Interview

The Professor Lord Darzi interview

Interviewed by Paul Thomas (Editor in Chief)

PT Today is the 13th of November 2014 – I'm Paul Thomas, the Editor of the *London Journal of Primary Care*, and I'm here with Professor Lord Ara Darzi who has agreed to update his vision for integrated care. Good afternoon Lord Darzi.

AD Good afternoon Paul. Lovely to see you again.

PT Well, a lot's happened since your *London Journal of Primary Care* interview in 2008, in which you described your vision for integrated care and personalised care. Now, 6 years later, everyone seems to share that vision – the 2012 Health and Social Care Act, the 2013 Francis Report and the 2014 Care Act all point in this direction. You must be very pleased with the sea change in policy?

AD I am pleased, in many ways in terms of policy, but I'm also saddened that we didn't take that opportunity in 2006 to accelerate our efforts in London to make it happen. In many ways over that period of time I feel that care has become even more fragmented and I feel the challenges to primary care itself have become significantly greater: in terms of its structure and its processes to facilitate that vision that we came up with in the London Framework for Action in 2006/07. I'm pleased that there is a bigger consensus, but at the same time, I think we missed an opportunity. We could have been in a better place.

PT So why do you think that opportunity was missed, with hindsight?

AD A number of factors I think. You always start by appraising whether you did the right thing. I think we did do the right thing, I think we badly communicated the right thing. Despite our engagement with the primary care community, I think somehow there was the perception of a threat rather than an opportunity and we failed to recognise that early enough and explain it as an opportunity rather than a threat. I think, sadly, it was interpreted as herding primary care physicians into one large building, when, in actual fact, that wasn't the case. We were just making the case, even in 2006, that we needed a better population approach to healthcare delivery, and primary care should lead population health.

PT But the sea change in thinking is enormous – the counter-argument would be that 8 years is a

natural, or even fast, timeframe for such an enormous change in ways of thinking.

AD I agree, absolutely. Policy is no different than a new drug or a new innovation in devices – it does take time. It takes time to get through that innovation pipeline, for people to realise that the only solution we have in terms of managing the burden of disease that is facing us – as well as the burden of health inequalities here in London – could only be delivered through a much more integrated approach to care. That integration doesn't have to be structural integration or organisational integration.

PT You say that you've seen increasing fragmentation in the last few years. Can I ask you in what ways you've seen real improvements in relationships? What things over the last 7 years have given you hope?

AD There have been huge improvements in many areas and I think London has a lot to celebrate. The ones most commonly reported are the classical ones, such as stroke care and its impact: again, if you look at the preventative side of stroke care – setting up TIA clinics in the community, having open access to TIA clinics, the comprehensive stroke centres – that's been a huge success, saving 200–250 lives a year. I think we've also seen this in trauma, in terms of secondary care provision, and I think we've also seen it in primary care. We've seen wonderful examples of more holistic approaches to care, but most of these have been based on local leadership – GPs [general practitioners] who put themselves above the parapet and take risks, who go out and look at the patients that are facing them and find solutions based on these patients' needs. There are numerous examples of that in London, and this is the right way of doing it – it's grown from the bottom up, rather than needing help or support from top down.

PT Does that include real improvements in relationships? Integrated care implies that people have better relationships – doctors with patients, doctors with doctors, doctors with nurses. Have you seen a real improvement anywhere?

- AD I certainly have. I've seen it here in West London – there's more trust and more social capital between the different constituents, and there's certainly more engagement, and talking and I think action as well, between primary care physicians and those in secondary and tertiary care. There's something good to be said about commissioning at a local level. The organisations that have matured, become good CCGs [clinical commissioning groups], have achieved that through building social capital. But it's also interesting because one of the drivers for this is that people are united because they feel they are facing the same threat. Their finances are tight, and it's taken them about 18 months to realise that, in actual fact, there's no point looking 'up' because there isn't a structure up there that's going to coordinate them. I think that in itself – that vacuum – has made them think 'Let's just get on with this, because ultimately the accountability lies on our shoulders. Let's come together and forget about the dividing lines [which have been historically budgets or organisational structures] and let's think through how we can come together based on the trust that exists between us, which drives improvements at a pathway level.'
- PT You're suggesting there that there are mechanisms at hand that help people to build trust and come together.
- AD What enthused me is that there is a lot of dialogue occurring at that level between different groups. There's a lot of disclosure happening. There's an openness and a transparency between these groups, who are historically very suspicious of each other mostly because of budgets being taken here and there. I also think people are a little more united in terms of what are the metrics in looking at the health of the population and the quality of the care that is being delivered. People are more open about this and having more appropriate dialogue.
- PT So repeated discussions with people from other disciplines and other parts of the system, especially if they can look at metrics for their work, provide a formula for building trust throughout the system?
- AD Absolutely. The successful groups that I've seen have put a huge amount of effort into identifying the risk component of a population, and using that information and data to create registries, look at misaligned incentives, look at the budgets and how they could pool to achieve a better return on that investment than merely individual contributions, and continually measuring throughout. I think some of them are closing that loop, by continual measurement so the system knows how wonderful the end product of continual improvement is.
- PT And presumably, if that learning cycle is one that repeatedly works, we could become increasingly sophisticated in applying it in different kinds of places.
- AD Absolutely. And the other thing which I've picked up in the areas I've seen it work is there's a lot of role-modelling – people are becoming role models and primary care has taken a huge leap as a result. That role modelling is infectious – people don't want to be left out.
- PT Do what I do and not what I say....
- AD Correct.
- PT You've recently chaired the London Health Commission for the London Mayor and produced a far-reaching report 'Better Health for London'. Tell me about that report and how it fits with the Five Year Forward Review.
- AD That was something the Mayor asked me to do. It was actually five years since I stepped down as a health minister, and I promised myself I wouldn't do any more. But he was very convincing. And I truly believe that the Mayor, in actual fact, is accountable for quality in health care as a whole, within a national policy of devolution and devolving powers. I thought that the Mayor could play a convening or enabling role. I'm not talking about the old strategic health authority here, I'm talking more about a leadership role that pushes for London and fights for London. So I agreed to do this. As you may have seen from the report, even the title of the report, a significant chunk of it is about attacking the public health agenda. The health inequalities in London remain a major challenge, and I think that's an area that I don't believe we have improved. I remember the old Jubilee Line life expectancy between Westminster and Canning Town, which was frightening when we looked at that around 2006/7. Although people do say that has slightly improved, and it may have, I think there are other areas of health inequality that have drastically gotten worse. London has become the number one global city for obesity in children – 40% of our kids by the time they've finished primary school are either obese or overweight. Sixty-seven kids a day – that's two classrooms of children – take up smoking. That really prompted me to come up with some well-evidenced, tried and tested sets of policies that I think the Mayor would be brilliant to lead on with Public Health England, supported by the local councils and the 32 CCGs. There are certain interventions that we need to undertake at pan-London level and others which are more relevant at local level. So, we've put in a framework for better co-ordination of these different activities to address the public health crisis facing London.

PT Let's just spend a little time looking at those two issues – inequalities and children – as exemplars of the huge number of other issues in the report, which by the way I find to be very impressive. Now it may sound absolutely self-evident, and I'm sure it is self-evident to our readers, but why do inequalities matter?

AD They do matter – this is the greatest city in the world and the last thing we want to see is a city of this size and global contribution having these major economic and health inequalities. These children, 40% of whom are obese or overweight, are the future of London and we need to tackle this head on (let alone the humungous cost associated with the burden of this). These kids are the future and we need to invest in the future of London.

PT And I suppose the more there is a gap between the haves and the have-nots, the more difficult it is to build a sense of community spirit and integration of effort.

AD Absolutely, and that's just the physical side. Let's not forget the mental health side of this, or the social care side of this. I think this is the first time I remember confidently with this population segmentation work we did, which made quite a strong case for children, that a pan-London approach to dealing with these big serious public health issues may become a reality.

PT You've mentioned a bit about children and about an obesity epidemic, and I noticed in the document you focused on parenting skills around the age of 3. Could you say a little bit more on your thinking about how schools, parents, society and general practice can help improve the health of children?

AD There's no question that all of these stakeholders you mention are unbelievably important. You firstly start with the families – there are vulnerable kids out there, and we know approximately two and a half thousand families we can help and support. We can make a huge difference and we know this. Where does the mother get an intervention? There are plenty of wonderful studies done in the US with grandparents being facilitated to intervene, support mothers and help bring up kids, but also much better structured support for these vulnerable families that's extremely important. I think we need to intervene at a school level. Ofsted should rate not just the curriculum and quality of teaching, but also their health and well-being agenda for the kids. I run a global health event which next year is in Doha, and we have a forum about well-being in children and the role of schools. There's something going wrong in schools and this needs to be tackled with the families on our side.

PT I guess that schools are also potentially quite a good place to convene community development and parental support.

AD Absolutely. Then obviously you have the role of the [National] Health Service, with primary care being the first contact, as well as the contribution of primary care to the preventative agenda. Then you have the local government – what are they doing? I've raised the issue of sugar tax, which I don't think is feasible to introduce in London alone – otherwise you're going to get sugar dens around the M25. It needs a national policy. I know that this is politically sensitive, and understand there are some ideologically driven thoughts and talk of the 'nanny state', but I also understand we have a public health crisis here and children are the ones who cannot make that choice. I think that's why I'm very tough on junk food outlets – it's ridiculous to be having 42 of them in Tower Hamlets surrounding one school. I don't care about 'nanny state' here – we have to intervene and take action.

PT If you can't help people to make healthy eating choices, you aren't really doing your job as a health service in my view. Let's explore a little bit then: you were talking about the role of general practice and the role of local authorities in public health. Could you tease those apart? Maybe talk about general practice first.

AD Ultimately, the contact on an individual basis – or even potentially at a population base – is your primary care physician. That is the person you listen to and take advice from, with the local government there to enable and support you. They have to have the funding for this, they have to have an effective health and wellbeing board and some of these are maturing and working exceptionally well. That interaction with the primary care physician, your GP, is a very important part of the delivery of the public health agenda and the purpose of this report is to raise awareness that primary care is probably the best vehicle for these sorts of interventions, and we need to maintain that.

PT Whilst I think everyone would agree that that is logical, one of the problems facing general practice is being overwhelmed by reactive medicine and demands from all over the place. How do you see that vision – general practice taking a strong role for all kinds of different groups – being practically realised?

AD I couldn't sympathise more. Even in this report, or even the previous London Framework for Action or High Quality Care For All, we are asking primary care and community services to do more and more and more, as the solution to most of our problems – lifestyle, diseases, aging

population, preventative agenda, public health agenda, whatever you can think of. And they do not have the infrastructure or human capital to achieve this. Look at some of the figures: 40% of primary care premises are not DDA [Disability Discrimination Act] compliant. Sixty per cent of primary care premises are in urgent need of refurbishment. If you look at the revenue turnout in primary care, percentage of expenditure, that has dropped by about 3% in the last 3 or 4 years. There is an incompatibility by asking to do more with fewer resources.

PT So how do we square that circle?

AD Well I think we need an investment in primary care, and that investment has to come with reform. At the same time, we need to invest in primary care as far as the human capital is concerned – we need more of a stream of GPs coming through and we need to make a huge effort towards retaining some of our GPs who are retiring prematurely. We need a more holistic approach not just to make their workload more manageable, but also increase their confidence in the service – if we don't have the human capital here, there's no point in spending a billion on infrastructure. The two are important, but we need to get the diagnosis right and support the primary care community. A £1 billion capital investment in primary care is the equivalent of one of the four or five major PFIs [private finance initiatives] that have been done in London; but 80% of the interaction between Londoners and the health service is through primary care. So through the cost of one PFI you can improve the interaction between primary care and four out of five Londoners. That is an amazing thing and I very much hope that the government makes that investment.

But capital infrastructure is one thing – there's another big piece about engaging the primary care community and understanding what are the challenges in their daily lives and interactions with the work burden and addressing those two, and at the same time finding the right incentives in all the graduates coming through medical school to really identify primary care as a specialty that is promising and at the same time give more value to the role of GPs. Universities have to show more regard, honorary titles, honorary professorships should be something that we should encourage the primary care community to embrace as part of their professional development.

PT I know that in large parts of London, especially West London, practices are clustering together into areas of around 30 to 50 000 in population in order to share the load and to facilitate collaboration. What is your view on this?

AD Oh it's fantastic – that was my dream in 2006/7, but I went wrong by not describing the business model. People thought we would essentially take away their practices and put them all into one big organisational structure. Small is beautiful and I've always supported that. I work in two separate organisations: I work in Imperial College Trust, which is very big, and the Royal Marsden, which is smaller. At the same time, there are other mechanisms of bringing people together that allow for resources and energy to be pooled into different areas so that the sum is greater than the parts. I think it's fantastic to see this happening at a primary care level, and in some areas between primary and secondary care too.

PT Perhaps it's possible that these organic entities, these polysystems [also called health networks, collaborating for service provision in local health communities] could become the new 'cell' – a 'village' where people focus their creative energies for collaboration of public health.

AD Absolutely, with their own energy. If you have a strong wind behind you, which is what they have, you don't need the engine.

PT If general practice is clustering into these little 'villages', is it the case that local authorities and public health can join to the same boundaries and work the public health agenda from that place?

AD I have no doubt – again, for the first time ever, I've done a report where I've really appreciated the importance of local government and its role. They were extremely engaging throughout, and I think they also realise the huge potential of co-commissioning certain services together and looking at the provider end and how to re-engage different ways of delivering that public health agenda. To answer your question, yes, certainly.

PT So how can that work in practice, let's say, for example, for diabetes care? You've got public health local authorities working with CCGs for co-commissioning, and GPs in clusters of 'villages', how might that pan out for diabetes care or indeed another long-term condition?

AD It would pan out by looking at the patient pathway, and I think what's missing from that is how do we repatriate many of the patients who are currently being treated at a secondary care level to treatment in primary care? Ultimately, what unites groups together is the patient pathway and looking at the evidence-based interventions along it, seeing if they can pool their budgets together and intervening – thus avoiding duplication. Duplication is occurring at significant cost. And I think everybody knows that the reason is that there hasn't been the dialogue we have had recently. In some places, that dialogue is very refreshing as people come together and work

together. But in some places, there is nothing. We need now to help peer pressure and some degree of convening powers such as the London Health Commissioner to help bring groups together to align their intellectual and financial resources.

PT I would expect in the doing of that, that specialist care can give more timely support to primary care and locality-based diabetes care, avoiding duplication and also making people feel more supported.

AD Absolutely. Certainly statements coming from the centre, like Simon Stevens' report on co-commissioning, seem to have led a lot of people to think 'Oh!'. It's one of these things in life – some people might have been waiting for permission; I think the clear message here is – 'Don't wait for permission; ask for forgiveness'.

PT You're painting the image of a very dynamic inter-relationship system where everyone is contributing in ways they can. And yet most people are used to more static, structural, bureaucratic solutions. Where are we going to look to, to understand the science of this more horizontal way of working?

AD Well, I think it's a good thing that people are starting to reclaim the freedom at a local level and do what they need to do. It does take time if you have a top-down system that's been there for 66 years to let it loose, and for people to build confidence to leave the cage. And I think that is happening. I think the science of horizontal integration is the science of incentives and alignment, leadership and co-ordination, innovation and the metrics of what makes a local organisation healthy. We know how to measure this and we know how to enable it. I think that is something that should be properly done at a local level rather than a national level. We need to identify who are the role models, who are the leaders, how do we empower them, how do we make them take risks and get on and do this? I know, for example, that what primary care and leadership did for some of the reconfiguration challenges in North West London was amazing.

PT Are there any particular organisational forms that we should be learning from about how to perform this local relationship building?

AD There are many organisational forms that people have described and there is plenty of literature about this. I think if you don't get the essentials of bringing people together, identifying what the problems are and having a strategic vision, then nothing works. Ultimately, we're trying to do something at a pan-London level. 'Better Health for London' for the Mayor. But I think at the same time, what is reassuring is that different communities in London are undergoing the same

process – they have their shared vision, they're coming up with their own local strategies, they know their population and the challenges they are about to treat, and are realising that the only way to treat this is by working together towards the same goals.

PT So that kind of organisational learning – this mutual, engaging kind of concept, has been around for a long time. But it has tended to operate at the margins. It may be that we need to start learning from these existing models for the next stage of development.

AD Absolutely. And there wasn't previously the freedom to do it. When you have a system designed to receive commands from higher up, you don't necessarily focus your own creative mind on how other organisations could come together. I think there's still some spicing up to be done in terms of accelerating that process, and the first movers are always just that – first movers. The diffusion of any innovation starts with its champions, but there remain other areas of London that need to be stimulated and driven forward. I very much hope some of the recommendations in this report will at least facilitate that.

PT So if somebody is used to looking up for the person who's in charge, and if that isn't to be the model going forward, where should people look for this form of leadership?

AD I think they need to look out towards their customer. There's plenty of leadership in London, plenty of leadership in primary care and the community services. People need to be supported, empowered and in many ways also enabled to get on and do these things. There's no shortage of leaders and I think there are many other organisations around – we should mention the colleges for example, the RCGP [Royal College of General Practitioners], the LMC [Local Medical Committee] and others, who really have a stake in this, to engage and identify areas that may need a bit of an 'oomph' to get things up and running.

PT I'm hearing from you a whole set of overlapping networks of people that are contributing to policy and supporting each other in a very profound way – networks of relationships that could be quite effective in reaching many different people. Do you have any more thoughts about how to practically achieve that without everyone falling over each other?

AD I think ultimately what unites people is knowing either the metrics of the burden of disease or the outcomes of care, and having a more transparent nature of that. I'm yet to come across clinicians involved in healthcare delivery who will ignore that – it's what brings us to work. If we start with that, and put the patient at the centre of that, then

I think everyone will unite around that very clear patient need and very clear, transparent set of outcomes. I think that will probably be the engine that will get them to work together and develop some of these networks.

PT So by repeatedly coming back to individual patients, care plans, care pathways and outcomes, those are the 'grit in the oyster' if you like.

AD Absolutely, that unites people. If we start talking about back office functions and finance then we won't get anywhere. Targets? It won't get anywhere.

PT Lord Darzi, you've given a very far-reaching vision for the future, which I'm quite sure readers of London Journal of Primary Care will warm to. Are there any messages of any kind you would like to put into this interview so that they can hear your views about anything else?

AD Well, just to say there is a huge amount of work that needs to be done out there in London. I very

much hope that this strategy is a very small contribution to that, and I very much hope that primary care will continue its leadership and try to address some of these major issues that are facing us. I would also very much hope that we do not have another structural change within the NHS, because it's the time for transformation – forget about the structures.

PT Continuous improvements, building one stage upon another.

AD Absolutely. That is called transformation. That is when you need leadership, you need vision, you need risk taking and innovation, and that's what we need to focus on.

PT Lord Darzi, thank you very much indeed.

AD Thank you.

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