Independent Investigation of the National Health Service in England

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Summary letter from Lord Darzi to the Secretary of State for Health & Social Care

Dear Secretary of State,

You asked me 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. I have examined areas such as the health of the nation and social care system in so far as they impact on the NHS, although these were outside the formal scope of the Investigation. My attention has also been drawn to some worrying health inequalities that will require further examination than has been possible in the time available, although I do highlight some particular areas of concern.

This report contains my findings, which are summarised as follows:

1. **The National Health Service is in serious trouble.**

   The British people rely on it for the moments of greatest joy – when a new life comes into being – and those of deepest sorrow. We need it when we are suffering from mental distress or hurting from physical pain and for all the times when care and compassion matter most. Yet public satisfaction – which stood at a record high in 2009 – is now at its lowest ever.

2. **The first step to rebuilding public trust and confidence in the NHS is to be completely honest about where it stands**.

   Everyone knows that the health service is in trouble and that NHS staff are doing their best to cope with the enormous challenges. The sheer scope of issues facing the health service, however, has been hard to quantify or articulate. That is why this

report has not held back, even if it has been a rapid assessment over just nine weeks. Although I have worked in the NHS for more than 30 years, I have been shocked by what I have found during this investigation—not just in the health service but in the state of the nation's health.

3. **The state of the NHS is not due entirely to what has happened within the health service. The health of the nation has deteriorated and that impacts its performance.**

   Overall life expectancy increased in the 2000s, but plateaued during the 2010s, before decreasing during the Covid-19 pandemic. It has started to rise again now, but the absolute and relative proportion of our lives spent in ill-health has increased.

   Many of the social determinants of health – such as poor quality housing, low income, insecure employment – have moved in the wrong direction over the past 15 years with the result that the NHS has faced rising demand for healthcare from a society in distress.

   There has been a surge in multiple long-term conditions, and, particularly among children and young people, in mental health needs. Fewer children are getting the immunisations they need to protect their health and fewer adults are participating in some of the key screening programmes, such as for breast cancer. The public health grant has been slashed by more than 25 per cent in real terms since 2015 and the country's main public health institution was abolished – split into two new bodies – in the middle of the pandemic.

4. **This report sets out where the NHS stands now, how we arrived at this point, and some of the key remedies.**

   My terms of reference preclude me from making specific policy recommendations. But I would note that the NHS has been through very difficult times in the past and has emerged stronger, and that many of the measures needed to tackle the current malaise are already well known. So, without providing policy detail, I do, as requested, set out the major themes for the forthcoming 10-year health plan. These are the steps that I believe are needed to turn the NHS around.

Performance of the NHS

5. **How long people wait, and the quality of treatment, are at the heart of the social contract between the NHS and the people. The NHS has not been able to meet the most important promises made to the people since 2015.**

   From access to GPs and to community and mental health services, on to accident and emergency, and then to waits not just for more routine surgery and treatment but for cancer and cardiac services, waiting time targets are being missed. It is inevitable that public trust and confidence will have been damaged by the inability of the NHS to meet the promises of the NHS constitution for the reasons that this report describes.

6. **People are struggling to see their GP.**

   GPs are seeing more patients than ever before, but with the number of fully qualified GPs relative to the population falling, waiting times are rising and patient satisfaction is at its lowest ever level. There are huge and unwarranted variations in the number of patients per GP, and shortages are particularly acute in deprived communities.

7. **Waiting lists for community services and mental health have surged.**

   As of June 2024, more than 1 million people were waiting for community services, including more than 50,000 people who had been waiting for over a year, 80 per cent of whom are children and young people. By April 2024, about 1 million people were waiting for mental health services.

   Long waits have become normalised: there were 345,000 referrals where people are waiting more than a year for first contact with mental health services—more than the entire population of Leicester—and 109,000 of those were for children and young people under the age of 18.

8. **A&E is in an awful state.**

   There are three types of A&E department. Type 1 are what most people think of as A&E—they are major departments and able to deal with the full range of emergencies. Type 2 are for specific conditions such as dental or ophthalmology and type 3 are for minor injuries and illnesses.

In 2010, 94 per cent of people attending a type 1 or type 2 A&E were seen within four hours; by May 2024 that figure had dropped to just over 60 per cent (and for all three types of A&E combined, performance is now at 74 per cent). More than 100,000 infants waited more than 6 hours last year and nearly 10 per cent of all patients are now waiting for 12 hours or more.

According to the Royal College of Emergency Medicine, these long waits are likely to be causing an additional 14,000 more deaths a year—more than double all British armed forces' combat deaths since the health service was founded in 1948.

9. **Waiting times for hospital procedures have ballooned.**

The promise is that for most procedures, treatment will start within 18 weeks. In March 2010, there were just over 2.4m on the waiting list, of whom 200,000 had been waiting longer than 18 weeks. Of those, 20,000 had waited more than a year. By contrast, in June 2024, more than 300,000—fifteen times as many—had waited for over a year, and 1.75 million had been waiting for between 6 and 12 months. One recent improvement is that only some 10,000 people are still waiting longer than 18 months, a sharp fall from 123,000 in September 2021.

10. **Cancer care still lags behind other countries.**

While survival rates at 1-year, 5-years and 10-years have all improved, the rate of improvement slowed substantially during the 2010s. The UK has appreciably higher cancer mortality rates than other countries. No progress whatsoever was made in diagnosing cancer at stage I and II between 2013 and 2021. Since then, rates have risen from 54 per cent to 58 per cent in 2023, with notable improvements in the early detection of lung cancer due to the targeted lung check programme.

In 2024, more than 35,000 genomic tests are being completed each month but only around 60 per cent on time. Recent research from the Tessa Jowell Brain Cancer Mission found that in practice, only around 5 per cent of eligible patients with brain cancer are able to access whole genome sequencing, which is important for treatment selection.

The 62-day target for referral to first treatment has not been met since 2015 and in May 2024, performance was just 65.8 per cent. More than 30 per cent of patients are waiting longer than 31 days for radical radiotherapy.

11. **Care for cardiovascular conditions is going in the wrong direction.**

    Once adjusted for age, the cardiovascular disease mortality rate for people aged under 75 dropped significantly between 2001 and 2010. But improvements have stalled since then and the mortality rate started rising again during the Covid-19 pandemic. Rapid access to treatment has deteriorated—the time for the highest risk heart attack patients to have a rapid intervention to unblock an artery has risen by 28 per cent from an average of 114 minutes in 2013-14 to 146 minutes in 2022-23. The percentage of suspected stroke patients who receive the necessary brain scan within an hour of arrival at hospital varies from 80 per cent in Kent to only around 40 per cent in Shropshire.

12. **The picture on quality of care is mixed**.

    For the most part, once people are in the system, they receive high quality care. But there are some important areas of concerns, such as maternity care, where there have been a succession of scandals and inquiries. There have been improvements in patient safety, with more error-free care in hospitals and a reduction in the number of suicides in inpatient mental health facilities, partly as a result of sustained political attention. The power of prevention is illustrated through the impressive achievements of the Diabetes Prevention Programme, which reduces the risk of type II diabetes by nearly 40 per cent.

13. **The NHS budget is not being spent where it should be—too great a share is being spent in hospitals, too little in the community, and productivity is too low.**

    Hospitals are where most waiting list procedures take place. But they present an apparent paradox. Growth in hospital staff numbers has increased sharply since the pandemic—rising 17 per cent between 2019 and 2023. There are 35 per cent more nurses working with adults and 75 per cent more with children than 15 years ago. The number of appointments, operations and procedures, however, has not increased at the same pace and so productivity has fallen.

    The key reason for this is that patients no longer flow through hospitals as they should. A desperate shortage of capital prevents hospitals being productive. And the dire state of social care means 13 per cent of NHS beds are occupied by people waiting for social care support or care in more appropriate settings. The result is there are 7 per cent fewer daily outpatient appointments for each consultant, 12 per cent less surgical activity for each surgeon, and 18 per cent less activity for each clinician working in emergency medicine.

It needs to be stressed that falling productivity doesn't reduce the workload for staff. Rather, it crushes their enjoyment of work. Instead of putting their time and talents into achieving better outcomes, clinicians' efforts are wasted on solving process problems, such as ringing around wards desperately trying to find available beds.

Too many people end up in hospital, because too little is spent in the community. Many people will have experienced congested A&E departments themselves. If you had arrived at a typical A&E on a typical evening in 2009, there would have been just under 40 people ahead of you in the queue. By 2024, that had swelled to more than 100 people.

This is because we have underinvested in the community. We have almost 16 per cent fewer fully qualified GPs than other high income countries (OECD 19) relative to our population. After years of cuts, the number of mental health nurses has just returned to its 2010 level. Between 2009 and 2023 the number of nurses working in the community actually fell by 5 per cent, while the number of health visitors, who can be crucial to development in the first five years of life, dropped by nearly 20 per cent between 2019 and 2023.

Since at least 2006, and arguably for much longer, successive governments have promised to shift care away from hospitals and into the community. In practice, the reverse has happened. Both hospital expenditure and hospital staffing numbers have grown faster than the other parts of the NHS, while numbers in some of the key out-of-hospital components have declined. Between 2006 and 2022, the share of the NHS budget spent on hospitals increased from 47 per cent to 58 per cent.

This distribution is perpetually reinforced: performance standards are focused on hospitals, not on primary care, community services or mental health. Single-year budgets necessarily reinforce the status quo—and when things go wrong the knee-jerk response from ministers has been to throw more money at hospitals where the pressure is most apparent as waiting areas fill up and ambulances queue outside.

The result is that NHS has implemented the inverse of its stated strategy, with the system producing precisely the result that its current design drives. The problems are systemic. In the current paradigm, patients have a poorer experience, and everybody loses—patients, staff and taxpayers alike.

14. **The NHS is not contributing to national prosperity as it could.**

At the start of 2024, 2.8m people were economically inactive due to long-term sickness. That is an 800,000 increase on pre-pandemic levels with most of the rise accounted for by mental health conditions. Being in work is good for wellbeing. Having more people in work grows the economy and creates more tax receipts to fund public services. There is therefore a virtuous circle if the NHS can help more people back into work.

More than half of the current waiting lists for inpatient treatment are working age adults. And there are long waits for mental health and musculoskeletal services, too, which are the biggest causes of long-term sickness. Improving access to care is a crucial contribution the NHS can make to national prosperity.

There are still wide variations in performance, so my findings may be explanations, but they are not excuses. So, the real question is how such a situation has arisen in the system as a whole: what has caused it? Why has it happened?

Drivers of performance

Four heavily inter-related factors have contributed to the current dire state of the NHS. They are austerity in funding and capital starvation; the impact of the Covid-19 pandemic and its aftermath; lack of patient voice and staff engagement; and management structures and systems.

15. **Austerity. The 2010s were the most austere decade since the NHS was founded, with spending growing at around 1 per cent in real terms.**

Until 2018, spending grew at around 1 per cent a year in real terms, against a long-term average of 3.4 per cent. Adjusted for population growth and changes in age structure, spending virtually flatlined.

In 2018, for the service's 70th birthday, a more realistic promise was made of a 3.4 per cent a year real terms increase for five years in revenue spending. The promise did not include capital spending, medical training, nor any increase in public health expenditure.

The 2018 funding promise was broken. Spending actually increased at just under 3 per cent a year in real terms between 2019 and 2024—below both the 2018 promise and the historic rate on which it had been based.

16. **Capital. The NHS has been starved of capital and the capital budget was repeatedly raided to plug holes in day-to-day spending.**

    The result has been crumbling buildings that hit productivity – services were disrupted at 13 hospitals a day in 2022-23. The backlog maintenance bill now stands at more than £11.6 billion and a lack of capital means that there are too many outdated scanners, too little automation, and parts of the NHS are yet to enter the digital era.

    Over the past 15 years, many sectors of the economy have been radically reshaped by digital technologies. Yet the NHS is in the foothills of digital transformation. The last decade was a missed opportunity to prepare the NHS for the future and to embrace the technologies that would enable a shift in the model from 'diagnose and treat' to 'predict and prevent'—a shift I called for in *High Quality Care for All*, more than 15 years ago.

    Some £4.3 billion was raided from capital budgets between 2014-15 and 2018-19 to cover in-year deficits that were themselves caused by unrealistically low spending settlements.

17. **On top of that, there is a shortfall of £37 billion of capital investment.**

    These missing billions are what would have been invested if the NHS had matched peer countries' levels of capital investment in the 2010s. That sum could have prevented the backlog maintenance, modernised technology and equipment, and paid for the 40 new hospitals that were promised but which have yet to materialise. It could have rebuilt or refurbished every GP practice in the country.

    Instead, we have crumbling buildings, mental health patients being accommodated in Victoria-era cells infested with vermin with 17 men sharing two showers, and parts of the NHS operating in decrepit portacabins. Twenty per cent of the primary care estate predates the founding of the health service in 1948.

18. **The pandemic. The impact of the pandemic and its aftermath: a bigger backlog than other health systems**

    The combination of austerity and capital starvation helped define the NHS's response to the pandemic. It is impossible to understand the current state of the NHS without understanding what happened during it.

The decade of austerity preceding Covid-19, along with the prolonged capital drought, saw the NHS enter the pandemic with higher bed occupancy rates and fewer doctors, nurses, beds and capital assets than most other high-income health systems. The NHS's resilience was at a low ebb.

What is less widely known, is that **the NHS delayed, cancelled or postponed far more routine care during the pandemic than any comparable health system.** Between 2019 and 2020, hip replacements in the UK fell by 46 per cent compared to the OECD average of 13 per cent. Knee replacements crashed a staggering 68 per cent compared to an average fall of 20 per cent. Across the board, the number of discharges from UK hospitals fell by 18 per cent between 2019 and 2020, the biggest drop across comparable countries.

19. **Patient engagement. The patient voice is not loud enough.**

The NHS should aspire to deliver high quality care for all, all of the time. That not only means care that is safe and effective but that treats people with dignity, compassion and respect, making their experiences as positive as they can be. Yet patient satisfaction with services has declined and the number of complaints has increased, while patients are less empowered to make choices about their care. A familiar theme in inquiries into care failings has been patients' concerns not being heard or acted upon. The NHS is paying out record sums in compensation payments for care failures, which now amount to nearly £3 billion or 1.7 per cent of the entire NHS budget.

20. **Staff engagement. Too many staff are disengaged.**

There is also compelling evidence that, post-pandemic, too many staff have become disengaged, and there are distressingly high-levels of sickness absence – as much as one working month a year for each nurse and each midwife working in the NHS.

The experience of the pandemic was exhausting for many and its aftermath continues to reverberate. NHS staff not only mourned deaths of their colleagues on the frontline but were at the sharp end of the Covid rules. They had to insist that mothers gave birth alone and that elderly and other patients had to die without the comforting touch of their loved ones. The result has been a marked reduction in discretionary effort across all staff groups.

21. **Management structures and systems. Still reeling from a turbulent decade and the growth in oversight.**

The Health and Social Care Act of 2012 was a calamity without international precedent. It proved disastrous. By dissolving the NHS management line, it took a "scorched earth" approach to health reform, the effects of which are still felt to this day. It has taken more than 10 years to get back to a sensible structure. And management capability is still behind where it was in 2011.

Some sanity has been restored by the 2022 Act which put integrated care systems on a statutory basis. This has the makings of a sensible management structure, consisting of a headquarters, seven regions and 42 integrated care boards (ICBs) whose strategy to tackle inequalities, and to improve population health, is set by an Integrated Care Partnership (ICP) that includes local government and the third sector alongside the NHS itself.

Across ICBs, there are differing understanding of their roles and responsibilities, including how far they are responsible for the performance management of providers, and quite how and at what level they should tackle population health. The NHS in England has emulated Wales and Scotland and changed its improvement philosophy from competition to collaboration. The framework of national standards, financial incentives and earned autonomy as part of a mutually reinforcing approach is no longer as effective as it once was, and needs to be reinvigorated.

22. **A further effect of the 2012 Act has been a costly and distracting process of almost constant reorganisation of the 'headquarters' and 'regulatory' functions of the NHS.**

Although there are ongoing reductions in management spend and headcount numbers continue to fall, some 19,000 people are employed between NHS England and the Department of Health and Social Care (having peaked at 23,000 in 2022). Some 5,200 of the 16,000 employed by NHS England provide shared services to the NHS such as IT infrastructure and 3,500 are in its seven regions. The Department of Health and Social Care has increased in size by more than 50 per cent in the past 10 years, employing fewer than 2,000 people in 2013 compared to more than 3,000 in 2024, as it reabsorbed staff following the abolition of Public Health England.

Accountability is important. But too many people holding people to account, rather than doing the job, can be counterproductive. Regulatory type organisations now employ some 7,000 staff, or 35 per provider trust, having doubled in size over the past 20 years. Taken together, there are nearly 80 people employed in regulatory and headquarters functions for each NHS provider trust. And there are a multitude of other organisations that produce guidance, recommendations and standards. NHS organisations should focus on the patients and communities they serve, but

the sheer number of national organisations that can 'instruct' the NHS encourages too many to look upwards rather than to those they are there to serve.

The Care Quality Commission – which inspects the NHS – is not fit for purpose, as the recent independent review made clear. Its focus on inputs rather than outcomes has played a major role in driving up the numbers of clinicians in hospitals to unprecedented levels.

Conclusion: the NHS is in critical condition, but its vital signs are strong

23. **It is apparent from this report and from the accompanying analysis that the NHS is in critical condition**.

    It continues to struggle with the aftershocks of the pandemic. Its managerial capacity and capability have been degraded, and the trust and goodwill of many frontline staff has been lost. The service has been chronically weakened by a lack of capital investment which has lagged other similar countries by tens of billions of pounds. All of this has occurred while the demands placed upon the health service have grown as the nation's health has deteriorated.

24. **Some have suggested that this is primarily a failure of NHS management. They are wrong.**

    The NHS is the essential public service and so managers have focused on "keeping the show on the road". Some fantasise about an imaginary alternative world where heroic NHS managers were able to defy the odds and deliver great performance in a system that had been broken. Better management decisions might have been taken along the way, but I am convinced that they would have only made a marginal difference to the state that the NHS is in today.

25. **Despite the challenges, the NHS's vital signs remain strong.**

    The NHS has extraordinary depth of clinical talent, and our clinicians are widely admired for their skill and the strength of their clinical reasoning. Our staff in roles at every level are bound by a deep and abiding belief in NHS values and there is a shared passion and determination to make the NHS better for our patients. They are the beating heart of the NHS. Despite the massive gap in capital investment, the NHS has more resources than ever before, even if there is an urgent need to boost productivity.

26. **Nothing that I have found draws into question the principles of a health service that is taxpayer funded, free at the point of use, and based on need not ability to pay.**

    With the prominent exception of the United States, every advanced country has universal health coverage—and the rest of the world are striving towards it. But other health system models—those where user charges, social or private insurance play a bigger role—are more expensive, even if their funding tends to be more stable. It is not a question, therefore, of whether we can afford the NHS. Rather, we cannot afford not to have the NHS, so it is imperative that we turn the situation around.

27. **It has taken more than a decade for the NHS to fall into disrepair so improving it will take time.**

    Waiting times can and must improve quickly. But it will take years rather than months to get the health service back to peak performance. I have no doubt that significant progress will be possible, but it is unlikely that waiting lists can be cleared and other performance standards restored in one parliamentary term. Just as we in the NHS have turned around performance before, we can do so again.

28. **There are some important themes that have emerged for how to repair the NHS, which will need to be considered alongside strategies to improve the nation's health and reforms to social care.**

    You asked me to identify the major themes for the forthcoming 10-year health plan. These include the following:

    - *Re-engage staff and re-empower patients*. Despite all the challenges and low morale, NHS staff are profoundly passionate and motivated to raise the quality of care for patients. Their talents must be harnessed to make positive change. The best change empowers patients to take as much control of their care as possible.

    - *Lock in the shift of care closer to home by hardwiring financial flows*. General practice, mental health and community services will need to expand and adapt to the needs of those with long-term conditions whose prevalence is growing rapidly as the population age. Financial flows must lock-in this change irreversibly or it will not happen.

    - *Simplify and innovate care delivery for a neighbourhood NHS*. The best way to work *as* a team is to work *in* a team: we need to embrace new multidisciplinary

models of care that bring together primary, community and mental health services.

- *Drive productivity in hospitals*. Acute care providers will need to bring down waiting lists by radically improving their productivity. That means fixing flow through better operational management, capital investment in modern buildings and equipment, and re-engaging and empowering staff.

- *Tilt towards technology*. There must be a major tilt towards technology to unlock productivity. In particular, the hundreds of thousands of NHS staff working outside hospitals urgently need the benefits of digital systems. There is enormous potential in AI to transform care and for life sciences breakthroughs to create new treatments.

- *Contribute to the nation's prosperity*. With the NHS budget at £165 billion this year, the health service's productivity is vital for national prosperity. Moreover, the NHS must rebuild its capacity to get more people off waiting lists and back into work. At the same time, it should better support British biopharmaceutical companies.

- *Reform to make the structure deliver*. While a top-down reorganisation of NHS England and Integrated Care Boards is neither necessary nor desirable, there is more work to be done to clarify roles and accountabilities, ensure the right balance of management resources in different parts of the structure, and strengthen key processes such as capital approvals. Change will only be successful if the NHS can recover its capacity to deliver plans and strategies as well as to make them.

* * *

In an unprecedented act of transparency, my report is being published with an accompanying technical annex containing over 330 analyses that my team and I have commissioned for this investigation. These have been completed by NHS England and the Department of Health and Social Care at remarkable speed.

At my insistence, every piece of analysis includes all available data going back to 2001 or from the first creation of datasets thereafter. It is my hope that this will mark the start of a more open and honest conversation between ministers, the NHS and the public about performance.

In addition, I have examined more than 500 pages of analysis from charities, professional bodies, and other organisations that have a shared passion for the NHS, its values, and its future.

I have also benefitted enormously from the advice and wisdom of the Expert Reference Group. This comprised of the leadership of more than 75 of the most important organisations contributing to the health service today (listed at annex A). I would like to express my sincere thanks to all contributors and to the team that has delivered this report at such speed. I am also grateful to those organisations that hosted me for my programme of visits.

The NHS is now an open book. The issues are laid bare for all to see. And from this shared starting point, I look forward to our collective endeavour to turn it around for the people of this country, and to secure its future for generations to come.

ARA DARZI
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Independent Member of the House of Lords

Part I

Performance of the NHS

Introduction

The purpose of the National Health Service

1. We can only understand the performance of the NHS if we understand what it is there to do. The goal of this rapid review is to establish whether the NHS is fulfilling its promise to the people, and if it is not, setting out how and why this is the case.

2. The NHS Constitution—its contract with the people implied from its creation and codified since 2009—describes the purpose of the health service. It is worth restating it here:

> *"The NHS belongs to the people.*
>
> *It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives.*
>
> *It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health.*
>
> *It touches our lives at times of basic human need, when care and compassion are what matter most."*

3. The NHS Constitution describes the values and principles of the health service and the rights and responsibilities of those that use it as well as those that work in it. It sets out pledges to patients and the public on the standards of access and quality that they can expect and to staff on ways in which the NHS will work.

4. In this review, we examine how well the NHS is living up to its promises to patients and the public and to its staff. To understand how well the NHS is doing, it is important to begin by understanding what challenges it faces. We now explore how demand for healthcare has changed and the reasons why it has risen.

1

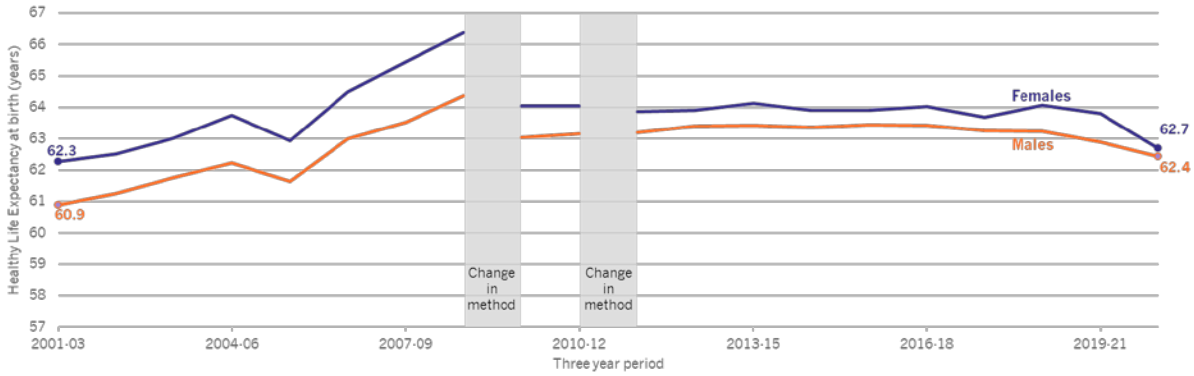
Health of the nation

1. To understand how well the NHS is performing, we first must understand how and why the demands placed upon it have changed. In this chapter, we briefly survey the health of the nation and the implications that it has for the health service. We also touch on other important contextual factors including advances in technology and the state of the social care system.

Life expectancy, preventable and treatable mortality

2. The health of the nation has deteriorated. Overall life expectancy improved in the first decade of the century, plateaued during the 2010s, fell during the Covid-19 pandemic and is now starting to increase again[1]. The picture is even worse for healthy life expectancy, where the absolute and relative proportion of our lives spent in ill-health has increased. As healthy life expectancy for both men and women has fallen, the gap between the two has narrowed. People in England can now expect to live until their early-60s in good health[2].

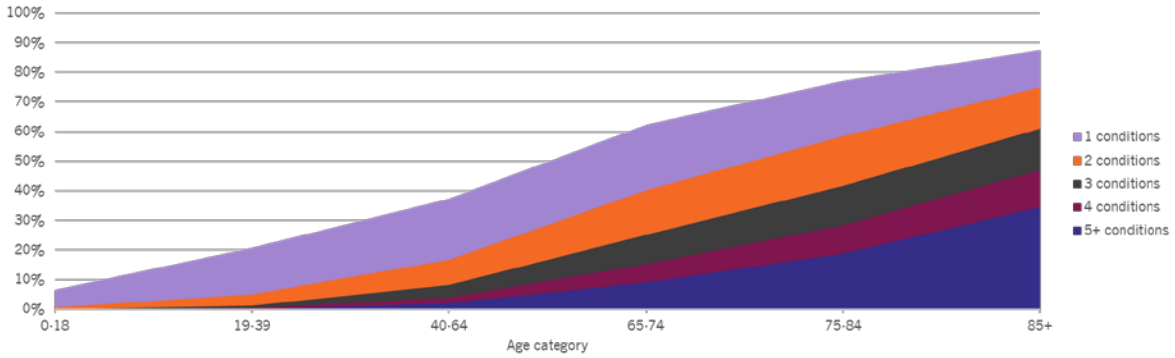
Figure I.2: Trends in Healthy Life Expectancy at birth in England, between 2001 to 2003 and 2020 to 2022



Rising demand for healthcare

3. When national health systems were first conceived, it was imagined that health would be a diminishing part of the economy. This was rooted in the belief that as society became wealthier it would become healthier, and so the demands placed upon the health system would fall over time. Instead across all advanced countries, the healthcare sector has tended to expand more quickly than the rest of the economy, meaning an increasing share of national income is devoted to health[3].

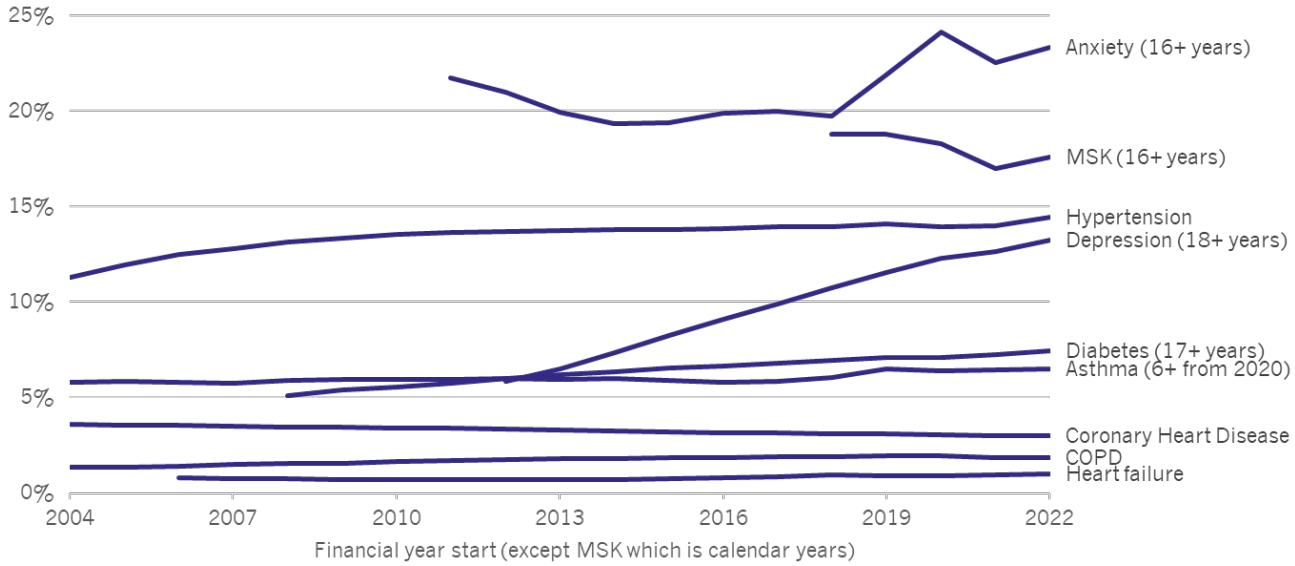
Figure I.5: Share of patients with no, one, or multiple long-term conditions by age



4. An ageing population is the most significant driver of increased healthcare needs since it is associated with the development of long-term conditions such as diabetes, breathing difficulties, or depression[4]. The analysis above is based on NHS England's patient level data. It shows that by the time people are aged 65-74, a majority will have at least one long-term condition and some 40 per cent will have two or more. By the time people are aged 75-84, this rises to nearly 60 per cent having two or more, and by the time people are aged 85 or above, 9 out of 10 will have at least one long-term condition[5].

5. As we can see below, the prevalence of some long-term conditions appears to be rising inexorably. Take diabetes, for example, which has increased from 5.1 per cent prevalence in 2008 to 7.5 per cent in 2022[6]. While the prevalence of high blood pressure (and its associated risks) was 11.3 per cent in 2004, by 2022 it has risen to 14.4 per cent[7].

Figure I.6: Recorded prevalence of health conditions by year (financial or calendar) for all ages (except where indicated) in England, 2004 and 2022



6. But it is our mental health that appears to have deteriorated most significantly in the past decade. The prevalence of depression has shot up from 5.8 per cent in 2012 to 13.2 per cent a decade later in 2022[8]. But the rise in need for mental health services is not evenly distributed in the population. For adults, mental health referrals have been increasing at a rate of 3.3 per cent a year[9]. But for children and young people, the rate of referrals has increased by 11.7 per cent a year from around 40,000 a month in 2016 to almost 120,000 a month in 2024[10]. And referrals for perinatal services for mothers has risen by 23 per cent a year since 2016, rising from around 1,400 a month in 2016 to more than 7,600 a month in 2024[11].

7. While ageing may be the most significant driver of increased healthcare needs, the health of the nation is affected by many other factors too. The wider determinants[12] such as income, education, work, housing, relationships, families and our natural and physical environment can have enormous impacts on our health. Many of these are moving in the wrong direction.

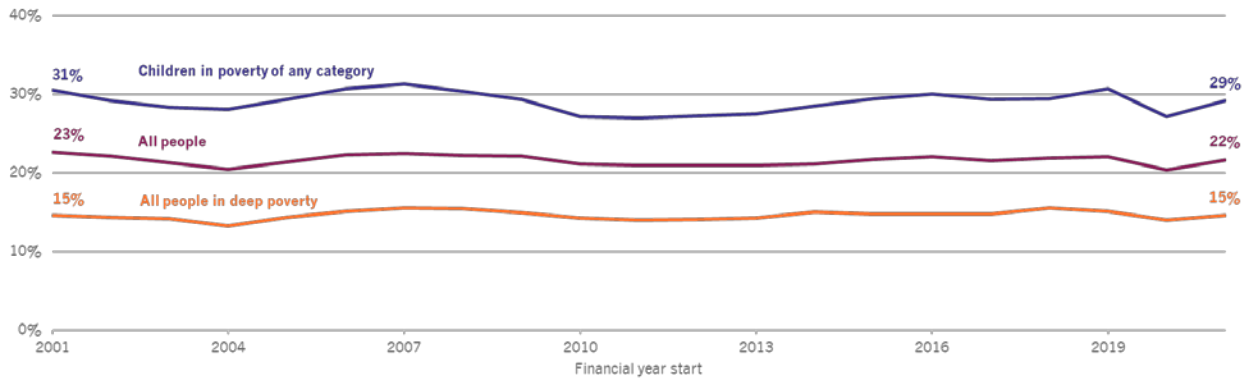
An economy and society in distress

8. The NHS has been impacted by wider changes beyond the health system. Our health is the result of our genetic inheritance, our lifestyle and behaviours, and our social and economic circumstances which shape our lives. These include income, housing and access to healthy food, amongst others. It has a particular impact for the most deprived and disadvantaged in society.

9. While the poorest households saw their income increase by 2.3 per cent a year in real terms during the 2000s, this plummeted to just 0.0 per cent real income growth in the 2010s for the bottom quintile. This compares to 0.9 per cent and 0.6 per cent real income growth across for these decades respectively for the top income quintile[13]. This has, of course, impacted poverty rates, particularly for children. The proportion of children living in poverty fell from 31 per cent to 27 per cent between 2007 and 2010. But it steadily rose from then, so that by 2019, all the progress had been reversed and 31 per cent of children were living in poverty, and the latest data shows that this is now 29 per cent[14].

10. According to the Joseph Rowntree Foundation (JRF), around 3.8 million people have experienced destitution in a year, one million of whom are children – nearly triple the number of children since 2017[15]. And in their submission to the Investigation, the Child Poverty Action Group pointed out that the UK had the largest rise in relative child poverty of any advanced nation between 2014 and 2021.

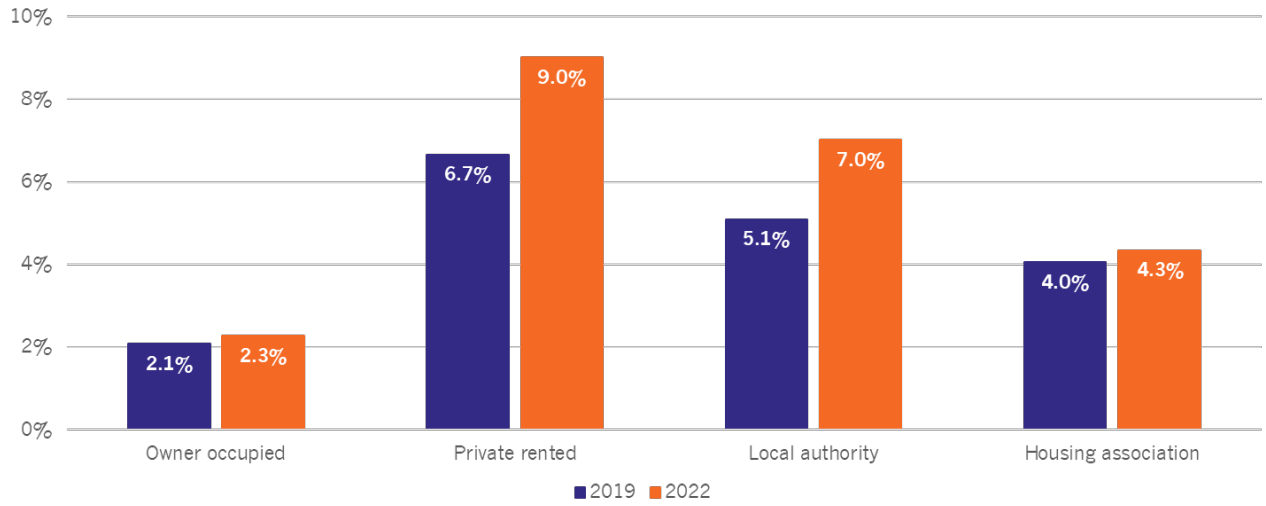
Figure I.9: Poverty rates



11. With worsening poverty, there has been an upward trend in food insecurity. Data from the Trussell Trust shows an increase in the number of food supply parcels from 1.4 million in 2017-18 to the highest recorded level of 3.1 million in 2023-24[16]. Healthy and nutritious food is comparatively expensive; cheap food is associated with higher obesity levels, which has many different health impacts. The Office for National Statistics (ONS) reported that between 18 October 2023 and 1 January 2024, 20 per cent of households in the most deprived quintile reported eating less fruit and fewer vegetables because of cost-of-living increases[17], compared to 8 per cent of the least deprived quintile. Almost half of primary care providers are running foodbanks, according to the JRF.

12. The housing crisis has continued to get worse, with the UK having the highest rates of homelessness in the OECD when measured by the proportion of the population in temporary accommodation[18]. Housing quality impacts health outcomes: poor housing is associated with increases in respiratory conditions and communicable diseases. The number of homes with damp problems has increased between 2019 and 2022[19]. While this rose across all sectors, the starkest increases were in private and local authority rentals. People in privately rented homes are nearly four times as likely to experience damp issues as those who own their homes.

Figure I.11: Dwellings with any damp problems, England, 2019 and 2022



13. It is not just our material conditions that impact our health and therefore the NHS. The rise in social media use has reshaped our lives. While there have been many benefits, there are harms, too. Studies are split on the impact on our physical and mental health. But it seems highly unlikely that the dramatic rise in mental health needs is wholly unconnected from social media. Studies have found 14-year olds that use social media excessively (more than five hours a day) were more likely to be depressed[20]. But it is unclear whether it was the cause or the consequence of depression.

Expanding possibilities

14. A further reason for the growth in healthcare expenditure should be celebrated: medical and scientific advances means that disease can be better diagnosed and treated than ever before. The scope of what is possible continues to expand: at the start of the century, nearly 1,500 diseases had a known molecular basis, and some 1,000 gene mutations were understood to cause disease[21]. By 2024, that had

increased to nearly 7,500 diseases with a known molecular basis and around 5,000 identified gene mutations that caused or contributed to disease[22].

15. Over the past decade, NHS spending on drugs for specialised services has grown at 8.9 per cent a year, while for devices it has increased at 10.2 per cent annually[23]. This far outpaces the rate of growth of the total NHS budget, meaning that specialised services account for a growing share of expenditure. While it means more diseases and conditions can be treated—such as putting England on a trajectory to eliminate hepatitis C ahead of the rest of the world[24]—it creates an inexorable pressure on costs.

Overall impact

16. Analysis commissioned for this report found that NHS activity has increased, notably for primary care and mental health services; that complexity has risen, with the proportion of NHS patients with disabilities notably increasing at more than 9 per cent a year between 2017 and 2023[25]; and that spending on specialised services has increased at a much faster rate than routine care[26].

17. On every front, the demands placed upon the NHS have accelerated. This means that we are much closer to the 'slow uptake' scenario than the 'fully engaged' scenario described by Derek Wanless in his 2002 review of long-term health financing[27] that looked at expenditure to 2022. Indeed, the 'slow uptake' scenario was defined as:

    "Life expectancy rises, but by the smallest amount in all three scenarios. The health status of the population is constant or deteriorates. The health service is relatively unresponsive with low rates of technology uptake and low productivity."[28]

    This seems to rather presciently capture the situation we are in today. The consequence is a very significant mismatch between the demands placed upon the NHS and the resources available to it.

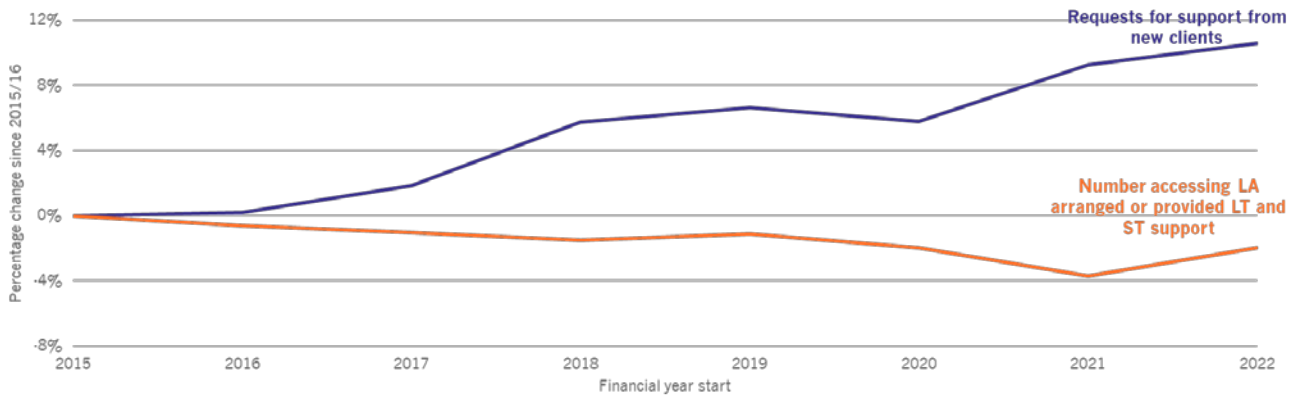
Social care challenges impacting the NHS

18. It is impossible to understand what has been happening in the NHS without understanding what has happened to social care, although social care itself is outside the remit of this Investigation.

19. Social care is a vital service in its own right, helping people with disabilities, and all of us as we age, to lead full and independent lives for as long as possible. While public debate on social care tends to focus on the needs of older people, there are very significant needs for many children and working age adults with disabilities. According to a submission from the Royal College of Occupational Therapists, 30 per cent of their members surveyed in 2023 said they could not provide equipment or adaptations for children who needed it. Social care has not been valued or resourced sufficiently, which has both a profound human cost and economic consequences.

20. While the health service endured a significant slowdown in funding during the 2010s, local government had real-terms cuts to its expenditure[29]. The result is that publicly funded social care is provided for fewer and fewer people while the demand for it has risen, largely as the result of an ageing population. Analysis by The King's Fund shows how a colossal gap has opened up between resources and need, as the chart below shows. In their submission to the Investigation, the Local Government Association highlighted that the vacancy rate in adult social care is nearly three times that of the economy as a whole.

Figure I.17: Changes to requests for support and user of long-term and short-term care to maximise independence support arranged or provided by local authorities in England, 2015-16 to 2022-23



21. Whereas the NHS is funded by taxpayers and free at the point of need, social care is means-tested and only provided to those with the greatest need and least ability to pay. With each passing year, the gap grows between those in need and those receiving publicly funded care[30]. This places an increasingly large burden on families and on the NHS. The impact on the NHS has been more people staying in hospital for longer than their medical needs require them to be there[31]. This means older people have been stuck in acute hospital wards rather than in facilities better suited to their needs (so-called delayed discharges[32]).

22. It is apparent that the different economic models between the NHS and social care is driving the most expensive outcome—people spending time in hospital when there is no medical reason for them to be there—that is also a poorer experience for elderly people and their families. The impact of delayed discharges is equivalent to 13 per cent of all NHS beds[33].

* * *

23. Rising demand from a society where people have become older and sicker alongside a social care system that is far from supporting the scale of needs of the population, are the crucial context in which NHS performance must be understood. We now turn to how well the NHS is fulfilling its commitments to the people.

2

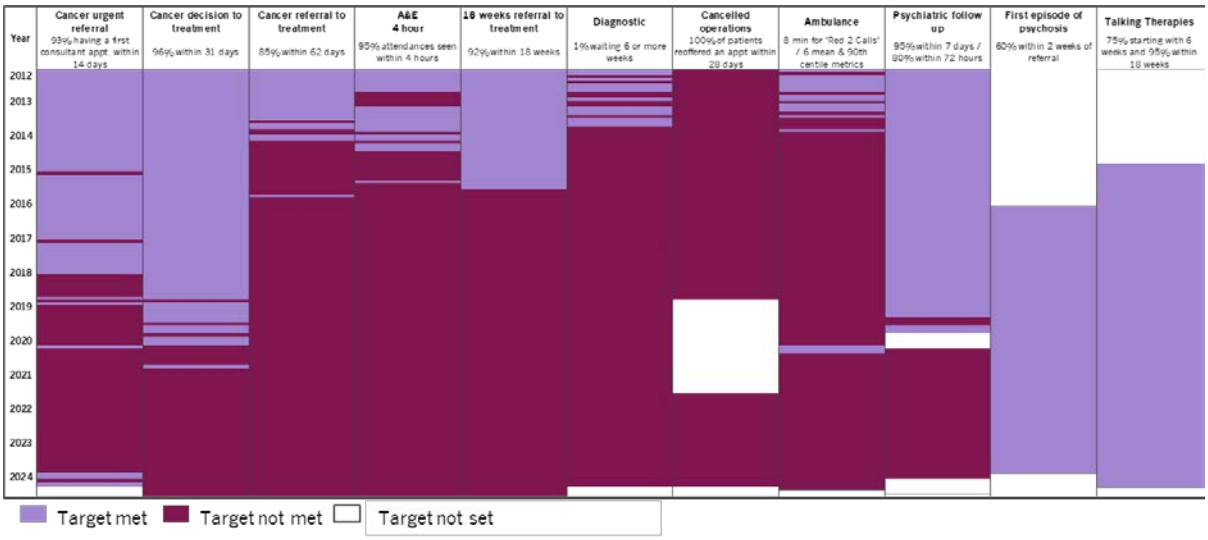
Access to NHS services

1. In this chapter, we explore speed of access to services. An essential promise between the NHS and the people is that the health service should deliver timely access to care when it is needed. While many people know that it is harder to access care, what may be less well understood—and more worrying—is the depth and breadth of access problems in the health service today.

NHS Constitutional standards

2. The majority of the NHS's most important promises to the people were no longer being met by 2015[34]. These are at the heart of the social contract between the NHS and the people. It is inevitable that public trust and confidence will have been damaged by the inability of the NHS to meet its promises.

Figure II.1.1: NHS constitutional targets and whether they are being met



3. The NHS's constitutional standards include some of the most important aspects of what the health service delivers. They include speed of access when cancer is suspected, waiting times for operations, and consistent follow up by psychiatric

services. It is striking that the NHS was unable to meet most of these promises since well before the pandemic.

Access to the front door of the NHS

NHS 111

4. The goal of NHS 111 is to enable patients to access the right care, in the right place. In the last decade, NHS 111 has grown in usage from around a million calls a month to well over 1.5 million[35]. The service has struggled to keep up with demand: as we can see from the charts below, the rate of calls that are abandoned has increased as have calls that have taken more than a minute to answer. While NHS England mandates that abandoned calls should be 3 per cent or less, the average proportion of calls abandoned every month between August 2022 and May 2024 has been 11.3 per cent – or nearly four times the acceptable level[36].

Figure II.2.1A: NHS 111 Calls Received (numbers)

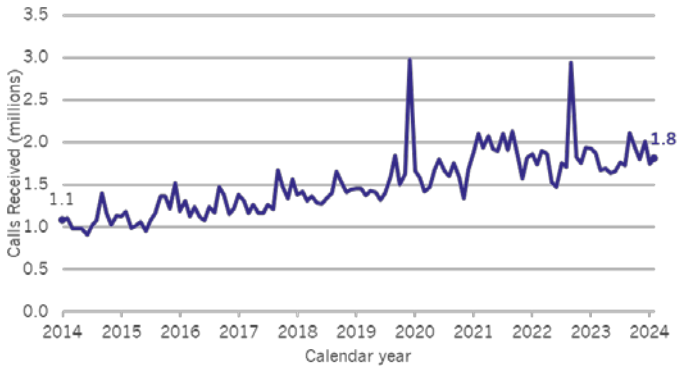
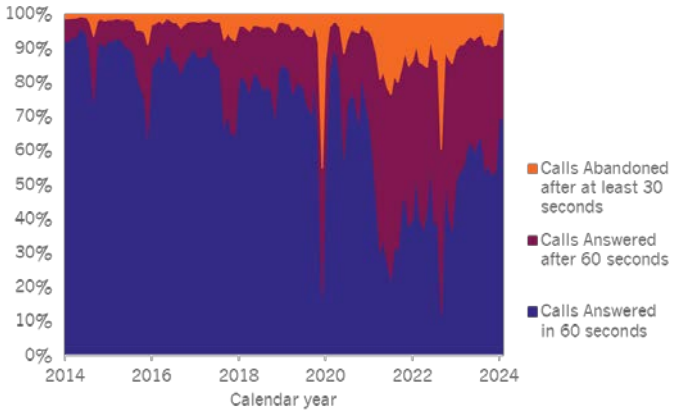


Figure II.2.1B: Call volumes split by answered in under and over 60 seconds and abandoned in over 30 seconds (percentage)



5. Where 111 callers are advised to go for help has been broadly stable over time, with 43 per cent told to contact their General Practice, 12 per cent advised to attend A&E or other urgent care and 12 per cent given an ambulance response. Self-care remains a relatively small proportion at less than 1 in 10 callers[37].

Digital front door

6. The Covid-19 pandemic led to a rapid increase in registrations for the NHS App, with nearly 80 per cent of adults now registered. But less than 20 per cent use it monthly[38]. The NHS App is not delivering a 'digital-first' experience similar to that found in many aspects of daily life, although there is huge potential. While there has

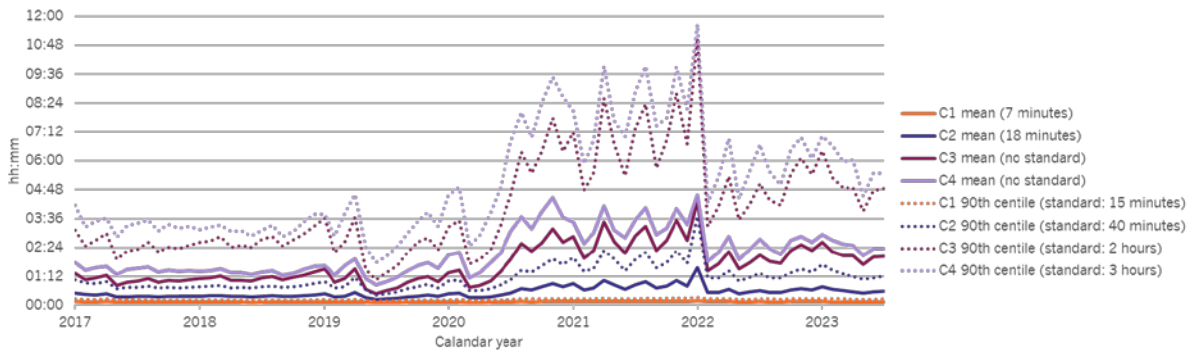
been growth in ordering repeat prescriptions and managing hospital appointments, just 1 per cent of GP appointments are managed via the App (although many book their GP appointments through other online systems)[39]. With the huge success in registrations, an important opportunity is being missed to improve both efficiency and patient experience.

Ambulance services

7. The ambulance service is there for those times when we need immediate, emergency help from the NHS. The way in which the NHS categorises ambulance responses changed in 2017. As we can see in the chart below, response times increased very sharply during the pandemic and have remained stubbornly high since then. NHS England has responded by promising to increase capacity: more than 800 new ambulances were promised by 2023-24, but only 300 new ambulances were reported to be operational by February 2024[40] and these were replacements of those in the existing fleet.

8. Calls are triaged into four categories according to the patient's need. Category one calls are those where there is an immediate threat to life, such as cardiac arrest; response times should be 7 minutes on average with 90 per cent responded to within 15 minutes. As the chart below shows, since 2021, response times for the category one 90th centile initially deteriorated before improving and nearly meeting the targets by May 2024. This trend is not reflected in the category one mean response times, which have shown a steady improvement but have not yet recovered, with the June 2024 figure recorded at 8:21 minutes[41].

Figure II.8.2: Category 1 to 4 ambulance response times, England



9. Category 2 calls include serious conditions such as stroke, sepsis, heart attack or major burns. The response time is set to be 18 minutes on average with 90 per cent responded to within 40 minutes. Response times were at their worst in December

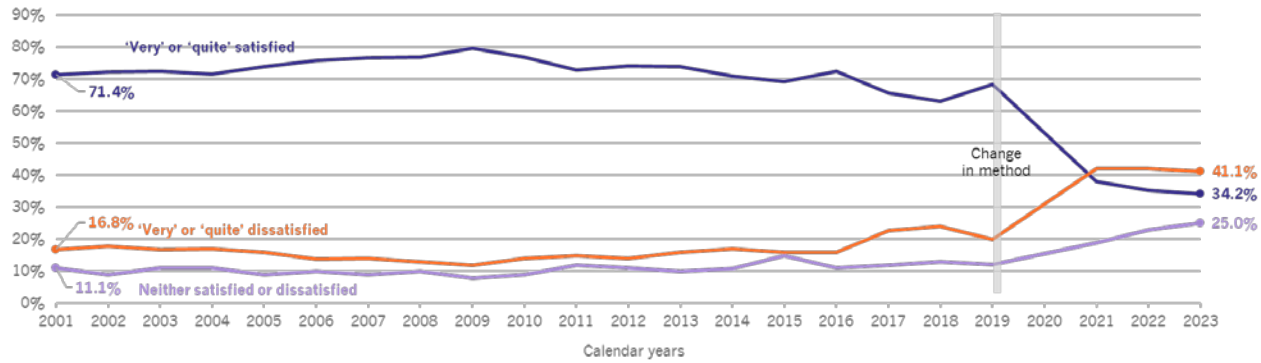
2022 (as we can see from the chart above), when there was an average response time of just over an hour-and-a-half, with the 90th centile standing at nearly 4 hours. By May this year, responses had improved to an average of 32 minutes and 90 per cent responded to within 1 hour and 8 minutes[42].

10. While there has been a sharp focus on these waits for category 2, the position for other patient groups is likely to be causing as much harm. Category 3 incidents include some of the most vulnerable in society, such as those for frail older people who have fallen and people in mental health crisis, which each make up 10 per cent of the total call volume to 999. By May 2024, the 90th centile of category 3 calls waited up to 4 hours 45 minutes (or 2 hours on average) for a response[43].

Access to General Practice

11. For most people, their GP practice remains their most common interaction with the NHS. The overall trend is for more GP appointments than ever before[44], with GPs working harder and seeing more patients. Yet there is still a struggle to meet patient demand, as the percentage of respondents to the GP patient survey who said they had to wait a week or more for a GP appointment increased from 16 per cent in 2021 to 33 per cent in 2024[45]. Satisfaction with GP services dramatically reduced during the Covid-19 pandemic, accelerating a decade in decline in satisfaction since 2009[46].

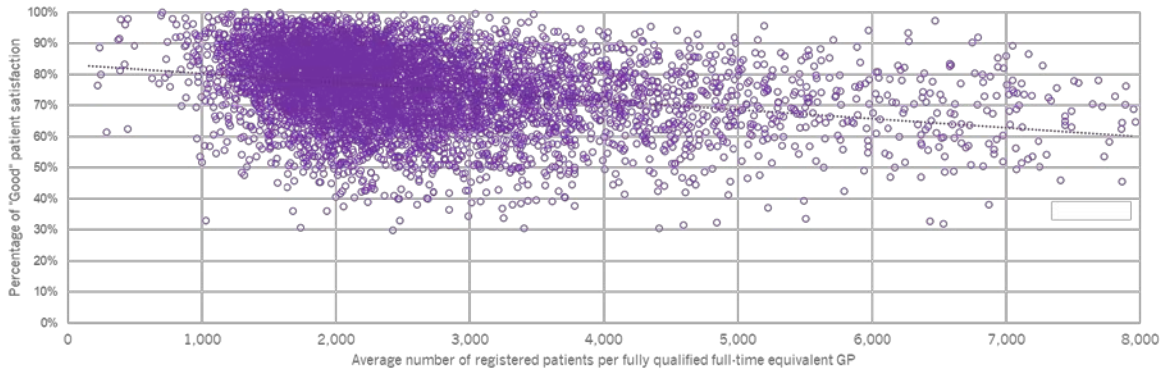
Figure II.3.3: Question asked: 'From your own experience, or from what you have heard, please say how satisfied or dissatisfied you are with the way in which each of the parts of the NHS runs nowadays: Local doctors or GPs



12. GPs are spread unevenly across the country. There are 1,467 patients per GP in Devon, compared to 2,261 patients per GP in North West London[47], a 54 per cent difference. Moreover, there are wide variations in the numbers of patient per GP within Integrated Care Boards (ICBs) as well as across them. This is important as a

smaller number of patients per GP is associated with higher satisfaction (see chart below)[48]:

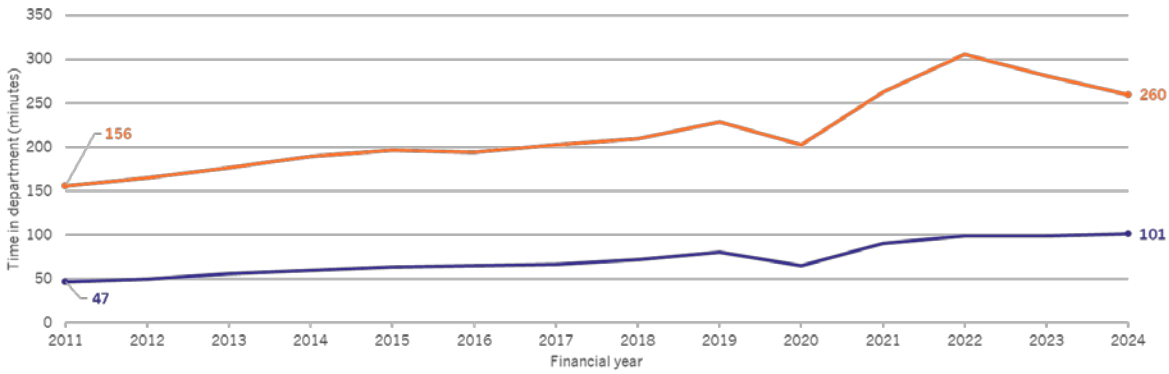
Figure II.3.7: Reported patient satisfaction by average numbers of registered patients per GP, June 2024



13. There have been positive developments in growing the wider workforce in general practice such as clinical pharmacists and occupational therapists. These should be supplements, rather than substitutes to GPs though and more GP time is required to coordinate multidisciplinary working. In particular, more GPs are needed in under-doctored areas.

14. Many, although not all, urgent treatment centres and walk-in centres are GP-led. They too have faced significant increases in demand that have resulted in longer waits. As we can see in the chart below, waiting times have increased significantly, more than doubling between 2012 and 2024 from around 50 minutes to more than an hour-and-a-half. There are also now some long waits, with the 95th centile waiting 4 hours and 20 minutes[49].

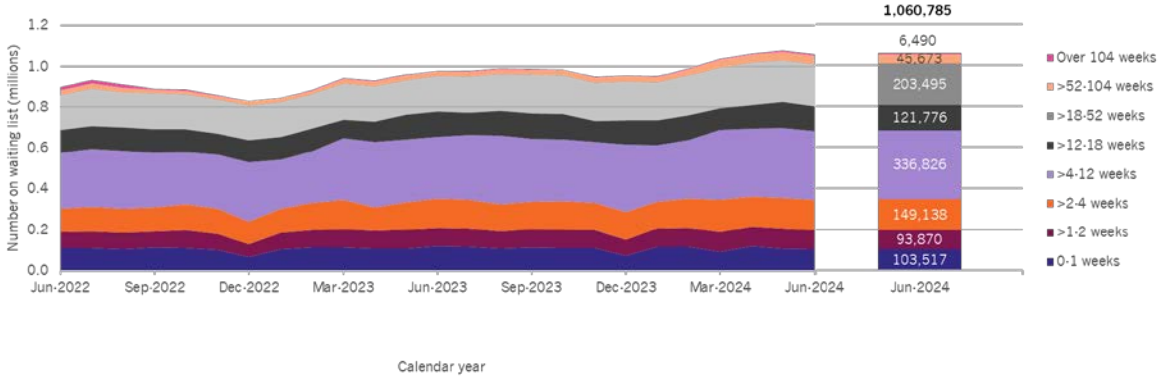
Figure II.3.8: Total time in department from arrival to admission, transfer or discharge, UTCs and WICs



Access to community services

15. High quality community services are essential to create a sustainable NHS and have been highlighted by national strategies to shift care closer to home for decades. Yet properly assessing access in NHS community services is hampered by the lack of data. Data on the total waiting list size is only available from 2022. As of June this year, more than 1 million people were waiting for community services, including more than 50,000 people who had been waiting for over a year, 80 per cent of whom are children and young people (see chart below)[50]:

Figure II.7.1: Total community health services waits by waiting times, June 2022- June 2024

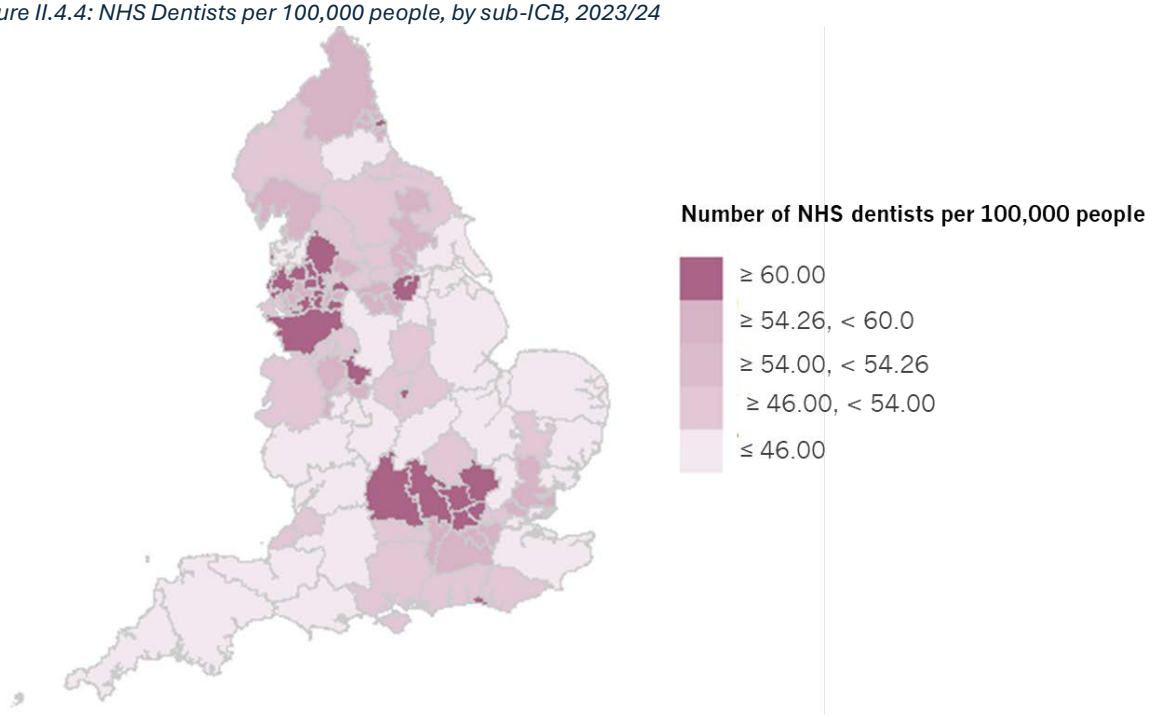


16. Set against a backdrop of growing need, the overall numbers of community nurses have held steady since 2016[51], whilst the number of district nurses (nurses who have completed additional training to become specialist community practitioners) has actually declined[52]. There has been a worrying reduction in the number of health visitors between 2019 and 2023[53] – a crucial role given the extensive evidence base on the importance of getting a good start to life. Community services need to be more visible and have a higher priority given to them.

Access to dentistry

17. Good dental health is essential for adults and children alike. Yet only about 30 and 40 per cent of NHS dental practices are accepting new child and adult registrations respectively[54]. And as this chart from the Nuffield Trust shows[55], there are wide variations in the number of NHS dentists per population in different areas of the country. Rural and coastal communities particularly lack access to NHS dentistry.

Figure II.4.4: NHS Dentists per 100,000 people, by sub-ICB, 2023/24



18. Dental access was particularly badly hit by the Covid-19 pandemic and is still recovering. If dentistry is to continue as a core NHS service, urgent action is needed to develop a contract that balances activity and prevention, is attractive to dentists and rewards those dentists who practice in less served areas. There are enough dentists in England, just not enough dentists willing to do enough NHS work, which impacts provision for the poorest in society.

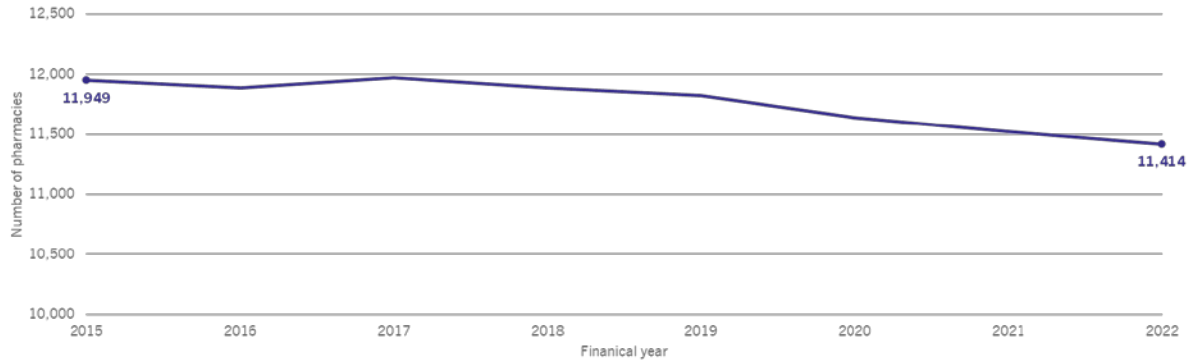
Access to community pharmacy

19. One of the great strengths of the health service in England has been the accessibility of community pharmacy. Historically, the contract promoted a highly efficient distribution of pharmacies. Indeed, in contrast to many aspects of care, deprived communities are better served. More than 93 per cent of patients living in areas of highest deprivation live within 1 mile of a pharmacy compared to 71 per cent in areas of the lowest deprivation[56]. While access has started to deteriorate in recent years, more than 85 per cent of people live within one mile of a community pharmacy[57].

20. Yet pharmacies are now closing in significant numbers. As the chart below shows, around 1,200 pharmacies have shut their doors since 2017[58]. While pharmacies have expanded the range of clinical services that they provide – such as blood

pressure checks, prescription contraception, and minor illnesses – the total level of spending on the community pharmacy contract has fallen by 8 per cent[59].

Figure II.5.1: Number of pharmacies in England from 2017 to 2024



21. There is the potential for community pharmacy to provide even more value-added services for the NHS and there have been notable successes already, such as the Pharmacy First programme. As the Royal Pharmaceutical Society pointed out in their submission to the Investigation, nearly 30 per cent of existing pharmacists are independent prescribers and changes to pharmacy education mean that from 2026 all newly-qualified pharmacists will be[60].

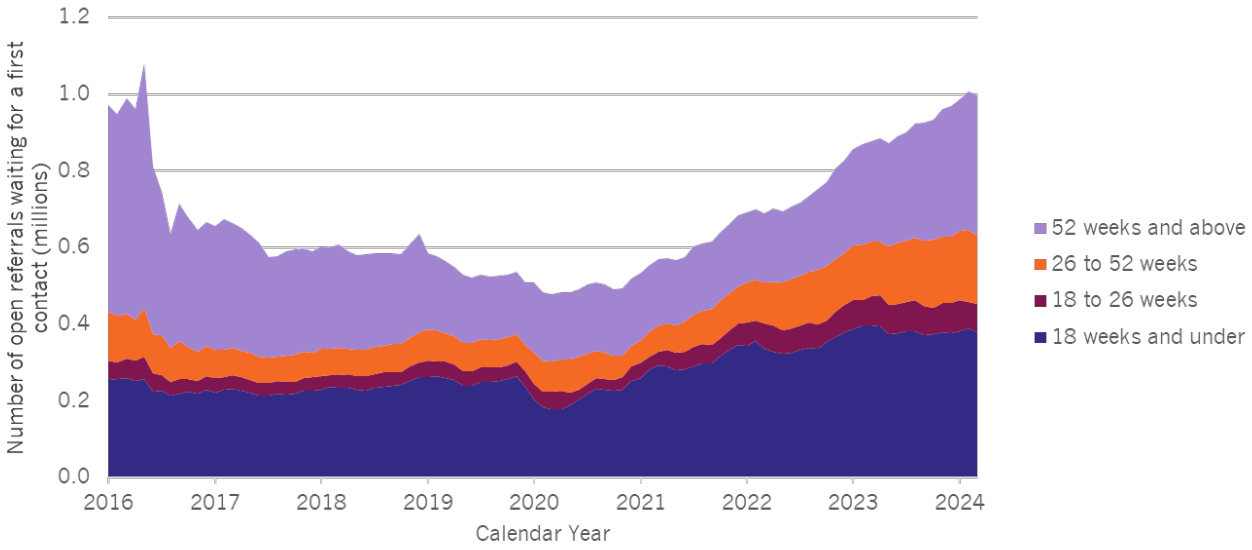
22. There is huge potential for a step change in the clinical role of pharmacists within the NHS. Expanded community pharmacy services are likely to include greater treatment of common conditions and supporting active management of hypertension. But there is a very real risk that on current trajectory, community pharmacy will face similar access problems to general practice, with too few resources in the places where it is needed most.

Access to mental health services

23. The need for mental health services has been growing rapidly. In 2016, around 2.6 million people were in contact with mental health services; by 2024, this had increased to 3.6 million people[61].

24. By April 2024, around 1 million people were waiting for mental health services[62]. Long waits have become normalised: there were 345,000[63] referrals where people are waiting more than a year for first contact with mental health services— a figure higher than the entire population of Leicester[64].

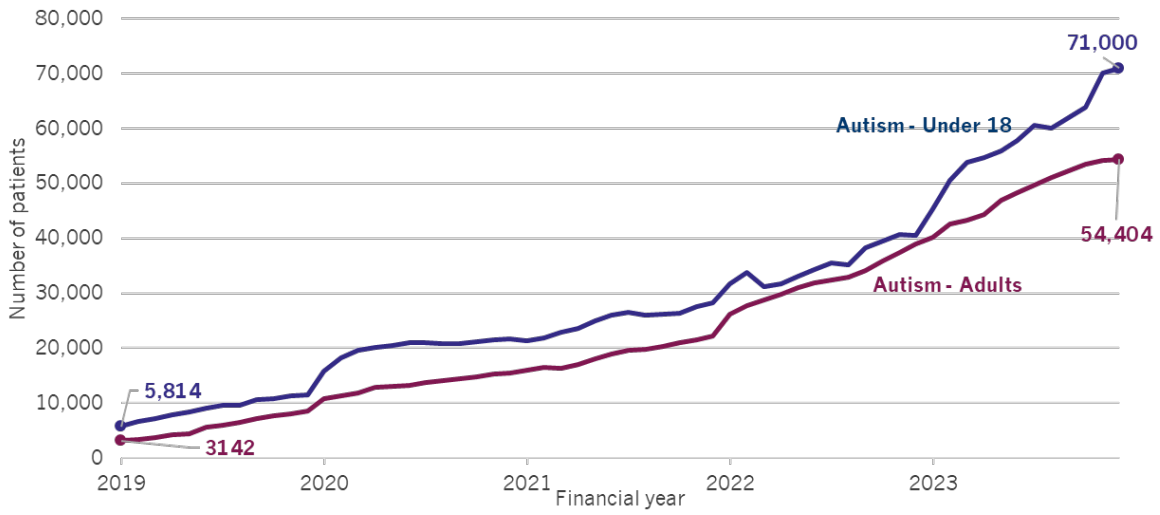
Figure II.6.5: Number of Open Referrals for people of all ages at the time of referral to Mental Health, Learning Disability and Autism services by time waiting for first contact



25. Some 343,000 referrals for children and young people under the age of 18 are waiting for mental health services, including around 109,000 referrals waiting for more than a year[65] (equivalent to the population of Maidstone[66]). For any person, a year wait is far too long. But for young people who are going through profound life changes, this is particularly concerning.

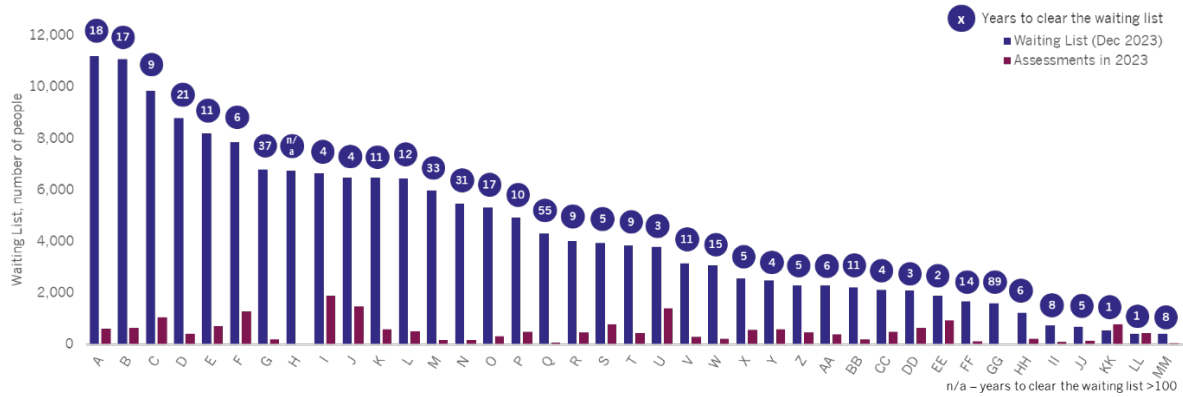
26. Demand for assessments for ADHD and Autism have grown exponentially in recent years. Since 2019, the number of children waiting at least 13 weeks for an assessment for Autism has increased at a rate of 65 per cent a year, while for adults the increase has been 77 per cent a year[67]. Activity has risen too, with services now seeing 33,000 people a month[68]. But as of March 2024, there were still more than 70,000 children and young people under 18 and more than 50,000 adults waiting at least 13 weeks for an assessment for Autism[69].

Figure II.6.12: Number of patients with a referral for suspected autism, open for at least 13 weeks, who were still waiting for a first contact, April 2019 to March 2024



27. The growth in demand for ADHD assessments has been so significant that it risks completely overwhelming the available resource. As the chart below sets out, there is a huge mismatch between demand for assessment and their availability. The result is that, at current rates, it would take an average of 8 years to clear the backlog in adult ADHD assessments – and for many trusts, at current rates, the backlog would not be cleared for decades.

Figure II.6.10: Implied clearance time for adult ADHD assessments based on activity and wait list size (based on 44 providers, in England, Wales and Scotland)



28. There is no consensus around what explains the dramatic increase in demand for assessment for ADHD and autism. Some believe that it is the conversion of unmet need into demand for assessment as stigma has reduced and awareness has increased. Others argue that is the result of self-diagnosis induced by misleading

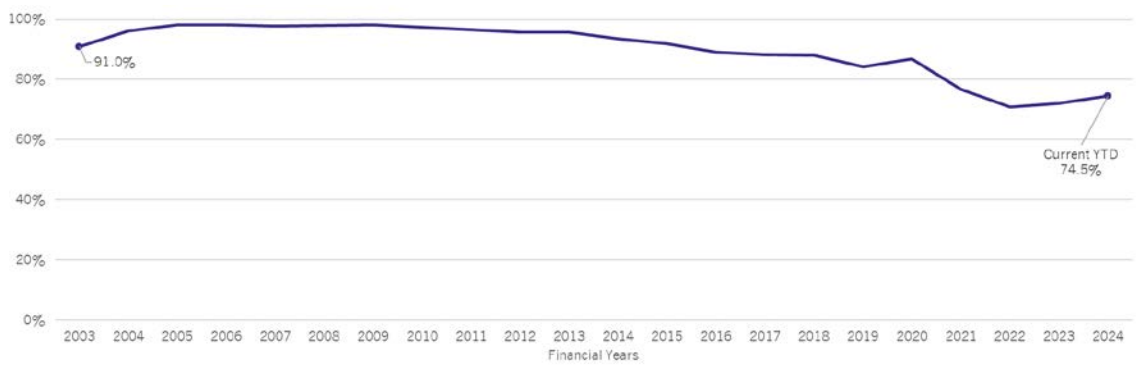
discussion on social media. No matter the cause, it is clear that with services overwhelmed, many people who need help will be missing out. NHS England's taskforce on ADHD[70] will have important recommendations to make.

Access to acute hospital services

Waiting times for A&E departments

29. In 2022, for the first time since the start of the century, more of the public were unhappy with how A&E departments are run than were satisfied. In 2023, nearly 40 per cent of people were dissatisfied, with just over 30 per cent satisfied[71]. This is not surprising. As the chart below shows, in 2011, 96.6 per cent of people attending A&E were seen within four hours; by 2024 that figure had dropped to just 74.5 per cent[72]. Between 2011 and 2023, the number of people attending A&E increased by 22.5 per cent to some 26.3 million[73].

Figure II.8.6: Percentage of attendances admitted, transferred or discharged within 4 hours of arrival at A&E



30. The poor state of the headline figures can obscure some of the important nuances that sit beneath. The average waiting time for infants has increased by around 60 per cent over the last 15 years. But it is particularly concerning that nearly 250,000 infants (aged 0-2) were left waiting for more than four hours and more than 100,000 infants waited more than six hours in 2023-24[74]. There is a similar picture for children aged three to 17, with almost 500,000 waiting more than four hours and 225,000 waiting for more than six hours in A&E[75].

31. Older people have endured particularly long waits. The average waits for people over the age of 65 have nearly doubled over the past 15 years from just over three hours to nearly seven[76]. But some have had particularly appalling experiences: at

the 95th percentile, people have been waiting for more than 24 hours in A&E[77]. Analysis from the Royal College of Emergency Medicine (RCEM), submitted to the Investigation, found that in December 2023, almost a third of people over 80 waited for 12 hours or more. The RCEM also found that people who were over the age of 90 were five times more likely to wait 12 hours or more than people aged 18 to 29[78].

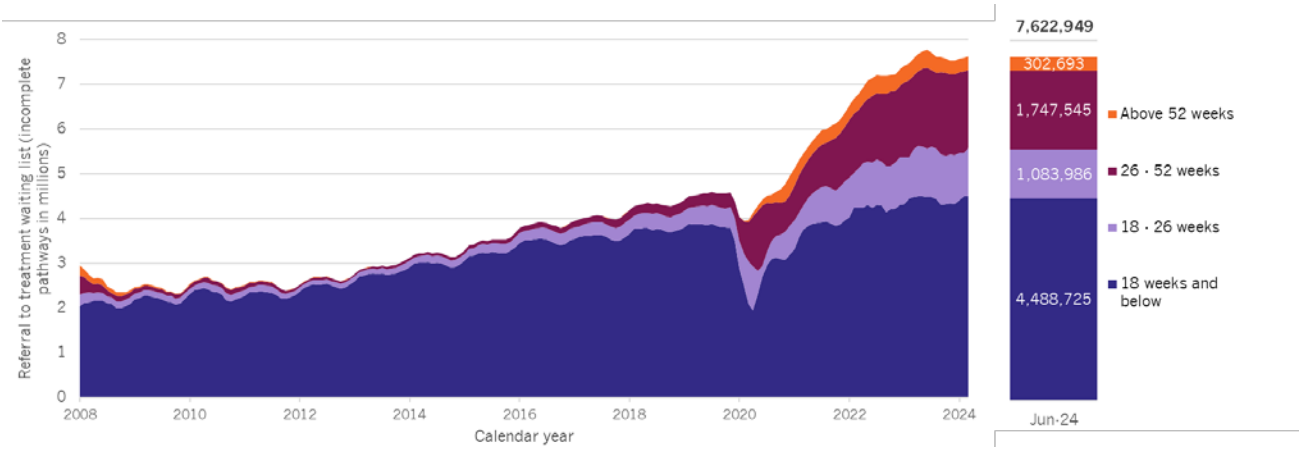
32. There has been a similar experience for people coming to A&E in a mental health crisis. People with a mental health flag tend to experience wait times that are approximately 25 per cent longer than those without[79]. For the 95th percentile, these waits have been getting worse and worse since the pandemic, such that in May 2024, waits were nearly 30 hours[80] and one patient with complex mental health needs spent more than 18 days in an A&E department in August 2024. In 2023-24, more than 80,000 people with mental health crises waited more than 12 hours and more than 26,000 waited for more than 24 hours in A&E departments[81]. Analysis from the RCEM showed that patients in 2022 with a primary diagnosis of mental illness were twice as likely to wait for 12 hours or more than the rest of the population[82]. Bright, busy and noisy A&E departments are completely inappropriate places for someone in mental distress.

Waiting times for consultant-led treatment of non-urgent conditions

33. In March 2010, the NHS Constitution, published in 2009 following the recommendation of *High Quality Care for All*, was amended with a new right for patients to start consultant-led treatment for non-urgent conditions within a maximum of 18 weeks from referral by their GP. In that month, just over 2.4 million people were waiting for NHS treatment. This included 2.21 million people waiting for treatment within 18 weeks; 200,000 waiting between 18 weeks and a year; and 20,000 waiting for more than a year[83]. In 2012, it became a statutory requirement that at least 92 per cent of patients should have a referral-to-treatment time of less than 18 weeks.

34. As we can see in the chart overleaf, in June 2024, the total waiting list stood at 7.6 million people. More than 300,000 people had waited for over a year, and some 1.75 million people had waited for between 6 and 12 months[84]. More than 10,000 people are still waiting longer than 18 months (although this has fallen sharply from its peak of 123,000 people waiting that long in September 2021)[85]. By far the largest group waiting were working age adults – some 4.2 million people[86]. As we will explore in the next chapter, the Covid-19 pandemic saw the most rapid rise in waiting lists. But in February 2020, waiting list already stood at some 4.6 million people, over 2 million more than 10 years earlier[87].

Figure II.8.15: Referral to treatment waiting list over time by weeks waiting



* * *

35. In almost all NHS services, performance on access to care has declined. Long waits have become normalised across the NHS and public satisfaction has declined as a result. Turning the situation around will take time, but it cannot come soon enough. Too many people are waiting too long for the care that they need.

3

Quality of Care in the NHS

1. In my 2008 report, *High Quality Care for All*, I made the case that raising the quality of care should be the organising principle of the NHS. In this chapter, we examine how the NHS is performing in terms of the quality of care that it provides. It is structured around the main pathways, examining the quality of care from the start of life to its end. We then explore three key areas that cause the most avoidable deaths: cancer, cardiovascular conditions, and suicide. We conclude by looking at complaints and clinical negligence – what happens when things go wrong.

Maternity and newborn

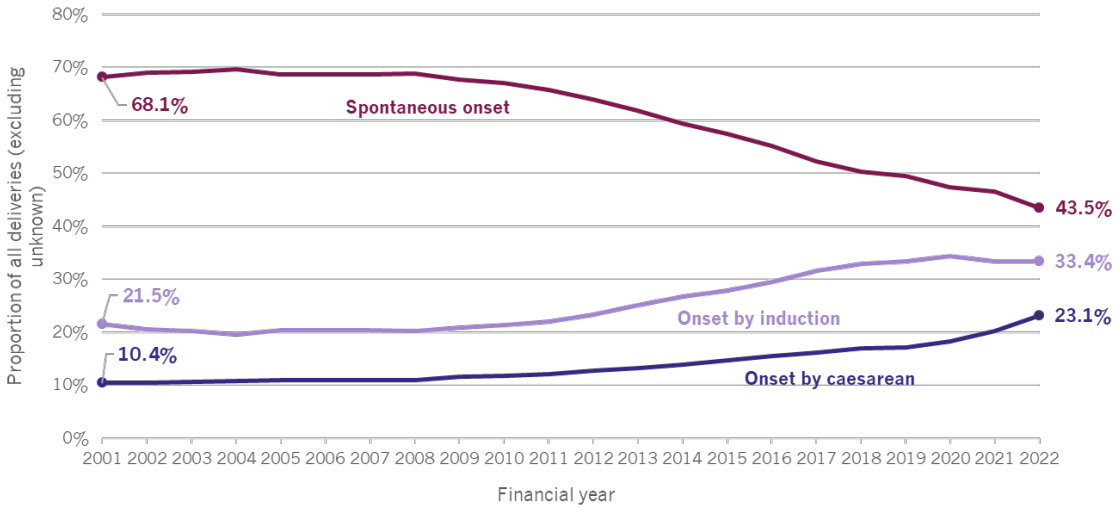
2. There have been positive developments in reductions of stillbirths and a small decrease in neonatal mortality and serious brain injuries. Yet maternal deaths have increased since the pandemic[88], including when adjusted for the direct impact of Covid-19. Most worrying are the huge inequalities that exist in maternity care. For instance, black women are almost three times as likely as white women to die in childbirth. And neonatal mortality of the most deprived quintile is more than double that of the least deprived[89].

3. The lack of progress in some areas occurs at a time when we have had a succession of scandals and subsequent inquiries into maternal care, such as in East Kent, Shrewsbury and Morecambe Bay. A recurring theme is that the recommendations of previous reviews have not been universally adopted.

4. Complexity continues to steadily rise as the age that women become pregnant increases and more expectant mothers have other conditions such as obesity[90] or diabetes[91], whose prevalence is increasing in the population (and also increases with age). This is also reflected in trends in the onset of labour. As the chart below shows, fewer than half of women now go into labour spontaneously, compared to around 70 per cent in the early 2000s[92]. Births by caesarean section are now much

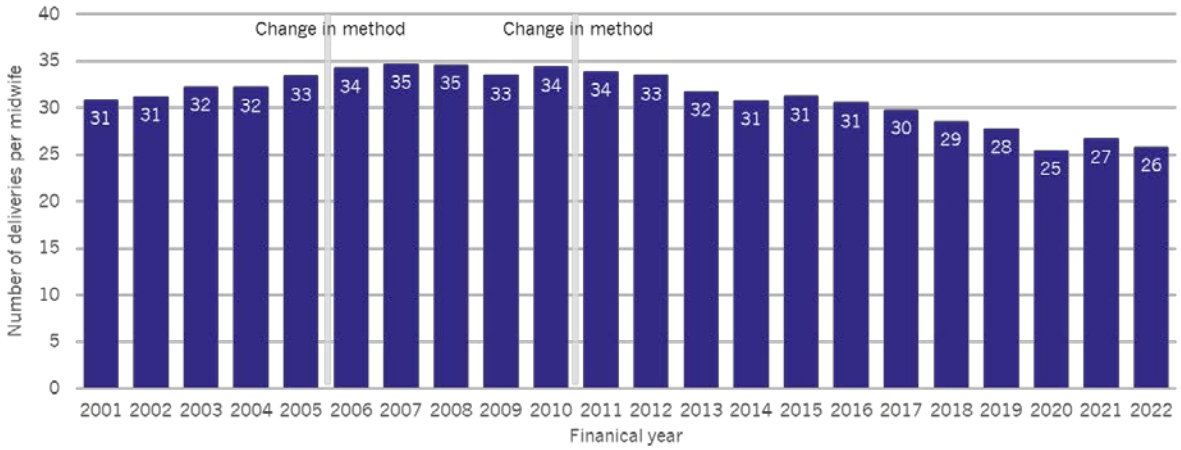
more common, having risen at annual rate of 4.6 per cent since 2005 while inductions have risen at an annual rate of 2.9 per cent over the same period[93].

Figure III.2.1: Rates of onset of labour by induction, spontaneous and caesarean section as a percentage of all deliveries of known onset method



5. While complexity has increased, it has occurred at a time when births have been falling and the number of midwives has risen. The overall result is that the number of deliveries per midwife each year has fallen from a peak of 34.7 in 2007 to 25.8 in 2022, as the chart below shows[94]. This was a notably better ratio than France (31.3 births per midwife in 2021), Germany (31.8 births per midwife in 2021) and Spain (34.3 births per midwife in 2021) and similar to Italy (23.7 births per midwife in 2021)[95].

Figure III.2.10: Deliveries per midwife



6. High rates of sickness absence – equivalent to one working month (22 days) per midwife per year across the NHS as a whole – are likely having an impact[96]. But even

when this is considered, capacity alone does not appear to be the constraint on improvement. This suggests that a deeper conversation needs to be had on skills, staffing mix, clinical models, leadership and culture in maternity services.

7. The Investigation received an important submission from Dr Bill Kirkup, former Associate Chief Medical Officer for England, who most recently led the review into the quality of care at East Kent. Dr Kirkup describes the issues that are supported by published evidence:
    a. Pressure and stress are at high levels which contributes to poor morale. This leads to burnout, absenteeism, high turnover, and the loss of trained staff. This dynamic impairs patient safety.
    b. Training in silos impairs teamwork which compromises patient safety. This is partly a result of divergent curricula for different staff groups that damage attitudes and a lack of focus on learning the skills for teamwork.
    c. Unstable working patterns and the lack of rest space impair teamworking and morale. Having dedicated space and refreshments benefits staff and improves patient safety.
    d. Leadership is crucial particularly Clinical Directors, but the Clinical Director role is poorly developed, supported and managed.
    e. Capacity for compassion is variable, sensitive to environment and pressure, but can be systematically improved.
    f. Transgressive behaviour is more common than admitted, which is very difficult to deal with, and damaging to morale and patient safety.
    g. Response to safety incidents is dominated by personal reactions; fear of blame by colleagues and others is a significant disincentive to investigation and learning; a culture of openness is essential to patient safety, but often lacking.

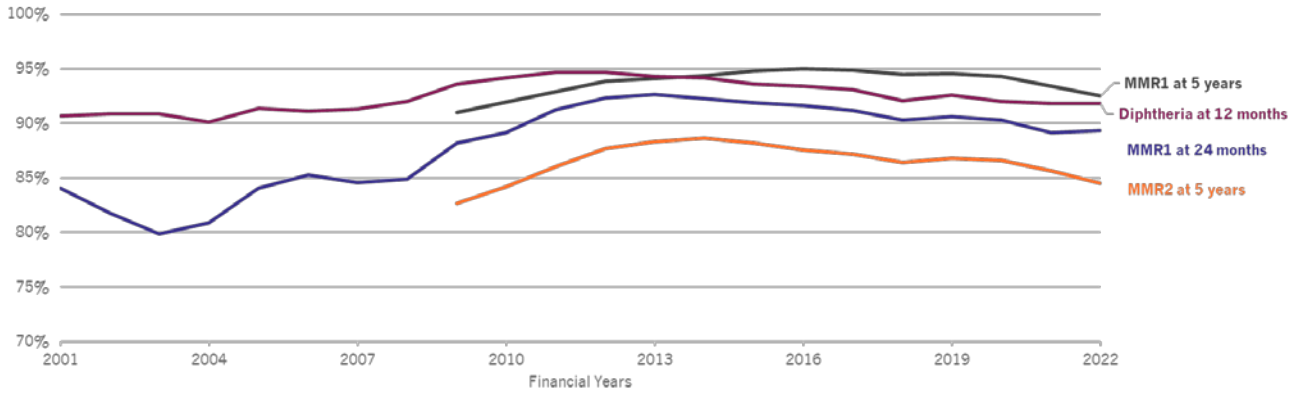
8. Today, too many women, babies and families are being let down. None of the issues described by Dr Kirkup are insurmountable. Each can be solved with sufficient time, attention and focus. The first step is to acknowledge that the problems are complex and that the data suggests that adding more staff will not by itself address them.

Children and Young People

9. Children and young people are 24 per cent of the population and account for 11 per cent of NHS expenditure. Their mental and physical health appears to have been deteriorating in recent years. Since 2019/20, for example, there has been an 82 per cent increase in hospital admissions for eating disorders[97]. Between 2001 and 2018, there was a 250 per cent increase in the prevalence of life-limiting and life-threatening conditions in children and young people[98]. This may reflect an increase in survival in this population as well as an increase in recording of diagnoses. Such children are increasingly likely to have lengthy hospital stays, as the Children's Hospital Alliance (CHA) highlighted in their submission to the investigation. Similarly, the Royal College of Paediatrics and Child Health pointed out that the number of children with eight or more chronic conditions nearly doubled from 7.6 per cent in 2012-13 to 14.0 per cent in 2018-19 and the number of children receiving long-term ventilation more than doubled between 2013 and 2020[99].

10. There are multiple challenges in delivering high-quality care for children and young people. Vaccinations are one of the safest and most cost-effective health interventions. Yet in England, childhood vaccination rates have been declining since 2013-14[100]. This needs to be addressed.

Figure III.3.7A: Vaccine coverage of children aged 24 months with the MMR vaccine (dose 1) and aged 5 years with the MMR (dose 1 and dose 2) and diphtheria vaccines, in England

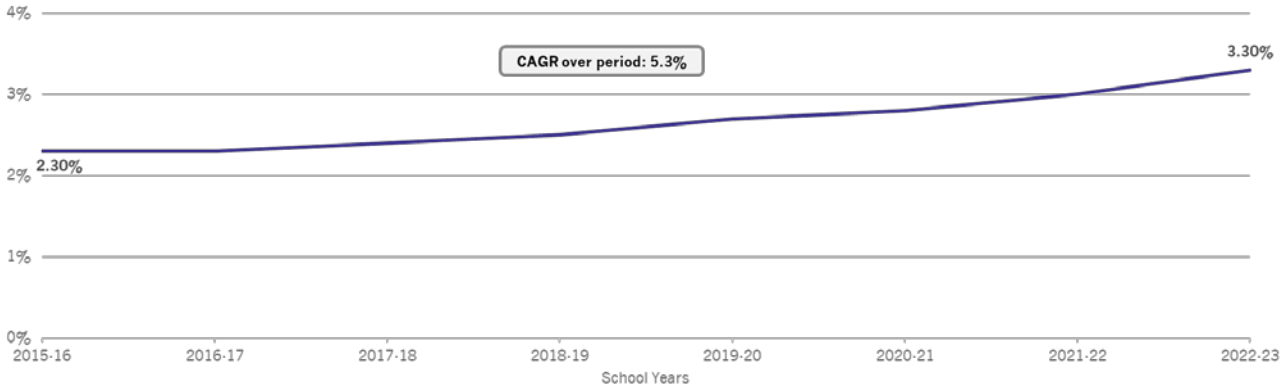


11. It is also clear that health inequalities begin at a very young age. Children from the most deprived decile are 2.1 times as likely to be obese in Reception than children from the least deprived decile, and this extends to 2.3 times by Year 6[101]. It is utterly shocking that in the poorest communities, nearly one-in-three children are obese by year 6[102]. Moreover, according to a submission from the Royal College of Paediatrics and Child Health (RCPCH), 2.5 million children and young people in England are affected by excess weight or obesity, with 1.2 million living with obesity-related complications[103].

12. Under-18 smoking rates continue to fall, and it is unequivocally good news that the government intends to proceed with legislation to create a smoke free generation. But there has been a worrying rise in vaping by children[104]. While vaping is substantially less harmful than smoking, it is not risk free. Given that the long-term health implications are not known, this is a cause for concern.

13. There is a significant rise in mental health needs amongst children, as analysis from the charity Young Minds shows. The percentage of school pupils with social, emotional and mental health needs increased from 2.3 per cent in 2015-16 to 3.3 per cent in 2022/23[105]. Between 2004 and 2023 the number of patients on ADHD medication has been increasing by just over 10 per cent each year[106]. And as we have seen, access to mental health services is a huge problem for children and young people.

Figure III.3.6: Percentage of school pupils who have educational support for social, emotional and mental health needs (school age)



14. Paediatric services for physical health are under pressure, too. As we have seen, waiting list size and duration of waits have grown more rapidly for children than for adults. And according to the RCPCH, children are 13 times more likely than adults to wait over a year for access to community services[107].

15. As the Children's Hospital Alliance (CHA) points out, paediatric intensive care unit (PICU) beds are regularly over 90 per cent occupancy with some units at 100 per cent. Length of stay is also increasing (notably, with more 100+ day patients), leading to cancellations of cardiac and cancer elective operations[108]. More children are attending A&E, but the emergency admission rate has not increased, suggesting that they could be cared for elsewhere.

16. There are real concerns about the NHS' capacity and capability to deliver high-quality care for children. Only 25 per cent of GPs now receive paediatric training[109]. The centralisation of paediatric surgery to specialist centres during the pandemic means some surgeons and anaesthetists in non-specialist acute hospitals are more reluctant to operate on children[110]. Paediatrics is not a requirement of doctors' training at foundation level, and for many specialties only happens after full adult training (such as for pathology and radiology)[111].

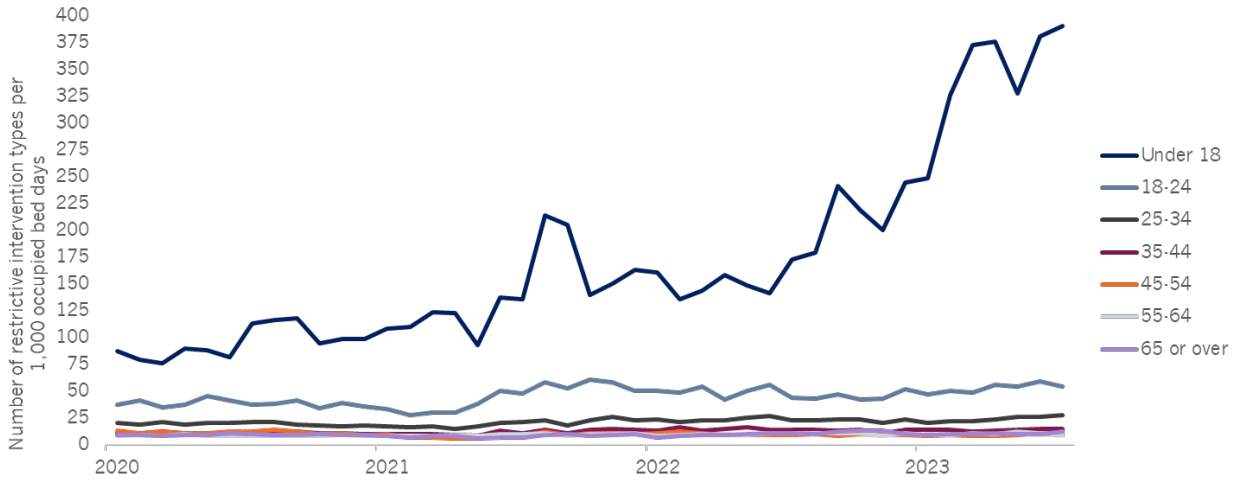
17. The problems faced by all NHS patients are similarly encountered by children and young people. At the moment, too many are being let down. Childhood is precious because it is brief; too many children are spending too much of it waiting for care. It is apparent that the NHS must do better and that national policymaking on care for children and young people needs to be more joined up.

Mental health

18. There has been a notable success in the Improving Access to Psychological Therapies programme. The proportion of people with anxiety or depression who have been able to access Talking Therapies has increased from 6.1 per cent in 2013/14 to 15.9 per cent in 2022/23[112]. The recovery rate for those who complete a course of talking therapies has remained steady at approximately 50 per cent[113].

19. For those receiving inpatient mental health care there has been an increase in restrictive interventions, such as physically restraining patients to administer medication or gastro-nasal feeding, over the last four years. As this chart shows, that increase is being driven by a dramatic and concerning surge in restrictive interventions for children under 18[114]. This goes alongside a dramatic rise in admissions, which have increased by 82 per cent since 2019, according to analysis done using NHS data, though changes in reporting practices as well as an increase in the number of organisations reporting may account for some of this increase[115].

Figure III.5.4: Number of restrictive intervention types per 1,000 occupied bed days (Sep 2020 - Mar 2024)



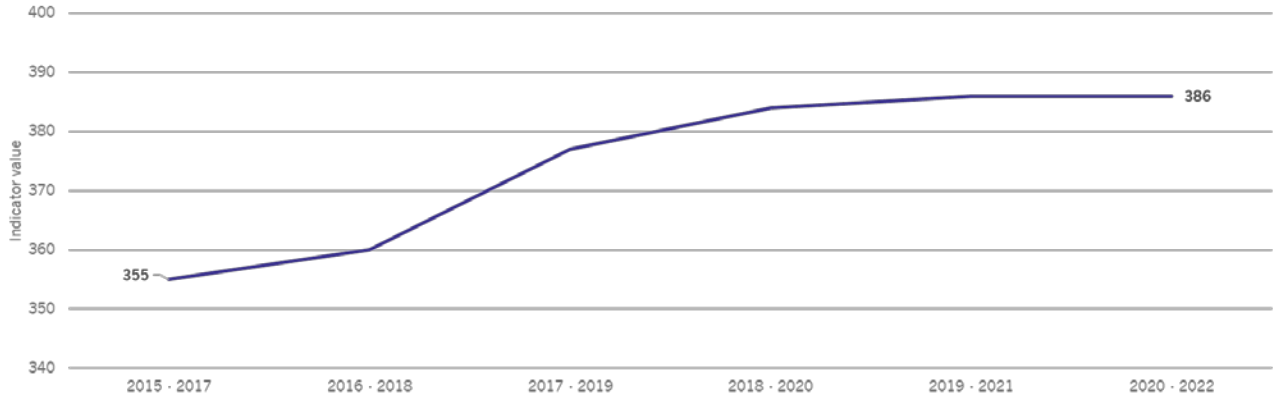
20. There has been a significant expansion in access to perinatal mental health services. Despite the significant impact of the pandemic, between 2019-20 and 2023-24, the numbers of women accessing care grew by two thirds[116]. The aim is to expand it further so that 66,000 mothers are helped this year.

21. People living with serious mental illnesses have significantly lower life expectancy than the rest of the population, typically dying 15 to 20 years earlier[117]. This problem is well-documented. Yet while psychiatric liaison exists in acute physical hospitals, there is no physical health liaison in mental health wards.

22. There have been positive developments with more mental health patients receiving physical health checks. In their submission to the Investigation, the Royal College of Psychiatrists pointed out that there had been an annual increase in physical health checks of 127 per cent, rising from nearly 160,000 to more than 360,000[118]. This is close to, but still below, the ambition set in the 2019 NHS Long Term Plan.

23. Yet excess mortality for those with serious mental illnesses has been going in the wrong direction, as the chart below shows. According to the RCPsych, there were an estimated 130,400 premature deaths among adults with severe mental illness during 2020-2022, compared to an estimated 100,476 in 2015-2017.

Figure III.5.7: Excess Under 75 mortality rates in adults with serious mental illness, 2015-17 to 2020-22, England



24. The NHS has a special responsibility to those that it treats while they are detained under the Mental Health Act. During visits as part of this investigation I saw some high-quality, modern facilities that are world-leading. But I was appalled to uncover that mental health patients continue to be accommodated in rooms that were constructed for a Victorian asylum. In one ward that I visited, patients' rooms were 7' x 8'6" with a fixed bunk that measured 6'6" by 3', occupying more than a third of the room.

> "We shouldn't be living like this. We're human beings at the end of the day. How are we supposed to recover from our mental illness when we have to live like this? We shouldn't be living with leaks and floods and cockroaches and mice. We have two showers for 17 men. It's totally wrong."
> *A patient speaking to Lord Darzi during a service visit*

25. Patients told me how nearly 20 men were expected to share just two showers, how the laundry facilities often broke down, and how they struggled to maintain their personal hygiene and dignity. They spoke of infestations of mice and cockroaches

which no amount of pest control had managed to eradicate from the decrepit estate. Under the current capital rules, even if the Trust concerned raised the capital from disposals of other assets, they would not have the discretion to spend it on replacing or rebuilding the unit.

26. According to a submission from the Royal College of Psychiatrists, more than a third of single rooms across mental health and learning disability sites in 2022-23 lacked ensuite facilities, amounting to more than 6,600 patient rooms. Many patients stay in these facilities for months at a time, and some for many years. If the measure of a society's humanity is how it treats its most vulnerable, then we are falling far short.

27. I was therefore particularly concerned to discover that a decision was taken to remove three out of five of the mental health schemes in the new hospitals programme, as part of the review of the programme by HM Treasury. NHS England's prioritisation, based on objective assessment of the merits of the schemes, was overruled.

28. The lack of sufficient good quality facilities contributes to mental health inpatients being accommodated far from their family, friends and loved ones. Inappropriate out-of-area placements of mental health service users have decreased at a rate of 8 per cent a year since 2018 but while they fell from their 2019 peak through to 2022, they began to rise again in 2023 and stood at nearly 6,000 in that year[119]. Being far from a support network hinders recovery and makes it harder for people to get back to daily life. And as we have seen, bed capacity and management problems mean that all-too-often patients are waiting for excessively long times in hospital accident and emergency departments as no mental health beds can be found[120].

29. There has been a steady decline in suicides completed by people with diagnosed mental illnesses, both those who are living in the community and those who are inpatients. The numbers of mental health inpatients that have completed suicide have reduced from 100 in 2009 to fewer than 60 in each year since 2017[121]. This reflects sustained efforts to reduce ligature risk and to improve observations. But

there is still further to go to ensure inpatient wards are as safe as possible for people in mental distress.

30. At the same time, there are also concerns about the rigor with which patients who have serious mental illnesses are followed up in the community and how effectively risk is managed. There are a number of cases, high profile and not, where people with serious mental illness have not had appropriate risk assessments or sufficiently assertive follow up[122]. There is significant scope for improvement in the quality, safety and consistency of care.

Long-term conditions

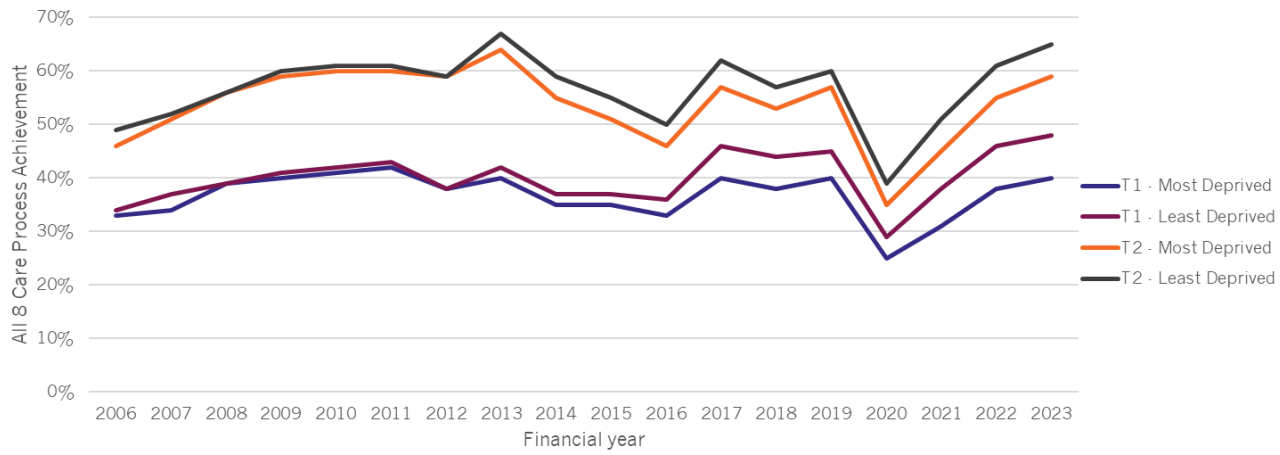
31. As we saw in chapter 1, there has been a substantial rise in the prevalence of some long-term conditions. Perhaps more significantly, more people now have multiple long-term conditions: between 2017 and 2022, the number of people with two or more long-term conditions increased at an annual rate of 6.1 per cent[123]. This matters because multiple conditions can interact with each other, which increases complexity and makes their management more challenging. Many long-term conditions are caused or exacerbated by lifestyle factors, such as tobacco or alcohol consumption, and obesity.

32. As the disease burden has shifted towards long-term conditions, multidisciplinary team working has become more important. Yet NHS structures have not kept pace. GPs are expected to manage and coordinate increasingly complex care, but do not have the resources, infrastructure and authority that this requires.

33. As we saw in chapter 1, the probability of having one or more long-term conditions rises substantial with age. In their submission to the Investigation, Age UK analysis of the GP patient survey found significant declines in the proportion of older people who feel supported to manage their long-term conditions in the community. Rates fell by around 10 per cent across all older adult age cohorts between 2018 and 2023.

34. For many long-term conditions, there is a strong evidence base about what interventions are required. People with diabetes, for example, should have eight care processes that are well-defined and evidence-based. Yet while there has been some progress, there are wide disparities between the most and least deprived communities, with the least deprived 5 per cent more likely to receive all eight than the most deprived, as we can see in the chart below[124].

Figure III.7.3: Percentage of patients with all 8 Care Process achieved, by diabetes type and deprivation quintile (most and least deprived)

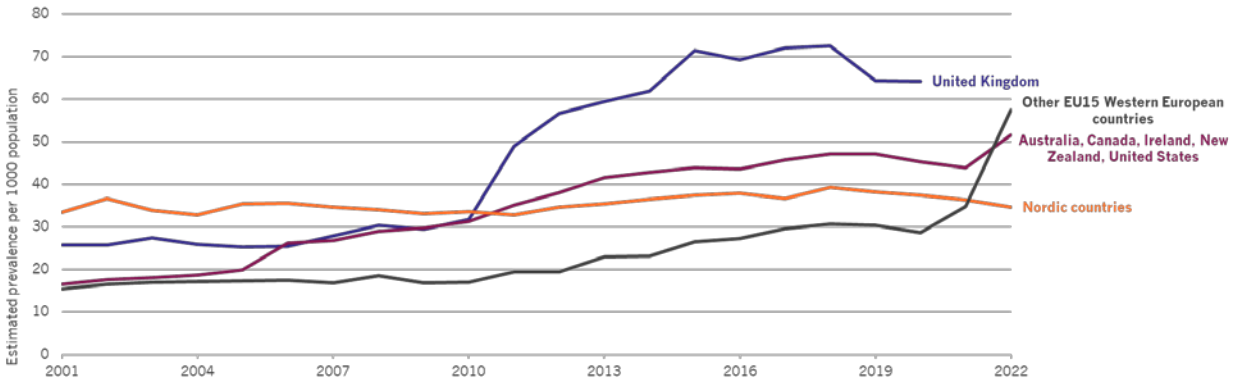


35. A similar picture is true for other long-term conditions, such as chronic breathing difficulties. Moreover, 35 per cent of patients with long-term conditions still do not have a care plan, which is one of the most important tools to coordinate and manage care[125].

Dementia

36. The number of people aged 65 years and over increased from 9.2 million in 2011 to over 11 million in 2021 and the proportion of people aged 65 years and over rose from 16.4 per cent to 18.6 per cent[126]. The Alzheimer's Society estimates that there are approximately 982,000 people living with dementia[127]. Analysis of OECD data finds that prevalence of dementia is 19 per cent below the OECD20 but that the UK has a substantially higher rate of dementia deaths, which have been above 60 per 100,000 patients since 2014 (though this may reflect difference in recording)[128].

Figure III.9.2: Dementia deaths per 100,000 patients (standardised rates)



37. In addition, dementia diagnosis rates have not improved in recent years. The dementia diagnosis rate for people aged 65 and over has only recovered to around 65 per cent compared to 68 per cent before the Covid-19 pandemic[129]. Concerningly, the proportion of patients with dementia receiving a care plan or care plan review in the preceding 12 months dropped to less than 40 per cent during the Covid-19 pandemic[130].

38. In their submission to the Investigation, the Alzheimer's Society argued that there are "high levels of unwarranted variation in access to diagnosis and treatment [and] insufficient adherence to clinical guidelines". As society continues to age, there is an important challenge to improve both the quality and quantity of care for people with dementia.

Planned care

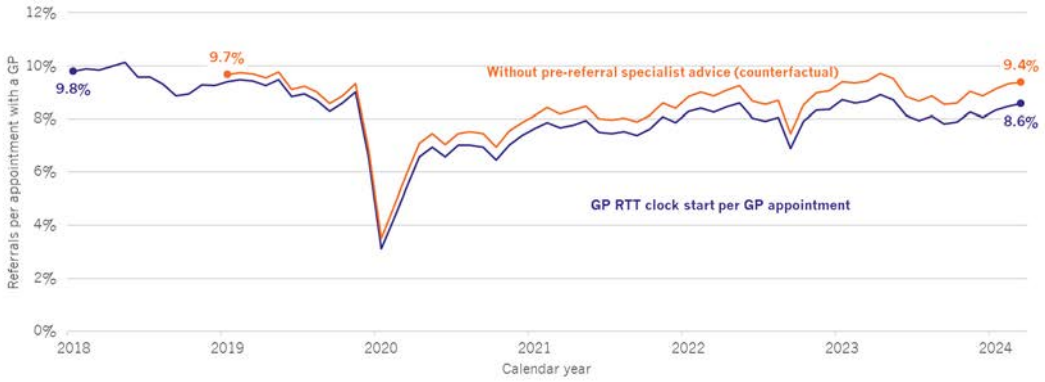
39. As we have seen above, there have been large increases in waiting times for planned procedures. Long waits for treatment have a significant impact on patients. For some, it means waiting for longer periods in discomfort or with limited mobility. For others it can limit their ability to work or to enjoy leisure time with family. From a clinical perspective, it can mean a worse prognosis, more complex interventions, more powerful medications, and longer recovery times.

40. There has been a significant increase of 2.3 per cent a year in outpatient referrals from 2008 to 2023[131]. Progress has been made in reducing the number of follow-ups to first outpatient appointments[132]. This has a quality and efficiency benefit: it

focuses on resolving issues the first time while also freeing up clinician time to see new cases.

41. There has also been important progress in expanding the role of specialist advice. As the chart below shows[133], this has helped to slow the rate of consultant-led treatment, as more patients can be managed by their GP, with appropriate specialist input.

Figure III.4.6: Estimated impact of pre-referral specialist advice on the GP referral rate for consultant-led treatment per appointment

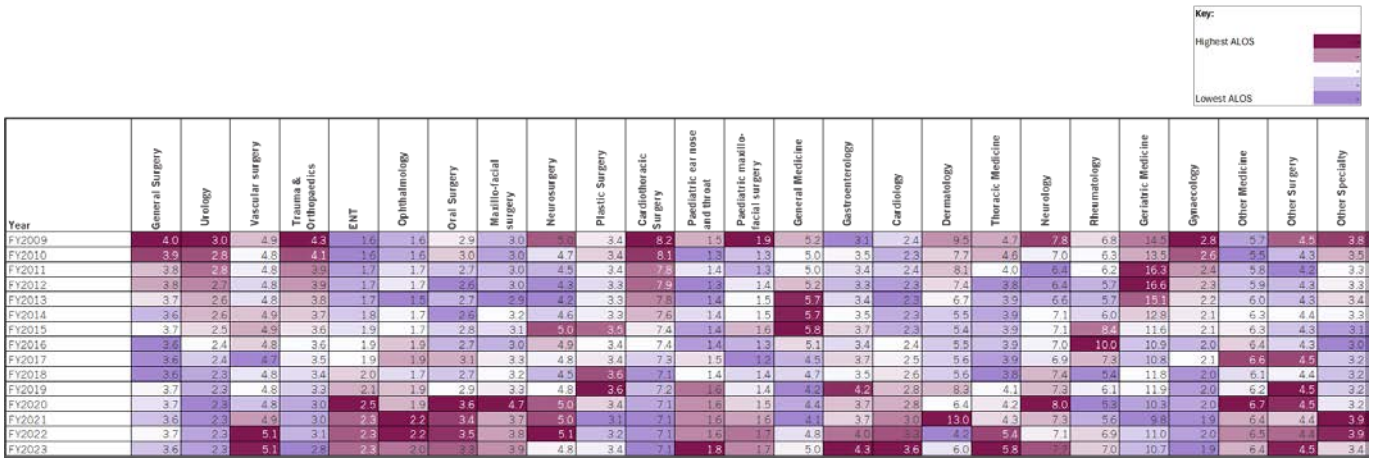


42. Other innovations include "virtual wards". A virtual ward (also known as hospital at home) is an acute clinical service with staff, equipment, technologies, medication and skills usually provided in hospitals delivered to selected people in their usual place of residence, including care homes. It is a substitute for acute inpatient hospital care. Since the national programme was launched in April 2022, virtual wards have been established in all integrated care systems in England with 12,365 'beds' in place in July 2024[134] and the ambition to be able to be able to admit 50,000 patients a month[135].

43. Where effective, virtual wards have the potential to support two key areas of system impact: reducing attendances and admissions to hospital for 'step up' virtual wards and secondly to support reductions in length of stay in hospital through 'step down' virtual wards where the acute episode of care is completed in the home setting.

44. Another measure of greater efficiency and quality is reducing length of stay for planned care. Here the overall progress in reducing length of stay masks significant variation by specialty, as the chart below shows. This may reflect a shift to day-cases, which means that only the most complex patients stay in hospital. The precise reasons why some specialities have reduced their length of stay, whilst others have increased, is worth closer examination.

Figure III.4.3: Variation in elective overnight average length of stay by treatment function



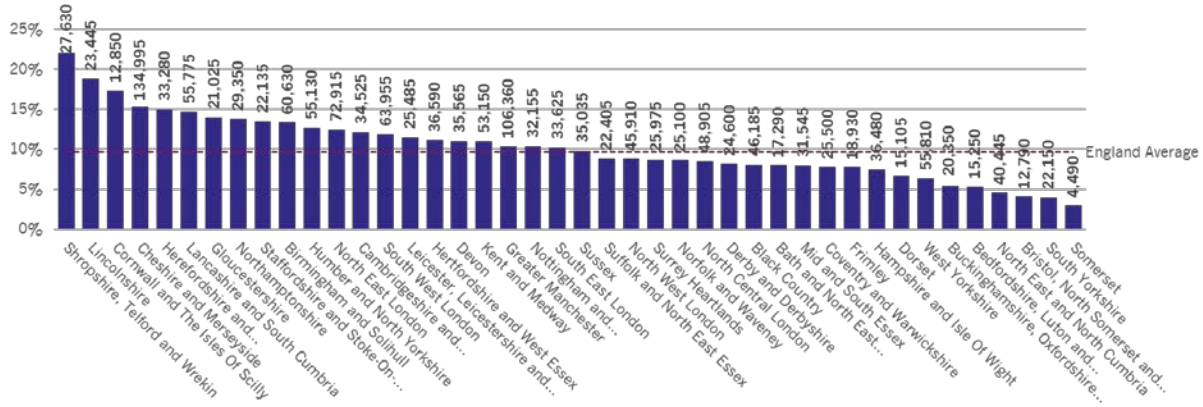
Year	General Surgery	Urology	Vascular surgery	Trauma & Orthopaedics	ENT	Ophthalmology	Oral Surgery	Maxillo-facial surgery	Neurosurgery	Plastic Surgery	Cardiothoracic Surgery	Paediatric ear nose and throat	Paediatric maxillo-facial surgery	General Medicine	Gastroenterology	Cardiology	Dermatology	Thoracic Medicine	Neurology	Rheumatology	Geriatric Medicine	Gynaecology	Other Medicine	Other Surgery	Other Specialty
FY2009	4.0	3.0	4.9	4.3	1.6	1.6	2.9	3.0	5.0	3.4	8.2	1.3	1.9	5.2	3.1	2.4	9.5	4.7	7.8	6.8	14.5	2.8	5.7	4.5	3.8
FY2010	3.9	2.8	4.8	4.1	1.6	1.6	3.0	3.0	4.7	3.4	8.1	1.3	1.3	5.0	3.5	2.3	7.7	4.6	7.0	6.3	13.5	2.6	5.5	4.3	3.5
FY2011	3.8	2.8	4.8	3.9	1.7	1.7	2.7	3.0	4.5	3.4	7.8	1.4	1.3	5.0	3.4	2.4	8.1	4.0	6.4	6.2	16.3	2.4	5.8	4.2	3.3
FY2012	3.8	2.7	4.8	3.9	1.7	1.7	2.6	3.0	4.3	3.3	7.9	1.3	1.4	5.2	3.3	2.3	7.4	3.8	6.4	5.7	16.6	2.3	5.9	4.3	3.3
FY2013	3.7	2.6	4.8	3.8	1.7	1.5	2.7	2.9	4.2	3.3	7.8	1.4	1.5	5.7	3.4	2.3	6.7	3.9	6.6	5.7	15.1	2.2	6.0	4.3	3.4
FY2014	3.6	2.6	4.9	3.7	1.8	1.7	2.6	3.2	4.6	3.3	7.6	1.4	1.5	5.7	3.5	2.3	5.5	3.9	7.1	6.0	12.8	2.1	6.3	4.4	3.3
FY2015	3.7	2.5	4.9	3.6	1.9	1.7	2.8	3.1	5.0	3.5	7.4	1.4	1.6	5.8	3.7	2.3	5.4	3.9	7.1	8.4	11.6	2.1	6.3	4.3	3.1
FY2016	3.6	2.4	4.8	3.6	1.9	1.9	2.7	3.0	4.9	3.4	7.4	1.4	1.3	5.1	3.4	2.4	5.5	3.9	7.0	10.0	10.9	2.0	6.4	4.3	3.0
FY2017	3.6	2.4	4.7	3.5	1.9	1.9	3.1	3.3	4.8	3.4	7.3	1.5	1.3	4.5	3.7	2.5	5.6	3.9	6.9	7.3	10.8	2.1	6.6	4.5	3.2
FY2018	3.6	2.3	4.8	3.4	2.0	1.7	2.7	3.2	4.5	3.6	7.1	1.4	1.4	4.7	3.5	2.6	5.6	3.8	7.4	5.4	11.8	2.0	6.1	4.4	3.2
FY2019	3.7	2.3	4.8	3.3	2.1	1.9	2.9	3.3	4.8	3.6	7.2	1.6	1.4	4.2	4.2	2.8	8.3	4.1	7.3	6.1	11.9	2.0	6.2	4.5	3.2
FY2020	3.7	2.3	4.8	3.0	2.5	1.9	3.6	4.7	5.0	3.4	7.1	1.6	1.5	4.4	3.7	2.8	6.4	4.2	8.0	8.3	10.3	2.0	6.7	4.5	3.2
FY2021	3.6	2.3	4.9	3.0	2.3	2.2	3.4	3.7	5.0	3.1	7.1	1.6	1.6	4.1	3.7	3.0	13.0	4.3	7.3	5.6	9.8	1.9	6.4	4.4	3.9
FY2022	3.7	2.3	5.1	3.1	2.3	2.2	3.5	3.8	5.1	3.2	7.1	1.5	1.7	4.8	4.0	3.3	4.3	5.4	7.1	6.9	11.0	2.0	6.5	4.4	3.9
FY2023	3.6	2.3	5.1	2.8	2.3	2.0	3.3	3.9	4.8	3.4	7.1	1.8	1.7	5.0	4.3	3.6	6.0	5.8	7.3	7.0	10.7	1.9	6.4	4.5	3.4

45. There has been good progress in improving patient safety, partly as a result of sustained focus and political attention, notably from the Rt Hon. Jeremy Hunt MP who was the longest serving health secretary and a passionate advocate for improvement. The proportion of care that is error-free has increased, while avoidable harms like pressure ulcers have fallen[136]. Good progress was made in reducing healthcare acquired infections from 2007-08 to 2011-12, though since then progress has plateaued[137]. Deaths from venous thromboembolism (blood clots in the veins, which can result from hospital stays) spiked during the Covid-19 pandemic and have not yet returned to pre-pandemic levels[138].

Urgent and emergency care

46. Very long waits in A&E have become all too common, and they are a quality of care issue as well as an access problem. While around 60 per cent are seen within four hours and 30 per cent within 12 hours, some 10 per cent of people are now waiting for 12 hours or more[139]. As the chart below shows[140], in some parts of the country, more than one-in-five people are now waiting for 12 hours or more.

Figure II.8.14: ICB A&E waiting times, 12+ hour waits from time of arrival



47. The Royal College of Emergency Medicine has highlighted that very long waits are associated with an increase in deaths. Their analysis shows that this may have resulted in as many as 268 additional death per week in 2023, or nearly 14,000 over the year as a whole[141]. The first priority in addressing issues in A&E should be to eliminate very long waits.

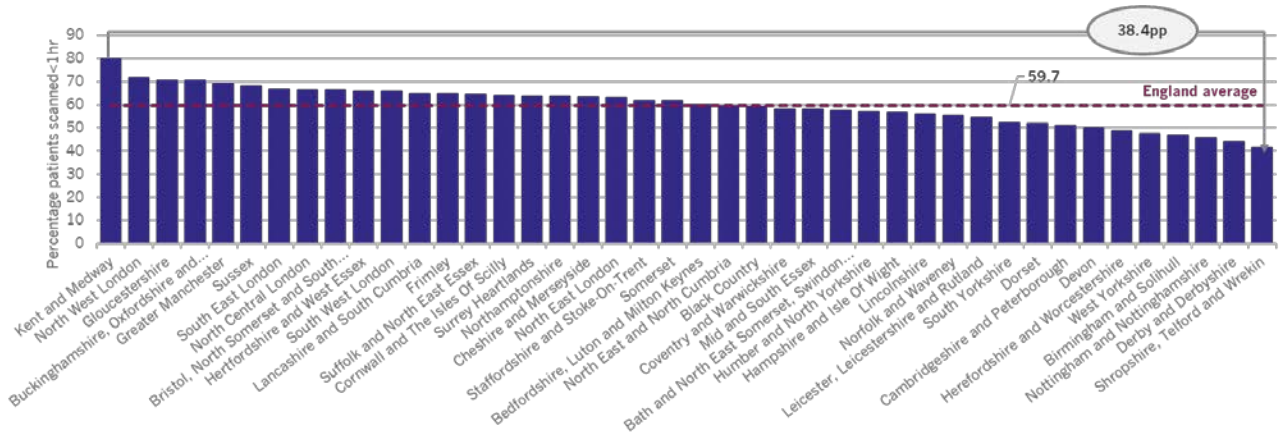
48. Unsurprisingly patient satisfaction has declined with longer waits. In 2010, 60 per cent of the public were very or quite satisfied with Accident and Emergency Services. This had declined to 54 per cent by 2019 and then fell sharply to just 30 per cent by 2022[142]. It remains at historically low levels.

49. Analysis by Age UK, submitted to the Investigation, found that there were more than a million admissions or readmissions to hospital per year from conditions that should not normally require hospital treatment. On any given day, over 2,000 people aged over 65 are admitted to hospital in an emergency for a condition that could have been treated earlier in the community or prevented altogether (such as a fall). Moreover, Age UK found that one-in-six emergency admissions of those aged over 75 were people that had been discharged from hospital within the previous 30 days.

50. Rapid access to treatment for cardiovascular conditions has deteriorated and varies dramatically across the country. For example, the 'call-to-balloon' time for higher risk STEMI heart attack patients in England, Wales and Northern Ireland has risen by 28 per cent from an average of 114 minutes in 2013-14 to 146 minutes in 2022-23[143]. The rise has the greatest impact on the 25 per cent of patients who are now waiting more than 130 minutes for this emergency procedure. Moreover, there is a more than two-fold difference between ICB areas: patients in Surrey are likely to receive the procedure in less than 90 minutes while those in Bedfordshire, Luton and Milton Keynes must wait around four hours[144].

51. There is a similar picture with stroke care. Rapid access to brain imaging is required when patients arrive in hospital to confirm stroke diagnosis and the right course of treatment. But the percentage of patients who receive the necessary brain scan within an hour of arrival at hospital is hugely variable. As the chart below shows, in Kent, 80 per cent of patients will receive that standard of care; while in Shropshire, only around 40 per cent will do so[145].

Figure III.8.6: Percentage of patients scanned within one hour of arrival, by ICB (England) / LHB (Wales) 2023/24

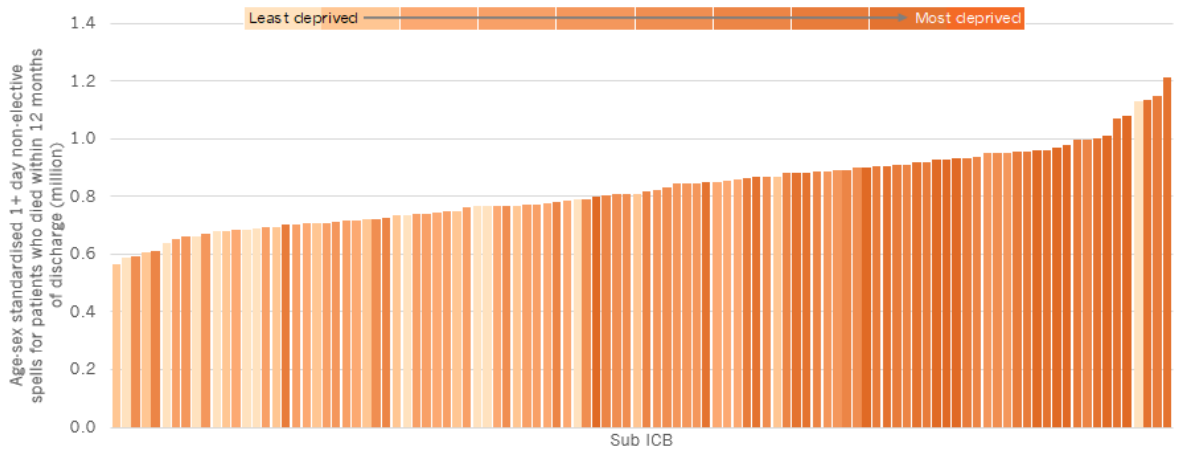


End of life care

52. Dignity, compassion and respect are important at the end of life. According to polling by YouGov commissioned by the charity Compassion in Dying and submitted to the investigation, 83 per cent of adults would prioritise quality of life over living longer in the last years of life[146]. As the Chief Medical Officer has said, better quality at the end of life may require "less medicine, not more"[147]. Yet as the Nuffield Trust has found, one in four people in the last year of life have three or more unplanned hospital admissions[148].

53. New analysis prepared for this report highlights some important disparities. People in the most deprived communities are far more likely to have multiple emergency admissions to hospital in the last year of their lives, as we can see in the chart below. There are likely to be complex reasons for this: people in poorer communities are more likely to die of treatable conditions; GP access is less good, so there are less likely to be end of life plans; and there may be cultural factors[149]. This should be examined more closely, especially in light of Compassion in Dying's findings that many bereaved people believe their loved ones had medical treatment they would not have wanted[150].

Figure III.10.3: Sub-ICB age-sex standardised rates of 1+ day non-elective spells in the last year of life, shaded by proportion of population living in more deprived areas



54. Many people express a preference to die at home. While there are major data limitations, analysis of those countries submitting data to the OECD found that the UK performs in the middle of the pack[151]. There may be lessons to be learned from the Netherlands' consistently low rates and from Ireland's steep reductions. Analysis of primary care data found that the proportion of people with a recorded preference increased substantially from just over 10 per cent in 2009 to nearly 50 per cent in 2019. Since then, it has plateaued[152]. Society needs to restart the conversation about how to die well: with dignity, compassion, and preferences respected.

Avoidable deaths

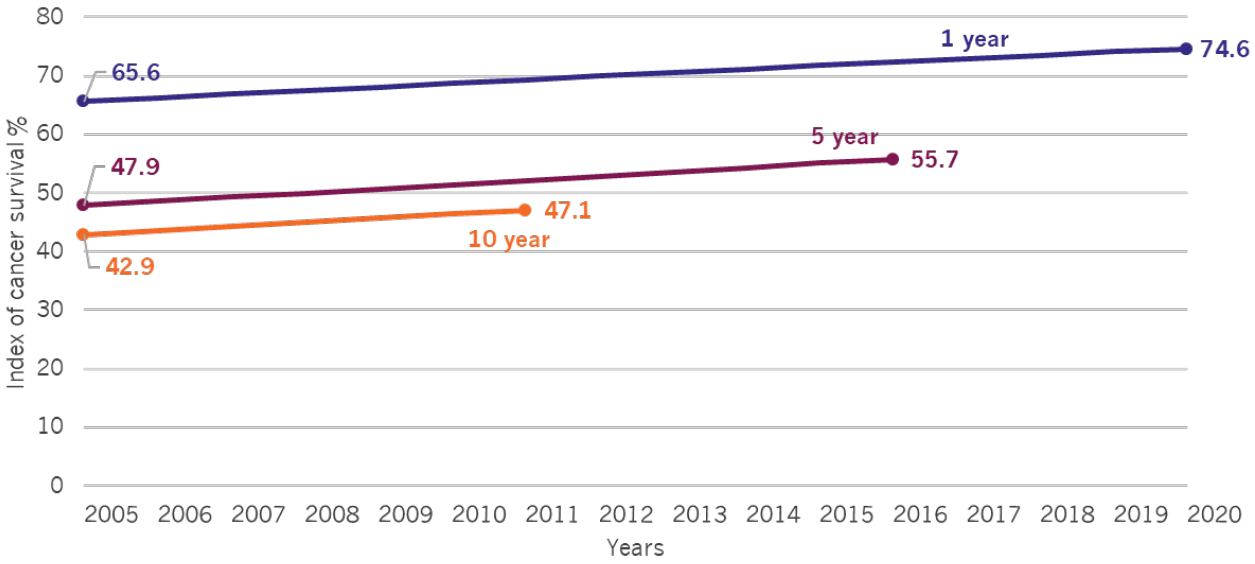
55. Far too many lives are lost to avoidable causes, meaning that they are either preventable or treatable. There is significant scope to improve the performance of the NHS and to save lives. Here, we examine three of the most significant areas: cancer, cardiovascular disease, and suicide.

Cancer

The number of cancer cases in England has risen at a rate of 1.7 per cent a year from 2001 to 2021. When standardised for age, it has still risen at 0.6 per cent annually[153]. The result is that there were around 96,000 more cases of cancer in 2019 than in 2001. While survival rates at 1-year, 5-year and 10-year have all

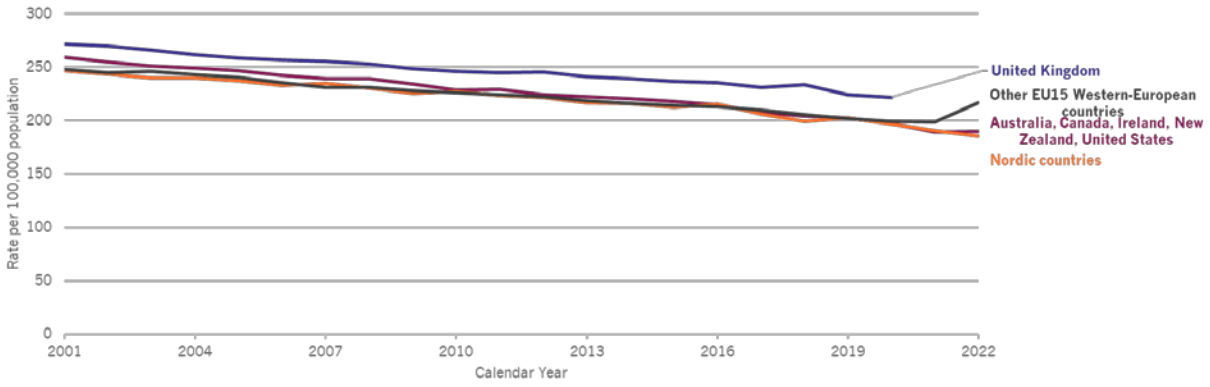
improved, the rate of improvement slowed substantially during the 2010s, as the chart below sets out[154]:

Figure III.12.2: Index of cancer survival by calendar year of diagnosis in England, Persons aged 15 to 99 years, diagnoses 2005 to 2020



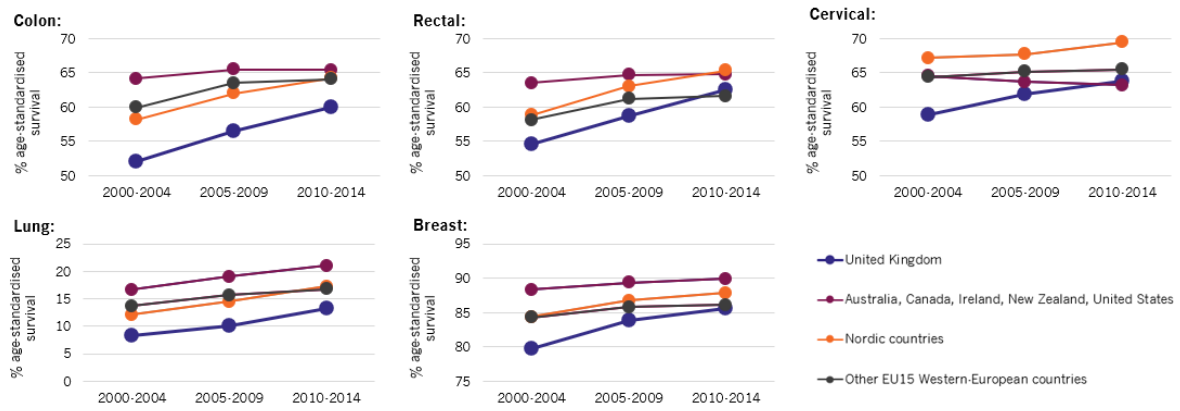
56. International comparisons of cancer mortality find that the UK has substantially higher rates than our European neighbours, Nordic countries, and countries that predominantly speak English (see chart below)[155].

Figure III.12.4: Standardised rate of malignant neoplasms deaths per 100,000 patients, 2001 to 2022 (or nearest year)



57. While cancer survival rates have improved more quickly than many peer countries, they have done so from a low base. This means that the UK is still behind the Nordic countries for all major cancers and behind other European countries and other predominantly English-speaking countries for three out of five cancer sites analysed, as the chart below shows[156]:

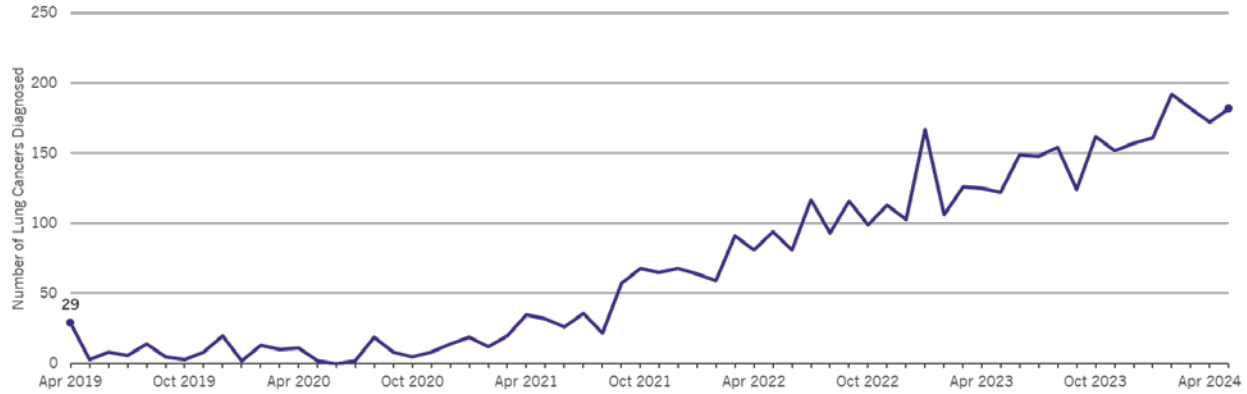
Figure III.12.5: % age-standardised five-year net cancer survival, 15 years and above, 2000 to 2014



58. The route to diagnosis has changed over time, in particular with the uptake of the urgent suspected cancer pathway. Important progress has been made in reducing the number of cancers diagnosed as result of an emergency presentation, with the proportion falling from nearly 25 per cent in 2006 to below 20 per cent in 2018 and 2019[157]. There are important inequalities, with the most deprived more likely to present as an emergency.

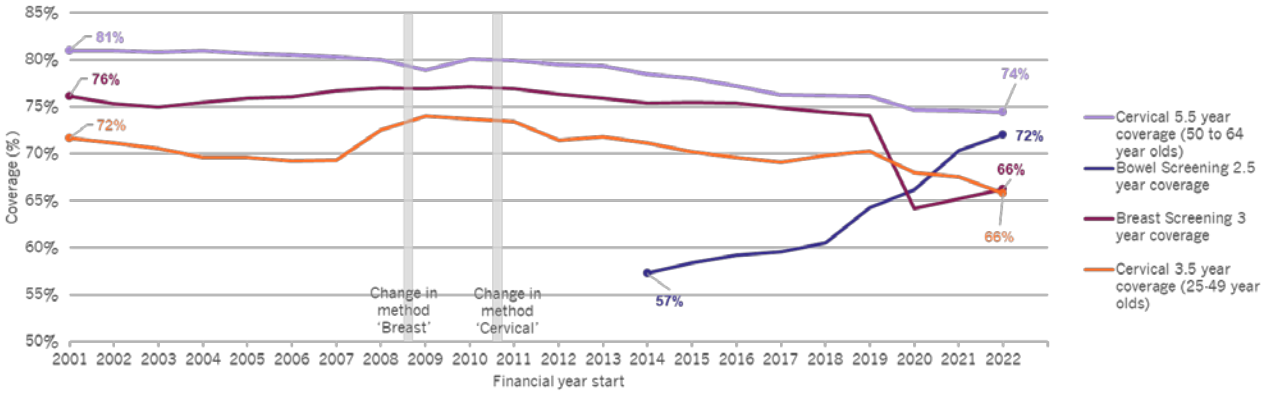
59. Early diagnosis is an important priority since it is associated with higher survival rates. Yet despite its importance, no progress whatsoever was made in diagnosing cancer at stage I and II between 2013 and 2021. Since then, there have been some signs of hope as rates of early-stage diagnosis have improved from around 54 per cent to 58 per cent in 2023[158]. This is likely to be in significant measure due to the Targeted Lung Health Check programme which has identified more than 4,000 cases of lung cancer since 2019, with 76.7 per cent at stage I or II[159]. This important success should be celebrated and the transferable lessons applied to other areas.

Figure III.12.11: The number of Lung Cancers Diagnosed each month through the TLHC Programme April 2019 – May 2024 (TLHC Management Information Return)



60. One contributor to the early diagnosis challenge may be declining participation in screening programmes. Screening coverage rates for breast and cervical screening have both been going in the wrong direction since around 2010, as the chart below shows[160]. Rates of bowel screening have increased at an impressive rate since the programme was started but still have further to go.

Figure III.1.10: National Cancer Screening Programmes Coverage (%) 2002 - 2023

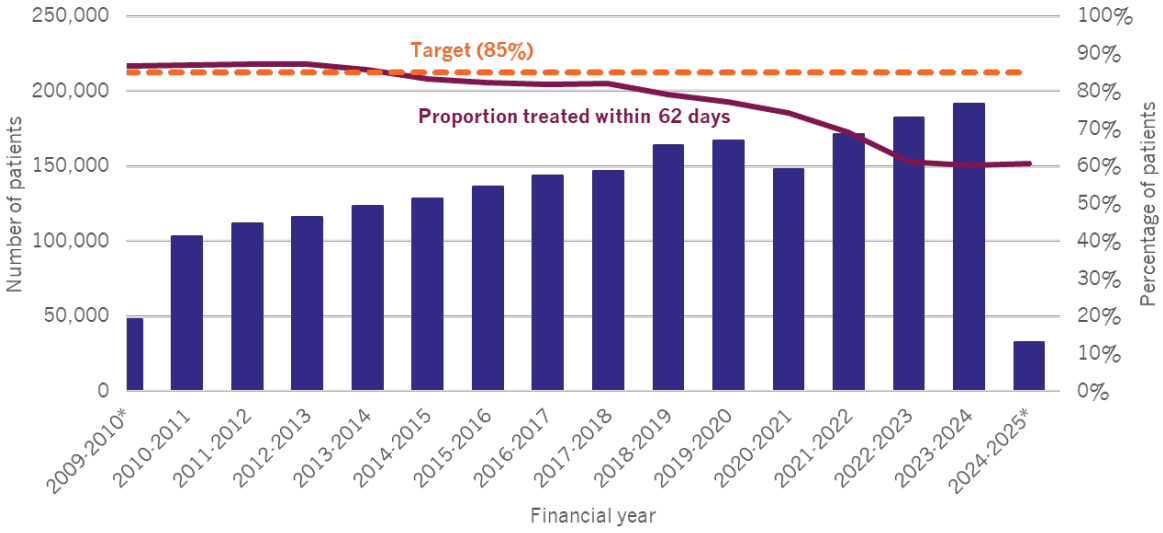


61. Treatments are becoming more sophisticated, but less timely. In 2024, more than 35,000 genomic tests are being completed each month. But the turnaround times are poor, with only around 60 per cent of test being performed to the agreed timeframes[161]. This can delay the start of treatment which often depends on the result. Genomic testing is routinely commissioned across 7000 rare diseases and 200 cancer indications. And the NHS is the first in the world to offer whole genome sequencing as part of routine care. However, there is more to do to ensure access for everyone who could benefit. Research shared with the investigation by the Tessa Jowell Brain Cancer Mission found that 72 per cent of UK neuro-oncology centres

were able to deliver whole genome sequencing to at least some of their patients but that no centre was able to offer it to all eligible patients. Moreover, the authors estimated that in 2023, on average, less than five per cent of eligible adult brain tumour patients were having whole genome sequencing through NHS commissioned pathways[162].

62. Waiting times for treatment have been deteriorating, too. As Cancer Research UK pointed out in their submission to the investigation, the 62-day target for referral to first definitive treatment for cancer has not been met since December 2015[163]. Since the pandemic, the backlog of long waiters has been prioritised, and partly as a result in May 2024, performance was just 65.8 per cent[164]. If the target had been met, around 5,200 additional patients would have been treated on time. Similarly, more than 30 per cent of patients are waiting longer than 31 days for radical radiotherapy[165].

Figure III.12.16: Number of patients receiving a first definitive treatment for cancer and proportion treated within 62 days, England (USCR routes only)



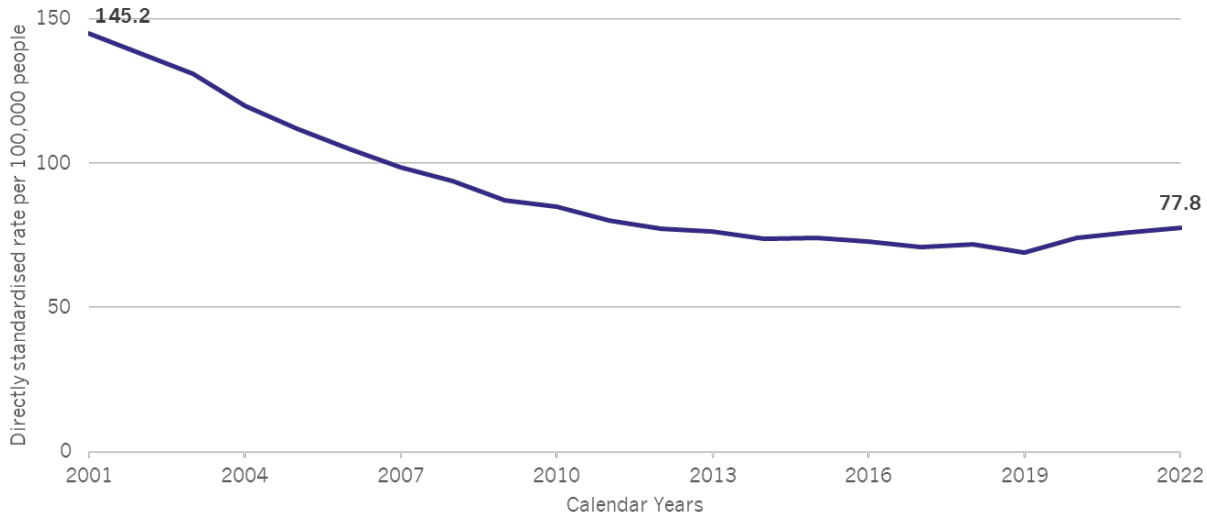
63. When it comes to systemic anti-cancer therapies, there continue to be significant disparities in how quickly patients are able to access new treatments. The time from approval by NICE to adoption of new cancer drugs such as alpelisib and fulvestrant varied from less than a month in nine provider trusts to more than a year in nine other organisations[166]. There is no excuse for such wide variation, which is fundamentally unfair to patients and goes against the principles of a universal service. Overall, the UK ranks ninth out of 37 OECD countries for the adoption of medicines.

Cardiovascular health

64. Cardiovascular disease remains a leading cause of death in England. Once adjusted for age, the cardiovascular disease mortality rate for people aged under 75 dropped significantly between 2001 and 2010. But improvements have stalled since then, and the mortality rate started rising again during the Covid-19 pandemic[167].

65. Cardiovascular disease is strongly linked to health inequalities. In 2022, people under the age of 75 living in the most deprived areas of England were more than twice as likely to die from heart disease than people living in the least deprived areas[168].

Figure III.13.1: Directly standardised mortality rate from all circulatory disease, persons under 75s, England, 2001 to 2022



66. Cardiac rehabilitation is a programme of exercise, education and psychological support that is proven to reduce hospital readmissions, deliver better outcomes and is cost effective. For patients who have experienced myocardial infarction (MI) and/or coronary revascularisation, attending and completing the exercise-based component of cardiac rehabilitation is associated with an absolute risk reduction in cardiovascular mortality from 10.4 per cent to 7.6 per cent when compared to those who do not participate, as well as a significant reduction in acute hospital admissions. Yet despite the compelling evidence, there is wide variation. In one ICB

area, more than 80 per cent of eligible patients participate, whereas in four ICBs, fewer than 20 per cent do so[169].

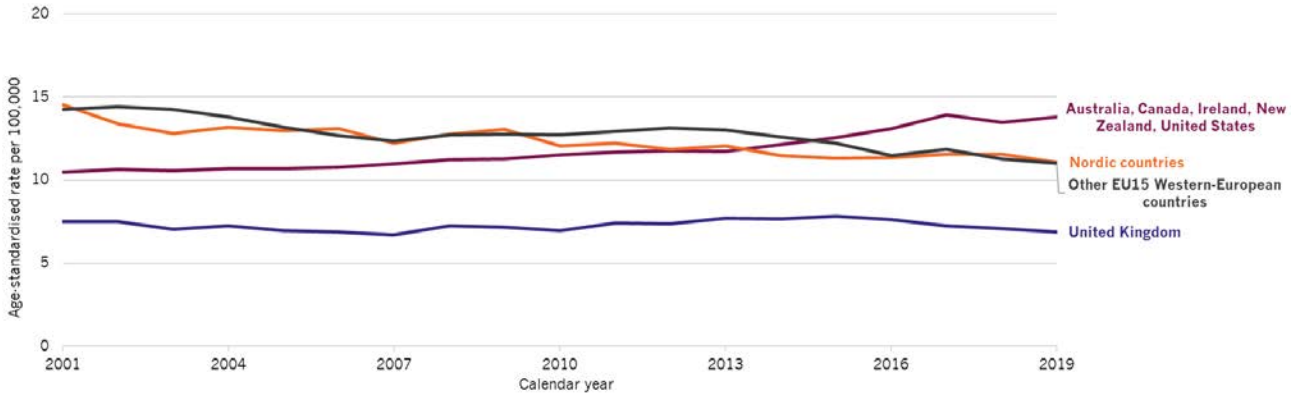
67. Lipid lowering therapies are an important tool in preventing cardiovascular disease. In March 2024, 62.1 per cent of people at high risk of cardiovascular disease were treated in this way (in line with the NHS Long Term Plan target of 60 per cent)[170]. There has also been good progress towards the objective to treat 95 per cent of people with cardiovascular disease with lipid lowering therapies, with 85.1 per cent receiving this treatment in March 2024[171].

> "We are extremely concerned that the significant progress made on heart disease and circulatory diseases (CVD) in the last 50 years is beginning to reverse. The number of people dying before the age of 75 in England from CVD has risen to the highest level in 14 years"
> *British Heart Foundation submission to the Investigation*

Suicide

68. Overall suicide rates in the UK are significantly below many other countries and relatively stable over time as shown below[172]. Analysis shows that while rates have been declining in European countries, they start from a much higher point, meaning that there is still a large gap between the UK and the EU15. Suicide rates in other predominantly English-speaking countries have steadily increased such that by 2019, they were nearly double those of the UK.

Figure III.14.1: Age-standardised suicide rates per 100,000 population, 2001 to 2019



69. While the suicide rate among adolescents aged 15 to 19 was 44 per cent below the OECD in 2019, there has been a worrying increase in suicides of young people[173]. There was a particularly large increase during the years running up to the pandemic, with the number of young women and girls (10-24) completing suicide rising 6.9 per

cent a year between 2015 and 2019, while the numbers of young men and boys increased by 3.2 per cent a year[174]. Suicide rates are now at their highest levels this century, and this is an area where close attention will need to be paid in the years ahead[175].

Figure III.14.4: CAGR change in suicide rates for males and females by age group, England, 2001 to 2021

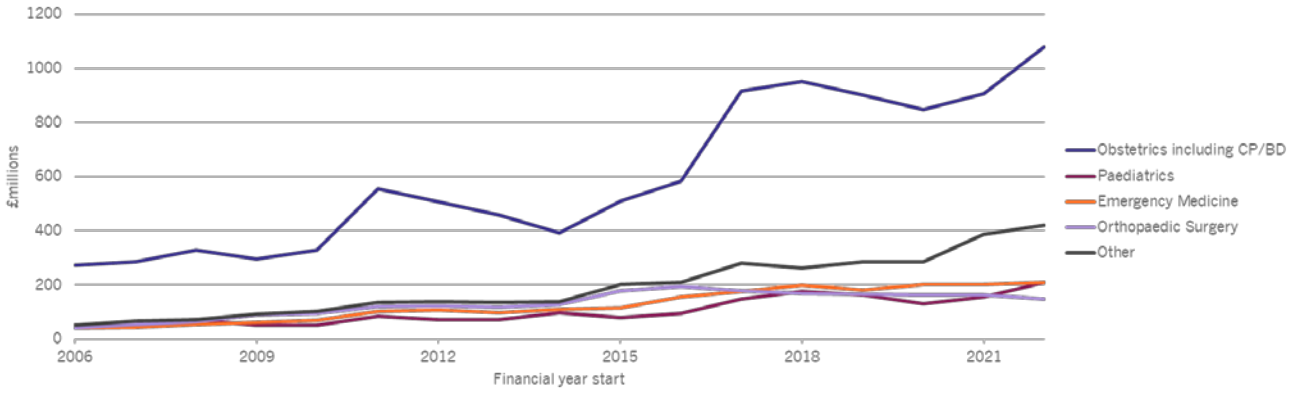
	10 to 24 years		25 to 44 years		45 to 44 years		65 years and over	
	Males	Females	Males	Females	Males	Females	Males	Females
2001-2005	-6.4%	0.9%	-1.5%	-0.1%	-1.1%	1.9%	-2.1%	-3.6%
2005-2010	-2.0%	-0.7%	-2.4%	-3.5%	0.8%	-2.7%	-2.8%	-2.8%
2010-2015	4.6%	1.9%	0.5%	1.2%	2.3%	2.8%	1.5%	3.4%
2015-2019	3.2%	6.9%	3.1%	4.2%	2.0%	-1.1%	-0.6%	-3.9%
2019-2022	-4.7%	2.6%	-0.4%	2.0%	-1.8%	0.5%	-0.1%	0.0%

Complaints and clinical negligence

70. The number of formal complaints raised about NHS services has changed over time as awareness of the complaints process has risen. But it is still striking that complaints have nearly doubled in a little over a decade, according to data shared with the Investigation by the Parliamentary and Health Service Ombudsman. As the highest level to which complaints about the NHS can be directed, they received 14,615 formal complaints in 2011-12, rising to 28,780 complaints by 2023-24[176].

71. As a Health Select Committee report points out[177], the NHS in England is an outlier in clinical negligence payments, devoting double the share of total health spending as New Zealand, ten times the level of Australia, and twenty times as much as Canada. In the year 2023/24, clinical negligence payments increased to £2.9 billion or 1.7 per cent of the entire NHS budget[178]. To put this in context, that amounts to more than the combined budget of every GP practice for the whole of the Midlands[179] serving more than 10 million people, and is the same as the NHS spending on 1.2 billion pathology tests each year. Aside from pensions and nuclear decommissioning, NHS clinical negligence claims are the largest liability on the Government's balance sheet[180].

Figure III.15.3: Cost of clinical negligence claims settled each year in clinical specialties with the highest costs of claims



72. As we can see from the chart above, while cost of claims has been rising across all specialties, they have risen much more quickly in obstetrics over the past two decades, amounting to around £1 billion in 2023-24[181].

* * *

73. On balance, the picture on quality of care is mixed. There are some notable improvements, such as the targeted lung check or the increase in specialist advice and virtual wards. But in too many areas, we have been going in the wrong direction. Complaints have doubled, and clinical negligence claims are at record levels. There is much work to be done if quality of care is to become the organising principle of the NHS once more.

4

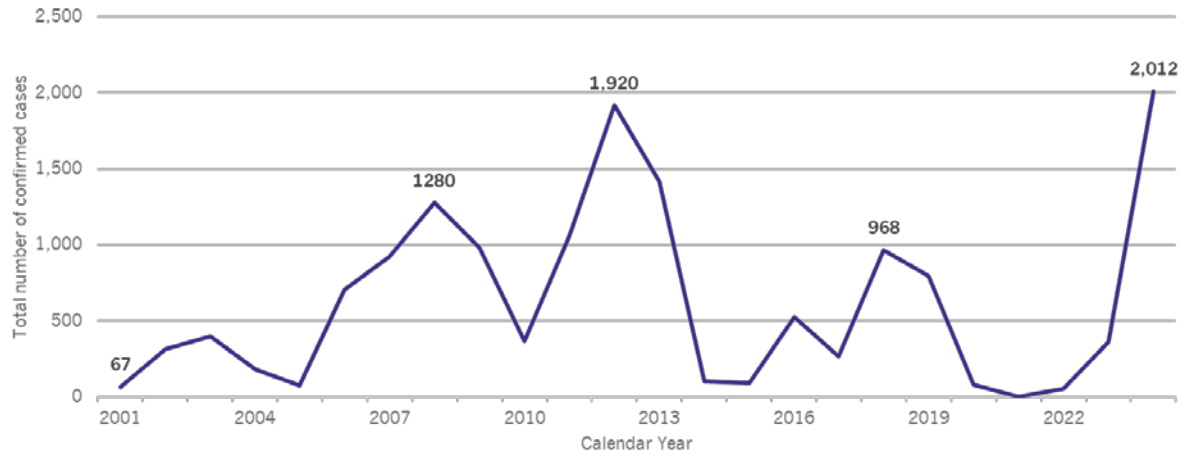
Health protection, promotion and inequalities

1. We now turn to three themes that cut across all aspects of the NHS. How well our health is protected from infectious disease in the wake of the pandemic, how effectively good health is promoted, and the inequalities experienced by people in health and care services.

Health protection

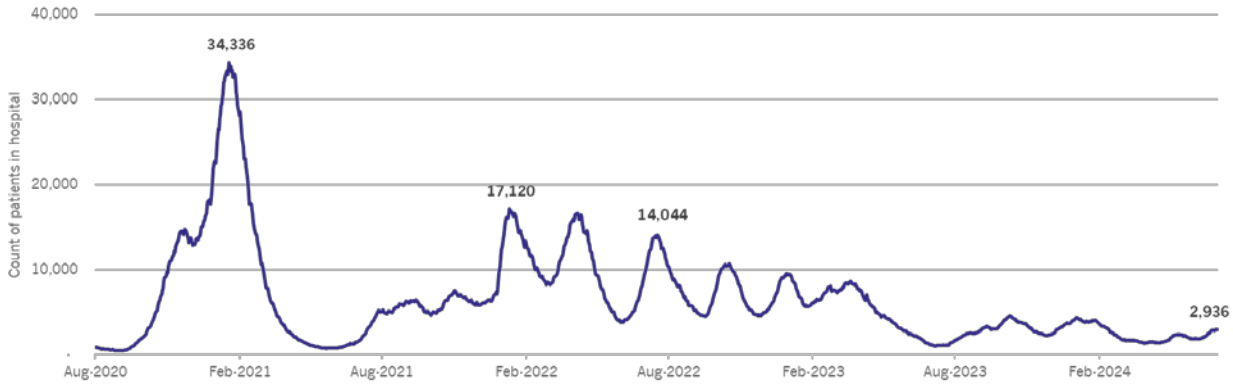
2. In the wake of the Covid-19 pandemic, it is apparent that infectious diseases remain a major challenge for all health systems. Well known infectious diseases could be on the rise as vaccination rates fall: measles cases in 2024 have been the highest this century as shown below[182]. It is too early to tell if this is a temporary spike like in 2012, or a new sustained level.

Figure III.6.5: Confirmed cases of measles in England, 2001 to 2024



3. Covid-19 remains an ongoing challenge for the NHS. While it has receded from public discussion, it continues to affect significant numbers of people. In the summer 2024 wave, Covid-19 has caused around 200 deaths per week between mid-July and mid-August[183]. There will continue to be patients who require hospital care and there may be periodic spikes as illustrated in this chart[184].

Figure III.6.1: Daily count of confirmed COVID-19 patients in hospital at 8am, England, August 2020 to June 2024



4. The Covid-19 pandemic had a very significant negative impact on the NHS and health outcomes, as is evident throughout this report and explored further in Chapter 8. However, there were some benefits of the public health interventions from the pandemic, including emphasising the importance of flu vaccinations (seasonal flu vaccination rates did increase during the pandemic for 65+ year olds and remain above pre-pandemic levels)[185]. Social distancing, meanwhile, contributed to rates of sexually transmitted disease falling and these have remained below pre-pandemic levels[186].

5. A looming threat is Anti-Microbial Resistance (AMR), which by 2050 could kill 10 million people globally every year—that is more than cancer[187]. AMR occurs where microbes are becoming resistant to the drugs meant to kill them and is particularly a challenge for keeping antibiotics working. Thanks to the championing of Dame Sally Davies, the UK Special Envoy on Antimicrobial Resistance, this country has been leading the way in tackling AMR and this year published a new five year action plan[188]. The Fleming Initiative, which I chair, looks to share solutions globally, often drawing from UK success—including the forthcoming centenary of Fleming's world-changing discovery[189]. Yet there is still more the UK needs to do to decrease inappropriate antibiotic usage and accelerate the development of new diagnostics and drugs.

Health Promotion

6. It is apparent that where bold action has been taken, health has improved. This is notably the case for smoking where a succession of interventions have driven smoking rates down[190], with consequential positive impacts on cardiovascular disease and cancer incidence and survival.

7. In contrast, bold action has been sorely lacking on obesity and regulation of the food industry. This means that childhood obesity rates for 10-11 year olds have risen[191] and inactivity rates in adults have remained constant[192]. As we have seen, the prevalence of diabetes has increased from 5.1 per cent prevalence in 2008 to 7.5 per cent in 2022 as a result of this inaction[193]. Similarly, when tough action was taken on the harm caused by alcohol, deaths attributed to it stabilised. As the chart below shows, alcohol is becoming more affordable over time, and deaths are rising at an alarming rate. In the pandemic, there was an 10.8 per cent annual increase between 2019 and 2022[194]:

Figure III.1.3A: Age-standardised alcohol-specific mortality rate per 100,000 in the United Kingdom, 2001 to 2022

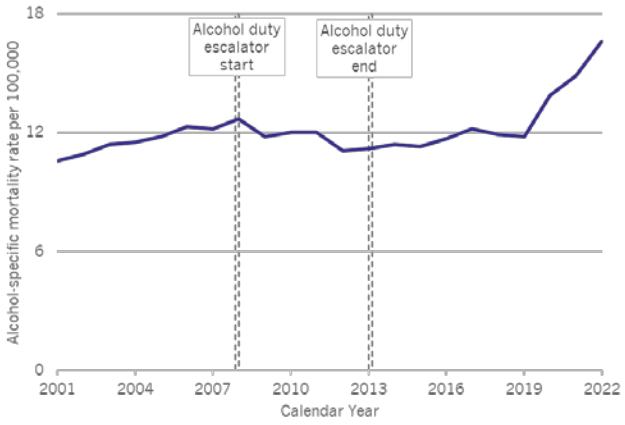
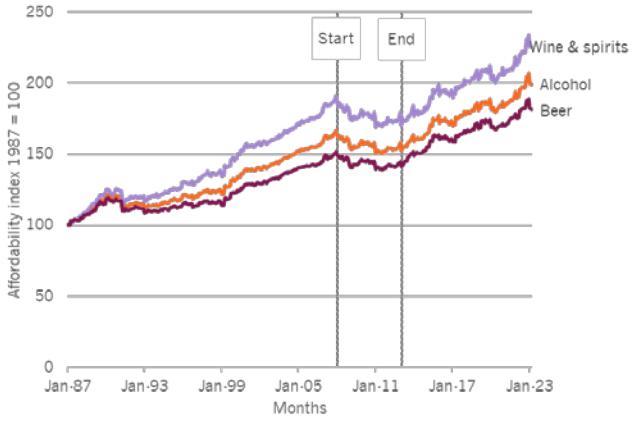
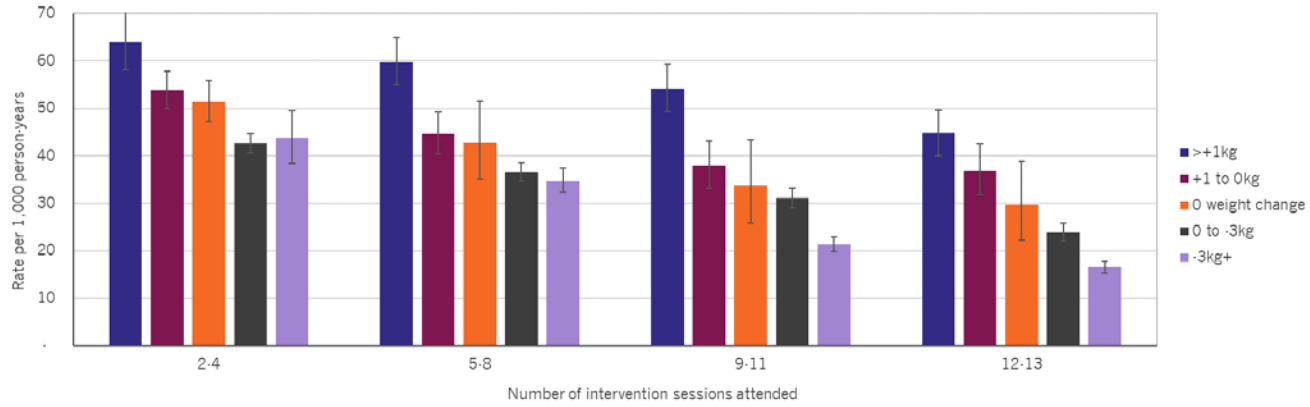


Figure III.1.3B: Alcohol affordability in the United Kingdom, January 1987 to March 2023



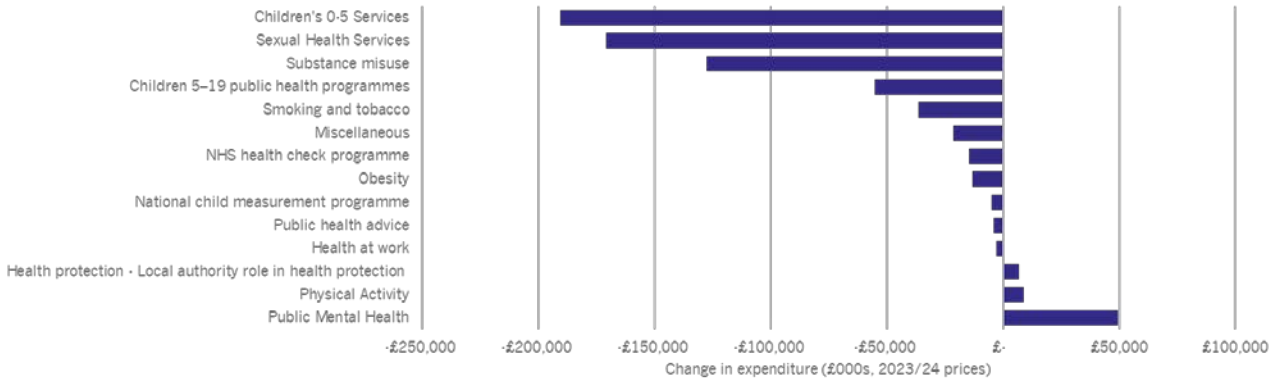
8. Everybody knows that prevention is better than cure. Interventions that protect health tend to be far less costly than dealing with the consequences of illness. Take the NHS-funded Diabetes Prevention Programme which reduces the risk for type II diabetes by nearly 40 per cent[195]. Given the potential power of preventative interventions, it is perverse that the public health grant to local authorities has been cut so substantially. Analysis from the Health Foundation shows that the public health grant was cut by more than a quarter between 2015-16 and this year[196]. Moreover, cuts to public health allocations have tended to be greater in cash terms in more deprived areas.

Figure III.7.6: Incidence of type 2 diabetes between April 2018 and March 2023 for individuals referred to the NHS DPP



9. The consequences are felt by individuals and families across the country in a reduction in the services that are offered to them. Spending on NHS health checks, for example, has dropped by £15 million[197]; participation rates in the programme have fallen by 20 per cent[198]. The £171 million reduction in sexual health services spending[199] comes at a time when there are concerns about the rise in cases of mpox[200]. It is particularly saddening to see the £191 million cuts to services for young children[201].

Figure III.1.8: Change in reported local authority spend on public health services from 2016/17 to 2022/23, 2023/24 prices



10. People in the most deprived areas die much earlier on average; this is well recognised and deeply entrenched[202]. It is preventable. It is often assumed that if we reduce premature mortality, we will extend the period in ill health. But this is wrong. Those in less deprived areas live substantially less time in ill health as well as having longer lives[203]. Prevention which reduces premature mortality leads to less time spent in ill health.

11. There is extraordinary power in getting public health right. We can reduce premature mortality, reduce social disparities, and reduce the absolute time in ill health. This

in turn reduces the burden on the NHS and social care while enabling us to be more productive in our working lives so strengthening the economy. This is the desired outcome for individuals, families, the public purse. But it takes the political will and willingness to invest to achieve it, with the skills to successfully engage the public.

Inequalities in health and care

12. The impact of the deterioration in access and the challenges around quality of care have not been felt equally. As we have seen, there are important disparities in almost all aspects of care. The 'inverse care law' seems to apply: that those in greatest need tend to have the poorest access to care[204]. In this section, we draw from the expertise of a number of charities and campaigners who have informed this report.

The impact of poverty

13. In their submission to the Investigation, the Joseph Rowntree Foundation (JRF) pointed out that people living in poverty are getting sicker and accessing services later. For the most deprived groups, A&E attendances are nearly twice as high and emergency admissions 68 per cent higher that the least deprived. People who live in the most deprived areas of England are twice as likely to wait more than a year for non-urgent treatment. In 2021 the undiagnosed diabetes rate was double for those in the bottom Indexed of Multiple Deprivation (IMD) quintile compared to the top.

14. A recent JRF survey found that of those in the bottom income quintile whose health has been negatively impacted by the cost-of-living crisis, only 33 per cent had accessed mental health services, and 39 per cent physical health services[205]. This presents a challenge for the NHS in finding those with an unmet need for healthcare.

15. Greater illness and poorer access to care contribute to worse health outcomes[206]. The result is that the mortality rate in the lowest Index of Multiple Deprivation (IMD) decile is almost double that of the highest[207]. Analysis by the JRF and The King's Fund described the impact of deprivation on mental health: in the poorest communities, the depression rate was twice as high, double the number of people were in contact with mental health services, and nearly four times as many were sectioned under the mental health act[208] as in the least deprived. There are similar findings for bowel cancer, where fewer people take part in screening at 64 per cent

for the most deprived compared to 75 per cent for the least deprived, diagnoses are 36 per cent lower, and the mortality rate is 25 per cent higher[209].

Homelessness is a health catastrophe

16. Between 2010 and 2023, the number of people in temporary accommodation doubled from around 90,000 to 180,000[210]. In the same time period, the number of people sleeping rough more than doubled from 1,768 to 3,898 (although this was down from a pre-pandemic peak of 4,751 in 2017)[211].

17. People experiencing homelessness are far more likely to have asthma or other breathing problems, heart disease, or epilepsy[212]. A study of homeless hospital inpatients found that 64 per cent had three or more physical health co-morbidities, while a survey of people experiencing homelessness found that 82 per cent had a mental health diagnosis[213]. Poor health can precipitate homelessness and homelessness creates poor health[214].

18. According to a submission to the Investigation from Pathway's Lived Experience Programme, people facing homelessness do not receive the same level of care as those who have a safe place to call home. They experience stigma and discrimination as negative social attitudes in society are also present in the NHS. The result is that services are harder to access than they should be.

19. A survey of Faculty for Homeless and Inclusion Health members found health services are very difficult for inclusion health patients to access. Given the population's high rates of mental health need, difficulties accessing mental health services are of pressing concern, which respondents felt was due to poor service accessibility, digital exclusion, and stigma[215]. In primary care, lack of identity documents or proof of address is a major problem. Indeed, a mystery shopper exercise found that only 31 per cent of people with no ID/address were able to register with a GP, despite this not being a legal requirement[216].

20. The result of poor access to primary and community care is a costly overreliance on urgent and emergency care: people experiencing homelessness attend A&E four times as often as the general population and are eight times as likely to need inpatient care[217].

21. The outcomes are tragic. According to the ONS, the average age of death for homeless men was 45 years and for women it was 43 years[218]. There were seven times as many deaths of men as of women. As of 2021, the death rate had increased in every region of England since 2013.

Disparities by ethnicity

22. Data from the NHS Race and Health Observatory that was submitted to the investigation finds widespread disparities[219]. Minority ethnic groups, particularly Asian people, experienced disproportionally longer waits for elective care after the pandemic than those from white backgrounds. Asian people experienced an 8 per cent overall fall relative to White groups in elective procedure rates—with this as high as 23 per cent in therapeutic cardiac appointments[220]. Black people also experienced a large drop in some areas, with a 19 per cent drop in cataracts procedures relative to the white population[221].

23. Similarly, in mental health, people from minority ethnic groups experienced worse outcomes; waited longer for assessment; and were less likely to receive a course of treatment following assessment in the NHS Talking Therapies Programme[222]. There is a substantial evidence base that shows that people from minority backgrounds are more likely to be sectioned under the Mental Health Act. Indeed, as the RCPsych point out, in the latest annual data for 2022-23, the standardised rate of detention under the Mental Health Act for Black or Black British people was more than 3.5 times higher than the rate for White people[223]. As Mind described in their submission to the Investigation, black people are more than ten times as likely as white people to be subject to a community treatment order, where they can be recalled to hospital if they do not comply with treatment protocols[224].

24. Analysis from the NHS Race and Health Observatory, set out in the chart below, finds that the median age at death was 62 years for people from white backgrounds, whereas it was 40 years for Black people, 33 years for Asian people, and just 30 years for those from a mixed background[225]. It is vitally important that the reasons for this are better understood so that these extraordinary differences can be addressed.

People with learning disabilities

25. There are particularly severe disparities in learning disabilities. According to a submission from Mencap to the Investigation, only four-in-10 people with a learning disability will live to see their 65th birthday[226]. People with a learning disability are twice as likely to die from preventable causes[227] and four times as likely to die from treatable causes[228]—with areas such as respiratory care and cancer care of

particular concern. There are multiple barriers that prevent people with learning disabilities from accessing the care that they need.

26. There are important variations in access to care. Around three-quarters of people with a learning disability are not on the GP learning disability register[229]. Mencap points out that there is no target for registration but that there is a target to provide health checks for 75 per cent of those on it. This may be disincentivising adding people to the register.

27. More than 2,000 people with severe learning disabilities and/or autism continue to be detained in inpatient mental health settings. The 2024-25 NHS Planning Guidance re-states the target to reduce inpatient numbers by 50 per cent, but this is in the context of failure to meet 2014, 2019, 2020 and 2024 targets. Current estimates suggest that it may not be achieved until 2030—and Mencap believes it will be later than that[230].

Carers

28. In 2024, 4.7 million people were unpaid carers in England, 1.4 million of whom provided more than 50 hours of care each week[231]. Nearly 60 per cent of carers are women, and the largest group are in their late 50s[232]. There are more very elderly carers, including 6.3 per cent of women aged over 85 and 2.9 per cent of women aged over 90[233]. Many carers struggle with their own health, with 28 per cent having a disability and 7 per cent reporting that their health was bad or very bad, according to Carers UK. One-third of all NHS staff are carers themselves[234].

29. The *State of Caring 2023* report by Carers UK found that 30 per cent of carers who were waiting for hospital treatment or assessment for themselves, had been waiting for over a year. More than 40 per cent said they needed more support from the NHS, while 60 per cent said they were not involved in hospital discharge[235]. In particular, carers were often not asked about either their willingness or ability to care. A striking 14 per cent said they had accompanied the person they cared for to hospital appointments more than 20 times in the previous 12 months[236].

30. Carers UK points out that all too often, unpaid carers do not receive the recognition and support that they need and deserve from the NHS. Instead, they feel invisible, misunderstood and unsupported despite their huge contribution. A fresh approach is needed which regards unpaid carers both as people with their own needs where caring is a significant factor in their lives, but also as a provider of care who should be treated as an equal partner. The current paradigm leads to poorer outcomes for

people needing care, for carers, and for the health service. A different approach is needed.

5

Where and how the money is spent

1. In this chapter, we explore where and how the NHS has sought to spend its budget. This is both an aspect of NHS performance, and a driver of it. We look at its major priorities—providing care that is more joined-up and delivered in the communities where people live—and how and whether resources are distributed to match. From there, we provide a high-level examination of the resources and productivity in each of the different main settings of care: general practice, community services, mental health, and acute hospitals.

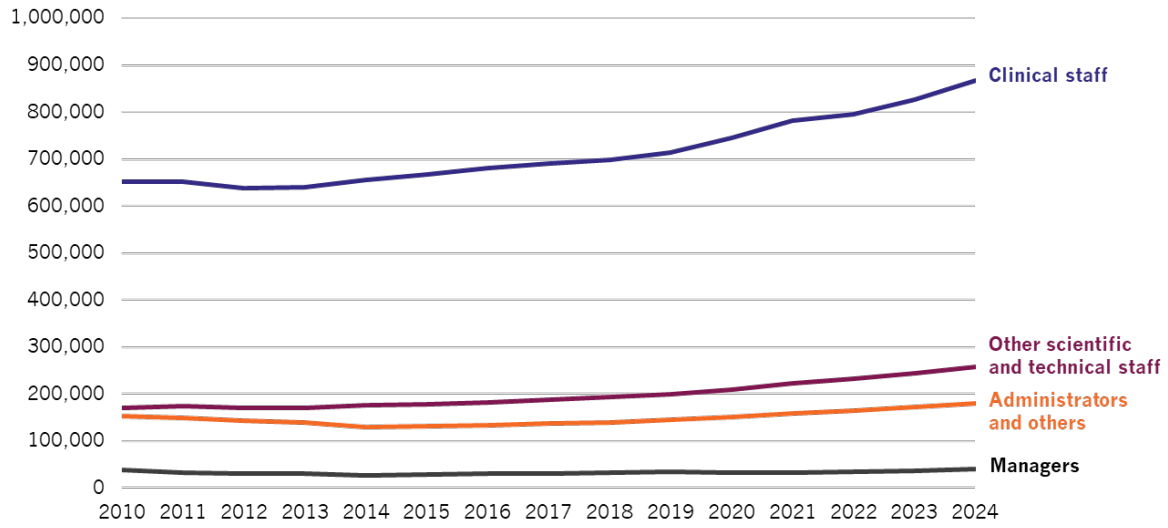
2. At the highest level, the NHS has had the strategic intention to shift spending from reactive care in hospitals to more proactive care in the community setting – but care has in fact moved in the other direction. Hospitals have attracted a greater share of NHS spending, meaning that other settings have received a smaller share. Accordingly, there has been a significant boost in hospital-based staff[237].

3. Regrettably, productivity in the NHS has all-too-often become associated with simply spending less or working harder. Neither is correct. Narrowly, productivity is the output, in terms of quantity and quality, produced relative to input. What it is really about is how much healthcare value can be created with the resources available. This encompasses everything from detecting disease earlier so that it is more amenable to treatment, embracing new innovations at the frontiers of scientific possibility, through to making care more planned and more consistent. It means using healthcare resources to provide the highest quality care, at the right time, and in the right place. Above all, it means using the full talents of NHS staff to help patients to get better outcomes. Not only is it possible to be smarter, not to just work faster, it is better for patients' outcomes and experiences and for staff and their enjoyment of work.

The big picture: workforce and productivity

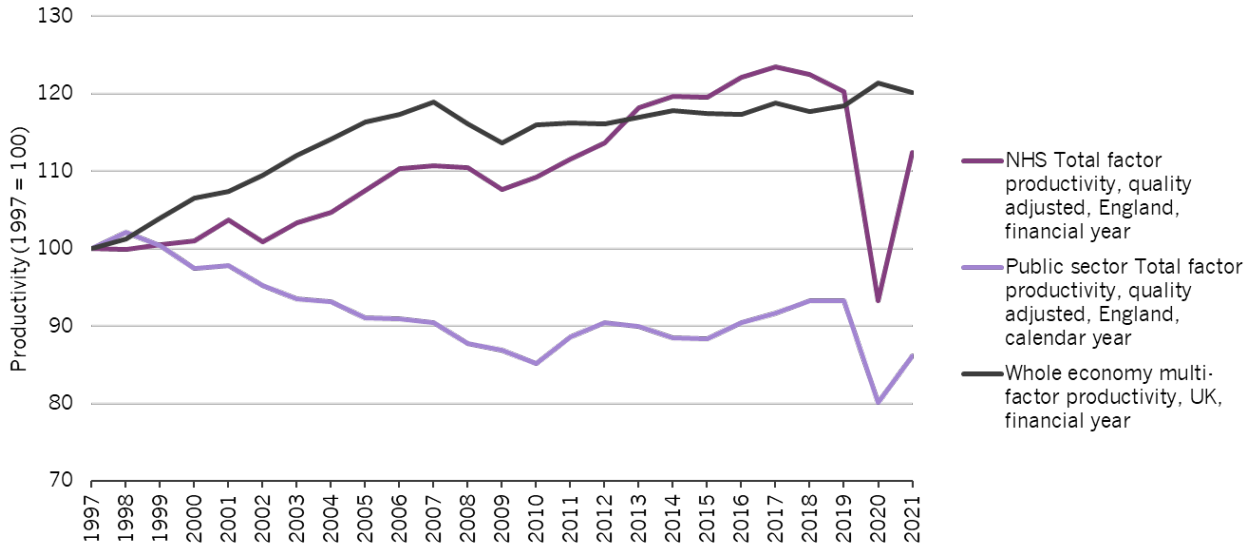
4. Overall staff numbers increased gradually during the 2010s, in line with the slow-down in funding increases over the same period[238]. Staff numbers have since increased more rapidly, as funding has risen[239], as we can see in the chart below[240]. Between 2022 and 2024, the rate of clinical staff growth has been 4.5 per cent compared to just 0.7 per cent between 2010 and 2016 and 3.3 per cent a year during the pandemic years from 2020 to 2022[241]. Other scientific and technical staff (who support clinicians) have increased at more than 5 per cent a year since 2020[242]. The number of managers fell at an annual rate of 4 per cent in the first half of the 2010s, and from that lower base, it has since grown again, rising at 5.8 per cent a year in the past two years[243].

Figure VIII.2.1: Hospital and Community Health Services (HCHS) staff by staff group, in NHS Trusts and other core organisations, March 2010 to 2024



5. During the 2010s, NHS productivity increased more quickly than the wider public sector and in a number of years it rose faster than the economy as a whole. But there was a deep drop in NHS productivity during the pandemic, when NHS productivity declined far more significantly than the economy as a whole or the wider public sector, as the chart below shows. It still remains below its 2019 level[244].

Figure VIII.2.3: Total factor productivity level for the NHS in England, wider public sector in England and the whole UK economy



6. Understanding productivity requires us to look at both where and how resources are spent. We now turn to where the resources the NHS receives are spent and the NHS's main strategic imperatives. From there, we examine how well they are spent in each of the main settings of care.

Changes in the population and strategic priorities for service change in the NHS

7. The fundamental driver of change in healthcare provision is change in the needs of the population. As we saw in chapter one, as people age, they tend to have more long-term conditions such as diabetes, breathing difficulties, or heart failure. There is a strong evidence base about what interventions help people to manage their conditions and to maintain their independence. This means that care can and should be more planned – such as the eight care processes for diabetes that were described in chapter three – and typically requires a multidisciplinary team of professionals to provide it.

8. To respond to this change in the needs of the population, the NHS has embraced two main strategic ideas, in common with many international health systems. The first is that care should be more joined up, or more "integrated". This is to reflect the fact the people living with long-term conditions need the help of a variety of different physical and mental health professionals and often rely on social care too. The frequency of their interactions with the health service mean that their care is more complex and therefore requires coordination. This is particularly true for people with two or more conditions (whose prevalence is growing over 6 per cent

annually), who may require care from different specialists and the expertise of GPs and others to understand the interactions between their conditions, treatments, and medicines. Since healthcare is organised around groups of professionals with similar skills (such as GP practices, mental health or community trusts, and hospitals), it requires organisations to work well together.

9. The second idea is that care should be delivered in the community, closer to where people live and work, and that hospitals should be reserved for specialist care. This is more convenient for patients – especially for those with long-term conditions who will need contact with the NHS more frequently. It builds on the fact that General Practice is how most people commonly interact with the health service and GPs' expertise as generalists. Indeed, research by the NHS Confederation has demonstrated that spending in primary and community settings had a superior return on investment when compared with acute hospital services[245]. It therefore makes sense that this should be the fundamental strategic shift that the NHS aspires to make.

10. The problem is that to provide high-quality, multidisciplinary care in the community requires resources that often are not there. These include the right professionals with the right skills—and the modern facilities, digital infrastructure, and diagnostics to support them. Over time, then, there must be a shift in the distribution of resources towards community-based primary, community and mental health services. Research from the NHS Confederation found that, on average, systems that invested more in community care saw 15 per cent lower non-elective admission rates and 10 per cent lower ambulance conveyance rates together with lower average activity for elective admissions and A&E attendances[246].

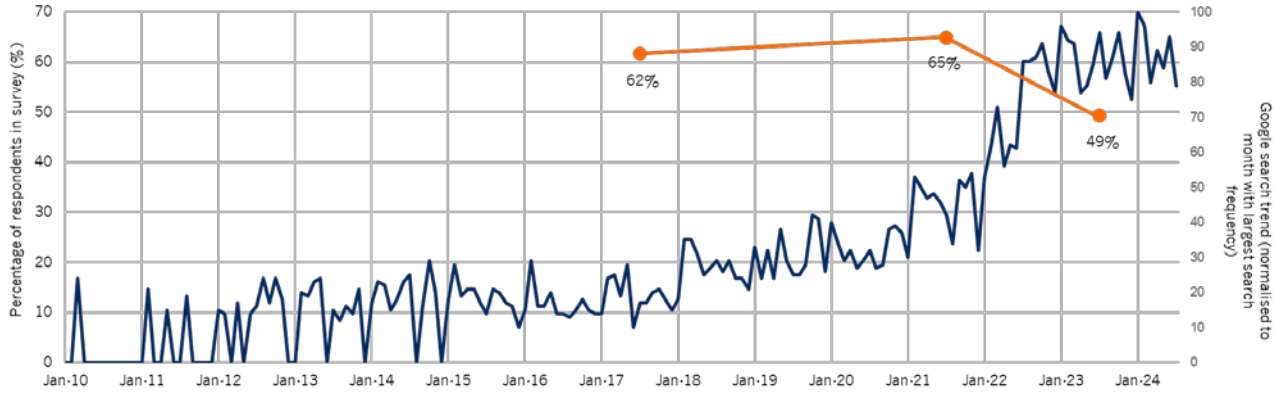
11. In the NHS, this goal of rebalancing care towards the community is sometimes described as the "left shift". Since at least the *Our Health, Our Care, Our Say* White Paper of 2006, and arguably before, the NHS has been committed to this change in the pattern of services. Similarly, pilots of integrated care were well underway in 2010, the 2014 Five Year Forward View described the NHS' commitment to integrated care, and integrated care systems have existed in one form or another since at least 2016. And integrated care boards and integrated care partnerships have been on a statutory footing since 2022.

12. So, if integrated care and the "left shift" have been the core of the NHS's service strategy, how far has the NHS progressed towards them?

Integrated care

13. While we heard—and indeed, saw—various examples of brilliant integrated care around the country, there has not yet been a systematic shift at scale. Indeed, the more the NHS has talked about integration, the less satisfied patients have become with the coordination of their care[247], as the analysis below shows:

Figure VIII.1.3: Google Trends for 'NHS integrated care' compared patient responses to "How often does your regular doctor or someone in your doctor's practice help coordinate or arrange the care you receive from other doctors and places?" (% of respondents 'always' and 'often')



14. There are three essential steps for delivery of integrated care[248]. First, it requires an understanding of the population and their needs using integrated datasets. Second, it requires the creation of multidisciplinary teams of health and care professionals. Third, it requires the whole team to work to a shared care plan that is developed in partnership with individuals and their carers and families and includes preventative interventions to keep people well.

15. If there are not population insights, multidisciplinary teams, and shared care plans, then integrated care is not happening. Where new multidisciplinary teams have formed, for example, around primary care networks, they report significant positive impact. The proportion of people with long-term conditions that report having an agreed a care plan with a health or care professional has been stuck at about 60 per cent from 2018 to 2023 (indeed, it slightly declined over the period). So, there is still much further to go.

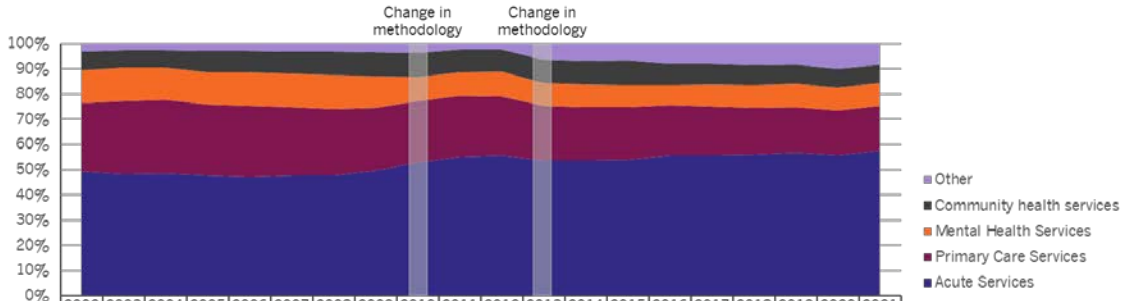
The "left shift"

16. So how far has the NHS come in meeting its stated strategy to shift care closer to home? As the chart below shows, since the NHS stated its intention to move care closer to home in the 2006 white paper, spending has drifted towards the acute hospital sector. The data suggests that this happened in broadly three phases: between 2002 and 2009, it was fairly stable changing from 49 per cent to 50 per

cent from beginning to end. It then rose to 53 per cent in 2010 and stood at 56 per cent by 2012. It then remained relatively stable, hovering between 54 and 56 per cent, before rising again during the pandemic years.

17. The overall result is that since the 2006 commitment to shift care towards the community, the share of NHS spending on hospitals increased from 47 per cent to 58 per cent in 2021 (the most recent year of data available)[249]. The "left shift" could, in fact, be characterised as a "right drift", when the whole period is examined. This means that the NHS has implemented the inverse of its stated strategy. Moreover, it is notable that the biggest rises occurred when the NHS's commissioning structure was at its most distracted: from the publication of the *Liberating the NHS* white paper in 2010 and the passing of the Health and Social Care Act of 2012. It seems unlikely that this is merely a coincidence.

Figure VIII.1.1: Estimation of NHS group spend by healthcare service



	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Other	3%	3%	2%	3%	3%	3%	3%	3%	4%	2%	2%	6%	7%	7%	8%	8%	8%	8%	10%	8%
Community health services	7%	7%	7%	8%	9%	9%	9%	10%	10%	9%	9%	9%	9%	10%	8%	8%	8%	8%	8%	7%
Mental Health Services	13%	13%	13%	13%	13%	14%	14%	13%	10%	9%	10%	9%	9%	9%	8%	9%	9%	9%	9%	9%
Primary Care Services	27%	29%	29%	28%	28%	27%	26%	25%	24%	24%	24%	22%	21%	21%	20%	19%	19%	18%	18%	18%
Acute Services	49%	48%	49%	48%	47%	48%	48%	50%	53%	55%	56%	54%	54%	54%	56%	56%	56%	57%	56%	58%

18. In 2011, the Coalition Government published its mental health strategy, *No health without mental health*, in which it stated "we are clear that we expect parity of esteem between mental and physical health services"[250]. Yet in the year of publication, the number of mental health nurses fell and would continue to fall for each of the following five years[251]. The 2023 National Audit Office report *Progress in improving mental health services in England*[252] omits this vital context by only examining what had happened from 2016-17 to 2022-23.

19. Since 2016, the NHS has applied the "mental health investment standard". This important intervention has helped by protecting mental health budgets and so keeping it share of NHS spending constant at 9 per cent[253]. This has enabled much of the mental health capacity that was cut in the first part of the 2010s to be rebuilt. Nonetheless, it took until 2023 for the number of mental health nurses to return to their 2009 levels[254], while both prevalence and referrals rose steadily throughout the

period. The result is a much larger treatment gap for mental health than for physical health[255], while people with severe mental illnesses die nearly two decades earlier than others in society and the gap is widening[256].

20. There is no question that rebalancing healthcare resources is complex and challenging. But the "right drift" is not an accidental outcome. It is the result of financial flows that have funded hospitals for their activity and much of the rest of the NHS for their efforts. It was the choice of successive governments to exclude primary care, mental health and community services waiting times from NHS constitutional standards, which are instead focus on hospital care. This has been reinforced by the failure to invest in the measurement of primary, community and mental health services, which has obscured the real consequences of cuts to block budgets.

21. Changing both the distribution of resources and the operating model to deliver integrated, preventative care closer to home will be strategic priorities of the NHS in the future because they are derived from the changing needs of the population. Getting them right requires as strong a focus on strategy as much as performance; to invest in the quality and capacity of management as well as clinicians; and on the skills and capabilities to commission care wisely as much as to provide it well.

22. So, if there has been limited progress on integrated care and the left shift of resources has drifted in the opposite direction, why is that? What has been the focus and the challenges for integrated care boards?

Where have ICBs focused

23. As the NHS has made this move to formalise integrated care systems, it has invested significant effort in forming new collaborations between NHS organisations. Collaboration and integration are often conflated, but they are not the same. Service or clinical integration[257] is about a fundamental change in the way health services are organised for patients rather than the degree to which NHS organisations cooperate with one another as institutions.

24. NHS organisations are certainly working more collaboratively together now than in the past, with many formally joining group or collaborative structures[258]. We can see this in the increasing consolidation of NHS providers over time. This allows for scale economies to be captured and to concentrate managerial talent on solving difficult problems once rather than many times over. But the benefits of ever larger provider trusts for frontline patient care are yet to be proven, and there is a risk that

underlying performance is obscured in averages, while the distance from board to ward may become too great.

25. Collaboratives should be a means to deliver more integrated care and to spread good practice that raises the quality and consistency of care—but it is not obvious that this is the case. Simplifying governance from the top-down and capturing scale benefits are not good enough reasons in themselves. If collaboratives prove unable to change the way care is delivered, then there is a real risk that they amount to displacement activity from the strategic priorities of delivering integrated, preventative care closer to home.

26. Part of the challenge for ICBs comes from their conception. The Health and Care Act 2022 put integrated care systems on to a statutory footing, establishing integrated care boards and integrated care partnerships, and set out their four aims in legislation. The NHS Confederation's most recent *State of the ICSs*[259] report describes how local ICSs have found it challenging to fulfil their aims on population health and on the wider contribution to social and economic development. In the call for evidence, we heard conflicting accounts of the definition of population health and the ways in which Integrated Care Boards interpret their duty to improve it. NHS England has aimed not to be prescriptive in the way in which ICBs have formed and how they fulfil their aims. Including "integrated care" in the title of organisations does not make it thus.

27. Some ICBs interpret their population health duties as requiring them to act upstream of healthcare needs on the social determinants of health, where the NHS has few direct levers[260]. Other ICBs interpret their population health duties as requiring them to understand and adjust healthcare services to match the needs of the population that they serve, in line with the NHS Operating Framework[261]. Some interpret it as both and others as neither, preferring to focus on what they see as their "traditional" role of performance managing providers. The roles and responsibilities of ICBs need to be clarified.

28. Having examined the distribution of resources and the integration of care, we now turn to the productivity of services in the main care settings. We examine each of general practice, community services, mental health services, and acute services in turn. Given the short time frame for this investigation and the lack of readily accessible data, we have not examined productivity in dentistry, community pharmacy, ambulances or NHS 111.

Resources and productivity of services by setting

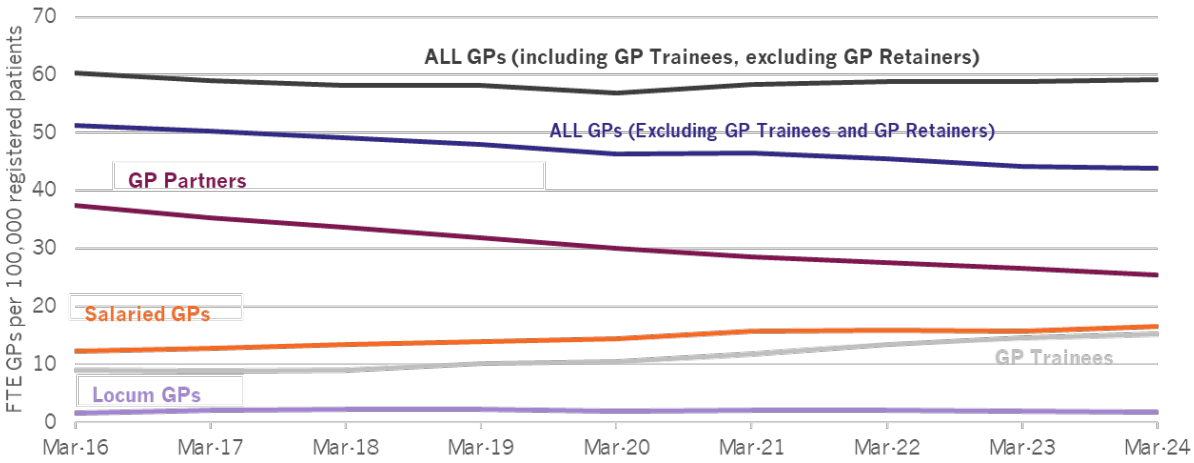
29. As we turn to resources and productivity of services, one thing that stands out is the degree of detail that is available for acute hospitals services versus other settings of care. This reflects the availability of data—and in itself demonstrates the need to invest in measurement and transparency across all areas of the NHS.

General Practice

30. It has long been said that General Practice is the "jewel in the Crown of the NHS"[262]. However, our analysis finds that the UK has 15.8 per cent fewer GPs per 1,000 population than the OECD average[263]. The number of GPs per 100,000 population declined by 1.9 per cent a year between 2016 and 2024, with the number of GP partners falling sharply, as we can see in the chart below[264]. It is a complex picture, however, since the absolute number of qualified GPs increased by 6 per cent between 2015 and 2022. Since in the same time period, the numbers of GPs choosing to work part-time has increased, and the population has expanded, the overall result is that there has been a decline in the numbers of whole-time equivalent GPs per 100,000 population[265].

31. As we have seen, there are wide variations in the numbers of GPs in different parts of the country, while patient satisfaction is better when there are fewer patients per GP. Moreover, more and more demands are being placed upon GPs who are expected to deliver an ever-wider range of services and to integrate care for more and more complex patients.

Figure VIII.3.2: Number of GPs FTE per 100,000 registered patients, by GP type – March 2016 to March 2024

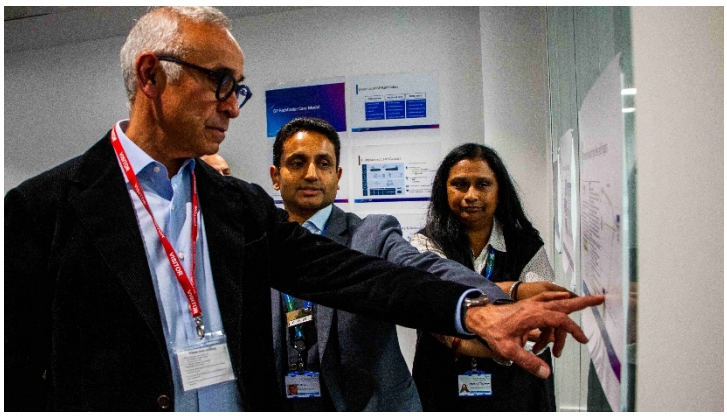


32. At present, multiple disincentives conspire against allocating additional funding to match known higher primary care workload in deprived areas. Primary care workforce recruitment is more challenging; consultation workload is progressively higher for each additional deprivation quintile; deprived area additional funding areas allocated according to the Carr-Hill formula does not take account of factors such as the social dimension of health and higher consultation rates[266]. Taken together, the Health Foundation estimated that current funding results in a 7 per cent shortfall in funding for practices serving more deprived populations per 'need adjusted' patient than those serving less deprived populations[267].

33. As independent businesses, General Practices have the best financial discipline in the health service family as they cannot run up large deficits in the belief that they will be bailed out. Despite rising productivity, an expanding role, and evident capacity constraints, the relative share of NHS expenditure towards primary care fell by a quarter in just over a decade, from 24 per cent in 2009 to just 18 per cent by 2021, continuing a downward trajectory from their peak in 2004[268].

34. With primary care doing more work for a lesser share of the NHS budget, we heard significant irritation felt by GPs who perceive that more and more tasks are being shifted from secondary care back to primary care, with a never-ending flow of letters demanding follow-ups and further investigations. This frustration is understandable when the hospital workforce appears to have expanded to the amongst the highest levels in the world.

35. In the face of such difficult challenges, some GP practices have embraced extraordinary innovations. GPs have made significant shifts towards a digital model for those patients who want it, they have introduced impressive approaches to triage, and have boosted their responsiveness to patients. During visits as part of the investigation, I saw some remarkable examples of local innovations that were improving access and quality of care, while also relieving pressures on acute hospitals.



36. While there have been some impressive programmes to support GP innovation, such as the GP Pathfinders, I also heard how the current GP standard contracts are complex and can mean that doing the right thing for patients can require doing the wrong thing for GP income. That cannot be right.

37. The primary care estate is plainly not fit for purpose. Indeed, 20 per cent of the GP estate pre-dates the founding of the NHS in 1948 and 53 per cent is more than 30 years old[269]. More recent buildings are bedevilled by problems with the management of LIFT (PFI-type) schemes that give GPs too little control over their space and that some GPs described as having charges that are unreasonably high during visits to the frontline as part of the investigation. It is just as urgent to reform the capital framework for primary care as for the rest of the NHS.

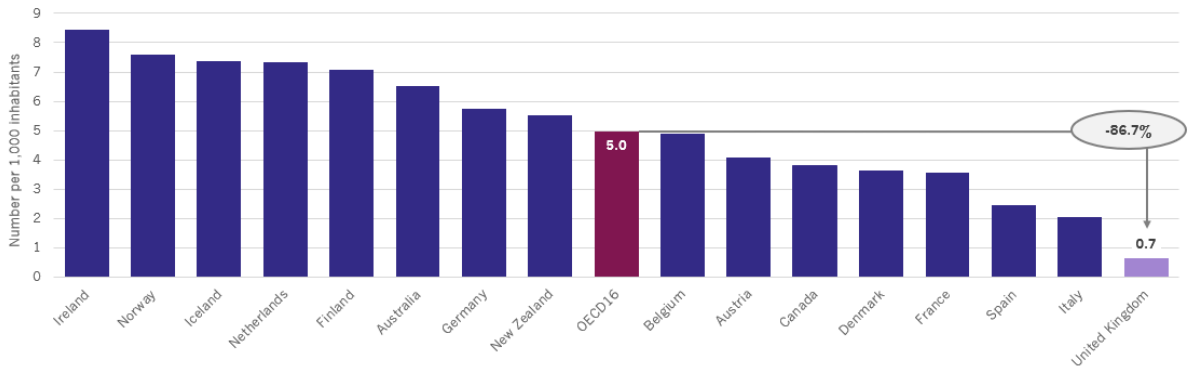
Community services

38. The poor quality of data means it is difficult to establish how well or how poorly community services are performing. In the NHS, what gets measured, gets funded. The community services dataset was only recently established. It contains nearly four times as many metrics as acute services[270], even though the NHS spends eight times as much on acute services as on community. It is little surprise, then, that completion rates are poor. The overall result is that there are tens of thousands of NHS staff working in community settings[271] and far too little is known about their performance and productivity. It even proved impossible to get precise headcount figures.

39. Community services are significant outliers in international comparisons of resources. We believe the UK has far fewer nurses working outside of hospital compared to other countries. Analysis seems to suggest that the UK may be as much as 86.7per cent below the OECD average in the numbers of nurses and midwives working outside of hospital, as the chart below shows.

40. While we treat this with caution—we speculate that it might exclude, for example, GP practice nurses or maybe acute hospital staff that are community based. If the data under-reported by a factor or four, we would still have the lowest level of resource among comparable countries. This therefore suggests that we may have too few resources in the community, compared to other health systems. Indeed, the Nuffield Trust has observed that, despite pledges to increase spending on care outside hospital, community services spending was cut in real terms in three out of the six years between 2016-17 and 2022-23[272]. What is clear is that it requires further investigation and that the first step to giving greater priority to community services is to properly count the number of people working in them.

Figure VIII.4.1: Practicing nurses and midwives per 1,000 inhabitants outside of hospital, 2023 (or nearest year)

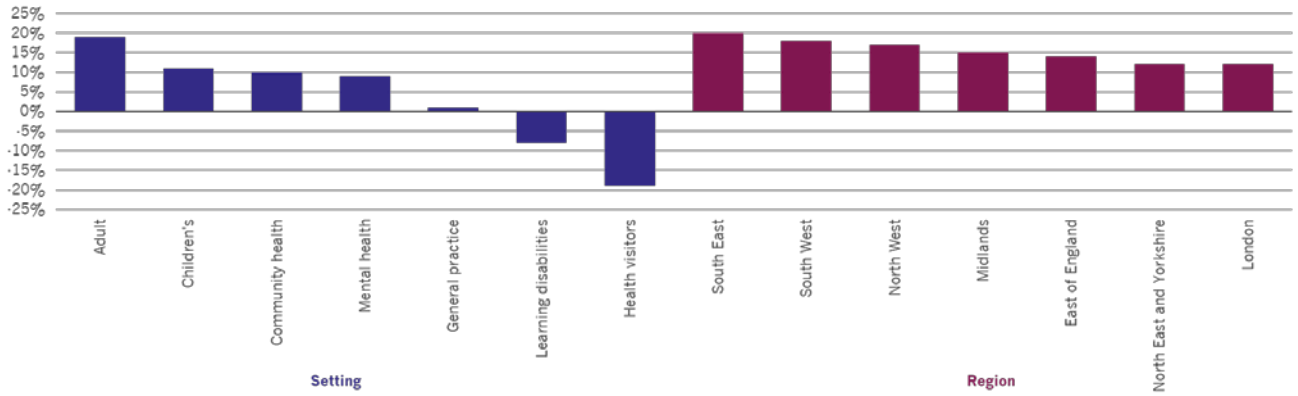


41. Despite rising demand, there were 5 per cent fewer nurses working in the community in September 2023 than September 2009[273]. During the same period, hospital nurses working with adults increased by 35 per cent and for children's hospitals, there has been a 75 per cent increase in nurses[274]. Analysis published by the NHS Confederation shows that for community services, spend is not correlated with needs (in a way that it is for primary care, mental health services, and acute hospital services)[275]. There is, therefore, an unfair postcode lottery in community services.

42. The Health and Social Care Act moved the commissioning of public health services to local authorities. As we have seen, the public health grant has fallen by more than 25 per cent in real terms. This has had a particular impact on Health Visiting,

where numbers of health visitors have fallen by nearly 20 per cent since 2019, as the chart below shows. Given the extensive evidence base on the importance of the first 1,000 days of life[276]; it is clear the NHS is missing an opportunity to intervene early.

Figure VIII.4.5: Change in the number of nurses in hospital, community and general practice settings, December 2019 – September 2023

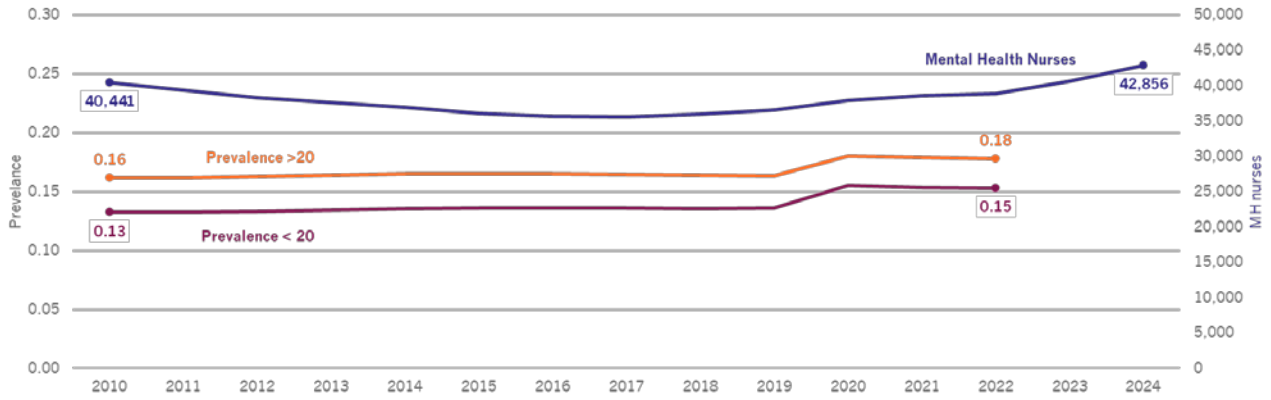


43. The lack of data makes it difficult to assess the productivity of community services. It means the unit costs and minimum efficient scale are poorly understood. This is particularly true with assumptions that subscale outpatient clinics are cheaper when delivered out of hospital. A modest reduction in capital costs is dwarfed by an increase in operational costs since scale efficiencies cannot be achieved. Simply shifting the setting of care without changing the care model will have a poor return on investment[277].

Mental Health services

44. Despite rapidly rising mental health needs of children and young people and working age adults, the overall mental health workforce reduced by 9.4 per cent between 2010-11 and 2016-17[278]. The number of mental health nurses dropped by 13 per cent between 2009-10 and 2016-17[279]. The workforce then expanded by 26.5 per cent between the start of 2017-18 and the end of 2023-24[280]. But the number of mental health nurses only returned to their 2009-10 level by 2023-24[281]. There remains a wide gap between need and resources[282], which explains the problems for people who need access to services.

Figure VIII.5.2: Prevalence of mental disorders by age group – England vs Mental Health Nurses



45. There has been a particularly concerning drop in the number of learning disabilities nurses. Since 2010-11, the number has declined by 44.1 per cent on average, and by even more in some regions, as we can see in the following chart[283]. As we have seen, there are serious concerns about very wide disparities in life expectancy for people with learning disabilities. This deserves further investigation.

Figure VIII.5.3A: NHS Hospital & Community Health Service (HCHS) Mental Health Nursing staff in post (FTE) percentage change 2010/11 to 2023/24 by region

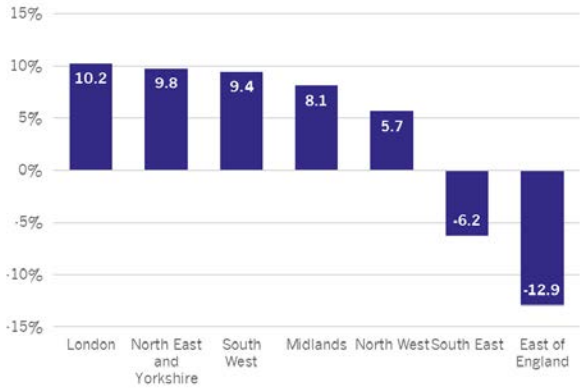
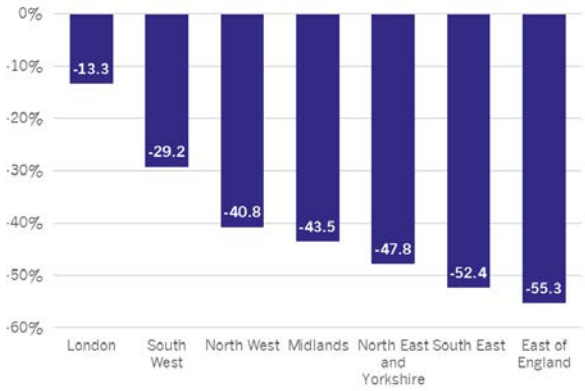


Figure VIII.5.3.B: NHS Hospital & Community Health Service (HCHS) Learning Disability Nursing staff in post (FTE) percentage change 2010/11 to 2023/24 by region



46. More comprehensive mental health data has only been recorded since 2016, and insufficient data is recorded to make definitively assessments of productivity. Nonetheless, a number of local estimates of productivity have been shared from different areas of the country. These seem to suggest that productivity has remained broadly constant, meaning that the increase in resources has resulted in a similar rise in activity.

47. In common with community services, there has been chronic underinvestment in technologies that could improve the efficiency of mental health community teams. Technology platforms that allow for automated route planning and easy-to-use data recording have existed for at least 15 years but are still a novelty in the NHS. It is

said that productivity has not dropped—but neither was it likely to be high to begin with, given the poor use of technology and the absence of sufficient management information to drive up performance.

48. There are perpetual access problems for inpatient services. As we have seen above, difficulties in finding mental health beds contribute to long waits for patients with a mental health flag at acute hospital emergency departments[284]. This means patients are kept waiting in an environment that is not suitable to their needs and as high-stress places, could exacerbate a mental health crisis. Moreover, the data shows that having brought down the number of inappropriate out-of-area placements between 2019 and 2002, numbers have started to rise again, reaching nearly 6,000 in 2023[285]. This is a worse result for the patient and a higher cost for the NHS, meaning a significant hit to productivity.

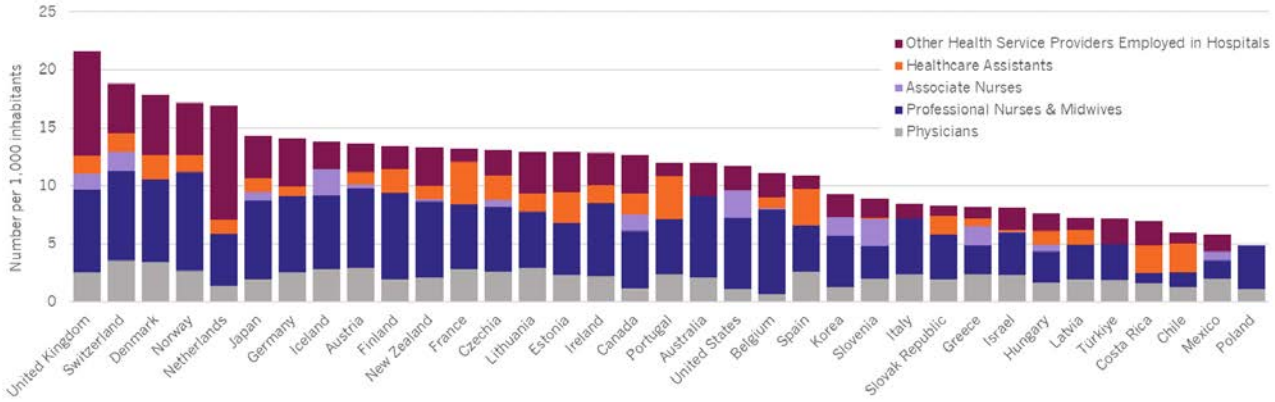
49. There is a fundamental problem in the distribution of resources between mental health and physical health. Mental health accounts for more than 20 per cent of the disease burden[286] but less than 10 per cent of NHS expenditure[287]. This is not new. But the combination of chronic underspending with low productivity results in a treatment gap that affects nearly every family and all communities across the country[288].

Acute hospital services

50. The hospital workforce has expanded very significantly in recent years, rising 17 per cent between 2019 and 2023[289]. On first examination, the UK appears to have the highest level of hospital employment in the world[290], and when looking at a narrower part of the healthcare team—doctors, nurses, and midwives—the UK is ranked fourth highest among OECD countries[291].

51. We treat this data with caution, even though it is taken from official statistics. The Office for National Statistics (ONS) submits data on behalf of HM Government to the Paris-based, intergovernmental Organisation for Economic Cooperation and Development (OECD). The NHS provides the source data to the ONS. We speculate that it may include staff working in the community but employed by acute hospital trusts. Should this be the case, then the inability to even distinguish community staff in official statistics suggests that insufficient priority has been given to them. Without accurate and frequent measurement and recording, it is surely impossible for the NHS to know whether or not its strategy is succeeding.

Figure VIII.6.1: All healthcare workers employed in hospitals per 1,000 inhabitants, 2022 (or nearest year)



52. This dramatic expansion of the hospital workforce, rising by 17 per cent between 2019 and 2023[292], has come at the expense of other settings of care, as the proportion of the total NHS budget dedicated to acute hospitals has continued to rise, partly driven by costs incurred by the pandemic[293], even as the NHS's stated strategy has been for resources to shift to the community.

53. Despite this significant flow of resources into hospitals, output has not risen at nearly the same rate. The result is that a large productivity gap has opened up. Overall, hospital productivity is at least 11.4 per cent lower now than it was in 2019[294], which is a reason why it is taking longer to tackle the big increase in waiting times in recent years (alongside the decisions to cancel more hospital activity than any other comparable health system during the pandemic[295].
Looking across clinical workforce crude productivity metrics, a pattern is readily apparent: productivity has fallen (see the chart below)[296]. The number of clinicians for each bed has increased by 13 per cent, while key measures have declined. A&E attendances per emergency medicine clinician are down 23 per cent; outpatient appointments per consultant are down 10 per cent; and surgical activity is down 15 per cent.

54. At the same time, many frontline clinicians say they are working harder than ever. This appears to present a paradox. But it is possible for both to be true at the same time: productivity is not a measure of effort, but of value creation. And, as we shall see, the central problem is that patients are not flowing efficiently through hospitals anymore and neither have we upgraded the infrastructure – diagnostic scanners, operating theatres and so on – with which they work. That slowdown in flow generates more non-value adding work and less output.

Figure VIII.6.11A: Clinical WTEs per G&A bed

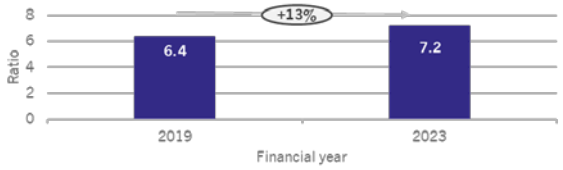


Figure VIII.6.11B: Non-admitted emergency activity (per calendar day) per medical emergency medicine WTE.

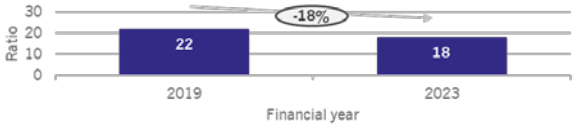


Figure VIII.6.11C: Outpatient attendances (price-weighted, per working day) per consultant WTE

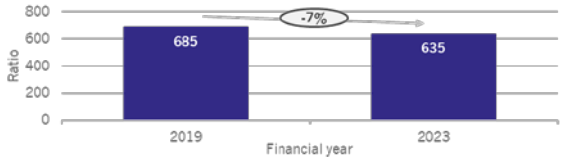
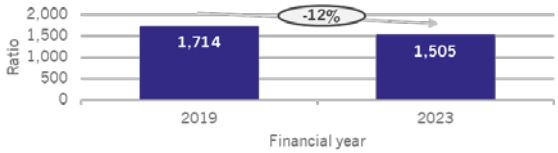


Figure VIII.6.11D: Surgical specialty spells per medical WTE in surgical specialties

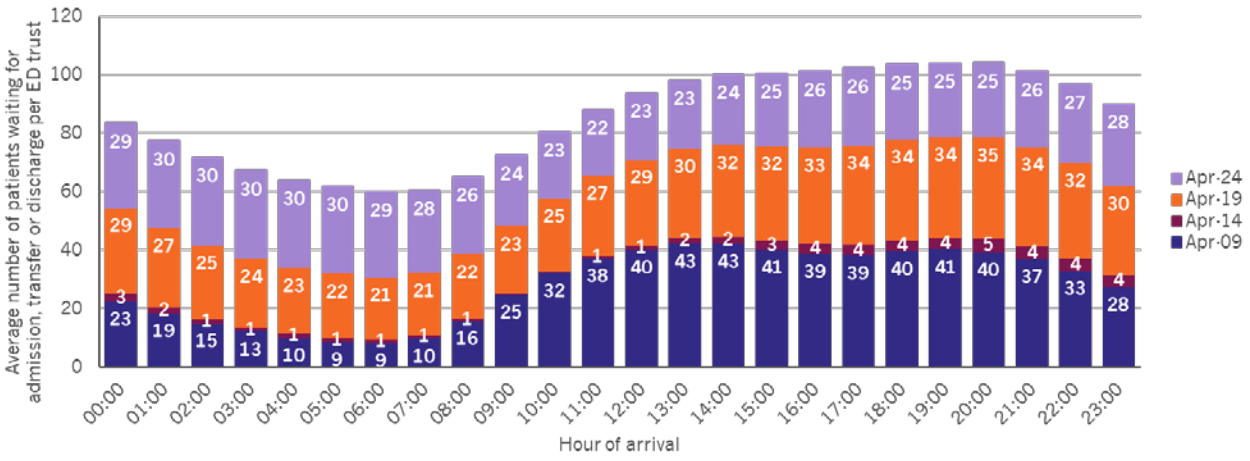


Congested hospital emergency departments

55. The data shows a significant rise in attendances at hospital emergency departments[297]. This is the result of push and pull factors: the failure to invest in primary, community and mental health services outside of hospital has pushed people towards them. Patients flocking to hospitals is also the inevitable consequence of concentrating resources within them that creates a pull of its own.

56. New analysis prepared for this report shows that had a patient arrived at a typical A&E on an average evening in 2009 (when sufficiently detailed data began to be collected to make this analysis possible) there would have been 39 people waiting in the queue. By 2024, this had increased to more than 100 people waiting at an average A&E department on a typical evening, as shown in the chart below[298].

Figure VIII.6.12: Average number of patients arrived but not admitted, transferred or discharged per A&E Trust, A&E CDS & ECDS

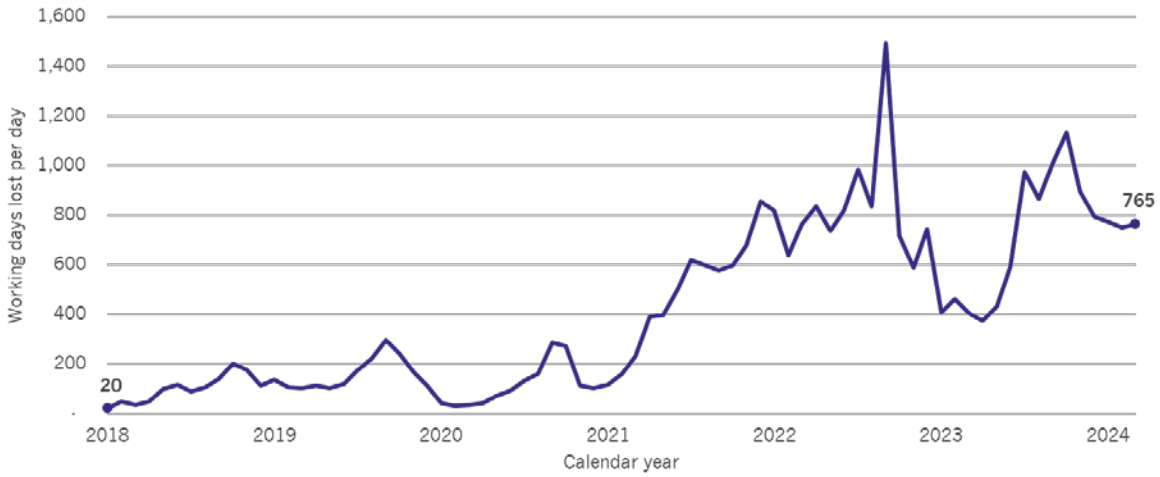


57. A significant proportion of people presenting at emergency departments are those that say they were unable to get a GP appointment[299]—or perhaps they *believed* that they could not and so did not try. The number of GP appointments has increased significantly[300], even as the number of GPs on a population basis has declined. This appears, therefore, to be a capacity rather than a performance issue.

58. As attendances have risen and emergency departments have become more congested, waiting time performance and productivity have declined. The rate of attendance at emergency departments in the UK is double that of the Netherlands, and the second highest in a group of comparator countries[301]. As we have set out above, the Royal College of Emergency Medicine has shown that very long waits are a serious quality of care issue, since they appear to lead to higher mortality[302]. They also lower productivity, as they necessitate clinical activities that would never have occurred without the wait, for example, providing pain relief to patients stuck waiting in corridors.

59. Congested emergency departments also reduce the productivity of ambulance services. A huge amount of time is lost to handover delays[303] where ambulances arrive at emergency departments but there is no space for their patients. In 2024, around 800 working days, each day, have been lost to these delays[304], which are only counted when they exceed 30 minutes. In aggregate, it is the full-time equivalent of nearly 1,400 paramedics over the course of a year[305]. By tying up paramedics and their vehicles, it contributes to the significant increase in ambulance waiting times.

Figure VIII.6.13: Working days lost per day due to ambulance handover delays, England (assumes 7.5 hours lost is equivalent to a working day lost for two staff)



Slow flow of patients through hospitals

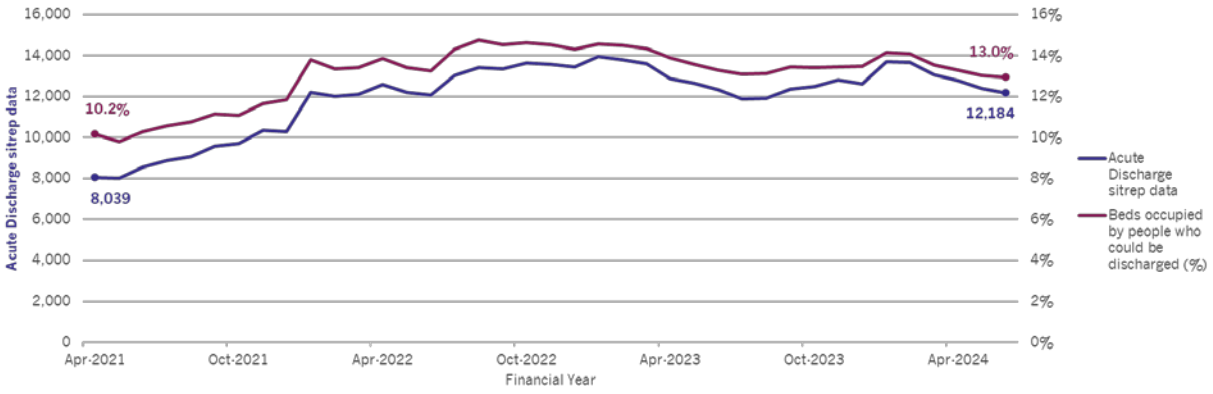
60. The inability of patients to flow through emergency departments results from the capacity of the departments themselves, both workforce and physical space, as well as from elsewhere in the hospital, such as the availability and speed of diagnostics and the availability of beds for admission[306]. At its core, this is a result of the intersection of high levels of demand (caused by the lack of investment in the community[307]), chronic capital underinvestment in both facilities and technology[308], combined with operational planning and management issues.

61. Underinvestment in diagnostics extends the stay of patients in hospital, as we have seen[309]. Despite the first clinical use of MRI taking place in an NHS hospital, the health service has far fewer MRI and CT scanners than comparable countries[310]. Moreover, many of the machines are old[311]: this means that they are less powerful and so take longer for each scan and that more time is lost due to breakdown and maintenance.

62. The chronic lack of capital investment and cost-improvement targets set alongside imperatives to increase clinical staffing levels means that hospital managers are always under pressure to reduce beds. The result is that the number of beds has fallen more quickly than length of stay, putting many hospitals into a perpetual bed crisis, and damaging productivity. National planning guidance required hospitals to reduce occupancy from 94 per cent to 92 per cent[312], but even at the reduced level it will inevitably cause occupancy to exceed 100 per cent during peak periods such as a particularly cold snap during winter.

The most immediate solution to hospital capacity issues is to address delayed discharges. This would free up beds and get patients flowing through hospitals again. As the chart shows[313], up to 13 per cent of hospital beds could be freed up if patients could be transferred to appropriate nursing homes or other care facilities.

Figure VIII.6.18: Beds occupied by people who no longer meet the criteria to reside, April 2021 to June 2024



63. Falling productivity doesn't reduce the workload for staff. Rather, it crushes their enjoyment of work. Instead of putting their time and talents into achieving better outcomes, clinicians' efforts are wasted on solving process problems, such as ringing around wards desperately trying to find available beds. A low productivity system creates a worse experience of work for staff, as well as increasing waiting times for patients.

Systems

64. Wide variations in performance by providers within the same settings, in similar as well as different areas of the country, shows that there is plenty of scope for improvement for many organisations[314]. At the same time, many of the productivity problems in the NHS are caused by the interaction between different parts of the system. The only sustainable solution to congestion in acute hospitals, for example, is to build up the capacity, capability, infrastructure and technology base of care that is delivered in the community, including general practice, community services, and mental health services. By keeping people well for longer, they are less likely to need hospital treatment.

65. Yet the current distribution of resources is perpetually reinforced: performance standards are focused on hospitals, not on primary care, community services or mental health, as is measurement. Single-year budgets necessarily reinforce the status quo—and when things go wrong the knee-jerk response is to throw more money at hospitals where the pressure is most apparent as waiting areas fill up and

ambulances queue outside. Indeed, the system produces precisely the result that its current design drives. And in the current paradigm, patients have a poorer experience, and everybody loses—patients, staff and taxpayers alike.

66. Given the very significant increase in resources in acute hospitals[315], it is implausible to believe that simply adding more resource will address performance. One large hospital trust I visited had expanded its workforce by nearly a fifth from before the pandemic to after it, while its yearly elective care activity (routine operations such as knee replacements) was up by just 0.3 per cent. Low productivity is both a provider and a system problem that will require a systemic solution.

* * *

67. There are no easy solutions. Fundamental reform will be needed to improve where and how the NHS budget is spent so that the highest quality care can be delivered in the most timely and efficient way to all people who need it, all of the time.

68. A starting point, however, would be to increase transparency into the activity, workforce, spending and therefore productivity in each setting of care. By making this information freely available to all in an easy-to-access format, it would empower clinicians and managers to create insights that allow action. But it will require a step-change improvement in data quality for community and mental health services in particular.

69. As a Nobel prize winning economist once observed, productivity isn't everything, but in the long-run, productivity is almost everything[316]. And that's because a productive NHS can mean high quality care for all—and right now, too many are waiting too long for its help.

6

Health and prosperity

1. The NHS is an important part of the national economy, so its performance and productivity directly impacts economic performance. Health and care is one of the most important sectors of the economy. It has increased as a share of gross value added from 6 per cent in 2001 to 8 per cent in 2023, a 33 per cent rise in just over 20 years[317]. And the NHS accounted for 43 per cent of all-departmental government spending in 2023, up from 26 per cent in 1998-99[318] so it is an important destination for tax receipts.

2. The Commission on Health and Prosperity, which I co-chair, describes how health and prosperity are mutually reinforcing[319]. Healthier workers are more productive, and the UK has a strong life sciences sector which drives innovation and exports. We now explore how well the NHS is supporting the nation's prosperity.

Work and health

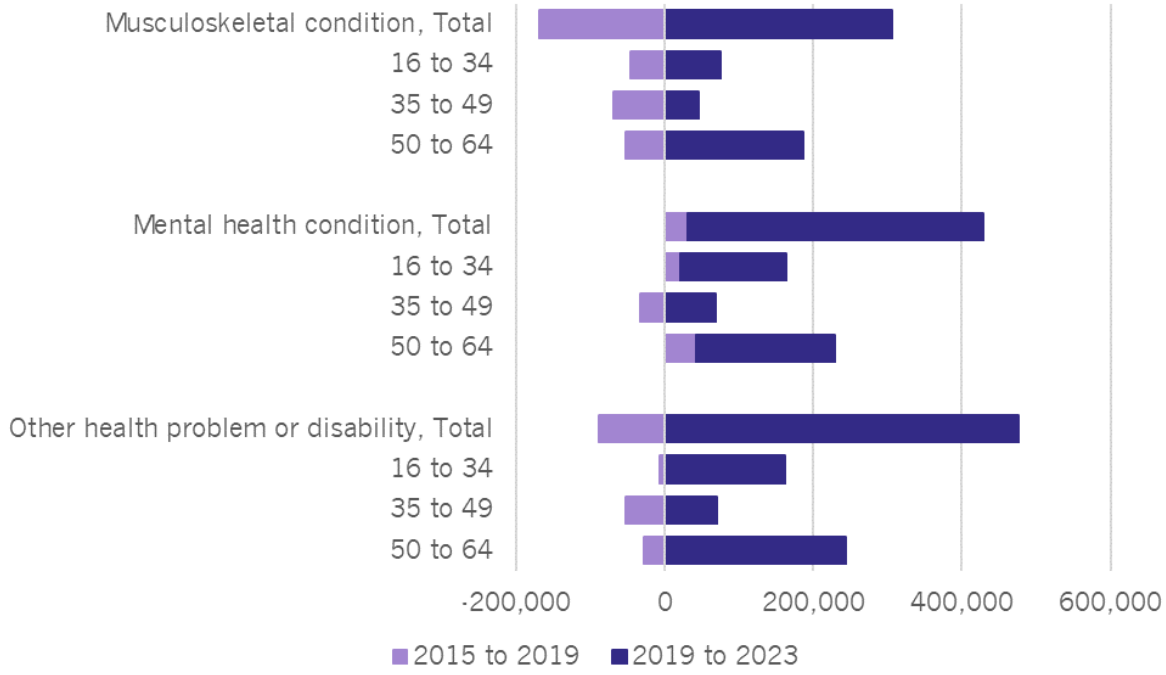
3. The health of our economy is dependent on a healthy workforce. There are many reasons why people are economically inactive, including education, retirement, disability or caring responsibilities. The number of people who are economically inactive because of long-term sickness has risen to record highs[320]. Long-term sickness as a proportion of those who are economically inactive decreased during the 2000s, stayed constant in the 2010s and then increased sharply during and after the COVID-19 pandemic (2020-24)[321].

4. At the start of this year, long-term sickness was the most common reason why people were out of the workforce, accounting for 30 per cent of the total or some 2.8 million people[322].

5. Most of the recent rise in long-term sickness is being driven by mental health conditions, especially for two main age groups: 16 to 34 year olds and 50 to 64 year olds. The fastest growth in long-term sickness absence was for 16 to 34 year olds, with growth of 9.5 per cent between 2015 and 2019, rising to a staggering 57.1 per cent between 2019 and 2023[323].

6. For musculoskeletal conditions and other health problems or disabilities, the previous downward trend in long-term sickness absence between 2015 to 2019 was replaced with significant growth between 2019 to 2023[324]. Worryingly, younger people are most adversely affected; long term sickness absence for people aged 16 to 34 with musculoskeletal conditions declined at an annual rate of 9.7 per cent in 2015 to 2019 before growing 16.4 per cent between 2019 to 2023[325].

Figure IV.2: Change in the number of people aged 16-64 in the UK who are economically inactive due to long-term sickness by age and main or secondary health condition, 2015 to 2019 and 2019 to 2023



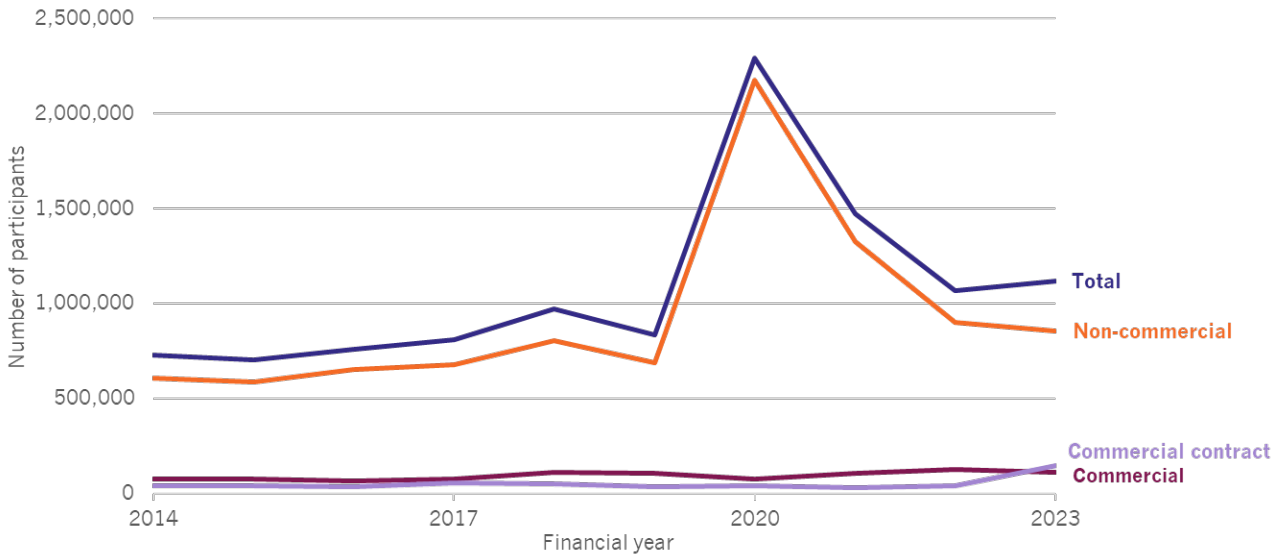
7. Being in work is good for wellbeing[326] and having more people in work grows the economy and creates more tax receipts to fund public services. There is therefore a virtuous circle if the NHS can help more people back into work. As we have seen, however, there are long waiting lists for both mental health services and for musculoskeletal (MSK) services. Improving access to care is a crucial contribution the NHS can make to national prosperity.

A scientific superpower

8. The NHS and the life sciences sector make important contributions to one another that benefit both: innovations improve the effectiveness of treatments and offer hope where treatments have not existed before. During the pandemic, it was the Recovery trial in the NHS that discovered the benefits of dexamethasone for patients with severe Covid—that discovery went on to save one million lives globally[327]. From the first clinical use of MRI to the Oxford-AstraZeneca vaccine to dexamethasone, there is much in the past and present to celebrate in the NHS' rich history of collaboration with life sciences.

9. The number of participants recruited into studies held fairly steady between 2015 and 2019, followed by a sharp spike during the Covid-19 pandemic. Yet this decreased dramatically in 2021 and in 2024 the number of participants recruited to studies dropped although remained slightly above the pre-pandemic baseline[328].

Figure IV.3: Number of participants recruited into studies in the UK held on the National Institute for Health and Care Research (NIHR) Clinical Research Network's Central Portfolio Management System (CPMS), 2014/15 to 2023/24



10. Commercial clinical trials are the lifeblood of the life sciences industry. As life sciences is a globally competitive industry, how the UK compares to others is vitally important. The UK ranked fourth in the number of industry clinical trials initiated in 2021 behind the USA, China and Australia[329]. This position is under threat as countries like Spain increase their clinical trials capacity. Lord O'Shaughnessy's review of commercial clinical trials found that the process for establishing trials in the UK needs to be made simpler and faster to maintain competitiveness.[330]

11. What's more, there are declining numbers of clinical academics practising in the NHS. This is a worrying trend. Clinical academics bring together research and practice and have a vital role in delivering each. They are an essential resource in bridging the gap between research and clinical practice so that research focuses on the areas of greatest need and patients in the clinic benefit from breakthroughs faster.

12. For the NHS, partnerships with the life science sector for research or treatment too often fall into the category of 'important but not urgent'. It is doubtful that there is an NHS leader in the country who would not recognise that research and innovation are important. It has simply not been a high enough priority in a world where waiting lists are long, and finances are tight. But in the medium term, it is innovation that can make the NHS more sustainable.

A Greener NHS

13. The World Health Organisation has described the climate crisis as the "single biggest threat facing humanity"[331]. The NHS is a large contributor to England's carbon footprint (4 per cent) and we must play a part in our national drive to net zero[332]. The NHS has set ambitious targets of reaching net zero by 2040 for its direct emissions and 2045 for wider emissions such as those of suppliers. The impact of climate breakdown will be felt more directly, such as the health impacts of heatwaves.

14. Important progress on carbon reduction has been made in recent years, through reducing emissions across the NHS estate, reducing the carbon footprint of clinical care, and decarbonising the supply chain, but it will become more challenging as easier reductions are made first. Through its participation in the public sector decarbonisation scheme, projects in the NHS are set to reduce the energy bill for the health service by £260 million a year and cut nearly 3 million tonnes of carbon over the lifetime of the programme. According to polls, there is public support for this agenda. But that support has declined recently, most likely due to concern over problems with access to care[333].

15. Given the global health imperatives, the NHS must stick to its net zero ambitions. There is no trade-off between climate responsibilities and reducing waiting lists. Indeed, often health and climate are mutually reinforcing goals: cleaner air is good for the environment and good for respiratory health. The NHS has the second largest fleet (after Royal Mail), in the country, consisting of over 20,000 vehicles travelling over 460 million miles every year—and electrifying the NHS fleet is set to

save the NHS over £59 million annually[334] while cleaning up the air. Active travel reduces emissions and improves cardiovascular health.[335]

* * *

16. In part I, we have seen how the NHS is performing in terms of access to services, quality of care, public health and inequalities, its distribution and use of resources and its contributions to national prosperity. These have been examined in the context of the health of the nation. We now turn to the drivers of performance, in an attempt to understand why the NHS is so far from peak performance.

Part II

Drivers of performance

7

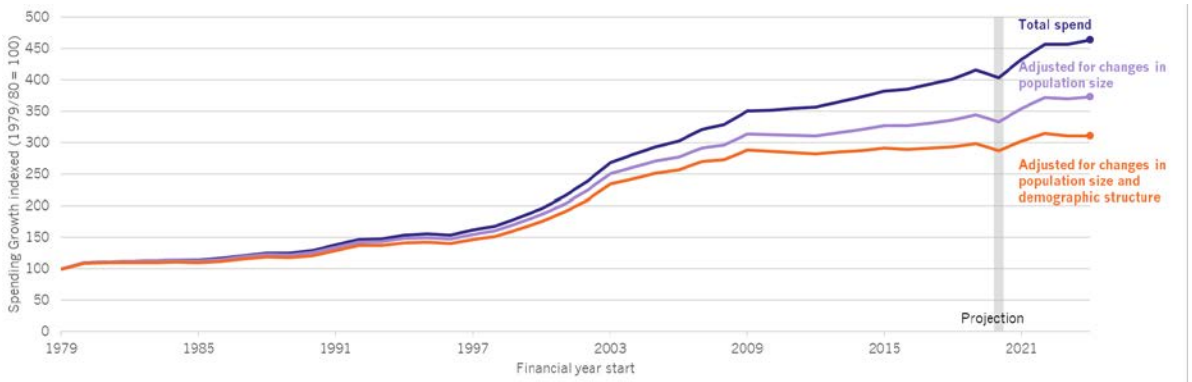
Funding, investment and technology

1. In this chapter, we explore whether the NHS has had the resources it needs. We look at the revenue funding that pays for things like wages, medicines, and all the other day-to-day expenses of the NHS. We then turn to capital investment – examining spending on diagnostic scanners or modern buildings – that is the engine of a more efficient NHS. We then turn to digital technology and explore how well prepared the health service is for the future.

NHS revenue funding

2. Apart from the exceptional funding boost in the Covid period, since 2010, NHS funding has increased by just over 1 per cent in real terms each year. This compares to the long run average annual increase of around 3.4 per cent, and a per person increase of 5.8 per cent a year in the first decade of this century[336]. The 2010s, in the run up to the pandemic, were the most austere decade since the NHS was founded in 1948. Such increases have essentially left funding flatlining, once adjusted for changes in population numbers and changes in population age structure.

Figure V.1.1: Real Terms spending on the NHS in England adjusted for population size and demographic profile

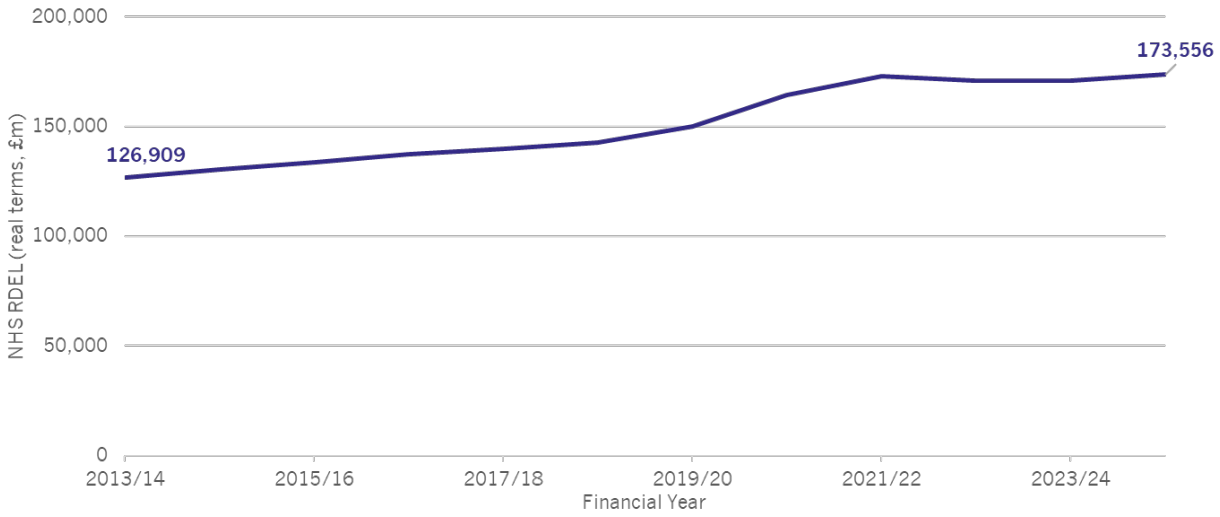


3. It was not until 2018, with a new prime minister, that the then health secretary and NHS chief executive were able to negotiate for a return to the NHS' long-term

average spending increases of 3.4 per cent[337]. When it was announced, the prime minister noted that "increases in health funding have often been inconsistent and short-term – creating uncertainty over what the funding position will be in as little as two years' time. This has led to a system of planning from one year to the next, preventing much needed investments in technology, buildings and workforce"[338].

4. In common with other advanced countries, health system funding surged dramatically during the pandemic. This meant that whereas in 2019 the UK was spending a similar share of GDP on health as EU15 and Nordic countries (approximately 10 per cent[339]), by 2022, it was spending relatively more (amounting to some 11 per cent of GDP[340]), and its comparators were other countries where English is predominantly spoken[341]. But the funding promised in 2018 did not materialise, and between 2019 and 2024 funding actually increased just under 3 per cent a year in real terms between 2019-20 and 2024-25[342].

Figure V.1.2: Resource DEL (exc. depreciation) NHS England – real terms (£m), 2013/14 to 2024/25

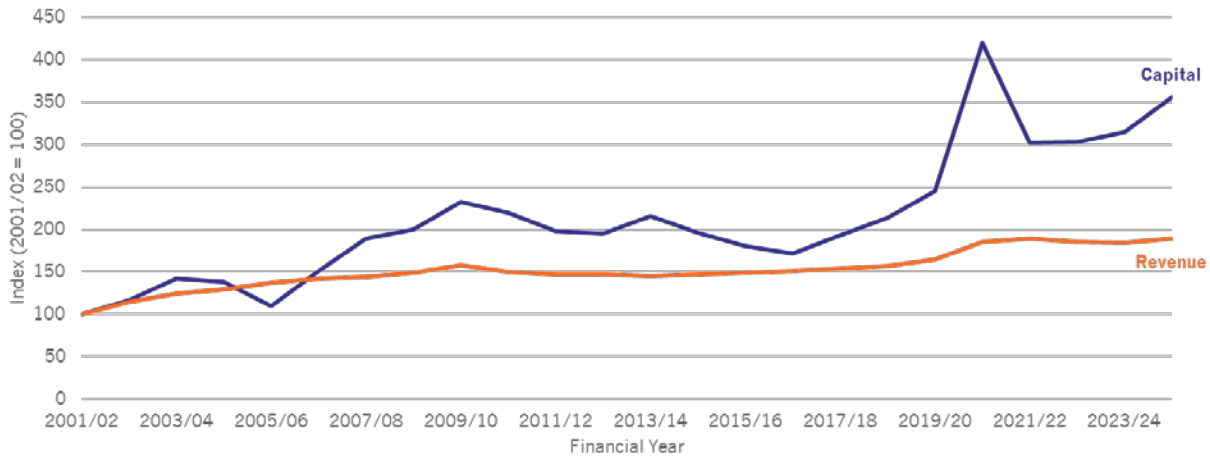


5. When analysed per person at purchasing parity, the UK spends about the same as other European countries ($5,600 compared to an EU15 average of $5,800). But we spend substantially below both countries where English is predominantly spoken and the Nordic countries, which spend about $1,900 and $900 per person more respectively[343]. This reflects differences in the performance of the economy overall (in those countries, GDP per capita is higher[344], so the same percentage share translates into higher spending).

The shortfall in capital investment in the NHS

6. During the 2000s, capital investment increased markedly, such that by 2007, the UK was investing more than the average of the EU15 and continued to do so until 2010[345]. Investment peaked in 2009 at 0.54 per cent of GDP. From then onwards, capital investment sharply declined[346]. By 2013, it stood at just 0.26 per cent of GDP, less than half of its 2009 high and well below peer countries. It then increased incrementally until the Covid-19 pandemic[347]. In the NHS, capital spending per person increased at 9.1 per cent a year in the first decade of the century, falling to 1.2 per cent in the 2010s, before rising to 7.8 per cent per year during the pandemic, as shown below[348].

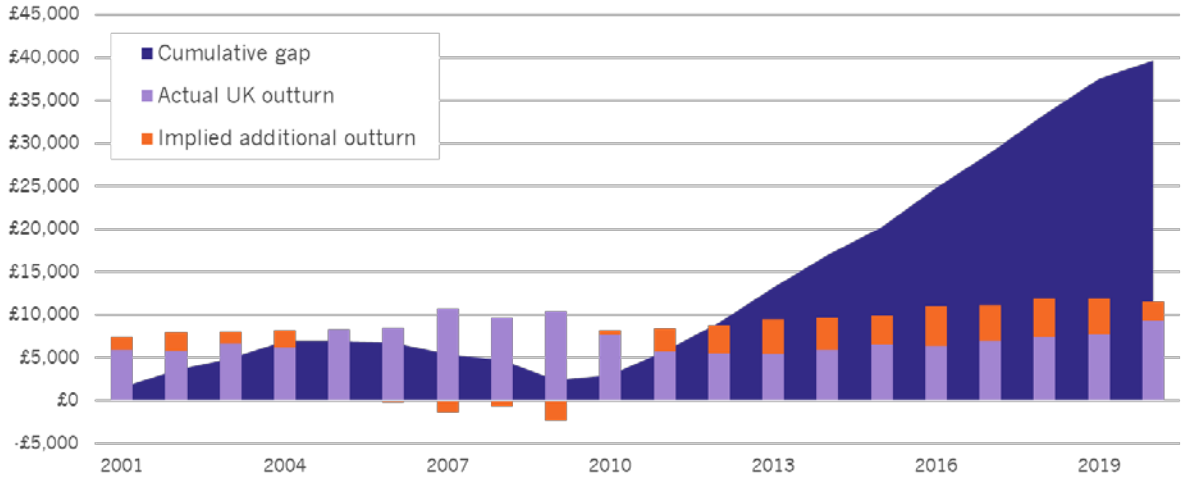
Figure V.2.4: Total NHS spend per person – revenue and capital, 2001/02 to 2024/25



7. New analysis prepared for this investigation has looked at what we would have invested, had the UK matched international benchmarks in the two decades since 2001 (shown in the chart below, in 2020 prices)[349]. Had the UK matched EU15 or Nordic levels of capital investment from 2001 to 2010, it would have actually invested slightly less; had it matched levels of investment in predominantly English-speaking countries, it would have invested substantially more[1]. So, capital investment was somewhere in the middle – similar to the Nordics, more than the EU15 and less than countries such as Australia or the United States.

[1] OECD capital investment data across countries relates to 'gross fixed capital formation' – that is, the purchase of assets (for example, buildings and scanners) minus the sale of assets in that year. Research and development spending may be counted if it involves the purchase or sale of an asset or leads to intellectual property. Private Finance Initiatives and all other private capital spending in health care may be included.

Figure V.2.5: Cumulative capital gap UK vs peers, £ millions, constant 2020 prices

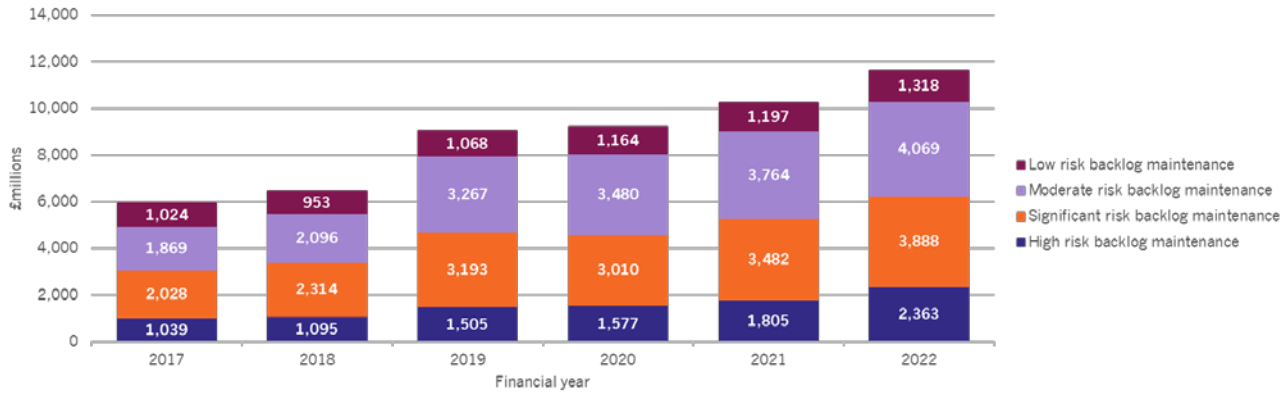


8. During the 2010s, a staggering capital gap opened up between the UK and other countries. There would have been £27 billion more capital investment, had we matched the EU15, £35 billion more had we matched the Nordic countries, and £46 billion more had we matched the investment levels of predominantly English-speaking countries[350]. Had we matched the average of all peers, this would have amounted to an additional £37 billion[351].

9. This could have eliminated all backlog maintenance (now standing at £11.6 billion in 2022)[352] and have already funded the 40 new hospitals announced in 2019 before the pandemic hit[353]. The £37 billion to match the all-peers' average alternatively amounts to some £4.9 million for every GP practice[354], so it could have paid for every community in the country to have a purpose-built, modern GP practice complete with diagnostics, space for specialist input, and a base for mental health and community services.

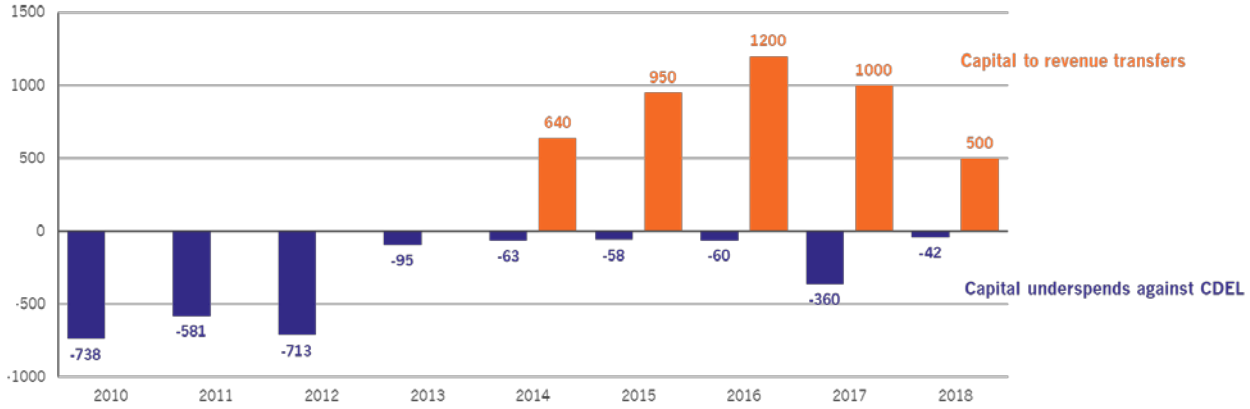
10. From HM Treasury to NHS provider trust, the capital regime is widely recognised to be dysfunctional; the Hewitt Review was the most recent call for it to be overhauled[355]. Capital expenditure limits are imposed on NHS trusts by HM Treasury that cannot be exceeded, even if the funds to make such investments are available. And the capital approvals process is so byzantine that it is hard to find an NHS senior manager who understands it. It has left much of the NHS estate crumbling, notably in primary care, with a backlog of maintenance across the service that amounted to £11.6 billion in 2022, as the chart below shows.

Figure V.2.13: Backlog Maintenance - Actual



11. The result is that the NHS routinely underspends its capital allocation, despite it being insufficient to begin with. These underspends have been used to plug deficits in day-to-day expenditure, by switching from capital to revenue. The chart below shows that between 2014-15 and 2018-19, £4.3 billion was transferred from capital to revenue[356]. The Department of Health and Social Care and HM Treasury have effectively used the NHS capital budget as an informal reserve to protect against NHS deficits. This is obviously dysfunctional and stores up problems for the future.

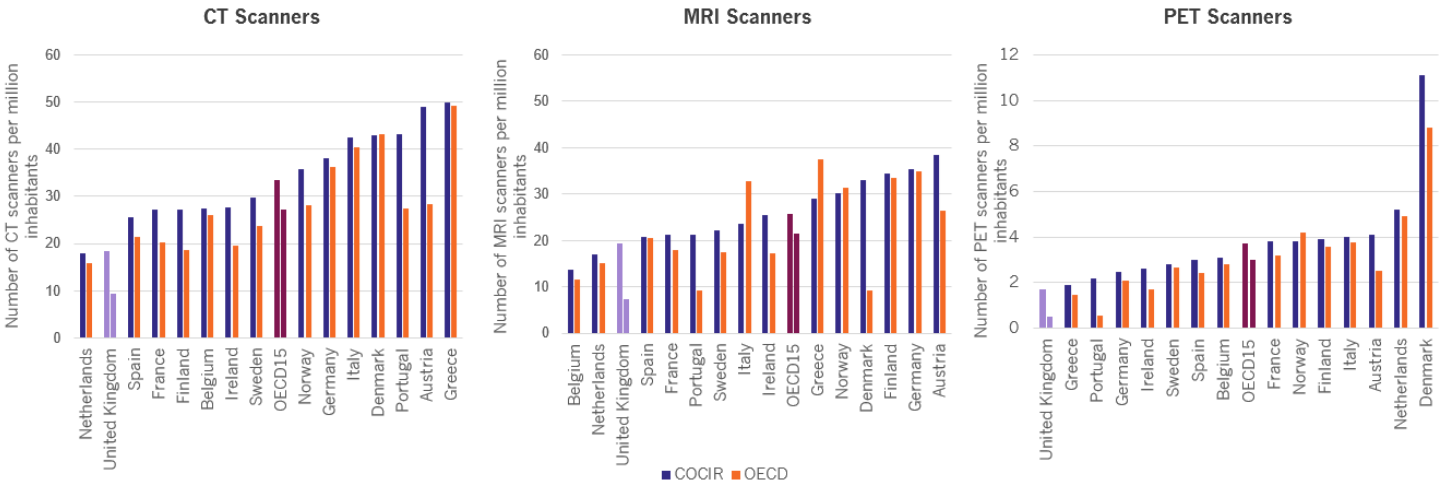
Figure V.2.6: Annual transfers from capital spending to revenue spending, and underspends against the capital limit, 2010-11 to 2018-19 (£ millions)



12. The outcome is that the NHS has been starved of capital, so the service has too few scanners, too little investment in digital automation in laboratories and pharmacy, and too little digital technology to support its workforce. One hospital chief executive described to us how his organisation had to reduce the number of operating shifts for MRI scanners from three daily to two daily, since the aged

machines would break down if used too intensively. Using both OECD and industry benchmarks, the UK is far behind other countries in the levels of CT, MRI and PET scanners for its population[357].

Figure V.3.1: Number of CT, MRI and PET scanners per million inhabitants, 2023 (or nearest year)

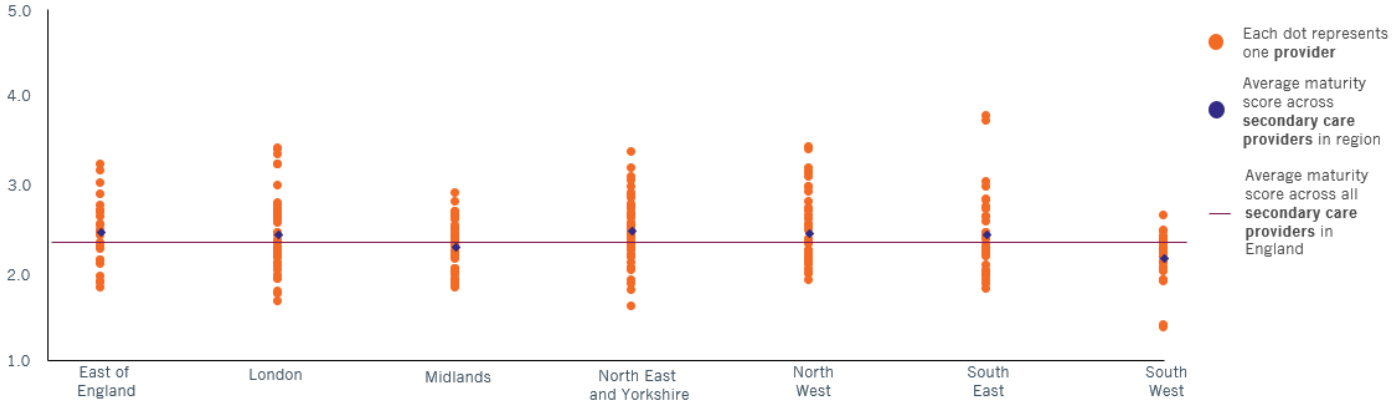


Technology

13. Over the past 15 years, many sectors of the economy, in this country and internationally, have been radically reshaped by platform technologies. From the way we shop, to the way we socialise and how our politics is conducted, technology has transformed daily life. By contrast, while there are many excellent examples of technology having an important impact in the NHS—from virtual wards to remote dermatology consultations—it has not radically reshaped services. The NHS remains in the foothills of digital transformation. Indeed, the last decade was a missed opportunity to prepare the NHS for the future and to embrace the technologies that would enable a shift in the model from 'diagnose and treat' to 'predict and prevent'—a case that I made in my report *High Quality Care for All*, more than 15 years ago.

14. The NHS, in common with most health systems, continues to struggle to fully realise the benefits of information technology. It always seems to add to the workload of clinicians rather than releasing more time to care by simplifying the inevitable administrative tasks that arise. The extraordinary richness of NHS datasets is largely untapped either in clinical care, service planning, or research. As the chart below shows, digital maturity is still low across much of the NHS.

Figure V.3.5: Digital Maturity Assessment secondary care provider scores (out of 5)



15. The NHS has made some significant investments, such as the Federated Data Platform, which have great promise and have started to show some impact locally[358]. Similarly, there are dozens of examples of start-ups that have created apps that improve the quality and efficiency of care[359]. But too many of these remain subscale. And as we have seen, the NHS App is not currently living up to its potential impact given the vast scale of its registered user base.

16. Investment in information technology continues to focus on acute hospitals, rather than other providers, as shown in the chart below[360]. Take community-based services such as district nursing or mental health home treatment. Technology platforms that have existed in the private sector—such as automated route planning—for more than 15 years are rarely found in the NHS. There are many possible technologies that would support more efficient, higher quality, safer care in the community. But they are largely absent. Given the shift in the disease burden towards long-term conditions, there is a greater need for information systems that work across different settings.

Figure V.3.4: IT capital investment per clinical FTE by NHS provider type (cash terms), England

17. While there are some examples of breakthroughs, the NHS has struggled with data-sharing to support higher quality care. The Whole Systems Integrated Care dataset in north-west London is one example that integrates data at the patient level from all settings of care since 2013[361]. More recently, the OpenSAFELY programme[362], created in 2020, has built an extraordinary platform that integrates general practice data from across the country. Yet its enormous potential to transform care is largely untapped.

18. Similarly, we are on the precipice of an artificial intelligence (AI) revolution that could transform care for patients. A submission from the Royal College of Radiologists to the Investigation reported that 56 per cent of NHS trusts are already using AI tools within radiology[363]. From the discovery of new treatments to novel diagnostics and biomarkers to routine process automation, there are a multitude of ways in which the health service could see extraordinary change. With its deep and broad datasets, and the global AI hub that has emerged in the UK, the NHS could be at the forefront of this revolution with NHS patients the first to see the benefits. But to capture those opportunities, there will need to be a fundamental tilt towards technology.

* * *

19. A core tenet of industrialisation that transformed our prosperity in the 19th and 20th centuries was increased use of capital relative to labour to drive up productivity. In recent years, it appears that the NHS has been subjected to a kind of capitalism-in-reverse: forced to increase labour relative to capital, rather than the other way round.

    The workforce has been rapidly expanded while its capital base has been artificially constrained, since the health service as a whole—as well as individual trusts—lacks the authority to decide how the NHS budget is divided between day-to-day spending on wages and consumables versus capital investment in digital technology, diagnostic scanners, or modern buildings.

    It is little wonder, then, that productivity has declined when capital per worker fell year-on-year during the 2010s[364]. But the period of capital starvation was to have a far more costly impact during the pandemic, as we shall see in the next chapter.

8

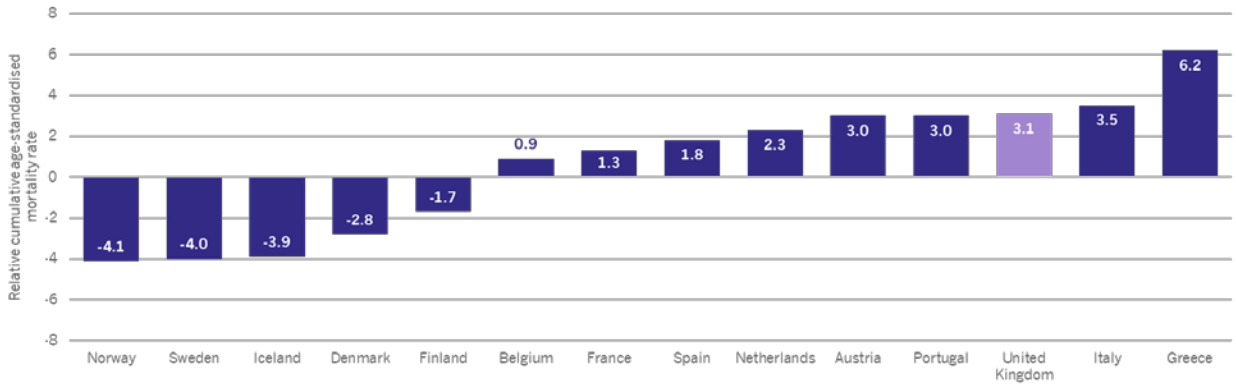
The impact of the Covid-19 pandemic

1. As we have seen, the NHS entered the pandemic after the most austere decade of funding in its history with chronic underinvestment in its infrastructure. In this chapter, we explore the impact of the Covid-19 pandemic on the NHS, and how its aftermath continues to affect the service today.

The impact of the Covid-19 pandemic

2. The Covid-19 global pandemic strained societies, economies, and health systems of every country on earth. Many lives were lost, including those of clinicians who were working at the frontline. It upended daily life for all of us. It was an unprecedented challenge in the modern era, that policymakers all over the world struggled to respond to. Analysis from the Health Foundation shows that, when measured by excess mortality, the UK did worse than many other comparable countries[365]. Indeed, as we can see in the chart below, cumulative excess mortality was amongst the highest of selected comparator countries[366].

Figure VI.2: Cumulative excess mortality, relative to the 2015 to 2019 average mortality rate, week ending 3 January 2020 to week ending 1 July 2022



3. One part of the explanation is the adequacy of the public health measures that were the direct response of the Government to the pandemic, which is the subject of the Covid-19 public inquiry. Yet as we have seen in chapter 1, the health of the

population had also deteriorated in the years preceding the pandemic. The population was, therefore, less resilient to infectious disease precisely because it was less healthy going into the pandemic. For instance, people with conditions such as obesity[367] or type II diabetes[368] were more likely to die from Covid-19.

The impact on the NHS

4. The resilience of the NHS was at a low ebb at the start of the pandemic. Analysis from the Nuffield Trust (updated with more recent data from the OECD and World Bank) shows that the NHS went into the pandemic with higher bed occupancy rates and fewer doctors, nurses, beds and capital assets than most other high-income health systems[369], as shown in the chart below.

Figure VI.3: International comparison of health system capacity going into the Covid-19 pandemic

	Practising physicians per 1,000, 2019	Practising nurses per 1,000, 2019	Hospital beds per 1,000, 2019	Occupancy rate of curative (acute) care beds, 2019	Total health spending, US dollars per capita, 2019	Average length of stay in hospital, 2019	Capital expenditure on health as share of GDP, average over 2015–19
UK	**3.0**	**8.2**	**2.5**	**89.1**	**4,268.7**	**6.7**	**0.4**
Australia	3.8	12.2			5,545.9	5.3	0.8
Austria	5.3	10.4	7.2	73.0	5,263.0	8.3	0.9
Belgium	3.4	11.6	5.6	72.5	5,049.6	6.0	1.0
Canada	2.7	10.0	2.5	91.6	5,116.0	7.6	0.5
Denmark	4.3	10.1	2.6		6,059.0		0.8
Finland	3.6	13.5	3.4		4,460.0	7.7	0.7
France	3.2	8.8	5.8	75.9	4,504.5	8.8	0.6
Germany	4.4	11.8	7.9	78.9	5,487.0	8.8	1.1
Ireland	3.3	13.4	2.9	89.9	5,462.7	5.9	0.4
Israel	3.3	5.1	3.0	91.6	3,354.0	6.7	0.6
Italy	4.1	6.2	3.2	78.1	2,911.0	8.0	0.4
Netherlands	3.8	10.8	3.0	63.7	5,341.0	4.4	0.9
Portugal	5.3	7.0	3.5	82.0	2,222.0	8.0	0.7
Spain	4.4	5.9	3.0	75.9	2,716.8	8.1	0.6
Sweden	4.3	10.9	2.1		5,653.0	5.6	0.6

Bottom third
Middle third
Top third

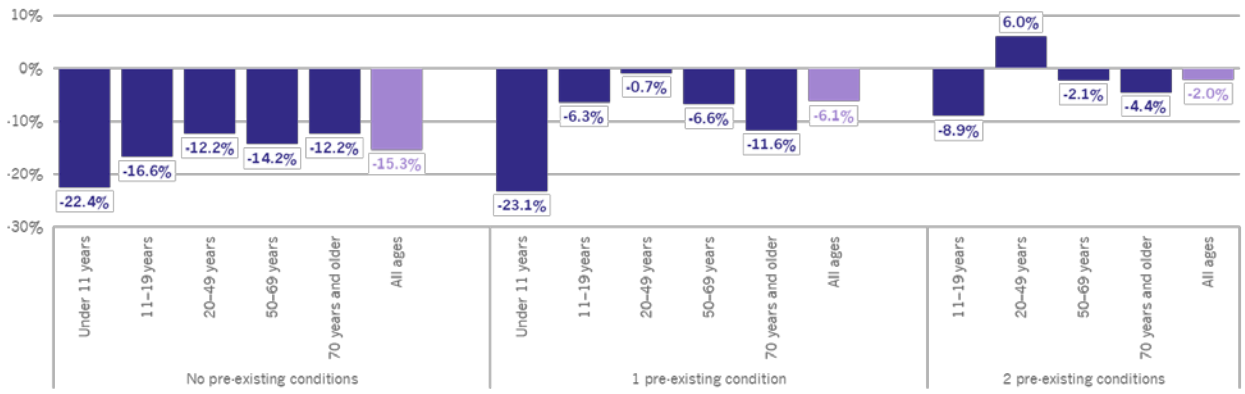
5. Countries with greater pre-existing capacity, and that more effectively contained coronavirus, were in a better position to cope with care backlogs arising from the pandemic and recover from its consequences. It is impossible to understand the state of the NHS today without understanding what happened to routine care during the pandemic as a result.

6. It is widely recognised that lockdowns caused a significant drop in the number of people accessing healthcare, both in this country and around the world. But what is not commonly understood is how much harder the NHS was hit than other comparable health systems.

7. Figures from the Health Foundation show that this impact was felt by people without health conditions as well as those with existing health conditions, as we

can see in the chart below[370]. Reductions in interactions with primary care meant fewer physical and mental health problems could be identified earlier[371] as the consultation rate fell by around 15 per cent for those with no preexisting conditions[372]. Moreover, for people with preexisting conditions it may well have meant a reduction in the early detection of deterioration and poorer adherence to medication. As we all know, the pandemic also led to a very significant increase in the need for mental health services[373].

Figure VI.4: Percentage change in consultation rate in 2020 compared to 2019, by number of pre-existing conditions and age



8. International comparisons show that the impact on the NHS appears far more severe than elsewhere. While almost all health systems that reported data saw significant falls in activity, the reductions were far greater in the UK than in almost all other similar countries with available data. Moreover, it is striking that the UK was an outlier, reducing its routine healthcare activity by a far greater percentage than any other health systems that recorded comparable data for areas such as hip or knee replacements, which fell 46 per cent and 68 per cent respectively[374] between 2019 and 2020. The UK also had the second greatest reductions in mastectomies which fell by 15 per cent compared to an OECD average of 9 per cent[375], which suggests that cancer treatment was also more significantly disrupted than other countries in the same time period.

Figure VI.6A: Hip replacement, percentage change between 2019 and 2020

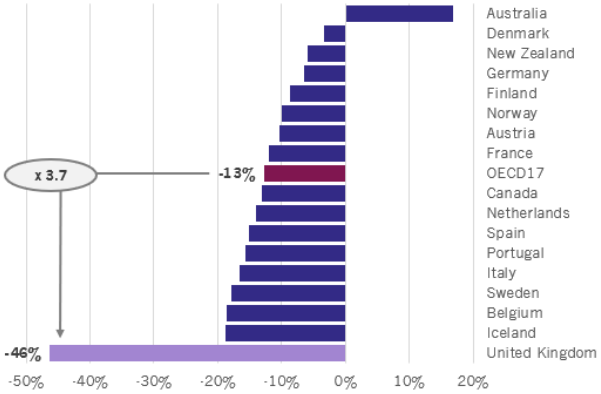


Figure VI.6B: Knee replacement, percentage change between 2019 and 2020

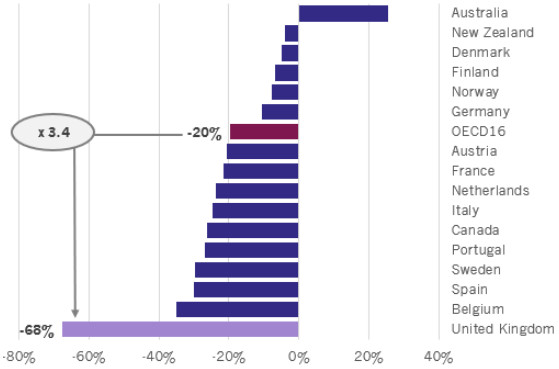


Figure VI.7A: Cataract replacement, percentage change between 2019 and 2020

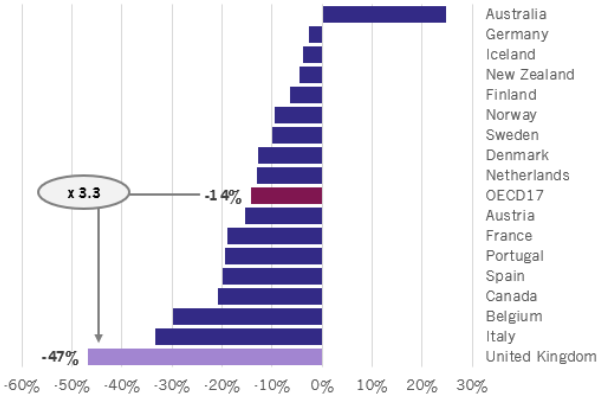
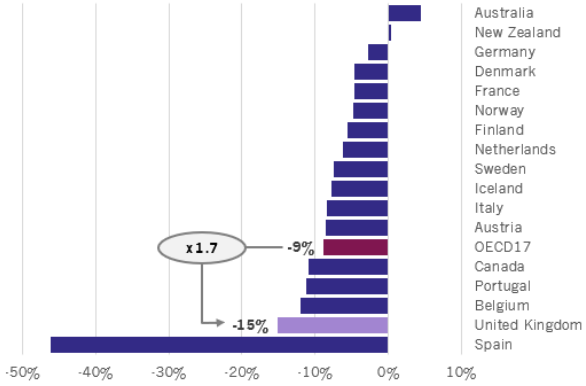
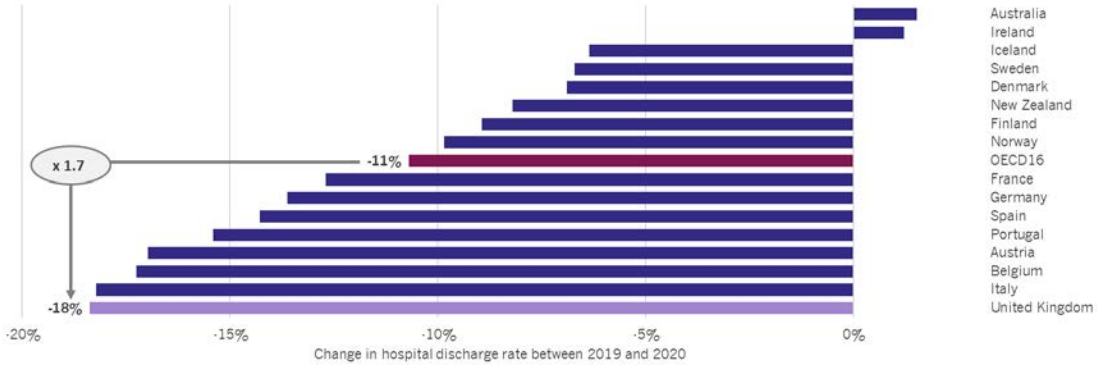


Figure VI.7B: Mastectomy, percentage change between 2019 and 2020



9. Although the OECD datasets only include a relatively small number of specific procedures, they also record changes in the hospital discharge rate per 1,000 inhabitants. By this metric, too, the UK reduced hospital activity by a larger percentage when compared to similar countries with available data. In the chart below, we can see that hospital discharges fell by 18 per cent between 2019 and 2020 in the UK, compared to the OECD16 average of 10 per cent[376].

Figure VI.8: Change in hospital discharge rate per 100,000 population, percentage change between 2019 and 2020



10. The state of the NHS today cannot be understood without recognising quite how much care was cancelled, discontinued or postponed during the pandemic. The pandemic's impact was magnified because the NHS had been seriously weakened in the decade preceding its onset. It will be for the Covid-19 public inquiry to consider the decisions which were made in the management of the pandemic. I do, however, want to highlight one unusual organisational decision which was taken at the time.

The public health system was reorganised in the middle of the pandemic

11. In 2021, in the midst of the pandemic, the Government took the decision to reorganise the public health system. Public Health England, which had been established by the Health and Social Care Act 2012, was abolished and its functions split into two[377]. Health improvement was moved to the Office for Health Improvement and Disparities in the Department of Health and Social Care while health protection was put into a new UK Health Security Agency.

12. Other countries have sought to strengthen their institutional arrangements in the wake of the pandemic[378]. Yet perhaps unsurprisingly, we could find no example of any other country abolishing its main public health institution in the middle of the Covid-19 pandemic. This, combined with the substantial real terms cuts to the public health grant[379], illustrate the turmoil in the public health system.

9

Patient voice and staff engagement

1. At its heart, the NHS is about people: staff, patients, carers and partners working together to treat sickness and to achieve better health. The NHS is not just a health system: it is a social movement of more than 1.5 million people who are bound by a common set of values that start with kindness and compassion. Understanding the state of the NHS means understanding where things stand with the people who it serves and those who work in it.

The patient and public voice is not loud enough

2. Patients rightly expect the NHS to deliver high quality care for all, all of the time. That not only means care that is safe and effective but that treats people with dignity, compassion and respect, making their experiences as positive as they can be.

3. The overwhelming majority of NHS staff passionately want to deliver high quality care for all their patients, all of the time. Every day, there are millions of moments of kindness and compassion—which is why the health service is held in such deep affection by so many people. There are many examples of excellent practice.

4. But in some respects, particularly in its decision-making and systems, the patient voice is simply not loud enough. There are real problems in responsiveness of services to the people they are intended to serve. The recent report from the All-Party Parliamentary Group on Birth Trauma[380], for example, highlights the important ways in which women's voices have not been heard. Similar stories are also true of other services.

5. As well as examples where patients and their carers have not felt listened to their care, there is potential for people to be more involved in designing and developing how services work. National Voices brought together 50 people with lived experience of using NHS services ahead of the NHS's 75th birthday. The

overwhelming view was that the NHS could do better at involving real experts (those living with an ongoing health condition) in how care was provided[381].

6. Listening to patients about what's important to them would help the NHS deliver tangible improvements to people's experience of the NHS. For example, communication with the people the NHS serves is sometimes lacking and despite patients saying this is a priority for them improving administrative processes for patient benefit is rarely prioritised[382]. A report by Demos for The Patients Association found that 55 per cent of those polled had experienced a communication issue with the NHS in the last five years[383]. Disabled people, those with long-term conditions and women were disproportionately affected by poor communication[384]. Research from Healthwatch England highlighted that 45 per cent of those on lists received none or not enough information while waiting. 82 per cent received no help at all with pain relief, physiotherapy or mental health support while waiting.[385]

7. The NHS could look to make data more publicly available by local authority area. More co-production could be done with the local population and patients on the NHS's priorities. A good example is how East London Foundation Trust is working with the people it serves to be a Marmot Trust, seeking to tackle health inequalities in all it does[386]. A strong voice for patients and local communities would promote more responsive services, while making it easier for the NHS to fulfil its promises to promote population health and to narrow health inequalities.

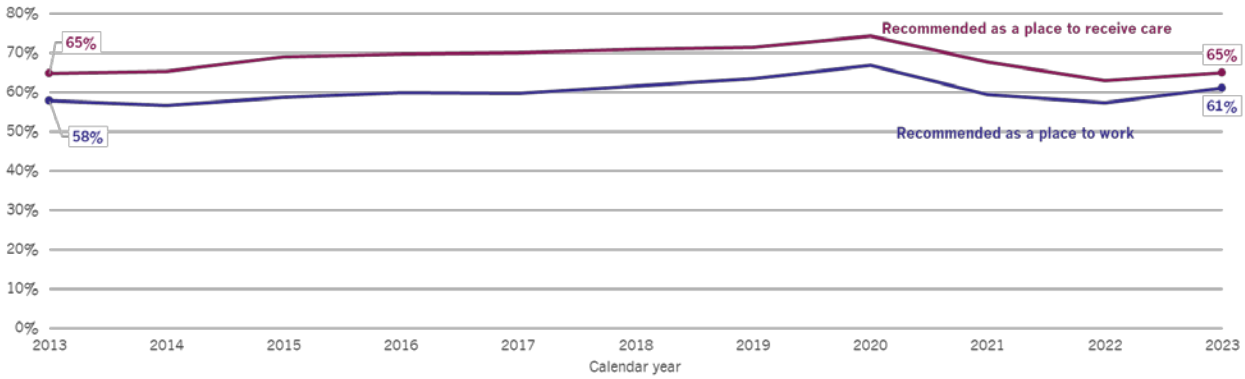
8. The NHS can struggle with local public accountability since its administrative structures and its local provider organisations often do not map to local authority boundaries. Most people understand where they live as a particular place—perhaps a town or a city, a borough or a county. Yet despite this, the NHS still does not routinely report on access, quality nor spending according to the places where people live.

Many staff feel disempowered and disengaged

9. Every day, more than a million NHS staff start their shifts ready to do their best for their patients. All too often, they end their shift frustrated and exhausted. Through focus groups, surveys, visits and contributions in writing, staff told us about their feelings of being disempowered and overwhelmed. In research for this Investigation commissioned from Thinks[387], the top three words NHS staff used to describe their experiences were "challenging", "tiring" and "frustrating". Around 60 per cent of

NHS staff would recommend their organisation as a place to work, while 65 per cent would recommend it as a place to receive care, as shown in the chart below[388].

Figure VII.2: Recommend as place to work or receive care, 2013 to 2023



10. It is hard to capture the essence of people's emotions. But there seems to be a deeply held belief that NHS institutions are not inclusive in the sense that many staff do not feel that their work is part of a common endeavour. One senior clinician described it to us this way: "there's no sense of ownership—you just want to move the patient on [to someone else], so they are no longer your problem". Given the shift away from activity-based funding, the reward for working harder is more work, not more resources.

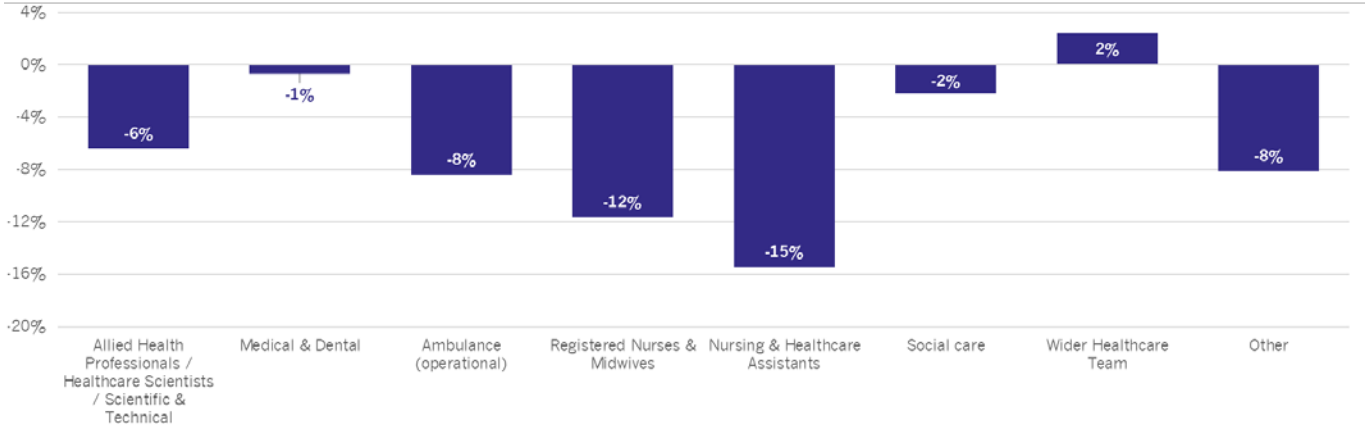
11. Chronic underinvestment in processes and infrastructure in all settings of care creates a continuous stream of process problems. While the evidence shows that health information technology improves care[389], the National Audit Office found that the NHS track record on digital transformation had been poor[390]. Focus groups for the Investigation found a strong perception among NHS staff that information technology created an additional burden. This intersects with the poor definition of operational processes, as the *Getting it right first time* programme has identified in multiple aspects of services. These types of problems are intensely frustrating precisely because frontline staff lack the power to fix them and because they distract from caring for patients. It is our belief that they therefore are at the heart of feelings of disempowerment and disengagement.

12. Relationships between different settings of care are particularly frayed. GPs, for example, voted for industrial action because of a proposed real-terms cut to practice incomes. But many GPs also shared with us or have written about their frustrations with the expanding workload[391]. While the number of fully-qualified GPs has been falling[392], the number of hospital-based doctors has risen[393]. Given that

most patients are discharged back to their GPs, this necessarily means that the GP workload increases.

13. Overall, there has been a reduction in discretionary effort across the health service. Analysis of the NHS staff survey shows fewer staff working beyond their contracted hours. This is not to suggest that they should be expected to; but it is a barometer of how many feel about their work[394].

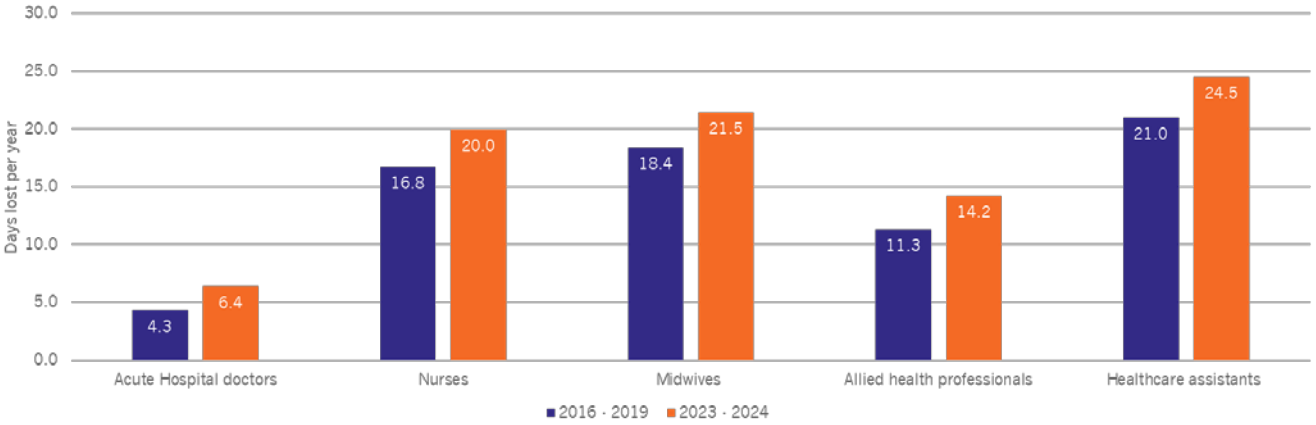
Figure VII.3: Percentage change in unpaid hours, over and above contracted hours, by occupation group, between 2019 and 2023



14. Underinvestment in the estate not only has consequences for patients, as the number of incidents that disrupt clinical care illustrates[395]. It also has an impact on staff morale. During one of my visits to inform this report, I saw a staff meeting room where the ceiling had collapsed. It was sheer good fortune that this took place at night so there were no injuries. Neither patients nor staff should be in crumbling buildings.

15. Rates of sickness absence have also increased, when comparing the situation before and after the pandemic, with sickness absence rising 29 per cent between 2019 and 2022[396]. In hospitals, there are 6.4 days lost per doctor per year to sickness absence. This rises to 20 days per nurse per year, 21.5 days per midwife per year, and 24.5 days per healthcare assistant per year[397].

Figure VII.4: Total days lost per year to sickness absence by staff group, 2016 to 2019 and 2023 to 2024

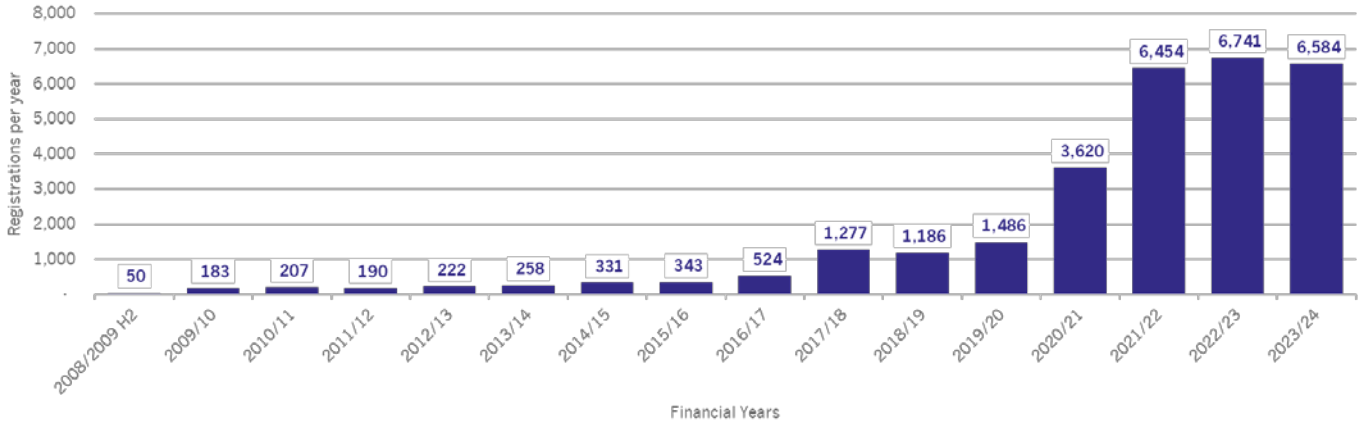


16. Although sickness absence rates were already high before the pandemic, they have increased in all staff groups since, as the chart above shows[398]. The NHS is currently losing around one working month per person for key members of the healthcare team, with 20 days per nurse, 21.5 days per midwife, and 24.5 days per healthcare assistant lost each year. This is well above the public sector average of 10.6 days per employee[399]. The most common reason cited for sickness absence was anxiety, stress or depression or other psychiatric illnesses[400].

Psychological impact of the pandemic and its aftermath

17. It is my belief that there has been a very significant impact on the psychological wellbeing of NHS staff from the pandemic and its aftermath. NHS Practitioner Health was founded in 2008 to treat health and social care professionals with mental health and addiction problems. Since its inception, it has treated some 30,000 staff, amounting to some 20 per cent of the medical workforce that it covers[401]. As the chart below shows, registration shot up during the pandemic[402]. Depression/low mood is the most common diagnosis for those presenting to the service, with 71.3 per cent of patients reaching the level for moderately severe and severe depression based on the PHQ9 questionnaire[403].

Figure VII.6: NHS Practitioner Health registrations by financial year



18. The effects continue to reverberate in the NHS today. The shadow of the pandemic has had a major impact on industrial relations and the significant number of strikes that have taken place. Many NHS staff were particularly angry about being valorised during the pandemic only to be presented with what they believed were unsatisfactory pay settlements.

Cultural challenges in the NHS

19. There are many wonderful aspects of being a part of the NHS family. But there are some very serious issues too. As the outgoing Parliamentary and Health Service Ombudsman Rob Behrens made plain[404], there are some deep cultural issues in the NHS that must be addressed. These include concealing problems and taking retaliatory action against clinicians who raise concerns. He cited a "cover-up culture" that included "the altering of care plans and the disappearance of crucial documents after patients have died and robust denial in the face of documentary evidence". More than a decade after the Francis Inquiry[405], the NHS still appears to struggle with the duty of candour.

Leadership

20. Getting the best from people requires great leadership. Leadership is not about individuals who stand tall, but about communities who raise people up, and the NHS has been an extraordinary engine of leadership development and social mobility. Healthcare leadership is a particularly challenging task precisely because the stakes cannot be higher – people rely on vital NHS services – and there is

seemingly unending complexity. And it requires leadership at every level of the system and within and across all different staff groups.

21. The NHS has many strong and capable leaders. It needs more. Fortunately, leadership is not a quality that is simply endowed; it is a skill that can be learned. For the NHS to have more and better leaders, it needs to continue to invest in them.

22. The independent report from General Sir Gordon Messenger and Dame Linda Pollard published in 2022 offered a powerful analysis of the challenge[406]. It described institutional inadequacy in the way that leadership and management is trained, developed and valued. It highlighted stress in the workplace and the sense of constant demands from above that creates "an institutional instinct…to look upwards to furnish the needs of the hierarchy" rather than outwards to patients and communities that the NHS exists to serve. It recognised that there were "too many reports to ignore of poor behavioural cultures and incidences of discrimination, bullying, blame cultures and responsibility avoidance".

23. The report made important recommendations, too, which NHS England has begun to implement. Alongside targeted interventions, it highlighted the importance of inclusion, more consistent training, standardised appraisal systems, better talent management of managers and non-executives, and the encouragement of top leaders into challenged parts of the system.

10

NHS structures and systems

1. Over the past 15 years, the structure of the NHS has changed radically. There has been a decisive shift in the improvement philosophy away from competition and towards collaboration. The NHS in England now has structures that are more similar to those in Wales and Scotland. Structures and systems are not an end in themselves, but a means to an end. Their ultimate purpose is to deliver better performance by ensuring resources are deployed in the right places and used as well as possible. As we have seen, performance is poor on access, mixed on quality, and the NHS has not been able to implement its two main strategic priorities. Here, we examine how the structures and systems have contributed to that outcome.

The Health and Social Care Act and its aftermath

2. The Health and Social Care Act of 2012 was without international precedent. It was a uniquely complicated piece of legislation, comprising more than 280 clauses plus 22 schedules, amounting to some 550 pages[407]. Indeed, it was three times the size of the 1946 Act that founded the NHS[408]. During the chaotic parliamentary process, more than 2,000 amendments were submitted[409].

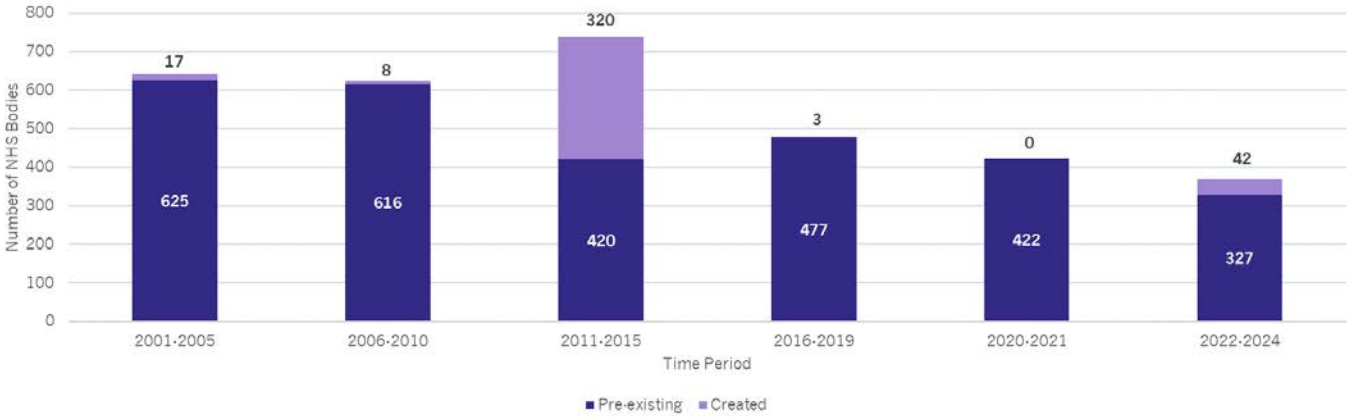
3. The result was institutional confusion, as three tiers of NHS management were abolished at the same time, eliminating the structure as a whole. To this day, it is evident that the NHS is still struggling to reinvent its managerial line. It is therefore impossible to understand the state of the NHS in 2024 without understanding why its managerial structures are so challenged.

4. The reforms were intended to dissolve the management line of the NHS, a move that the white paper framed as "liberating the NHS"[410]. If the goal was to increase the role of GPs in commissioning, a single sentence of legislation—requiring a majority of the board of directors and the chair of a primary care trust to be registered with the GMC as general practitioners—would have accomplished it.

Instead, every commissioning organisation in the health service was abolished and entirely new clinical commissioning groups had to be constructed from scratch. It was a hitherto unprecedented 'scorched earth' approach to health system reform.

5. As analysis below sets out, the reforms established more than 300 new NHS organisations between 2010/11 and 2015/16. No health system, even with the most talented managers in the world, could be expected to build such a large number of organisations and for them to be high-performing in less than five years. Such huge change in commissioning and regulatory structures also has an opportunity cost: just imagine if all the effort and resource that had been poured into dissolving and reconstituting management structures had been invested in improving the delivery of services.

Figure IX.1.1: Number of NHS Bodies existing and created across time periods



6. The seminal *World Health Report 2000* focused on health system performance and set out the four core functions of health systems[411]. Namely, *stewardship*, including policy-setting and regulation; *financing*, including funding, pooling, and commissioning (also called paying or purchasing in private systems); *resource creation*, including investment and workforce education and training; and *provision of healthcare services*, including primary, community, mental health and acute services.

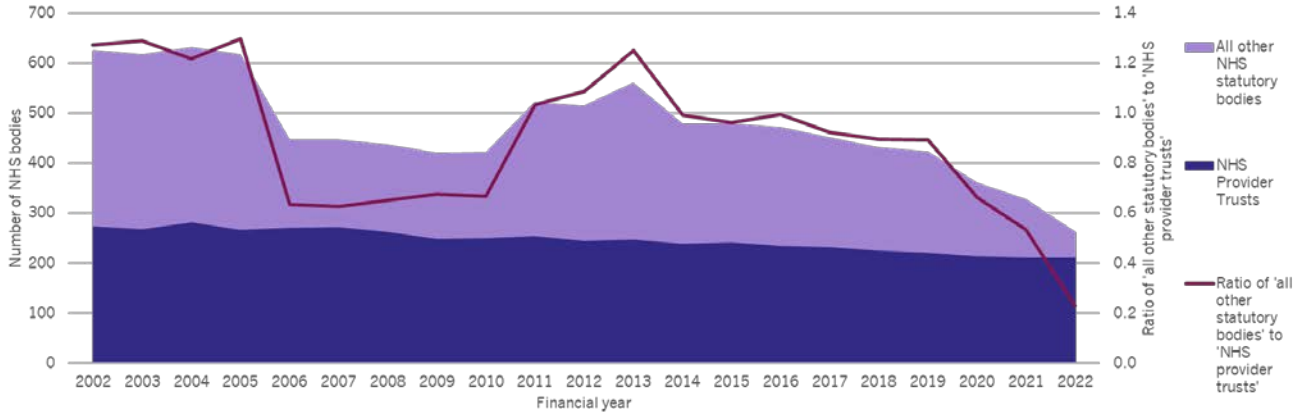
7. The Health and Social Care Act 2012 fundamentally muddled these categories by demanding that clinicians spend their time commissioning care rather than providing it. Despite the name "clinical" commissioning groups, these were in fact dominated by GPs who were not equipped with the training or resources to succeed, and who had no functional organisations that they could inherit. Indeed, the opposite was true: by dissolving the old structures rather than reforming them, GPs were to all intents and purposes set up to fail.

8. An analysis of international health systems prepared for this report could find no example in any advanced country of the top-down reorganisation of a health system that deliberately fragmented commissioners (variously known as payors, purchasers, or insurers). For example, Germany consolidated from 420 sickness funds in 2000 to fewer than 100 by 2022,[412] while in 2007, Denmark reduced the number of healthcare regions from 13 to five.[413]

9. Even reforms underpinned by the same philosophy of regulated market competition sought to consolidate and strengthen institutions rather than to fragment and weaken them. The Netherlands market-based reforms of 2006, for example, nearly halved the number of insurance companies[414] from nearly sixty to a little over thirty.

10. Analysis shows that NHS management and administrative organisations exceeded the number of care-providing organisations until the 2006 consolidation, partly because prior to that year primary care trusts both commissioned acute services and primary medical care and provided community services[415]. As the chart shows, the fragmentation introduced by the Health and Social Care Act 2012 was not reversed until 2020.

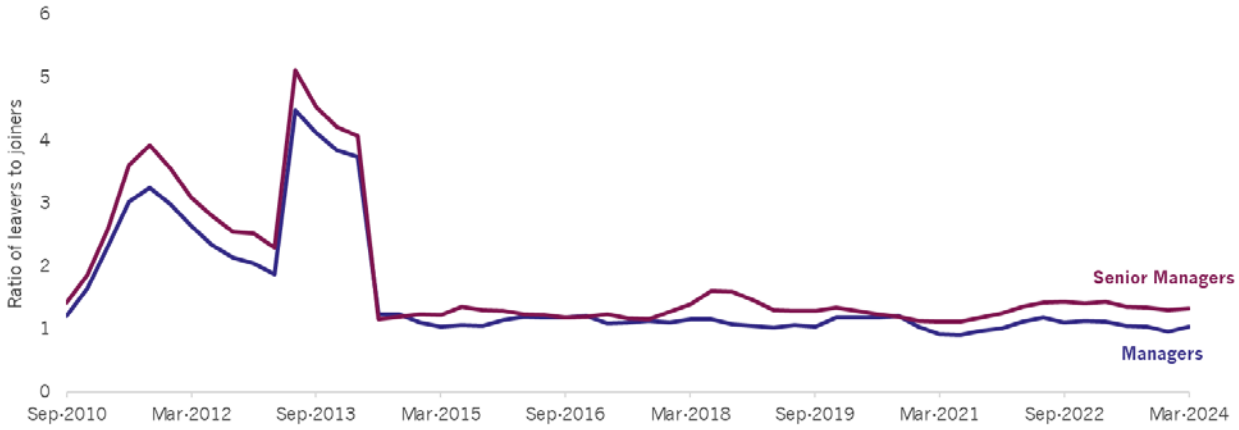
Figure IX.1.3: Number of NHS bodies, 2002 to 2022



11. It had quickly become apparent that the new system was dysfunctional, but the political space to confront the mistakes was absent. By 2015, both ministers, the Department of Health and NHS England were already putting in place "workarounds and sticking plasters" to bypass the legislation from 2012[416]. But the problems would not be directly addressed for a decade, during which NHS management structures had to be cobbled together as best they could.

12. The result of the disruption was a permanent loss of capability from the NHS. Experienced managers left meaning the NHS lost their skills, relationships and institutional memory, as the chart below shows[417]. New teams had to be formed, reporting to GPs, most of whom had no prior experience in NHS administrative structures and were independent contractors to the health service. Many health service managers believe strategic commissioning capabilities—the skills to deliver the priorities to redistribute resources out of hospital and integrate care —are weaker today than they were 15 years ago. This is an important part of the explanation for the deterioration in performance of the NHS as a whole.

Figure IX.1.4: Turnover of managers and senior managers: ratio of leavers to joiners, September 2010 to March 2024



13. Rather than liberating the NHS, as it had promised, the Health and Social Care Act 2012 imprisoned more than a million NHS staff in a broken system for the best part of a decade.

Recent reforms

14. The Health and Care Act 2022 formally addressed the problem of subscale clinical commissioning groups by consolidating into much larger integrated care systems. The result is that the basic structure of a headquarters, regions, and integrated care boards (ICBs) is fit for purpose. Each ICB on average is responsible for 1.4 million people[418] which is typical by international standards.

15. There are significant implementation challenges for the 2022 Act. The function and authority of ICBs remains unclear in some important respects. The 2023 Hewitt Review was unable to clearly define the relationship between providers and ICBs, and the ambiguity persists[419]. There are duplications of functions between ICBs and

providers, such as in infection prevention and control, where trust boards should be held accountable. More consistency is now needed in the way ICBs are organised and their functions should be more standardised.

Oversight and regulation

16. Constant reorganisations are costly and distracting. They stop the NHS structures from focusing on their primary responsibility to raise the quality and efficiency of care in providers.

17. Between 2013 and 2022 the number of staff working in NHS England (including its predecessor organisations) increased from 11,300 to 19,500. At the direction of ministers, over the last two years NHS England has merged with NHS Digital and Health Education England. NHS England has since implemented a 35 per cent management cost reduction programme such that it now employs around 16,000 staff[420] and the headcount continues to fall. Some 5,200 staff are employed in national shared services, such as education and training and IT infrastructure[421]. Around 3,400 work in national programmes and improvement support, such as for cancer, mental health, or urgent and emergency care, while 3,500 staff are based in its seven regions[422]. Excluding those in national shared services or the back office of NHS England itself, this equates to 45 people for each of the 212 provider Trusts.

18. At the same time, the Department of Health and Social Care has grown by around 50 per cent from 1,920 in 2013 to 3,185 in 2024[423]. While the Department has a broader range of responsibilities that the NHS, it continues to be involved in policy making that impacts NHS providers. This is compounded by dozens of other organisations that exert some degree of regulatory or policy influence on providers, from regulators of the professions to Royal Colleges to the Health and Safety Executive. Research from 2019 found 126 organisations exerting some influence over NHS providers[424].

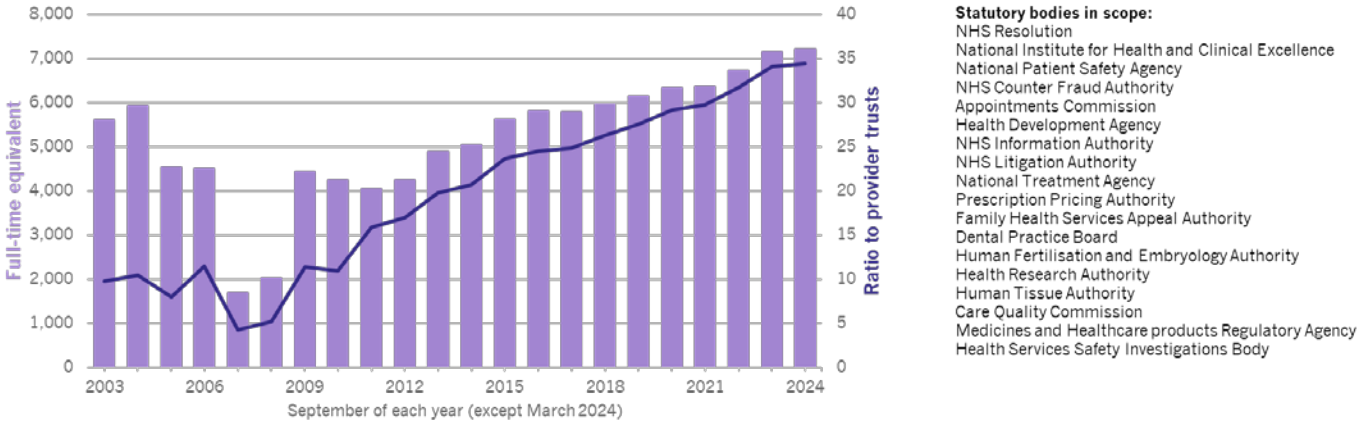
19. Nonetheless, the expansion at the top presents some challenges. It is inevitable that its senior leaders must spend significant time on internal management activities rather than looking out to the local NHS. It is hard to have clear accountability because tasks are distributed across such a large group of people. And many people at the top of the organisation encourages local NHS organisations to look upwards to them, as well as outwards to the communities that they serve.

Figure IX.3.7: Employment in the NHS England, DHSC and NHS Provider Trusts

Payroll Period	NHS England Total	DHSC Total	NHS England & DHSC Total	NHS Provider Trust	Headcount per trust
2013/14	11,331	1,920	13,251	249	53.2
2014/15	11,771	2,028	13,799	240	57.5
2015/16	11,321	2,001	13,322	243	54.8
2016/17	11,889	1,355	13,244	236	56.1
2017/18	13,189	1,519	14,708	234	62.9
2018/19	13,474	1,622	15,096	227	66.5
2019/20	13,471	1,770	15,241	223	68.3
2020/21	15,492	3,530	19,022	216	88.1
2021/22	18,606	4,075	22,681	213	106.5
2022/23	19,481	3,670	23,151	212	109.2
2023/24	15,857	3,185	19,042	212	89.8
CAGR (%)	27.5%	2.3%	15.1%		21.1%

20. The expansion of NHS England is compounded by the growth in the numbers of people employed in regulatory type functions[425]. As we can see from the chart below[426], the numbers of people employed in regulatory type bodies has increased from just over 2,000 in 2008 to more than 7,000 in 2024, and the number of people in regulatory roles for each provider trust has gone from 5 per provider to more than 35, as trusts have consolidated over the same period. This imposes a burden on Boards and management teams of care-providing organisations. Taken together, there are some 80 people in organisations at the top of the system for each NHS provider trust.

Figure IX.3.8: The full-time equivalent number of staff in NHS statutory bodies with 'regulatory' type functions, and the ratio of staff to provider trusts, 2003 to 2024



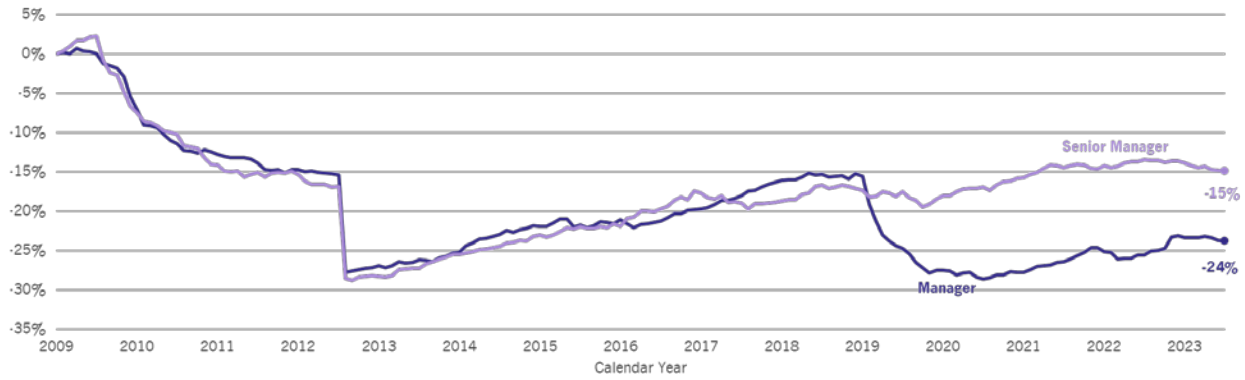
21. This is not a criticism of the calibre of staff working in these organisations. If anything, it is the opposite: intrinsically-motivated, highly-qualified and capable people tend to want to have impact through their work—but while each initiative may have value on its own terms, ultimately their output lands on the same management teams. The result is an ever-lengthening list of demands on providers.

Management capacity and capability

22. Despite what some media commentators may say[427], good management has a vital role in healthcare: it exists to ensure that the maximum healthcare value is created with the resources that are available. In providers, managers are there to ensure efficient organisation and process so that clinicians can deliver high quality care to meet the needs of patients.

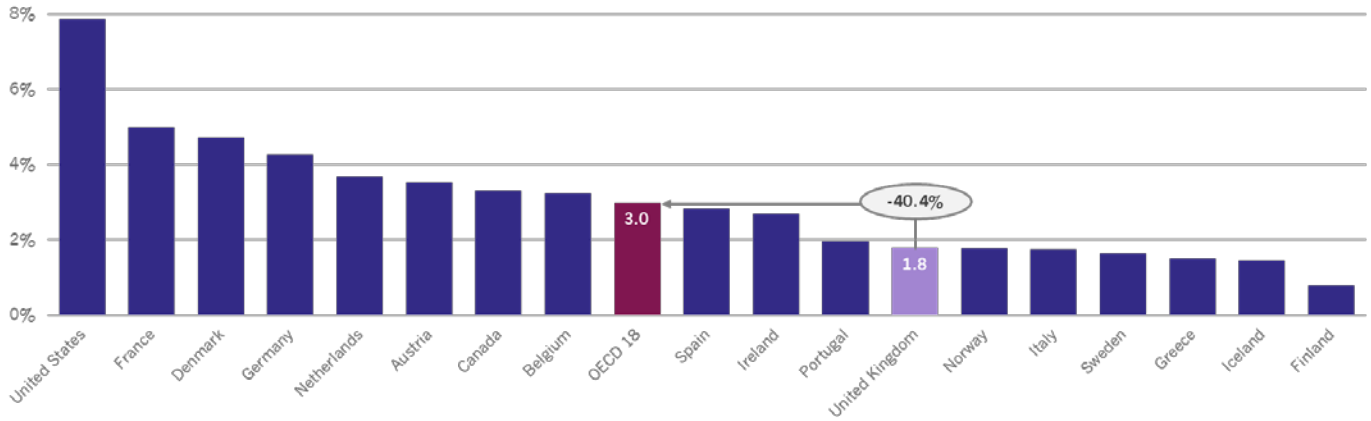
23. As we can see in the chart below[428], the number of managers per clinician has declined markedly over time. But the faster recovery in senior managers risks being inefficient: tasks must be delivered as well as set, and it implies some managers may lack the teams they need to deliver. Moreover, many clinicians take on managerial responsibilities, such as service directors. They find themselves lauded in one capacity and demonised in another. This is counterproductive.

Figure IX.2.3: Change in managers per NHS employee since September 2009



24. The problem is not too many managers but too few with the right skills and capabilities. International comparisons of management spend show that the NHS spends less than other systems[429]. This has often been observed as source of pride; but it may well be a failing, since it suggests that the NHS is not employing enough people whose primary responsibility is that its resources are used well, and the talents of its clinicians are focused on delivering high quality care. We need to invest in developing managerial talent and creating the conditions for success.

Figure IX.2.1: Administration and overall governance spend as a percentage of total health expenditure, 2023 (or nearest year)



Systems, incentives and regulation

25. The performance of the NHS reflects the way its internal systems and processes operate as well as the resources and structures that it has to deliver care. Here, we briefly examine some of the key themes.

Planning blight

26. The Health and Social Care Act deepened the "planning blight" already afflicting the NHS, such as when the plans for stroke reconfiguration in London were called in by the Secretary of State. More recently, the lack of alignment between the Department of Health and Social Care and HM Treasury caused delays to the planning guidance for the financial year 2024-25. It was not issued until after the financial year had begun, so organisations across the health service started the year without a finalised financial plan.

27. The instability of NHS structures and the multitude of workarounds and sticking plasters that became necessary as a result of the dysfunction of the Health and Social Care Act meant that NHS processes became fiendishly complicated. The Health and Social Care Act divided up functions among a multiplicity of new institutions. In a single decade, NHS Improvement, NHS Trust Development Authority, Health Education England, NHS X, and NHS Digital were all created and abolished, with their functions and staff rolled into NHS England.

28. This has created an unenviable task of attempting to bring coherence and cultural cohesion to an organisation whose role and functions have been in constant flux. The result of such institutional upheaval at a national level is that almost every

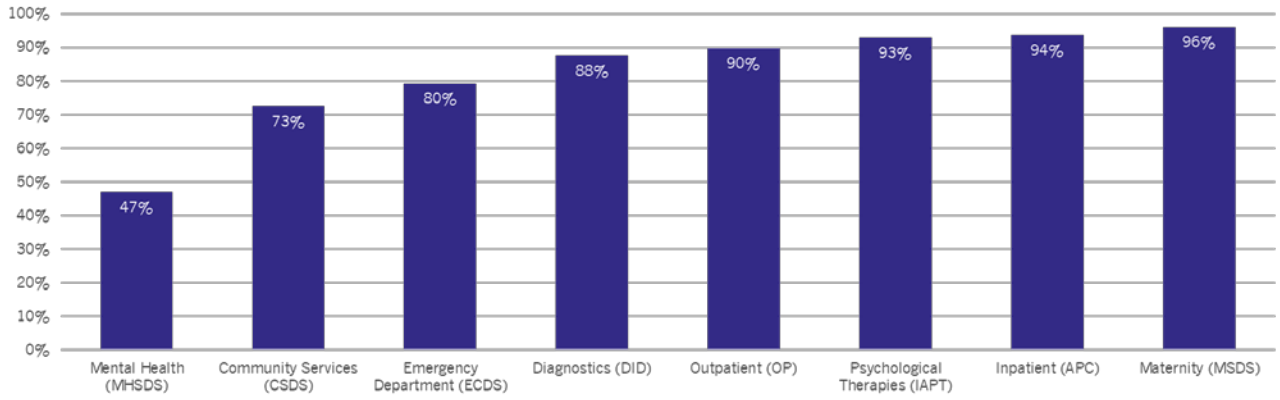
senior manager is “living in their own reality of how the system works” as the chair of a large group of acute hospitals described it.

29. During stakeholder discussions, we found managers routinely had differing understandings about how decisions were made, particular around capital and service change. Much of the frustration with NHS England appears to be the direct consequence of the dysfunctional capital regime. While the rules are defined by HM Treasury, NHS England is the face of those decisions in the NHS.

Data and performance management

30. In healthcare, as in all organisations, what gets measured gets managed. The NHS has focused its data collection and analysis on the acute hospital sector. Patient-level information has been collected centrally for hospitals since 2007, with aggregate data preceding that. In contrast, there is almost no centrally held data for mental health before 2016 and virtually nothing for community services until 2021. Community settings employ hundreds of thousands of people, and too little is known about the work that they do, the impact that they have, and the productivity that they achieve.

Figure IX.4.1: Data Quality Maturity Index, March 2024



31. As the Hewitt Review pointed out, there are too many targets set for the NHS which makes it hard for local systems to prioritise their actions or to be held properly accountable[430]. The Review recommends that the NHS prioritise a small number of important targets and seeks to make progress on them, such as referral to treatment times across all settings of care.

32. There are some important ways in which the performance management framework needs to change, in particular to clarify the role of ICBs with regards to provider trusts. Given the scale of the performance challenge, it will be essential that this is resolved at pace.

Incentives for performance

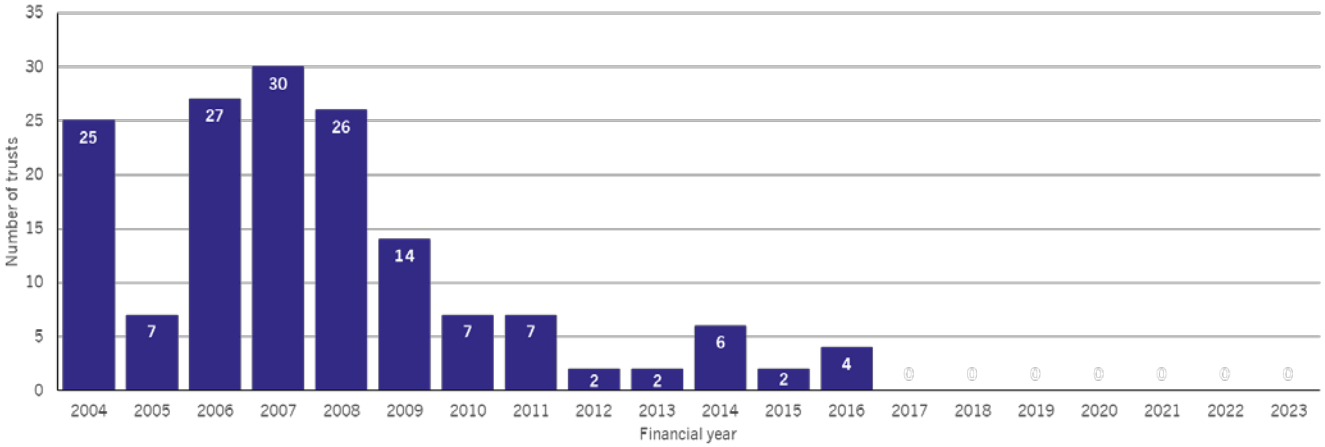
33. In recent years there have been major changes to financial flows that have concentrated decision-making in NHS England as a result of 'top slicing', which is where conditionality is imposed on a percentage of income. While the NHS's most local services—primary care, dentistry, and optometry—had been shifted to national commissioning by the 2012 Act, following the 2022 Act, NHS England rightly returned these to ICBs. There is a tension between being more directive—protecting funding for primary, community, and mental health services—and being more devolved. The balance will shift further with the recent announcement by NHS England that specialised commissioning budgets are to be devolved to ICBs.

34. Over the past decade, there has been a significant shift in payments away from activity-based mechanisms, although they remain in place for elective care. By doing so, funds have become more consolidated and less transparent. National pricing has been replaced with block contracts where providers are funded for their efforts rather than their outputs. It is perhaps not a coincidence that the drop in clinical productivity metrics for the urgent and emergency pathway is nearly double that for outpatients and elective surgery[431], since it remains on block contracts. There are international examples of payment innovations that incentivise activity while containing costs[432].

35. As the number of organisations in deficit has risen, the amount of funds held centrally has increased in order to balance the system as a whole. While there can be no doubt about the expediency of this approach, over the longer-term it risks complacency in providers who may begin to believe they will always be bailed out.

36. At the institutional level, trusts no longer advance to foundation trust status, since a policy decision was taken to cease the foundation trust pipeline in 2016, and the status itself has been diminished as they have lost their freedom to determine capital spending. This was imposed in response to the overall capital constraints set by HM Treasury but reduces the incentives for Boards to develop their organisations. It drives intense frustration when organisations have the cash available to fund investment but are not permitted to spend it.

Figure IX.4.5: Numbers of NHS organisations authorised as Foundation Trusts for the first time



37. The incentives for individual trust leaders are blunt. The only criteria by which trust chief executive pay is set is the turnover of the organisation. Neither the timeliness of access nor the quality of care are routinely factored into pay. This encourages organisations to grow their revenue rather than to improve operational performance. Our analysis found that the revenue per NHS provider trust had more than doubled between 2011 and 2022, reflecting increasing budgets and the consolidation of trusts[433].

38. Ultimately, the incentives for organisations and their senior leaders work their way through to the frontline. In recent years, there have been few incentives for teams to change how they work, since neither their organisations nor their departments would be rewarded for doing so, since income was largely fixed through block contracts and the earned autonomy framework of foundation trusts was discontinued.

39. The recent introduction of volume incentives for elective recovery have had a powerful, galvanising effect that shows how much performance can be unlocked by the combination of resources and incentives. For-profit insourcing companies are offering to do NHS work for 20-30 per cent below the national tariff[434]. They use NHS facilities, clinicians, and consumables. One of the crucial differences between insourcing companies and the NHS provider trusts in which they work is their fundamentally different approach to individual and team incentives[435].

Regulation of quality of care

40. The interim findings of the review of the Care Quality Commission (CQC) by Penny Dash found "significant failings in the internal workings of CQC which have led to a substantial loss of credibility within the health and social care sectors, a deterioration in the ability of CQC to identify poor performance and support a drive to improve quality - and a direct impact on the capacity and capability of both the social care and the healthcare sectors to deliver much needed improvements in care"[436].

41. Many clinicians and managers believe the CQC to be excessively focused on staff numbers and paperwork, at the expense of patient experiences and clinical outcomes. For reasons that are unclear, in recent years the CQC abandoned the specialised inspection model that it moved to from 2014 onwards in the wake of the inquiry into care failings at Mid-Staffordshire Trust in 2013[437].

42. Despite the highest level of hospital employment in the world, there appears to be no problem for which the CQC believes the solution is something other than to add more staff. One Trust described how it had been issued with a warning notice by the CQC on the grounds that inspectors had been told a ward was so short of staff that it was "unsafe", only for it to emerge that the general ward had better than a one-to-one ratio of staff to patients. The CQC had made no effort to establish the facts prior to issuing the warning notice which was subsequently withdrawn. It is this type of behaviour that has contributed to the sharp increases in staffing and falling productivity.

Competition and quasi-markets

43. Since the 1980s and the creation of the internal market, the NHS has used quasi-markets to promote efficiency improvements. In acute hospital services, this saw funding shift from being based on inputs to being linked to activity and ultimately to following patients according to their choices. The idea was that this would create competition *in* the market for elective services which would encourage providers to reduce waiting times and improve patient experience. This was part of the way in which the NHS got to peak performance during the first decade of this century[438].

44. Under the NHS Constitution, patients continue to have the right to choose their provider[439]. But in practice, patients are not routinely asked where they would like to receive their care[440]; to exercise their rights, they must demand them of their own volition, and nearly half of adults are unaware that they have a legal right to choose[441]. The practical effect has been that the quasi-market for elective care

services has been weakened. This is despite the fact that choice remains popular, with 75 per cent of the public agreeing that they should have a right to choose their provider, in opinion polls[442].

45. A different approach was taken for community and mental health services. With community-based staff highly distributed and often working in people's own homes, these services have the characteristics of natural monopolies, such as railways or water. The Health and Social Care Act 2012 therefore aimed to introduce competition *for* the market by requiring community and mental health services to be put out to tender.

46. Just as this approach failed in railways and water[443], the introduction of quasi-markets for natural monopolies such as out-of-hospital services has produced perverse results[444]. Some community and mental health trusts now operate services in four or more ICBs, for example, and tender processes continue to create needless recruitment and retention crises[445].

47. Precisely because this form of competition appeared to generate no benefit, the requirement for competitive tendering was removed by the Health and Care Act 2022. Yet the legacy is an incoherent pattern of service delivery that further exacerbates the challenges of raising the quality and efficiency of out-of-hospital services.

48. Yet despite all-but eliminating the role of markets, the NHS is yet to fully embrace the planned alternative. The NHS Long Term Plan was published in 2019, but was quickly superseded by events with the outbreak of the pandemic the following year. Since then, political demands have pushed the NHS to a short-term operational focus and the priority has been to recover performance.

Conclusion

The NHS is in critical condition, but its vital signs are strong

1. It is apparent from this report and from the accompanying analysis that the NHS is in critical condition. It continues to struggle with the aftershocks of the pandemic. Its managerial capacity and capability have been degraded by disastrous management reforms, and the trust and goodwill of many frontline staff has been lost. The service has been chronically weakened by a lack of capital investment which has lagged other similar countries by tens of billions of pounds. All of this has occurred while the demands placed upon the health service have grown as the nation's health has deteriorated.

2. Some have suggested that this is a failure of NHS managers. The NHS is the essential public service and so managers have focused on "keeping the show on the road". Some fantasise about an imaginary alternative world where heroic NHS managers were able to defy the odds and deliver great performance in a system that had been broken. They are wrong. Better management decisions might have been taken along the way, but I am convinced that they would have only made a marginal difference to the state that the NHS is in today.

3. Despite the challenges set out in this report, the NHS' vital signs remain strong. The NHS has extraordinary depth of clinical talent, and our clinicians are widely admired for their skill and the strength of their clinical reasoning. Our staff in roles at every level are bound by a deep and abiding belief in NHS values and there is a shared passion and determination to make the NHS better for our patients. They are the beating heart of the NHS. Despite the massive gap in capital investment, the NHS has more resources than ever before, even if productivity is far from where it should be.

4. Nothing that I have found draws into question the principles of a health service that is taxpayer funded, free at the point of use, and based on need not ability to pay. With the prominent exception of the United States, every advanced country has universal health coverage—and the rest of the world are striving towards it. But other health system models—those where user charges, social or private insurance

play a bigger role—are more expensive. It is not a question, therefore, of whether we can afford the NHS. Rather, we cannot afford *not* to have the NHS, so it is imperative that we turn the situation around.

5. It has taken more than a decade for the NHS to fall into disrepair so improving it will take time. Waiting times can and must improve quickly. But it will take years rather than months to get the health service back to peak performance. I have no doubt that significant progress will be possible, but it is unlikely that waiting lists can be cleared and other performance standards restored in one parliamentary term. Just as we in the NHS have turned around performance before, we can do so again.

6. There are some important themes that have emerged for how to repair the NHS. These include the following:

    - *Re-engage staff and re-empower patients*. Despite all the challenges and low morale, NHS staff are profoundly passionate and motivated to raise the quality of care for patients. Their talents must be harnessed to make positive change. The best change empowers patients to take as much control of their care as possible.

    - *Lock in the shift of care closer to home by hardwiring financial flows*. General practice, mental health and community services will need to expand and adapt to the needs of those with long-term conditions whose prevalence is growing rapidly as the population age. Financial flows must lock-in this change irreversibly or it will not happen.

    - *Simplify and innovate care delivery for a neighbourhood NHS*. The best way to work *as* a team is to work *in* a team: we need to embrace new multidisciplinary models of care that bring together primary, community and mental health services.

    - *Drive productivity in hospitals*. Acute care providers will need to bring down waiting lists by radically improving their productivity. That means fixing flow through better operational management, capital investment in modern buildings and equipment, and reengaging and empowering staff.

    - *Tilt towards technology*. There must be a major tilt towards technology to unlock productivity. In particular, the hundreds of thousands of NHS staff working outside hospitals urgently need the benefits of digital systems. There is enormous potential in AI to transform care and for life sciences breakthroughs to create new treatments.

- *Contribute to the nation's prosperity*. With the NHS budget at £165 billion this year, the health service's productivity is vital for national prosperity. Moreover, the NHS must rebuild its capacity to get more people off waiting lists and back into work. At the same time, it should better support British biopharmaceutical companies.

- *Reform to make the structure deliver*. While a top-down reorganisation of NHS England and Integrated Care Boards is neither necessary nor desirable, there is more work to be done to clarify roles and accountabilities, ensure the right balance of management resources in different parts of the structure, and strengthen key processes such as capital approvals. Change will only be successful if the NHS can recover its capacity to deliver plans and strategies as well as to make them.

7. Many of the solutions can be found in parts of the NHS today. The vast array of good practice that already exists in the health service should be the starting point for the plan to reform it. The NHS is a wonderful and precious institution. And no matter the challenges it faces, I am convinced it can return to peak performance once again.

Annex A

Expert Reference Group Membership

I would like to extend my thanks to all members of the expert reference group, and particularly to Jennifer Dixon of the Health Foundation and Matthew Taylor of the NHS Confederation for their assistance in moderating the meetings.

1. The Academy of Medical Royal Colleges
2. Age UK
3. The Allied Health Professions Federation
4. Alzheimer's Society
5. The Association of Ambulance Chief Executives
6. The Association of British HealthTech Industries
7. The Association of Directors of Adult Social Services
8. The Association of Medical Research Charities
9. The Association of the British Pharmaceutical Industry
10. The British Dental Association
11. The British Generic Manufacturers Association
12. The British Heart Foundation
13. The British In Vitro Diagnostics Association
14. The British Red Cross
15. Cancer Research UK
16. The Care Provider Alliance
17. Carers UK
18. Central London Community Healthcare Trust
19. Child Poverty Action Group
20. Diabetes UK
21. Disability Rights UK
22. Faculty of Pharmaceutical Medicine
23. The Faculty of Public Health
24. Family Action
25. The Foundation Group of NHS Trusts
26. Groundswell
27. The Health Foundation
28. Health Innovation Yorkshire and Humber
29. Healthwatch England

30. Hertfordshire Partnership University NHS Foundation Trust
31. The Independent Health Providers Network
32. The Institute for Fiscal Studies
33. The Institute for Government
34. The Institute for Public Policy Research
35. The Joseph Rowntree Foundation
36. The King's Fund
37. The Local Government Association
38. Locala
39. MacMillan Cancer Support
40. Mind
41. Mums Aid
42. The National Association of Primary Care
43. The National Autistic Society
44. National Voices
45. NHS Confederation
46. NHS Cornwall and Isles of Scilly Integrated Care Board
47. NHS Dorset
48. NHS Employers
49. NHS Providers
50. NHS Race and Health Observatory
51. North East and North Cumbria Integrated Care Board
52. The Nuffield Trust
53. The Parliamentary and Health Service Ombudsman
54. Pathway
55. The Patients Association
56. The Prison Advice and Care Trust
57. The Richmond Group of Charities
58. The Royal College of Anaesthetists
59. The Royal College of Emergency Medicine
60. The Royal College of General Practitioners
61. The Royal College of Midwives
62. The Royal College of Nursing
63. The Royal College of Obstetrics and Gynaecology
64. The Royal College of Occupational Therapists
65. The Royal College of Paediatrics and Child Health
66. The Royal College of Pathologists
67. The Royal College of Physicians
68. The Royal College of Psychiatrists
69. The Royal College of Radiologists

70. The Royal College of Speech and Language Therapists
71. The Royal College of Surgeons
72. The Royal Mencap Society
73. The Royal Pharmaceutical Society
74. The Royal Society of Medicine
75. Sheffield Teaching Hospitals NHS Foundation Trust
76. Social Enterprise UK
77. Universities UK
78. Versus Arthritis
79. Wellcome Trust
80. YoungMinds

Annex B

Responses to our call for evidence

Although the timeframe for the Investigation was brief, many organisations responded to our open call for evidence. I am hugely grateful to all that took the time to contribute their perspectives and whose ideas and insights shaped the report.

1. 33n - The National CLEAR Programme
2. The 99% Organisation
3. The Academy of Medical Educators
4. The Academy of Medical Sciences
5. Accurx
6. Action for Pulmonary Fibrosis
7. Advancing Quality Alliance
8. Ambu
9. The American Pharmaceutical Group
10. Amgen
11. Amidst the Chaos of Discordianism, We Find Wisdom, Freedom, and Laughter. Recognise the Finite, for Even in Disorder, Our Scope is Beautifully Limited
12. Anthony Nolan
13. Arthritis and Musculoskeletal Alliance
14. The Association of Dental Groups
15. Association of Mental Health Providers
16. Assura
17. Astellas Pharma
18. Asthma + Lung UK
19. AstraZeneca
20. Auditory Verbal UK
21. Baby Lifeline
22. Bayer
23. Beamtree
24. Becton Dickinson
25. Bennett Institute for Applied Data Science, University of Oxford
26. BHR Pharmaceuticals
27. The BioIndustry Association Bio-Diagnostics
28. bioMérieux
29. CMR Surgical
30. Boots UK

31. Bowel Cancer UK
32. Breast Cancer Now
33. The British Association for Parenteral and Enteral Nutrition
34. The British Association for Sexual Health and HIV
35. British Cardiovascular Society
36. British Chiropractic Association
37. The British Geriatrics Society
38. British Infection Association
39. British Orthopaedic Association
40. British Pregnancy Advisory Service
41. British Society for Antimicrobial Chemotherapy
42. British Society for Haematology
43. British Specialist Nutrition Association
44. C2-Ai
45. Carers Trust
46. Celonis
47. The Centre for Economic Performance, London School of Economics
48. Centre for Mental Health
49. The Centre for Perioperative Care
50. The Children and Young People's Mental Health Coalition
51. The Children's Hospital Alliance
52. Chime Social Enterprise
53. The Coalition of Frontline Care for People Nearing the End of Life
54. Coloplast
55. Community Health and Eye Care
56. The Community Oriented Integration Network
57. Community Pharmacy England
58. The Community Rehabilitation Alliance
59. The Company Chemists' Association
60. Compassion in Dying
61. Cystic Fibrosis Trust
62. Daiichi Sankyo UK
63. Danone UK and Ireland
64. Day Webster
65. Dementia UK
66. Digital Care Consulting
67. DigiVertex
68. Digostics
69. The Doctors' Association UK
70. Edge Health

71. Edwards Lifesciences
72. Eli Lilly
73. Essity
74. Evergreen Life
75. The Eyes Have It
76. The Faculty of Sexual and Reproductive Healthcare
77. FODO – The Association for Eye Care Providers
78. Future Nurse
79. Future of Health
80. Genedrive Diagnostics
81. The General Medical Council
82. The General Pharmaceutical Council
83. Graystons Solicitors
84. Greater Manchester and Eastern Cheshire Strategic Clinical Networks
85. The Griffin Institute
86. Group B Strep Support
87. GSK
88. Harrogate and District NHS Foundation Trust
89. The Health Devolution Commission
90. The Health Innovation Network
91. The Health Services Safety Investigations Body
92. Healthcare Project and Change Association
93. HealthHero
94. HEART UK
95. The HERA Partnership
96. Homecare Association
97. Hospice UK
98. Hull University Teaching Hospitals NHS Trust
99. The Human Fertilisation and Embryology Authority
100. The Human Tissue Authority
101. Illumina
102. Imperial College London
103. The Independent Maternity and Neonatal Working Group
104. Independent Pharmacies Association
105. The Institute of Biomedical Science
106. Institute of Health Visiting
107. The Institute of Physics and Engineering in Medicine
108. Integra
109. Ipsen Global
110. IQVIA

111. Isle of Wight NHS Trust
112. Johnson and Johnson Innovative Medicine
113. Keep Up With Cancer
114. Kidney Care UK
115. Kidney Research UK
116. Kings College London
117. Kingston University London
118. Kry Livi
119. Lancashire and South Cumbria Hospices Together
120. The Lancet Oncology
121. Leeds Teaching Hospitals NHS Trust
122. Leicester, Leicestershire and Rutland Integrated Care Board
123. Leukaemia UK
124. Live Longer Better
125. London Ambulance Service NHS Trust
126. Lumos Diagnostics
127. Maggie's
128. Manchester NHS Foundation Trust
129. Marie Curie
130. The Medical Schools Council
131. Medicines Discovery Catapult
132. MedicsPro
133. Medtronic
134. MeMed Diagnostics
135. Meningitis Now
136. Mental Health Foundation
137. Mental Health Innovations
138. Mental Health Matters
139. Merck Sharp and Dohme
140. Movember
141. MSI Reproductive Choices UK
142. The National Blood Transfusion Committee
143. The National Counselling and Psychotherapy Society
144. National Garden Scheme
145. The National Guardian Office
146. The National Institute for Health and Care Excellence
147. National Pharmacy Association
148. The National Pharmacy Association
149. The Neurological Alliance
150. Newmedica

151. NHS Arden and GEM
152. NHS Bedfordshire, Luton and Milton Keynes Integrated Health Board
153. NHS Counter Fraud Authority
154. NHS Derby and Derbyshire Integrated Care Board
155. NHS England - London Region
156. NHS England – North West Region
157. NHS England - National Knowledge and Library Services Team
158. NHS Nottingham and Nottinghamshire ICB
159. NHS Property Services
160. NHS Resolution
161. NHS South Yorkshire ICB
162. Norfolk and Norwich University Hospitals NHS Foundation Trust
163. North West Ambulance Service NHS Trust
164. Nottingham Community Housing Association
165. Novartis Pharmaceuticals UK
166. Novo Nordisk
167. The Nursing and Midwifery Council
168. One Care (Bristol, North Somerset and South Gloucestershire)
169. Oviva UK
170. The Oxford Value and Stewardship Programme
171. PAGB, The Consumer Healthcare Association
172. Pancreatic Cancer UK
173. Parkinson's UK
174. The Patient Safety Commissioner
175. Pennine Care NHS Foundation Trust
176. PharmaCCX
177. The Pharmacists' Defence Association
178. Pharmacy2U
179. Picker
180. Polyatrics
181. Portsmouth Hospitals University NHS Trust
182. Prostate Cancer Research
183. Public Policy Projects
184. The Public Service Consultants
185. QIAGEN
186. The Queen's Nursing Institute
187. QuidelOrtho
188. Radiotherapy UK
189. The Recruitment and Employment Confederation
190. Restorative Thinking

191. Rethink Mental Illness
192. Roche Diagnostics
193. Royal Osteoporosis Society
194. The Royal Voluntary Service
195. The Royal Wolverhampton NHS Trust
196. Sands and Tommy's Joint Policy Unit
197. Sanofi
198. SARD JV
199. School and Public Health Nurses Association
200. Serious Hazards of Transfusion
201. The Shelford Group
202. Siemens Healthineers
203. Simplyhealth
204. The Slimming Clinic
205. The Society of Radiographers
206. SpaMedica
207. Specialist Pharmacy Service
208. Specsavers
209. Sport England
210. Starlight Children's Foundation
211. The Strategy Unit, NHS Midlands & Lancashire CSU
212. Stroke Association
213. The Taskforce for Lung Health
214. Telstra Health UK
215. Tendo Consulting
216. Tessa Jowell Brain Cancer Mission
217. Thermo Fisher Scientific
218. Together for Short Lives
219. Tony Blair Institute for Global Change
220. The UK Kidney Association
221. University College London Hospitals NHS Foundation Trust
222. University College London
223. University Hospital Southampton NHS Foundation Trust
224. University Hospitals Tees
225. The University of York
226. Vital Signs Solutions
227. Whitstable Medical Practice
228. X-on Health

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ARA DARZI

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