replication of fund-holding was not an option when there was a change in government. But we are beginning to see some of that opportunity which is commissioner-led through PCT's, but it requires clinical leadership at the heart of that process. That's a strong ethos within our PCT that clinical leadership and engagement are important if we are to improve our health equality and life expectancy - which is a challenge in the North East.

Ed – When you commission from the secondary care sector how much input do the clinicians working in secondary care have in decision making?

HD – I think that is going to be increasing. I think there is wider answer to that question. It is about the clinical involvement in commissioning. We are moving from a situation of a large amount of care being delivered in secondary care to more care being delivered in primary care and therefore we do need clinical engagement across many

more areas in secondary care. Increasingly I would wish to see more engagement of secondary care in the commissioning process. It is a developing and deepening development within the PCT that we want to embed this as part of our process.

Ed – Do you think we are going to see any polyclinics in Darlington or Durham?

HD – Obviously we know that everyone has got problems with the word polyclinic. But there may well be a situation where we have a number of services in a specific building specifically delivering the care that's required but I would have thought that the word polyclinic would be a term to be avoided. I don't think anyone really defined what a polyclinic was - it just appeared to be a large amount of clinical services in one specific spot. I think we really need to deliver what people need and where they need it - whether that is in the hospital environment or in a community hospital or GP practice - that would be my approach.

Ed – On a more personal note, you are clearly spending a lot of time on medical management. Are you still a proper doctor and do you still do clinical sessions?

HD – I spend one day a week as a GP. I have always felt that if I were to do this job I would still have to remain grounded in my own clinical practice, particularly as I enjoy it and derive great benefit from regular contact with patients, with primary care and other GPs.

Ed – So you have never been tempted to become a full-time manager?

HD – No, it's a difficult job for four days a week as a clinical director of two PCTs and to serve as a GP. But I would lose something, not least a degree of credibility among my fellow clinicians. I am conscious now that I am clinical director – which is a more inclusive role - not a medical director. A medical director suggests that actually this is only about doctors … clinical services are about clinicians.

Ed – So you don't have a separate medical director?

HD – Not a separate medical director no, but my deputy clinical director is a GP and we have a number of other GPs involved who are now clinical champions which span the range of clinicians – GPs, pharmacy, dentistry and other health professionals.

Ed – You mentioned two PCTs - are Darlington and County Durham still strictly speaking separate PCTs?

HD – They are separate statutory organisations but we have gone through the process of "commissioning provision split" whereby County Durham PCT will commission services on behalf of Darlington PCT but Darlington PCT are providing services as a provider arm across both County Durham and Darlington. It is an arrangement by which obviously as commissioner, Darlington PCT will hold us corporately to account for our commissioning on their behalf and obviously we will hold Darlington PCT to account for the provision of the services that we commission from them.

Ed – But are there two separate boards?

HD – Well there are two separate boards and the only two people on both who are Tricia Cresswell (Executive director of public health) and I - as Clinical Director for both PCTs.

Ed – So you sit on both boards?

HD – Yes.

Ed – Is that sustainable long term or will there be a formal merging?

HD – The answer is I don't know the answer to that! The present system we think is

working OK. Both boards and directors are working closely together to ensure that the system actually works and I think that the processes we have in place are robust. But it has been a difficult process trying to ensure that we retained our primary functions.

Ed – So has this model that has been used anywhere else?

HD – I don't know. Other PCTs have done different things. Some have transferred their provider arm into an acute trust. So there are different models but the principle is to separate the provision from the commissioning part so that we can allow the market to be opened up. We have to ensure that there is choice and competition. Difficult - and it has been a challenge - but I think it is there.

Ed – So if I were to ask you to look into your crystal ball what do you think the configuration of medical services in this part of the world will be like in five or ten years time? I will not hold you to it!

HD – That is very difficult to say. There are questions I think for providers to look at. General practices by and large are too small. We are in a world of big providers, big foundation trusts, so if we want to move services into the community we need to look at new models. Certainly the Royal College of GPs have looked at the federated model. The silos of working we have had between primary and secondary care will be broken down and I would absolutely support specialists working more in the community and that may well be the consultant or a GP specialist in a community environment.

Ed – So have an out patient clinic in a general practice?

HD – We have been there before but it is important that it is needs-led not just simply ideas-led - the relationship needs to be evidence-based. If we do it, let's evaluate it and see whether it is delivering what patients need. I also think the integration between health and social care is something that we have got to look at. There is a difference in life expectancy of 12 years for men between the most deprived and most affluent wards of Darlington and actually that's got wider - we have allowed this to happen. We need to look at processes and services in a different way. So I think care closer to home and the involvement and integration of services on the basis of need is a real opportunity for hospital-based clinicians working more closely with primary care.

Ed – Do you think we will have a breather from mergers or are they any further mergers or reshuffling?

HD – I think we need to settle down to allow changes to embed and allow clinicians to begin to take a greater leadership role. So we can then have a situation where we start thinking more locally. I think a central approach to healthcare has at times been necessary to change the direction in terms of the process. But it probably has gone on too long and now needs to be a bit more of a locally-driven process with time to embed.

Ed – Do you want to tell us a bit about yourself and what you do other than being a doctor … what interests you?

HD – My interests include skiing, fishing, walking and maintaining contact with the family. My wife Anne is a GP in Darlington and we have three children: one is a doctor working in New Zealand, one involved in computing and working in Bristol, and our daughter is a Physio working in Swansea. So they are not local, but we try to make sure we see them often and keep in contact.

Fishing - sea trout fishing, fell walking in the lakes and skiing - obviously in the

winter; I don't do enough of it!

Ed – So where do you ski?

HD – The French alps is where we usually go. Fell walking in the lakes - I have done all the Wainwright walks in my time. Fishing - up to my waist in water, usually late at night!

Ed – So you have not been Munro bagging?

HD – I have done some Munros but I don't really have the time to do it. There's an awful lot of them and you wonder if you'll live long enough to complete them!

Ed – Do you have any more ambitions or is this it?

HD – I don't know, I never had a career plan as a GP, I never thought I would be a trainer, but we needed another one in the practice and I decided to have a go at it. I suppose in terms of my career path the real difference was becoming an examiner for the Royal College of GPs which made me retake my MRCGP exam. I think my leadership development began then. I remember when I was an examiner thinking "I wonder what the background of all this testing is all about?" I was fortunate at that point that there was an education research fellowship provided by Newcastle University which I applied for which was a taught doctorate over five years. I can remember being fascinated by issues of assessment but I didn't understand all the underlying background and the research processes. There was a great degree of debate about assessments - how we assess doctors, what we assess doctors, are the present processes robust. There was a lot of debate about all that and I found it a really interesting process and my research basically was on what should the assessment process be for the GP registrars completing their vocational training. That's how I developed my expertise in assessment because of my role and I found it fascinating so I ended up back in research at the end of my career having thought I had finished right at the beginning! When I finished at the end of 2004 there were no other avenues and I thought 'what do I do with this?'

Ed – This was for an MD?

HD – Doctorate of education in Newcastle. There was no obvious avenue at that point so I thought 'let's just see what happens' - and then the medical director role came up! Basically I was approached because I had been involved in the PCG and in the PCT. That was a time when clinical leadership really was a big problem and the PCT felt different to the PCG where clinical disengagement was happening. I was appointed as Medical Director three days a week, resigned as senior partner in Denmark Street, began to work one day a week as a family doctor, three days a week at the PCT and I wanted one day a week for me. The great bit about it was that, all of a sudden, having thought that my involvement in research was not going to be developed further, the R&D part of it was in the portfolio. We were about to enter into an agreement with Durham University to commission a research and evaluation unit. Greg Rubin who is the Professor of general practice in Sunderland and was appointed to head the unit.

Ed – This is with the Medical School?

HD – Well it's in the Wolfson unit. But actually a specific area needing research and evaluation is our commissioning process: does this newly commissioned service or pathway or whatever - does it work? Does it deliver value for the patient? Does it actually deliver better quality care, is it safer? And that will actually be a combination of quantitative and qualitative research. This goes back to our earlier discussion about

medical involvement and understanding of research methodology. I think this is a critical role because providers of services will have to challenge themselves to ensure that they are delivering what commissioners need.

Ed – Will you yourself be doing some research?

HD – I'm still doing a bit of research. Because I am still involved with the College exam, we still undertake research projects and I am still involved in that a bit. What I want to do now is to facilitate research and see it embedded.

Ed – So as an examiner, do you need to travel around the country a great deal?

HD – Because the exam now is based in London, the clinical skills assessment which I have done is very time-consuming but I am involved in the construction of the knowledge test. We meet three times a year - producing questions and being challenged on our questions. It is very healthy the way that we actually do business and is greatly refreshing for me. I am very realistic about the fact of what I can do as it is a very challenging job.

ED – So you don't think after you retire you might do a classics degree?

HD – No, I don't know what I'll do … I think it's more a question of what my wife asks me to do! I honestly don't know - I do believe we have to embed where we are now as it has been a very difficult process over the last few years and we have to have better clarity, where we are going and it isn't easy. I think I have plenty to do for the next two or three years.

Ed – So you think you will retire at 60?

HD – My personal view is that I don't think I should be doing clinical practice beyond 60. We are in a rapidly changing world. Other doctors may be able to keep up beyond that by doing a day a week. I will be sad to leave clinical practice but I think there is a reality that people need to understand how long they want to go on with that level of pressure of the job, that's my personal view.

Ed – I haven't asked you about the gramophone records you would take to a desert island, but if you had just one book what would it be?

HD – I would like to take seven books - the Wainwright series - so that if I was sitting in the sunshine on a desert island a long way from the lakes, I could at least capture a lot of the lakes and they would take me back with my imagination to my experiences of walking in the fells.

Ed – Should we try and find a desert island with some fells?

HD – Yes preferably - it would be very large one I think!

Ed – Hilton, thank you very much for talking to us.