North West London

Brent Health and Wellbeing Board
28 October 2024

Report from the Managing Director of Brent Integrated Care Programme

Lead Cabinet Member for Community Health and Wellbeing - Councillor Nerva

Report on the Independent Investigation of the NHS in England (known as the "Darzi Report 2024")

Wards Affected:	All
Key or Non-Key Decision:	Non-Key
Open or Part/Fully Exempt: (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)	Open
List of Appendices:	Appendix 1 - **Lord Darzi – Independent Investigation of the NHS in England report**
Background Papers:	None
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1.0 Executive Summary

1.1 The new government commissioned a report into the current state of the NHS in England from Lord Darzi. Lord Darzi is a Chair of Surgery and a Professor at Imperial College NHS Trust and was involved in making recommendations to the previous Labour government (1997-2010).

1.2 The report was commissioned by the Secretary of State for Health and Professor Darzi was asked to undertake a rapid investigation of the state of the NHS, assessing patient access, quality of care and the overall performance of the health system.

1.3 As such, the report is a record of the current "state of play" within the NHS. It is not a plan to improve the NHS or a set of recommendations. It does however identify some themes on how to "repair" the NHS.

1.4 The report, published on 12th September 2004, sets the context and tone for the coming NHS 10 year Plan, which is expected to be published in spring 2025.

2.0 Summary of Key Findings

Health of the nation

2.1 An ageing population is the most significant driver of increased demand for healthcare. For example, the majority of people aged 65-74 will have at least one long-term condition and 40% will have two or more. However, many of the social determinants of health - such as income, housing, education – are also moving in the wrong direction. Pressures in social care, and cuts to funding for the public health grant, are also crucial context for the health of the nation and the performance of the NHS.

Access to NHS services

2.2 The NHS's constitutional standards, which sit at the heart of the social contract between the NHS and the public, are not being met.

2.3 Performance on access to care has been declining, for example:

- Nearly 10% of all patients are now waiting for 12 hours or more at A&E.
- The 62-day target for referral to first treatment for cancer has not been met since 2015.
- As of June 2024, more than 1 million people were waiting for community services, including 500,000 people waiting over a year, 80% of whom were children and young people.
- As of April 2024, about 1 million people were waiting for mental health services.
- Autism and ADHD are areas of particular concern, with long waits for assessment and treatment despite increased activity. For instance, since 2019 the number of adults and children waiting at least 13 weeks for an autism assessment has increased by 65% and 77% a year respectively.

Quality of care in the NHS

2.4 There is a mixed picture on quality of care. For the most part, people receive high quality care from the NHS. There have been improvements in patient safety in recent years, with more error-free care in hospitals and a reduction in the number of suicides in inpatient mental health facilities. New innovations, like virtual wards, are also contributing to reductions in attendances and admissions to hospital, as well as reduced length of stay in hospital. However, clinical negligence claims are at record levels, and significant areas of concern remain. For instance:

- Maternal deaths have been increasing since the Covid-19 pandemic. Complexity in care needs has been increasing, but numbers of midwives has fallen, and the recommendations from a series of inquiries have not been universally adopted.
- Children and young people's physical and mental health has been deteriorating over recent years, and there are challenges in young people being able to access acute, mental health and community services.
- Mortality rates for people with serious mental illnesses has been increasing, and there is a lack of suitable accommodation for inpatients.

- There is scope to reduce avoidable deaths from cancer, cardiovascular disease and suicide.

Health protection, promotion and inequalities

2.5 Health protection - Infectious diseases, including Covid-19, remain a major challenge for all health systems. Despite important progress in the UK, there is further to go to tackle the threat of anti-microbial resistance.

2.6 Health promotion - More needs to be done to tackle obesity and regulate the food industry. Childhood obesity rates for 10–11-year-olds have risen, and the prevalence of diabetes across the whole population has increased from 5.1% in 2008 to 7.5% in 2022. Cuts to the public health grant have contributed to this and have been deeper in more deprived areas. A focus on public health is key to reducing premature mortality and time spent in ill-health, as well as on reducing pressures on the NHS and strengthening the economy.

2.7 Health inequalities - People living in poverty are getting sicker and accessing services later. People who live in the most deprived areas of England are twice as likely to wait more than a year for non-urgent treatment. This leads to more acute illness and poorer outcomes. There are also concerning disparities in access to care and outcomes for homeless people, those with learning disabilities and carers.

Where and how the money is spent

2.8 During the pandemic productivity in the NHS declined far more significantly than the economy as a whole or the wider public sector. It remains below 2019 levels. Underinvestment in care delivered in the community is contributing to high demand on hospitals. Although successive governments have promised to shift care away from hospitals and into the community, expenditure and staffing numbers have grown faster in the acute sector than elsewhere, while the number of health visitors fell by 20% between 2019 and 2023. This is reinforced by performance standards focused on hospitals, not primary, community or mental health services. Likewise, single-year budgets reinforce the status quo.

2.9 Although ICBs have duties around improving population health, roles and responsibilities remain unclear, hindering progress on population health management.

Health and prosperity

2.10 At the start of 2024, 2.8 million people were economically inactive due to long-term sickness, and more than half of the current waiting list for inpatient treatment are working age adults. Being in work is good for wellbeing, having more people in work grows the economy, and creates more tax receipts to fund public services. Improving access to care is a crucial contribution the NHS can make to national prosperity.

2.11 Key findings: drivers of performance Funding, investment and technology Spending growth sat at around '1% per year in real terms' during the 2010s, much lower than the long-term average of 3.4%. In 2018 the government committed to increasing spending by 3.4% annually for five years. However,

actual increases fell at just under 3% for 2019-2024, and this did not include capital spending, medical training, nor any increase in public health expenditure.

2.12 In terms of per capita spending, the UK spends about $5,600 per person on health, similar to the EU15 average but below countries where English is predominantly spoken and the Nordic countries. Capital investment peaked in 2009, declining sharply after this date This led to deteriorating infrastructure, outdated technology, and a significant maintenance backlog.

2.13 During the 2010s, a substantial capital gap opened between the UK and other countries. A shortfall of £37 billion in capital investment has further exacerbated these issues. The report outlines key figures demonstrating the strain on capital investment, including:

- The backlog maintenance bill now stands at more than £11.6 billion.
- £4.3 billion was taken from capital budgets between 2014-15 and 2018-19 to cover in-year revenue deficits.
- 20% of the primary care estate predates the founding of the health service in 1948.

The impact of the Covid-19 pandemic

2.14 The NHS entered the Covid-19 pandemic after a decade of austerity and underinvestment, which left it with fewer resources and lower resilience compared to other high-income health systems. The pandemic strained health systems globally, but the NHS was particularly impacted, with higher excess mortality rates and significant drops in routine care. Overall, hospital discharges in the UK decreased by 18% between 2019 and 2020, the largest drop among comparable countries. Key points include:

- Low resources and squeezed capacity: The NHS had higher bed occupancy rates and fewer doctors, nurses, and beds than comparable health system.
- Severe impact on routine care: The NHS delayed or cancelled more routine care than other systems, with significant drops in procedures like hip and knee replacements. For example, hip replacements in the UK fell by 46% compared to an OECD average of 13%,
- Increased mortality: The UK had higher excess mortality rates compared to other countries. The health of the population had also deteriorated in the years leading up to the pandemic – making it less resilient to infectious disease since it was less healthy going into the pandemic.
- Reduced healthcare access: Reductions in interactions with primary care due to lockdowns meant fewer physical and mental health problems could be identified, hindering early detection and management of health conditions.
- Mental health: The pandemic significantly increased the need for mental health services. The NHS's current state is heavily influenced by these factors, with ongoing challenges in recovering from the pandemic's impact.

Patient voice and staff engagement

2.15 The voices of patients and the public are not sufficiently heard. Patient satisfaction with the NHS has declined, complaints have increased, and patients feel less empowered to make choices about their care. There is potential for greater patient involvement in designing services. A recurring issue in care failings is that patients' concerns are not being heard or addressed. Consequently, the NHS is paying nearly £3 billion in compensation for care failures, which is about 1.7% of its total budget. Disabled people, those with long-term conditions, and women are disproportionately affected by poor communication. Making data more publicly available and involving local communities in decision-making could also help the NHS become more responsive and accountable

2.16 Many staff experience feelings of powerlessness and detachment Many NHS staff describe feeling disempowered and overwhelmed. Around 60% would recommend their organisation as a place to work, and 65% as a place to receive care. Staff feel that NHS organisations lack a sense of common purpose.

2.17 Chronic underinvestment in processes and infrastructure leads to challenges, adding to staff frustration. There has been a reduction in discretionary effort, with fewer staff working beyond their contracted hours. Sickness absence rates have also increased since the pandemic. The most common reason cited for sickness absence was anxiety, stress or depression or other psychiatric illnesses.

Psychological impact of the pandemic and its aftermath

2.18 The pandemic has deeply affected the psychological wellbeing of NHS staff. NHS Practitioner Health, which treats health and social care professionals with mental health and addiction issues, saw a surge in registrations during the pandemic. The pandemic continues to affect the NHS, having a major impact on industrial relations including strikes. Staff felt undervalued despite being praised during the pandemic, especially regarding pay settlements.

Cultural challenges in the NHS and leadership

2.19 Cultural challenges within the NHS, such as concealing problems and retaliating against whistleblowers, persist. Effective leadership is essential in tackling these issues and will require further investment in NHS leaders.

2.20 The 2022 report by General Sir Gordon Messenger and Dame Linda Pollard highlighted issues around the training and development of leadership and management and recommended improvements, which NHS England has started to implement.

NHS structures and systems, including the role of ICBs

2.21 The Health and Social Care Act of 2012 had a 'disastrous' impact on NHS management, leaving long-lasting effects.

2.22 The 2022 Act introduced integrated care systems, creating a more coherent management structure with headquarters, seven regions, and 42 ICBs. However, there are still different understandings of roles and responsibilities between ICBs, including how far they are responsible for the performance management of providers. More consistency and standardisation in the organisation and functions of ICBs is needed. There is also a need to revitalise the framework of national standards, financial incentives and earned autonomy to reflect the shift from competition to collaboration.

2.23 Frequent reorganisations within the NHS are expensive and disruptive, hindering efforts to enhance care quality and efficiency, as is the growth in the number of organisations that exert some degree of regulatory or policy influence on providers. Senior leaders spend considerable time on internal management instead of focusing on local NHS issues.

2.24 The performance of the NHS is shaped by its internal systems, processes, resources, and structures. Key themes include:

- Planning blight: The Health and Social Care Act 2012 divided functions between a number of organisations, leading to delays and complications in planning.
- Data and performance management: -The NHS has focused data collection on acute hospitals, with limited data on mental health and community services. This lack of data limits understanding and management of these sectors.
- The Hewitt Review recommended a focus on fewer key priorities to improve accountability and performance.
- The performance management framework needs to change, at pace, to clarify the role of the ICB with regards to provider trusts.

Incentives for performance:

2.25 There is a tension between protecting funding for specific services and devolving decision- making. NHS England plans to devolve specialised commissioning budgets to ICBs.

2.26 There has also been a shift in payments away from activity-based mechanisms, although they remain in place for elective care. This can impact on clinical productivity.

2.27 Trusts are no longer able to advance to foundation trust status, driving frustration among organisations that funding is available to invest, which they do not have the freedom to spend.

Regulation and quality of care:

2.28 The interim findings of the review of the Care Quality Commission (CQC) by Penny Dash has found significant internal failings and a deterioration in the ability of the CQC to support quality improvement.

2.29 The CQC has also been criticised for emphasising inputs over outcomes, contributing to an increase in the numbers of hospital clinicians.

Competition and quasi-markets:

2.30 The 2022 Act removed the competitive tendering requirement, but the result is an incoherent service delivery pattern. Despite moving away from market-based approaches, the NHS has not fully adopted the planned alternative.

3.0 Recommendation(s)

3.1 Whilst the Darzi report does not specifically make recommendations and is more about "baselining" the current state of the NHS, it does identify a number of "themes". These include:

- **Re-engage staff and re-empower patients** to harness staff talent and passion and enable patients to take as much control of their care as possible.
- **Lock in the shift of care closer to home** by hardwiring financial flows to expand general practice, mental health and community services.
- **Simplify and innovate care delivery** for a neighbourhood NHS to embrace new multidisciplinary models of care.
- **Drive productivity in hospitals** by fixing flow through better operational management, capital investment, and re-engaging and empowering staff.
- **Tilt towards technology** to unlock productivity, particularly outside hospitals, as the workforce urgently needs the benefits of digital systems, use of automation and AI and for life sciences breakthroughs to create new treatments.
- **Contribute to the nation's prosperity** by supporting more people off waiting lists and back into work.
- **Reform to make the structure deliver** by clarifying roles and accountabilities, ensuring the right balance of management resources at the right levels and strengthening key processes such as capital approvals.

4.0 What Might This Mean For Brent?

4.1 It confirms that our approach to inequalities, the wider determinants of health and mental health is the right emphasis, given that these are drivers of both high cost utilisation across the NHS and the public sector, and because reducing inequalities is inherently the right thing to do.

4.2 There is likely to be a continued emphasis on neighbourhood working and the roll out of Integrated Neighbourhood Teams – the report states "we need to

embrace new multidisciplinary models of care that bring together primary, community and mental health services”. In reality, this will involve a wider range of partners as well from local authorities and the VCS sector.

4.3 We are currently engaged in an ICB planning cycle for the ICB’s Joint Forward Plan, but the NHS Plan is likely to be released in Spring 2025 and further clarity on what we the government requires us to do will become clearer at this stage.

4.4 Whilst further re-organisation of statutory bodies is unlikely, there may be further clarification from the government on the roles and responsibilities of ICBs – for example in relation to acute system performance.

5.0 Financial Considerations

5.1 The Darzi report outlines the impact of austerity on the NHS, and sets out the need for further investment in various areas. This is currently outside of our control and subject to Treasury decisions.

6.0 Legal Considerations

6.1 The report outlines the impact of medical negligence litigation on the NHS budget and the need to reduce this.

7.0 Equality, Diversity & Inclusion (EDI) Considerations

7.1 The report references various impacts on EDI including the need to address population health inequalities and the need to improve staff wellbeing by treating all staff fairly and equally.

8.0 Climate Change and Environmental Considerations

8.1 The report does not include specific proposals, but the NHS Plan will need to have due regard to climate change and environmental impacts.

9.0 Human Resources/Property Considerations

9.1 None at present.

10.0 Communication Considerations

10.1 The report has already been communicated widely and has been widely reported by the UK media.

Report sign off:

Tom Shakespeare – Managing Director
Brent Integrated Care Partnership