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Interview

The Professor Lord Darzi interview

Interviewed by Paul Thomas (Editor in Chief)

On 23 April 2008, in London, Professor Lord Ara Darzi (AD) was interviewed by LJPC editor Professor Paul Thomas (PT) about his vision for primary care in London. This is a transcript of the interview. It is also available as a podcast.

PT First let me ask a bit about you. What experiences have informed your thinking about a good health care system?

AD I qualified back in 1984 so I've done more or less 28 years. I qualified in 1984, then I started my post-graduate training back in Ireland. I did my higher degree in Trinity College. It was part of the Irish tradition to gain further expertise by going abroad – many came to the UK because the NHS did provide something very unique, not just in surgical training, but also to see the whole health care system, being much larger and much more complicated. It certainly had very unique characteristics that the Irish health care system didn't have in those days. So I was here for about a year or eighteen months. Then I worked in an organisation for about a year as a registrar, and recognised that we were going through an interesting evolution in surgery, which is moving from open surgery into keyhole or laparoscopic surgery. There was tremendous excitement about the potential of keyhole surgery to reduce the physical and psychological trauma of surgery. But on the other hand, there was significant resistance from a large number of very senior colleagues, some of them were actually my tutors who said that this should never happen because it is bad for patients, and no good for surgery. So I remember this as being my first interaction with resistance to change. We could see on one hand some of the advantages from the patients' perspective, but on the other hand we were much more resistant to that change as a profession. So anyhow, I was very fortunate that the organisation I was working in, which was actually a district general hospital in Park Royal, which was looking after a very deprived population – a tremendous amount of inequalities there – approached me to become a consultant surgeon there. I worked there for about a couple of years as a consultant, which was most enjoyable and gave me tremendous access to not just what secondary care is, but more importantly, when you work in smaller DGHs you see tremendous interaction between secondary care and primary care. Because it was small, because it was a small community. I remember a patients' pathway in those days between primary and secondary was much more streamlined than what it is now. It was not uncommon that I received one or two phone calls a day from a GP colleague saying, 'I have a patient, this is what's wrong with them. What do you think? Would you want to see them tonight? Would you want to see them tomorrow?' So that's my experience about primary care in the UK.

PT Were there previous experiences of health care systems before you were qualified that gave you insight into the primary care arena, rather than the specialist arena?

AD Yes, in my undergraduate years I had a lot of exposure to primary care in Ireland. What's interesting is that some of my best mates at undergraduate school ended up being GP colleagues, and they're actually the most gifted and brightest in the class. I probably didn't entertain the idea as long as I should have, but I kept in touch with them. In those days getting through your post graduate training in primary care was much quicker, so I found myself as I was trying to apply for my registrar jobs, some of my colleagues became partners in primary care in cities in Ireland. So I've had a lot of exposure to that, yes.

PT From a GP's perspective the diseases that people have, and their treatment, is only a tiny and not necessarily the most important part, of the role. People come in with a whole mish-mash of life problems and part of my job is to help them tease those apart and to help them work out what is medical and what should not be medicalised. I think that a concern from the primary care sector about you leading this is your lack of experience in this area. How would you respond to those critics?

AD I think I've got to be even more explicit than what you've been. Primary care is a very holistic way. The best primary care provision I've seen, whether

it's in this country or elsewhere, is this holistic approach to care. It's not just health care. It is health care, social care – all aspects of care that a community needs. So, primary care's relationship with its community is very different than any other health care provider that you can think of, whether in this country or outside. That is the essence. That is the significant part of the purpose of primary care provision.

The answer to your second question is very much reflected in the complexity of medicine and health care. Who should lead a health care review? Should it be a surgeon? Should it be a GP? Should it be a neurologist? A specialist physician? Should it be a nurse? Should it be a midwife? I just happen to be extremely fortunate to be in the position I am in. It's a privilege to be asked to do something like this, and so that's the reason I've committed myself to do this piece of work. I think ultimately you need to ask 'what is the purpose of all of us who work in healthcare?' What we are trying to achieve here is to improve the quality of care to the patients we serve. That is what brings us together. Once we start saying 'you wear a primary care hat and I wear a surgical hat' then, just by making that statement, we build silos between me and you. I think most colleagues whether in primary care ... need to look at health care outside of their box. I constantly challenge myself on a daily basis to look at health care completely out of my box, because once I start looking at it from a surgeons perspective, I'm sure we won't get anywhere.

PT Intrinsic to your thinking is that we need better integration, in which local practitioners and patients work together to improve health. Both horizontal and vertical dimensions need to be addressed. What do you consider to be the main principles underpinning successful integration?

AD Well first of all let's look at the history, where we are now and where we were 10 or even 20 years ago. Thanks to technology, the advances in health care that we are seeing have been tremendous, whether you happen to be a patient on the receiving end of health care, or whether you happen to be a health care provider, providing health care. But one of the side-effects of any new intervention or new treatment as you complicate a system ... as you come into complex systems ... and healthcare I would describe as a very complex adaptive system. When you see systems like that, and if you don't maintain the purpose – and the purpose from the patients perspective is a pathway of care – then we lose sight of where it is going. They don't really understand some of these fragmented silos, because of the complexity that healthcare has created.

Quality isn't just about outcome. Quality is also about the experience of the user. If you look at the experience of the user, very clear messages are coming. When I did the London Review as a clinician, when I do the national review now as a minister I get clear feedback from patients – 'the care we are receiving is fragmented; we want more integration'. That is the challenge. The solution is different – there is never one solution to a problem; I would be the first person to admit that. And the solution should only be decided at a local level, based on local circumstances. The principle is clear – the principle for me is to achieve integrated patient centred care, which I've described as personalised care, which is care tailored around the needs of the patients – that's my definition of it. Now how do you achieve that? I think no one sitting in this department could make that happen. We can put the right levers to allow a degree of integration, but we have to remember, and I'm very explicit about this, we should not in any way change what's good at the moment. We should be very proud of the quality of primary care we have in this country. We have achieved, since 1948, a primary care provision which is actually something all of us, not just primary care colleagues but all within the health care system in this country, should be very proud of. But any system over sixty years old gets challenged. The challenge of technology and fragmentation is one. And we need to find local solutions. Solutions to vertical and horizontal Integration depend on the local circumstances. Solutions are very different in different parts of the country.

PT You highlight the important role of signposting various options for care, and also taking care of the quality every link in the chain.

AD Absolutely, it's a quality of process. Besides the quality of what primary care colleagues deliver – which is excellent. Besides the quality of my secondary care colleagues – which is excellent. And social care. It's the bits in between where there are the little holes that patients fall into.

PT Then would you also say that because there are thousands of care pathways and thousands of practitioners, the whole system may feel overwhelming to practitioners as well as patients, and we collectively need to think through solutions to that?

AD Absolutely. And what I've learnt from these two reviews that I've done in London and what I'm doing at the moment, is the value of bringing different practitioners into a room and saying, 'let's talk about any one of us who may have a condition out of these eight pathways from birth to end of life, and ask 'what is the type of care we

wish to see?' That's question one. Question two: 'let's test this against the evidence', because at the end of the day all of us who practice health care, medicine, whether you're a nurse or a doctor, there's a pool of evidence base out there. We constantly need to challenge ourselves with that evidence base, and then design the best pathway; and try ourselves to remove these, what I call, 'virtual boundaries', that actually only exist in our minds. Patients don't see these boundaries. The payer doesn't see these boundaries either.

PT That is a helpful link to discuss polyclinics. If I hear you rightly, you say that by getting groups of colleagues together to clarify what are the care pathways and ways to communicate, that is much more helpful way of doing things than when people do things individually. Also the overwhelming mass of it all would overwhelm one individual, but may be managed better by groups of people. Is that correct?

AD Absolutely. I strongly believe we must get together people from these different health care settings, which are historically built around primary, secondary, and tertiary ... and colleagues doesn't mean just medical colleagues, it means nursing colleagues. And I've seen numerous examples. I do that in my own practice now. Ten years ago we did not have a multi-disciplinary meeting once a week discussing every case of cancer which we are about to operate on. Now we do that. Something we should also be proud of in relation to the cancer reform and the cancer plan is that we are the only country achieving compliance rates of a multi-disciplinary meeting per patient discussion in about ninety-five percent of cases. I go across the Atlantic places to centres of excellence and they still haven't achieved this degree of multi-disciplinary discussions. That is one of the most refreshing things. If we do multi-disciplinary meeting, not on a patient but on a service redesign which is what I'm referring to, then you will come up with some fascinating outputs from that. And that is the process I went through in eight different pathways. Not personally, with 200 clinicians in London, some of which were eminent primary care physicians in London.

PT So let us agree that the complexity and enormity of this requires multi-disciplinary team-working. If I translate that to the primary care field, explain to me how polyclinics are going to help, because one argument would say that large buildings are impersonal; they fragment teams; they are not conductive to relationship building. We don't want that to happen – we want the opposite. We want friendly relationships, good understanding of the system, and good collaboration across the sectors. How can a polyclinic achieve the good rather bad.

AD Well first of all, I'm not correcting you, but let me put on record. Polyclinics are not buildings. Polyclinics are my way of describing integrated service provision. That is what polyclinics are. And I described a number of ways in which a polyclinic could be structured, and my small little brain came up with three models. A federated model may be best in an area where groups wish to work together but have separate practices. In other words you could have five different practices not necessarily in the same building, in a federated model. I was very very pleased to see the description of the federated model and the leadership of the Royal College of General Practice when you published three months later in September your vision of primary care, and then subsequent to that I saw the NHS Alliance and the NHS Confederation reports.

So I think what we've done is started a healthy debate, and we are also coming to the consensus of what our investment, our reform, should be in primary community setting, because, if I could take you back to your first question – you don't see many secondary care clinicians, if I'm considered as that because I'm a surgeon, actually believing that in the next ten years the biggest opportunities we have in health care is primary and community. There aren't people who will stand up in secondary care and say, actually, 'it's not where I'm working, it's actually out in primary care settings'. And the reason I say that is because I strongly believe in that, based on the evidence that I gathered in London.

When I did London it became very apparent to me, even our work in the health care system which should have been apparent to me that the biggest challenges facing health care in London over the next decade is firstly the ageing population. Secondly, long term conditions, which is the success of what we have done over the last ten to fifteen years, converting an acute lethal illness into a chronic long term condition. Third, a population that is very mobile in London. So I felt strongly, if you look at these three and the evidence base that we have, the dynamics of change at the moment, I came to the conclusion that the investment has to be in primary community settings. But again, I'd like to reinforce the point, it's not to change what's good now, it's to build what we have now, to address some of the problems we have now and potentially some of the major challenges, that if we don't sort out now, we will have a paralysed health care system, despite the massive expenditure of tax payers money into health economy, like London.

PT I hear that as a positive challenge to PCT's, Practice Based Commissioning Groups, GP's,

and all Primary Care workers, to think wisely about the polyclinic notion, as an attempt to produce quality integrated care of collaboration for the local good, and not get distracted by the idea that this is meant to be a building. Is that correct?

AD Absolutely. And I've constantly stated that in the report, subsequent to the report, and in the Health Select Committee which I attended. I feel that I've done a lot of good by starting this debate, but at the end of the day I think the solutions are local, and the publication of the report has stimulated even more expert input, like the publication of the Royal College of General Practitioners in September,because that clearly said these are the models, but we as primary care physicians, as a professional body, believe that this probably would be the preferred model in the future. So we are all saying the same thing – it is semantics we are talking about.

PT I think some people have got distracted by the notion of buildings from the more fundamental purpose, and I hope that this interview can go some way towards rectifying that misunderstanding. I also heard you say that it's not just enough to do this. We need to evaluate it. We need to evaluate both in the vertical dimension of care pathways for medical conditions and in the horizontal dimension of cross organisational multi-disciplinary partnerships.

AD Absolutely. Could I just add to that we should always evaluate what we're doing now, as well evaluating pilots, because it is not uncommon to feel that what we have now is good – but that is not the case. I evaluate what I do on a regular basis. If I didn't evaluate what I do on a regular basis I would have not started to do laparoscopic surgery. I think any system must be evaluated ... and that is what I believe professional leadership is all about ... because if we don't constantly evaluate what we are doing as professionals, then someone else will come in and try to find a different kind of solution.

PT Perhaps inevitably from where you're coming from and the needs of these reviews, many of the specific ways of achieving success that you promote have been perceived as very top-down, as opposed to more bottom-up solution. For example, you advocate Academic Health Sciences Centres, but don't mention the need for local development units to foster local collaborations. What do you say to your critics about the balance of top-down and bottom-up?

AD I am a great believer in bottom-up. My purpose in life always has been bottom-up and at all levels. When I want to change something in a ward environment I go and talk to the student nurses on the ward, because they know exactly what is happening on the ward. Could I just remind you, I think this is very important, when I did the London Review, it was bottom-up. I was a clinician working in a hospital, I was invited by the then strategic health authority who felt that there was a gap between what the top was sending down versus what they wanted to see as a vision for London; they felt London was very different; and that is how I built the momentum very quickly because suddenly there were 200 clinicians in London who had a tremendous desire to be part of this review. So the London review was a very bottom-up approach and I kept those principles, even when I joined the department. There are nine different reviews across the country. You may ask yourself 'is the SHA bottom enough?' And you have a point, because I think the more grounded you are, the better it is. But we've picked up GP's, we've picked up nurses, we've picked up social care workers, we've picked up public health docs from different providers and different commissioners in London and brought them together for eight pathways and said 'this is it, let's design a system from the bottom-up'. This was unique, and I'm surprised you haven't asked me yet, because London was never short of reviews. I could take you back to 1928; someone called Dawson who did the first review, in actual fact he got involved in polyclinics in those days, he described something I have some references to that. And then the latest ones we've seen. But these reviews, if you really look at them, they were mostly about buildings, number of beds. They weren't bottom-up clinically led evidence based reports, so I think it's important again to clarify for critics, if they are critics, in actual fact London report was a bottom-up exercise, and what we do in the rest of the country is what we've learnt from London. But there's another principle from that, which is very important, what works for London doesn't necessarily work elsewhere. So that is why we need to do exactly the same bottom-up in nine different Regions

PT And I imagine you would put a challenge to all RCGP members and all primary care workers to continue that bottom-up thinking. Not to just accept things the way they are, but to constantly ask questions about how to make environments for health?

AD Absolutely, I think we all need to need to reach that maturity, to be fair. Not just the Department of Health – because people have been critical of the Department of Health for being top-down. Actually all the national organisations need to think about bottom-up because the purpose and the future .... whether you're the Royal College of General Practice, whether you're Royal College

of Surgeons ... and I've had this debate with presidents of colleges. We really need to talk to our constituents who need to decide the care, not us. As I said, whether you're happy to be a minister here or a president of the college, it's the constituents who need to design the health care, and that is the process in which we will organise.

PT That leads on to a discussion about non-medics. Historically nurses have adopted quite a nurturing role for patients. There is a bit of a nursing crisis in London. Nurses feel disenfranchised from the development process. The devolution of the provider function in PCTs is causing a great deal of uncertainty. What are your views about future nursing roles, and how should the nursing voice be best heard in local policy?

AD Well firstly I'm an extremely strong believer in my whole career, since back in 1984, that nurse leadership is not just vital. It's the crux of the system; no question about that. You recognise very quickly that no ward, no GP practice, no community system, could work without the competencies and the leadership that the nurses play in that extremely important role that they play. I was delighted back in the year 2000 when the NHS plan came round, there were very strong incentives and a very strong leadership expressed in that report, in the role of the nurse of the future. And nurses are playing a significantly greater leadership role. Nurses play a significant role in providing healthcare. I know twenty years ago what I did, and what I'm doing now, a significant amount of work that I used to provide for example back in 1995 I instigated a nurse endoscopy role. That didn't go down very well with medical colleagues, I can tell you that. And within three years the individual, Paula Taylor, who became nurse consultant gained nurse of the year award. I recognised very quickly that I could provide a much better quality care to the patients that are filling up my clinic in those days, if we had a more multi-disciplinary approach. We have now three specialist nurses. We have a nurse consultant in the team. It was me and a nurse before .... You go to a ward – nurse leadership is extremely important. I strongly believe we need to encourage innovation in nursing.

I want to come back to one point which I didn't say when we discussed polyclinics. I also believe we need to inject time and innovative thinking into primary community setting as well. I'm talking about academic involvement. There's tremendous opportunities of translation research in primary community setting. We really need to make investment in that and enhance the profile in the university sector. Ten years ago we had Brian Jarman who is an international leader when it comes to primary care research. We really need to stimulate inquiry in primary/community settings because I think there are wonderful opportunities there.

Back to the nursing side of things, I strongly believe in the nurses' role, also they have management roles now as you probably know. The SHA has a senior nurse who sits on the board. Most NHS trusts have nursing directors who sit on the board, and as you have very eloquently said: in primary care nurses are playing more important roles. And I've also seen, which is fantastic, nurse partners in some practices managing, leading and also providing health care.

PT I read into that agreement of the importance to develop the nursing role. There may be some urgency to develop platforms from which they can develop those roles and exert those leadership roles, including practice based commissioning

AD Absolutely – practice based commissioning. Primary care through my eyes isn't about GPs. Primary care is what we see in primary care. The strengths of primary care is the multi-disciplinary approach to care. Nurses make a significant contribution either to the provision of care or the commissioning of care.

PT I am sure that readers of this journal would heartily agree with that, although may have difficulties in realising it through present constraints ....

You and Lord Wanless have both emphasised the need to integrate health and social care. But they belong in different parts of the system, have different accountability mechanisms, different cultures and geographic boundaries. How do you think we can practically realise integration of health and social care?

AD I think there are tremendous opportunities there. And it is not uncommon that we get fixated about structures, because they have separate accountabilities. But resolving these doesn't necessarily mean that people work better. I think if we're really going to tackle some of the challenges of the future, for example long term conditions, we need closer working – getting these two sectors to work more closely. They are two different systems in one way. The social care system is means-tested, whereas health care is not. But that doesn't mean you shouldn't be working together, if you have the right incentives in the system. I've seen some fantastic examples in London specifically, for example Westminster PCT working with the local authority, where they have service level agreements to manage certain conditions. And I think mental health is a good example. I think we really need to start putting the right incentives and the commissioners must use the right levers in joint

commissioning. Primary care should make the most of these levers. These might be the solutions to a lot of these issues.

PT And perhaps also a challenge there to the academic institutions to provide programs to teach those skills to be able to manage that level of operation which is novel in primary care.

AD Absolutely. Could I just come back to one point you raised because I think I didn't answer fully the specific point about evidence base. You asked about bottom-up approaches. You referred to Academic Health Science Centres. It was bottom-up, I think I made that case. But the reason for Academic Health Science Centres .... I recognised, if you look at London, London is one of the best known capital cities on this globe. It competes when it comes to business, and if you look at where the city of London is in the business world, if you look at science, you will then come across at least three or four universities where they are actually also competing globally.

I'll give you an example of Imperial, where I work, and I've never been shy of saying this. Imperial College is ranked fourth on global biomedical research. Now you have this organisation which is ranking fourth, and we know its business cannot run if its hospital business is not supporting it. So the purpose of an Academic Health Science Centre is very clearly to create closer integration of clinical service and scientific output, the sum of which will be greater than its parts. And the evidence base for that is clearly there – and if you cross the Atlantic you can clearly see that – some of the tremendous translational work, the innovation uptake in clinical practice when you have the two working together. And that was one of the reasons why we suggested that we should have in London, being the capital, at least a few of these which will compete on the international basis. We need to start changing our way of thinking. We need to talk about world class health care. We can do this. We need to really think out of the box and be confident enough, because if we're not confident enough while we're trying to get there, we won't get there.

PT And also the mechanisms. I read into what you're say a challenge to PCTs to increase their partnerships with academic institutions to find a win-win, whereby academics can research in primary care, and primary care can think about its own domain – as an equal partnership.

AD Absolutely. We talk about bringing the problem from the bed to the bench. The primary community setting is a huge bed base. Just look at that holistic approach of health care. We're not just talking about health. We're talking about millions of interactions on a daily basis that we can really capture a tremendous amount of information to find solutions. At the end of the day, why are we all in this business? Purely to improve the care of the patients we look after. Not just patients, public.

PT How can RCGP members, and this journal particularly, be most helpful to you, to develop truly integrated health care, that makes sure that the strengths of both specialist and generalist health care workers are used to really improve care and services for our patients?

AD It's a professional body. Any professional body from my perspective has a role to play in exercising leadership. I've been very grateful to the leadership that the College has exercised over the last eight months, whether it's in publications, whether it's the meetings I've had with senior members of Council or with its president, and I very much hope that we will keep that momentum going, and at the end of the day if we just remind ourselves what is the purpose of what we're doing, whether you happen to be a member or fellow of the Royal College of General Practice, or a member of any other organisation who's interacting with the review, is to exercise that leadership. What we're trying to change here is to improve things rather than try to get sucked into other aspects which are essentially irrelevant.

PT Lord Darzi. Thank you very much indeed.