

Health and Social Care Committee

Oral evidence: Independent Investigation of the NHS in England, HC 388

Wednesday 20 November 2024

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Watch the meeting

Members present: Layla Moran (Chair); Danny Beales; Ben Coleman; Dr Beccy Cooper; Deirdre Costigan; Jen Craft; Josh Fenton-Glynn; Andrew George; Paulette Hamilton; Joe Robertson; Gregory Stafford.

Questions 1-54

Witnesses

I: Rt Hon. Professor the Lord Darzi of Denham, Independent Peer, Academic Surgeon and Author of Independent Investigation of the National Health System in England and Tom Kibasi, Chairman, NHS Community and Mental Health Providers, North West.

Written evidence from witnesses:

– [Add names of witnesses and hyperlink to submissions]

Examination of witnesses

Witnesses: Lord Darzi and Tom Kibasi.

Q1 Chair: Welcome everyone to the first public sitting of the Health and Social Care Committee for this Parliament on Wednesday 20 November 2024. We are excited to be up and running and extend a warm welcome to all of those in the room, our witnesses, and indeed anyone watching at home.

Today we will be taking evidence from Lord Darzi, the author of the famed Lord Darzi report. He is an independent peer and an academic surgeon. We also have Tom Kibasi here to support him; he is chair of NHS Community and Mental Health Providers in north-west London, former executive director of the IPPR from 2016 to 2020, and he was the senior policy adviser to Lord Darzi for his landmark 2008 “High quality care for all” review. It is wonderful to have you both with us today; thank you so much for coming.

Lord Darzi, I do not know if you know this, but since the report’s publication in September, it has appeared—or indeed your name has—127 times in *Hansard*. For those who do not know what *Hansard* is, it is the official report of all parliamentary debates.

Your report diagnosed the key challenges facing the NHS today, and although we appreciate that you are not a Minister and therefore it is not your job to come up with all the answers, we very much appreciate you being here to give us a bit more insight into the creation of the report, the analyses you did and some of the conclusions you started to point at without necessarily reaching for what to do next.

In that spirit, we will get going—Committee members are very excited to hear from you. I will start by asking about something that I know we share a passion about, which is the data. This report relies incredibly heavily on data; in fact, over 300 new analyses were commissioned as part of it. Lord Darzi, how difficult was it to get this data? Can you talk us through the process of getting the data on which you have drawn in this report?

Lord Darzi: Thank you for having me here. I have been here before, in a different context. It is a great privilege to be asked to lead this piece of work. I have a few words to say and then I will go straight on to the data question, if that is okay with you.

Chair: How long do you plan to speak for?

Lord Darzi: No more than five minutes.

Chair: Can we make it shorter than that, please?

Lord Darzi: I will try my best.

Chair: We have two hours with you; I am confident you will get through it in that time.

Lord Darzi: That is a lot of time.

Chair: Indeed.

Lord Darzi: Okay. First, it is a great privilege to share the findings of the independent investigation of the NHS. The investigation was conducted with meticulous analysis—I will come back to that—and contributions from 75 organisations, and it shines a light on the pressing issues facing our health system today. The NHS stands at a crossroads, facing unprecedented challenges, but also immense opportunities to rebuild, innovate and thrive.

The report makes it abundantly clear that the NHS is in crisis. Public satisfaction, as we all know, is at an all-time low, with patients and staff alike grappling with systems that struggle to meet expectations. Frustrations abound—including my own. That is not just anecdote; it is the lived reality for millions across the UK.

Compounding the crisis is the overall decline in the nation's health—that is the bit that I was most alarmed by—particularly since 2010. Life expectancy improvements have stalled, and we now face a heavier burden of long-term illnesses. The social determinants of health—factors like poor housing, incomes and instability—have worsened. These trends have led to increased demand for healthcare services, further straining an already overstretched system.

The NHS's performance is falling short across critical areas, and I will go through a few of them. Severe shortages of GPs, particularly in deprived areas, have driven down waiting times and patient satisfaction. Over a million people are waiting for community services, with mental health delays disproportionately affecting children and young people. A&E departments are overwhelmed, with only 60% of patients seen within four hours, down from 94% in 2010. Waiting lists for surgeries have ballooned, with hundreds of thousands waiting more than a year.

In my own specialty, cancer, delays in diagnosis and treatment mean that survival rates lag behind comparable countries. Despite all the efforts I could put in as a surgeon, with technology, the sad fact is that a late presentation is one of the most important determinants when it comes to cancer survival. Cardiovascular care has also suffered, with critical treatment delays.

Beneath all of these performance gaps lie systemic issues that must be addressed. One is budget allocation and productivity. Too much funding is directed to hospitals at the expense of primary and community care—I say that as a hospital doctor, by the way—and productivity gains have not matched staffing increases. On the capital investment shortfalls—I work at St Mary's and I would love to take you round and show you the infrastructure there—years of underinvestment in infrastructure have left



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us with outdated equipment, crumbling buildings and insufficient digital modernisation. The impact of covid-19, exacerbated by pre-existing weaknesses, created larger backlogs and further disruption of services.

What about staff and patient engagement? Sadly, declining patient satisfaction and low staff morale have become significant concerns, and I see it in the coffee rooms and the canteens. Post pandemic, we are seeing reduced discretionary effort by many colleagues and high sickness absence among some staff. Complex management structures and excessive oversight, worsened by the Health and Social Care Act 2012, which I mention in my report, have created a lot of insufficiencies. While the 2022 Act made partial reforms, more work remains.

The report offers a road map for recovery, with seven key recommendations, which I will not go through because you have probably read them. That is my starting point.

Coming back to the data, as a clinician I have always known that, as a system—which, by the way, is the envy of many—we have a huge amount of data, “from the cradle to the grave”. We have decades of amazing data, but we have never managed to use that data. I say that wearing my academic hat. The best would have been Brian Jarman, who, if you remember, used data in coming up with his patient safety or mortality figures many years ago.

Turning back to the report, when a Secretary of State asks you to do something like this, it is obviously a privilege—it is a privilege to make any contribution, and I have worked both for Conservative Governments and for the Labour Government previously as a Minister, as you said—but what levers do you have to get the data? More importantly, when he threw the question at me, I said, “Fine, I’m happy to do it,” but his deadline was eight weeks. I have never really done a review of this nature in eight weeks—it is a big, big ask. The only way you can do something like that is to have high-quality data. That is the only way. Thanks to Tom, who is a genius in this area, we asked the Department for nearly 330 datasets, and we really wanted to go back to the millennium.

Q2 Chair: What determined the millennium as your starting point?

Lord Darzi: 2001, essentially, where we—

Chair: There are a couple of graphs from 2000—but why there? Why not earlier?

Lord Darzi: Well, the data did not exist.

Tom Kibasi: The data just does not exist, because IT systems were not as developed before then. There is some data that precedes 2001—some goes back to 1948 or even before that—but most of the data does not.

Chair: That is very helpful, thank you.



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Lord Darzi: That really was the key to solving this eight-week dilemma of how to get it done. We tried our best to come up with hypothesis-based questions for how we were going to address it.

Q3 **Chair:** I was going to ask about that. How did you decide which nearly 330 analyses to do? Was it, "I've got this question, show me the data"? Then what happened?

Lord Darzi: For us, it was to look at the big themes: access themes, quality themes—at the end of the day, I am a clinician and those are the things I would be looking at. Where are we with the different pathways of care? Where is cardiovascular disease—are we getting better, are we getting worse? I come back to stroke services, and maternity was another one. Then we dug deeper; it was not just the maternity, but the workforce element associated with it. That is how we picked it up.

It is not just the major themes that might be exciting to the public or to the politicians. I went deeper. As a clinician working in the service, and an academic in many ways, I wanted to learn and see what we could find from the data. We can go into the details of the data, but I can tell you that no one else could do this.

Chair: No other health service?

Lord Darzi: No other health system could do this. We are so endowed by this. We have to use it. Something you learn as a clinician academic is that you can only improve things by measuring them. If we do not start measuring it, it becomes a very subjective discussion. Let me hand over to Tom to say a little bit more about the depth of the data.

Tom Kibasi: When it came to the data, we started off with essentially an analytical framework, which maps to the structure of the report. Then there are some things that are more intuitive. It makes sense to measure access to care by setting, but you could not measure quality of care purely by setting of care, simply because that would be too high level, so we took it down to the same pathways set out in "High Quality Care for All" back in 2008. We used the pathways of care to cut the data on quality, and then looked at some of the biggest killers and the areas where there were the most avoidable deaths.

For the other parts, which get into questions of costs and productivity, those are better understood by setting, partly because the health system is organised by settings of care rather than by pathways of care. Therefore, it makes sense to interrogate the data for that by the different settings. That really drove an analytical framework, and from that came a set of analyses that we specified, and the Department of Health and NHS England did a remarkable job of assembling that data at such a rapid pace.

There are a couple of facts that I think are worth sharing. At the peak of this work, something like 200 analysts across the Department of Health and NHS England were contributing data to the report—a colossal team effort.



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The other bit was that there are 76 completely novel analyses that required the Department and NHS England to publish 40 new datasets, which had not been in the public domain before, on the day the report was published. It was therefore also a radical act of transparency.

- Q4 **Chair:** Was there anything you could not get data for that frustrated you, either because it was not measured or because it was too messy?

Tom Kibasi: There is a very clear example of a real data gap. If the big strategy is to shift care from hospitals to community settings, the most shocking data gap is that we do not currently measure the number of people working in community settings. We have got some hypotheses. We discuss some of those data limitations in the report. An example is where a hospital also runs the community services. We all know St Thomas' across the river. It runs the community services in that part of Lambeth, but we cannot differentiate in the datasets a nurse who works in the community setting and a nurse who works in the main hospital building. That limitation is critical if the stated strategy is to shift care from hospital to the community, and we do not know the division in the workforce. However, for the most part, we did not have any real problems in getting what we had asked for. It may have taken a bit to trying to get there—obviously there is a process of iteration to refine and improve the data—but the degree of co-operation was remarkable.

Lord Darzi: This could be tagged very easily by saying, "This person is hospital employed but a community worker." It has not been done, but it is a simple solution.

- Q5 **Chair:** That is very helpful. You start to reach some conclusions on the basis of the data. You mentioned one in your opening remarks. It was about the 2012 Act, which you describe in the introduction as a calamity, which proved disastrous. Does the data prove the causality of that, or could other factors have contributed? You pinpoint the specific moment in time.

Lord Darzi: Several things happened from 2010. I start with the austerity measures. We all lived through this: 2008 and the global downturn was a shock to many, not just the United Kingdom. The Budget was in 2020 and the focus was: "How can we deliver this, with this tight budget?" There was a lot of anxiety among the management, but less among the clinicians; it had not really filtered down to us.

The 2012 Act was one of the biggest reconfigurations. You probably remember that David Nicholson, former CEO of the NHS, described it as so big that you could "see it from space". The destruction that caused had two consequences. The management spent weeks of their time trying to reapply for their jobs. Managing austerity at the same time as major disruption amplified the deficits that we went into immediately afterwards.

- Q6 **Chair:** That is an assertion that you have made from looking at the data. It is not necessarily causal, but there is a strong correlation. Is that fair?



Tom Kibasi: If you have the report in front of you, you can see that we do not just assert things. We have some analytical basis for what is said. If you look at page 119, it is striking that during the period of those reforms, there was an attempt to create 320 completely novel organisations. If you look at any other periods, before or since, you see that there was no such substantial disruption. To demonstrate analytically that this was not just an assertion, you can see clearly that, from an institutional perspective, there had not been another period in which an attempt had been made to create such a large number of institutions. If you turn the page, you can also see on page 121 the noticeable, significant spike in the turnover of management, and that is some explanation for the argument that those reforms led to a permanent loss in managerial capacity and capability. Rather than being assertions, you can see that in the data.

Lord Darzi: To add to that, as I said, most people were reapplying for their jobs at that time, so there was huge turbulence. The controls at a time of austerity were, I think, another factor.

Q7 **Chair:** That is very helpful, thank you. I have one last question before I pass on. We now have these three broad themes; as you said, you recommended seven. To what extent do you feel that those three themes capture the direction that you were trying to push in the report? One that seems to be missing—there is no sign of it—is the recommendation to reconsider how the NHS can help to deliver prosperity. That is not mentioned specifically in the three themes. If any of your themes are not covered by the 10-year plan, what would be the consequences of that, in your view?

Tom Kibasi: The prosperity argument is an outcome of having a better-performing health system—it is arguing that it can do that not intrinsically, but if you can get the NHS to perform at a better level, so that people are not on waiting lists, for example, and can get back to work.

The majority of the people on the waiting list at the moment are of working age, and there is an increase in long-term sickness of something like 800,000 people that is principally driven by mental health conditions and by MSK conditions. We know that, for both those things, there has been a big increase in the waiting times.

Q8 **Chair:** I don't think you have quite answered my question. There are the three themes in the 10-year plan, and you have your seven, some of which have been included and some have not. You have told me how you came to that conclusion and what you are driving at, but in the IPPR report and in *The Guardian* article, you have said, "Well, if that is the problem, prosperity is in part the cure." You point again in that report to this point.

I am trying to invite you to tell us what would happen—what were you trying to say beyond, "This is a problem"? You are offering it as a solution, in a sense, to drive something. Lord Darzi, will you answer on this point?



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Lord Darzi: The IPPR report clearly showed that poor health and weak economic performance are deeply connected. That is what we tried to get at. The covid pandemic obviously worsened both. That is the big punchline in relation to all that. It was not just the three themes, but at the same time, the poor health of the nation, which became more and more apparent, as we say in the report, entering covid.

Chair: As you said in your opening remarks, that is what shocked you the most.

Q9 **Andrew George:** As someone who was a member of the Health Committee during the 2012 reforms and who sat on the Government Benches and opposed those reforms all the way through, you have picked at the scabs of my war wounds.

Moving on to this excellent report, I wanted to cover a couple of themes about primary care and acute care, and their accessibility. The Government have responded with three very creditable themes, which will not be controversial. Certainly, no one is arguing for the corollary—in other words, from prevention to sickness—or to ditch technological advances.

In the area of going from hospital care to the community, I want to pursue the extent to which you found the capacity within the service to make that change, and the resistance to that. Although you were analysing the data—as we found out, and we are looking at the problems—you also advised in terms of identifying major themes, and one was to lock in the shift of care closer to home and to provide a neighbourhood NHS. So although you are not recommending policy, you are clearly pushing in that direction.

Given the capacity within primary care at present—and it has reduced over time: according to the RCN, there has been a 45% reduction in district nurses in the last 10 years—to what extent do you think that the mismatch between demand and supply will ever be met within that sector?

Lord Darzi: It is a great question. In fact we have been talking about this since 2006. It wasn't the last Government; it was the Government before. Patricia Hewitt came up with Better Healthcare Closer to Home. Obviously, I championed that when I was in office at the time, in Gordon Brown's Government. The problem with that is, although we have talked about it, and there is plenty of evidence to support it and it is probably the highest quality of care that we can provide nearer to home, we have never done it.

At the end of the day, reform needs the resources that follow it, and the sad fact is that that never happened, whether that was in 2006, or whether that was "High quality care for all", in which we also made significant recommendations about shifting care to the community. But to do that you need to invest in the community.

You will probably all know some of the scars on my back in respect of the polyclinics. Polyclinics was just a name. What it was trying to describe is



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that if we are to shift care into the community, we need all the tools that exist and a significant amount of the technological innovation that currently exists in hospitals—for example, diagnostics. Why are we sending patients to hospitals to get their bloods done? How do we shift diagnostics into the community setting? The same applies to endoscopy and imaging.

Then you come to the challenge—"Well, we can't do that: we can't put a lab in every duty practice," and so on. What I was thinking through is that if you are serving a population of 25,000—Tom may remember this—you can invest in diagnostic tools. Once you have diagnostics, you are empowering many of our general practitioner colleagues and giving them the tools. They have gone through the same medical school as I have, working in a hospital. They are working in the community, and they have the same skills as I have—I have obviously specialised to do something else.

One of the unique features of our health system is primary care—it is the envy of people in the world. Why don't we give these tools to our primary care colleagues, through which we can shift much of the care into the community setting? Because if you have the diagnostics, you know what you are dealing with, and then you can stratify patients and their treatment and their management programmes accordingly, manage chronic disease better. We have never achieved that; it never happened.

By the way, if you look at this report, the sad fact is that the reverse has happened. Actually, more resources have gone to the acute setting and we have deprived the community and primary care—community beyond primary care—of the resources to do what they are supposed to be doing.

- Q10 **Andrew George:** A lot of people are focusing on delayed discharge. There is a rather two-dimensional view about delayed discharge, that it is the inadequacy or lack of resource in social care that is causing that resistance.

However, in Cornwall I have been asking similar questions and they have come up with datasets that indicate that only 25% of cases of delayed discharge are caused entirely by social care packages—that in fact, primary care and acute care at home, and all the other elements of the package required to safely discharge patients, are actually down to NHS problems. Is that something that you identified as well?

Lord Darzi: Yes, absolutely.

- Q11 **Andrew George:** Is it those kind of proportions?

Lord Darzi: I don't know the exact figures. We have them somewhere, but—

Tom Kibasi: About 13% of NHS beds across the country are currently occupied by people with no criteria to reside, but you can—as you say—decompose that. Some of those are purely by social care, some are waiting for care in other settings, and some are waiting for a package of community services. The data definitely exists for that breakdown—



Chair: We will come back to this point.

Tom Kibasi: I don't know whether it is actually in the report.

Q12 **Andrew George:** Exactly: I could not find it in the report.

In terms of geographic variation, you highlight the distinction between Devon and north-west London, where there is a very significant difference in terms of caseload for GPs. Would you agree that there are demographic variations? Just walking around London, you get knocked over by—it is a much younger population, and in north Devon it is an older population, so those variations are bound to happen. Is that a good or bad thing? Are you suggesting that that needs to be righted, or is it simply an observation?

Lord Darzi: I am not trying to re-arrange the demographics of different parts of the country. The issue is how you plan and commission the health resources available to you based on the population you serve, and obviously Devon's needs will be slightly different from north-west London's needs.

Q13 **Andrew George:** My last question is on emergency care. In response to your report, I notice that Dr Adrian Boyle, the president of the Royal College of Emergency Medicine, has said that there is a ward of patients waiting to be admitted in every tertiary centre. The pushback against the shift of resource from hospital to community has already begun. From the emergency medicine point of view, they are saying that because of the ambulances queuing outside they are unable to admit patients, so there is more resource needed within tertiary centres to be able to admit patients. Is he right that that resource also needs to be increased?

Lord Darzi: There is an upstream and there is a downstream. You cannot admit more patients if you do not discharge the patients who could be discharged, and if you do not fix the problem in primary and community settings you are always going to have patients lying in beds and others waiting in the A&E department to be admitted into those beds. We are not going to be doubling the number of beds that we have in a hospital setting. Otherwise, we will end up with hospitals providing community services, and that is not the model or the right thing to do.

We have always struggled with this historically, but it is significantly worse than it has ever been. I shall give you one example of the consequences. I am a surgeon. Many of my colleagues are sitting in operating theatres, scrubbed and ready, at eight o'clock in the morning, waiting until about midday for a patient to come down to the operating theatre. An operating theatre is like an airplane—it is expensive, it has about six or seven people working in it, but it is vacant because we are all waiting for a bed to become available to admit a patient for an elective procedure, who has been fasting from the night before. Their relatives have got them into the car and to the hospital. They are waiting in a cold waiting room to be dressed up, for a bed to be available, to get into the bed, to get the diagnostics and then to be brought up to theatre. That has to change.



Q14 Jen Craft: I would like to move on to a slightly different area, but again it is about where you see the sweet spot between more investment in prevention work and dealing with what is quite a significant backlog of acute treatment, and it is in the area of mental healthcare access. You highlight that it is particularly acute for children and young people experiencing a mental health crisis.

Where do you see the switch occurring, and should the priority be to address the backlog of a significant increase in children and young people experiencing a mental health crisis or should it be more looking to prevent that from occurring in the first place? Is there a sweet spot or harmony to be achieved between the two?

Lord Darzi: I think you have to do both: you have to reduce the burden and you have to address the burden currently in front of you. We have a huge burden when it comes to mental health services, and we are not addressing it—we have to get on and do it. One hundred thousand adolescents with ADHD are waiting for a year for an out-patient appointment. That is not good. That means an urgent and immediate action.

We are talking about the future of this country, about young people. The other figure—probably not mental health-related—was two-year-olds: 100,000 are waiting in A&E for more than six hours. There is an immediate acute problem that has to be addressed and, at the end of the day, it is about the management, physicians, nurses and allied healthcare professionals all working together to address that acute problem, with the support that comes from the centre and locally.

The second question is, how do we prevent these things? You are absolutely correct: at the end of the day, prevention is better than cure, as we say. We have probably one of the most distinguished public health physicians as our chief medical officer, and working with the profession, prevention has to be core.

One of the unique advantages of the national health service single-payer system is that we can do this. We have done it before, in the Victorian era, and we led the world; we could redo it again, based on the new technology platforms available to us—digital and all aspects of innovations in technology that could address the major issues. Online CBT, for example—who would have thought, 15 years ago, that we will have cognitive behavioural therapy online? There are many innovations in the field that we need to utilise and expedite.

Q15 Jen Craft: Specifically, you touched on more serious implications for children and young people not being seen in a timely manner. You mentioned childhood being precious, and it being eaten away by being on a waiting list, which is unacceptable. I wondered whether you would like to expand further. Is there perhaps a strong argument for putting more investment into services for children and young people—not necessarily just in the field of mental health—as opposed to adult services? Is now the time to look at moving more towards paediatric, particularly mental



health services?

Lord Darzi: I am not the expert in shifting budgets here—I am not running the national health service—but I will make one remark. Our children are our future, the future of this country. Their educational years are the most important years for what happens to them. If we do not invest in them, there is something wrong with our societal values per se. That is why, if there was one area that I was most shocked by, it was the mental and physical health of our children and our future. That is a no-brainer—this is the future of this country.

- Q16 **Jen Craft:** Briefly, another thing that emerged from the report seemed to be a recurring theme: the lack of responsiveness to the patient voice in terms of quality of care. That is where there have been fairly serious issues with maternity services, learning disability care for adults and, again, mental health care. Do you see that as being about having more of a specialised patient voice co-ordinator on an individual level, or about, more, the design of services and how that is implemented?

Lord Darzi: To be honest, both. Half of being a good clinician is about listening; otherwise, you are in the wrong profession. We can only improve things by capturing what the users of the service think should change. Why do we do huge public consultations? Why do we do a lot of co-production of pathways of care, as we did in “High quality care for all”? We involve thousands and thousands of patients.

The one that I was most proud of was when I did the London “A Framework for Action”: we had 100 members of the public and patients with me for one year, looking at every pathway of care. That included children and adolescents. We sought their views about what should happen and what the transformational opportunities were. We have to co-produce and empower not only the user of the service, but the public—who are paying for this, by the way—in redesigning health. That is the essence of high-quality provision.

- Q17 **Jen Craft:** What are the blocks to that happening on a wider basis?

Tom Kibasi: As performance deteriorates, the pressure on staff tends to go up and the degree to which they are responsive tends to go down. There is a virtuous circle whereby, as performance improves, you get better and more responsive care for patients, so these are related issues. If staff are feeling rushed off their feet, if they don’t have the right equipment, and if they are spending their times trying to chase beds and deal with all those issues that we know exist, they are much less likely to be immediately responsive to patient needs.

If you are a patient, the first thing you want is to be able to get through the door. That is the first level of responsiveness. At the moment, the elective waiting list is 7.6 million people. If you are right at the back of the queue, the first question on the degree to which it is responsive is: can you get access? Once you are through the door, there is a question about the quality of the interaction and the quality of care—we know that there have been issues in maternity and a number of other services—but those



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things tend to be related. If you can solve the access and productivity problems, you can start to raise the quality of care and be much more responsive to patients.

Lord Darzi: Happy patients, happy doctors, happy nurses—that's the model. I agree with Tom that there is a huge amount of strain on many clinical and managerial colleagues. It is not easy to work in the national health service at the moment, and we should all recognise that. We have to address that, because if we do not, that sadly removes more patient-facing services. That is tragic, because it is the last thing patients need. They come in there for support and care. If someone is really overstretched and has not slept overnight because they are on call, and everything is delayed in the morning, you can see how it can end up in a bad place.

Chair: Thank you. I am sure those thoughts are echoed by everyone on this Committee.

- Q18 **Joe Robertson:** Lord Darzi, thank you very much. The remit of your report did not deal specifically with social care, but you understandably and rightly refer to it, to the extent that it impacts on the NHS, so I will ask you some questions on social care. To what extent is it fundamentally sustainable, if we are to achieve integrated health and care, to have a social care system—if it can even be called a system—that is funded and dealt with so differently from the NHS, which of course is universal and free at the point of use? Social care is means-tested, and there is a mixture of private funding and funding through local authorities. Is that a fundamental problem for the future, particularly given our growing older population?

Lord Darzi: It has been a serious problem, it is a serious problem, and if we don't fix it, it will get significantly worse. By the way, we know that, and successive Governments have really failed to address this issue. In Gordon Brown's era—I was just appointed at the time—he introduced the proposal of free personal care, paid for by a compulsory levy, if I am correct, on the person's estate. It was called the death tax—do you remember that?—and the whole thing fell apart and sadly did not get anywhere.

The Dilnot Commission made recommendations following that. It certainly recommended a more generous means test and a life cap on the cost of care. Then David Cameron came in, and as you will remember there was a lot of talk about that at the time, but it didn't happen. Theresa May came in with her proposal for—I'm not sure what that was called; the dementia tax—am I correct?

Joe Robertson *indicated assent.*

Lord Darzi: Then the last one was obviously Boris Johnson. I remember having a conversation about that at the time. It was based on national insurance.



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If we don't address this issue, we will keep the strain on the NHS. The problem with that is that we are not getting value for money from every pound we spend on the NHS if we have not fixed social care. That is really all I have to say about this. The impact is clear—you know that—and it is something critical that needs to be addressed.

- Q19 **Joe Robertson:** Your report finds serious long-term underfunding in social care, quite apart from the structural issues, and also remarks on the knock-on effects in the NHS. The current Government have made their first decision on funding through the Budget, and allocated broadly £26 billion for the NHS and £600 million for social care. In percentage terms, that is 98% for the NHS and 2% for social care. In your view, is that an appropriate apportionment of the funds available between the NHS and social care—98% versus 2%?

Lord Darzi: Besides the input, which is the money, social care needs a complete reform and revamp. I don't think it is fair for me to answer whether £600 million is adequate to really sort out social care. I think it needs a much deeper surgical procedure.

- Q20 **Joe Robertson:** I appreciate that it is not your decision, or mine, where the money goes, but given that your report looks into decisions made by previous Governments, I am inviting you to comment on the current Government's funding decision made in October. I appreciate that the system may not be perfect.

Lord Darzi: My advice would be for all political parties to come together to think through the best solution to the problem, which always gets batted off to the side, because if we don't fix it, we are not serving our elders. Let's start with the principles rather than thinking about the NHS. Obviously, it has significant consequences for the NHS, but we need to address the big gap that exists in caring outside hospital—in social care.

- Q21 **Joe Robertson:** Continuing healthcare, which is effectively social care commissioned by the NHS, isn't directly dealt with in your report, but I accept again that social care falls outside of it. I think it is uncontroversial to say that fewer people are receiving continuing healthcare, and in many cases there is a breakdown between the NHS and providers. I wonder whether you have any comments to add on the way that continuing healthcare is provided and the challenges that it faces.

Lord Darzi: Tom may come up with the figures. The only thing I will say is that if we don't have reasonable continuity of care in the community, the sad fact is that a lot of these patients will be back in the system. Somehow, we have to find a way to break that cycle, because it ends up costing twice, if I am correct—I don't have the figures here. That is one of the principles of keeping people healthy and preventing relapses out in the community.

Tom Kibasi: On social care, it is important to remember that it is not just old adults; I think even the majority of the spend is on working-age adults with learning or other disabilities, so a huge amount of it is just taking care of the most vulnerable in society, as well as older people. In terms of



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what needs to happen, in a way, there have been plenty of different proposals and different commissions. It is just a question of making a decision to execute it. I don't think there is a way to answer immediately whether the funding distribution is correct or incorrect.

On continuing healthcare, we didn't cover it within the report, but it is worth clarifying the definition. It is not just social care paid for by the NHS; it is care for people who have a continuing medical need, which is why it falls within the scope of NHS services to cover it. It is not just the NHS making a particular decision to provide social care for one person over another. There are very clear criteria, and it is principally a question of medical needs driving the cost, rather than social care needs.

Joe Robertson: Thank you.

Chair: I was interested in your point, Lord Darzi, about people coming back into the system. This is not for now, but you may be aware that the Committee has launched an inquiry into social care and the cost of inaction. If you have further thoughts on the subject, may I invite you to submit evidence to that inquiry, which is now open? We will be returning to this issue in depth in the new year. Ben Coleman.

Q22 **Ben Coleman:** Lord Darzi, it is good to see you here today. I very well remember your distinguished time as a Health Minister under the last Government, and that informs all of what you are saying. I would like to talk a little about local authorities and their relation to the national health service. I speak as a former cabinet member for health and adult social care and former member of an integrated care board, and the council where I was a cabinet member is the only place in the whole of England that provides care at home for free. I just thought it was worth mentioning that.

You talk about the system needing complete reform and revamp, but isn't part of the problem the failure of the NHS and local authorities to understand each other as well as they could? My experience is that local authorities understand the NHS to a degree, but that the NHS really does not understand local authorities. Partly, that is a result of the NHS being top-down and local authorities being bottom-up. That is my perception. Do you recognise this situation? If so, what impact do you think it has on how social care is perceived and addressed by the medical establishment? Do the NHS and medical establishment see it as an essential part of the system as a whole, or is it seen as an inferior part of the system?

Lord Darzi: These are two separate questions. I think our system will never work if we do not have social care and the NHS on two sides of the same coin. They have to be working hand in glove together. At a patient level, if I have operated on someone in their late 70s and we are ready to discharge the patient, that patient remains in bed for another four or five extra days, despite the huge amount of innovation—doing it robotically or keyhole. You cannot discharge the patient without adequate support back in the community. As clinicians, it is very difficult for us to address that.



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The two need to come together. By the way, it also depends on which local authority and which NHS hospital—there are some amazing partnerships where it works extremely well; in some areas, it does not work well. That needs to be addressed and aligned.

You ask about social care thinking the NHS is not the greatest partner, and the NHS talking about social care as not ready to receive patients. It is somewhere in between, and I think, with your political hats, you can try to find ways of addressing that issue. At the end of the day, the losers here are the patients, including obviously other patients who might be coming in to have a procedure. So there is plenty of scope to do that. By the way, in the old HIV days, if you remember, local authorities played a significant role in driving community delivery, and even setting up clinics in the community. There is huge scope for innovation, but I did not cover this in my report, as you may know.

- Q23 **Ben Coleman:** Do you think it would be helpful if people in the NHS took more trouble to understand how local authorities work? I think there is a danger of dictating from on high, and that is not really how it operates effectively on the ground.

Lord Darzi: I agree with that. I support that.

- Q24 **Ben Coleman:** On local authority resourcing, you talk about the importance of addressing housing, damp and mould. Local authorities obviously have their own social housing, and they will be getting more powers soon as regulators of standards in the private sector. Do you think that the NHS should argue for more resourcing for local authorities when it comes to housing? We talk about public health and social care, but should the NHS see it as part of its job to battle for more local authority resource?

Lord Darzi: For itself, or to support local authorities?

Ben Coleman: From the Government to local authorities, so that you have fewer people living in damp, mould and other situations.

Lord Darzi: The very logical answer is yes.

- Q25 **Ben Coleman:** It is not possible to get the NHS outcomes we want without funding these other things better, is it?

Lord Darzi: I could not agree more, but there are also smoking cessation interventions and many other interventions that local authorities could make that would have a positive impact on the NHS.

- Q26 **Ben Coleman:** Finally—forgive me, but this is slightly off beam—a particular aspect of the relationship with local authorities that concerns me is what happened in covid and what has happened since covid. I notice that your report says that the impact of covid on the NHS seems to have been far more severe than elsewhere, and that we went into the pandemic much less well prepared than other countries. My interest is in what we have learned since. I have the impression—again, you may correct me—that there has been very little attempt from the health and



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care system to learn from covid and in particular the way in which the NHS and local authorities worked differently during covid, including where the local authorities on occasion intervened forcefully to stop the NHS doing things that might have endangered lives. That has not been explored. Do you know whether any attempt has been made to explore how the NHS and local authorities worked differently and better? Do you think one should be made?

Lord Darzi: This is well above my pay grade—I am a surgeon who works in a hospital, sir—but in what you are saying there is a lot of logic. There is no question but that the two should be working hand in glove in addressing the demand side of health needs, but also reforming the supply side. I very much hope that that will be part of the 10-year plan that the Secretary of State has launched, and I am sure you can feed evidence into that.

Ben Coleman: Thank you; that is helpful.

Lord Darzi: On covid, we just need to wait for the inquiry. There are many, many lessons to be learned from covid, and we are all anxiously waiting to see what the inquiry will say.

Q27 **Ben Coleman:** Is the inquiry, which you know more about than I do, looking particularly at this? It does concern me, because in my area I was the cabinet member and other people here were cabinet members during covid and trying to protect our populations, and it was extremely difficult when the NHS, for example, pushed patients, at the beginning of the covid pandemic, out to care homes without testing them. We lost 50 people living in our care homes at that time. I think we were the only council in the country to close our care homes because the NHS would not stop doing that. A lot can be learned from how local authorities acted and from their role in preventing more deaths during covid. Do you think, from what you know, that the inquiry will look at that, or should separate work be done on it?

Lord Darzi: I am not involved in the inquiry, and thank goodness I have not been asked as a witness to the inquiry—

Chair: I don't think it's fair to ask Lord Darzi—

Ben Coleman: It's just that he knows more about the inquiry than I do.

Lord Darzi: I am as anxious as you are to read the recommendations of the inquiry.

Chair: Thank you. I will now go to Deirdre Costigan.

Q28 **Deirdre Costigan:** Thank you very much, Lord Darzi and Tom, for coming today, and thank you for your very sobering but sensible report. I want to ask you today just a few questions about inequalities and prevention. The report outlines the deterioration of access to health services, but how that has been felt differently by different communities. There has been an inequality in how those services have been



experienced.

I represent Ealing Southall, which is in north-west London, and we know that north-west London has a ratio of one GP for every 2,268 patients, which I think is the worst in the country. There are some 550 extra patients for every GP, compared with the national average. Ealing Southall is an area where preventable deaths are significantly higher than the UK average, and where people of Asian descent in particular die much earlier than they should, because of diseases like diabetes. That is just one example. I think GP funding is a concern when it is based on the number of older people in an area. In an area like Ealing Southall or north-west London, people die earlier, so it does not make sense to base it on that. That is just one example.

How can we take the steps outlined in your report in a way that does not just replicate the inequalities that are currently in the system in a new NHS, as part of the 10-year plan?

Tom Kibasi: It is a great question. It is clearly a serious issue. What I would say specifically on north-west London is that although the number of GPs is relatively lower, the spend on primary care is actually significantly higher than the national average, and one of the consequences of that is that actually the productivity of the hospitals is better in north-west London than it is in any other part of the country. You can see that virtuous circle of having more investment in primary care. There is a specific problem—are there enough GPs? But actually the investment in primary and community care in north-west London is, I think, 40% above the national average.

When it comes to the implementation of the plan, there is a question in all these things: how do you change services and how do you incentivise the right thing? For example, we know that, across the country, a number of places have too few doctors; they are called under-doctored areas, in the sense that they have, compared with the needs of the population, a smaller proportion of doctors. One of the reasons behind that was the decision to change the allocation formula to shift the emphasis from deprivation towards a greater emphasis on ageing—on age structure. I think that the deprivation index weighting went down from something like 15% to something like 10.7%. It sounds like a very technical point, but it has real-world consequences for inequality.

As the plan gets developed and they think about things like the financial flows, there is also a choice in how you design those mechanisms. Do you design them in a way that they are blind to these issues, or design them specifically to try to shift resources so that they more accurately reflect the population need? I think that that will be an important theme for the 10-year plan—making sure that the resource profile matches the actual need of the population in each different place—because, as you say, more deprived communities have greater healthcare needs.

Q29 Deirdre Costigan: The report also outlines that one of the shifts is about moving from sickness to prevention—looking at the cause rather than the symptom—but we have been talking about prevention now for decades.



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Equally, as you say, we have talked about moving to the community for decades, but it is a similar issue with prevention. One of the barriers has been funding, because, of course, while you fund preventive measures, sickness continues—there is not an immediate impact on sickness—so the NHS still has to pay for those acute services as people fall ill.

Do you have any insight into how the NHS can, in a sense, fund both of those things at the same time, for a period of time, while we move towards a model in which the need for the sickness services reduces, and reach an equilibrium?

Tom Kibasi: There are actually two different types of prevention. There is primary prevention, which is about improving modifiable risk factors—about making sure that people do not get sick in the first place—and there is secondary prevention.

Take diabetes: there are, I think, eight care processes that everybody who has diabetes should have every year. That includes things like foot checks—so podiatry would be a good example—or screening for any macular degeneration, which is also associated with diabetes.

In terms of that secondary prevention, across the country as a whole, something like 60% of people who have diabetes get all eight care processes. The immediate opportunity, which would in fact free up resource, is to ensure that 100% of people who have diabetes get those care processes. There is also the NHS Diabetes Prevention Programme, which I think has shown an impact of a 35% reduction in the number of people who go on to get diabetes.

Therefore, the long-term answer is that we need to do both of those things simultaneously, but, with secondary prevention, you see a much more immediate gain, partly because, if you improve the quality of care for someone who has long-term conditions, they are less likely to have an acute exacerbation and therefore less likely to show up at hospitals.

There was a question earlier about, “Well, the patients keep coming to hospitals, so shouldn’t we put the resource there?” The answer in part is that if you were to do those care processes now for all the people who have long-term conditions, they would be much less likely to show up at an emergency department. Therefore, I think the answer to your question on prevention is that you need to be able to do both of those things.

On primary prevention, it is also worth being aware that, since 2015, there has been a 25% real-terms cut to the public health grant, so, in practical terms, we are investing significantly less on public health, and have been over the past decade. That is a choice, of course, for any Government; does it wish to invest in public health, which tends to have a long-term payoff, or does it put its resources into the immediate issues of patients in emergency departments?

Chair: We will soon be returning to that point.



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Lord Darzi: This is quite close to my heart as well. I always say that all surgical careers end up with failure, when you realise that you should have done public health. Tom very eloquently answered that.

We have an unbelievable chief medical officer in Sir Chris Whitty; he is just phenomenal in terms of public health and what he is trying to get through. We had some structural changes during covid—we dissolved Public Health England—we were the only country to dissolve its public health body in the midst of the covid pandemic. As Tom said, the Health Security Agency deals with the threats of infectious disease, so who will deal with the public health delivery side? That is, as Tom said, in the NHS, but it is important to get the balance right. You could say they are aligned, because if we do not invest in public health, we will increase the burden of disease on the utility of our hospitals or health infrastructure. Something needs to be done about that.

I also want to talk about primary prevention. There are some amazing scientific advances happening in primary prevention, in terms of detecting pre-disease states before symptoms. Being a single-payer system, how could we exploit these opportunities? Public health is an amazing opportunity for us to re-engage in, re-invent and believe in. We have the right leadership for it, so I hope the Government put as much resource into public health as they have promised.

- Q30 **Deirdre Costigan:** I think Beccy will follow up with a couple of more questions around public health, but finally from me, I think it is the IPPR report that refers to 900,000 people who are unnecessarily off work due to long-term sickness. You focus on how we can bring those people back into work and where they want to work. Is there anything you can say, however, about those who are currently in work, but have potentially a long-term condition, and are not getting the help they need from their employer for reasonable adjustments? I know that research has been done by my previous employer, Unison, finding that people often wait a year or more for reasonable adjustment requests to be put in place. How can a properly preventive healthcare system work with employers to avoid these people falling out of work and avoid that waste of talent and loss to our country's prosperity?

Lord Darzi: The return on investment in public health is obvious to everyone. It is a multiplier of at least 15 to what we spend for every £1 on treating illness. That is not new—we all know that. The IPPR report made some suggestions on the estimated £5 billion loss in tax revenues due to long-term sicknesses. The recommendations we made at the time were new levies on unhealthy foods, better health regulation to de-incentivise insecure and difficult working, and setting a 30-year target to increase healthy life expectancy by 10 years. The only way we could do this—again, with someone like Sir Chris Whitty—is as a cross-government, mission driven opportunity. It is crucial to drive this, and I hope it happens as part of the 10-year plan.

- Q31 **Deirdre Costigan:** Could either of you say anything on the reasonable adjustment point about people who are currently in work?



Tom Kibasi: It is a very good point. We know that work is good for people's health overall. It is good for their health and wellbeing, and so keeping people in work successfully is likely to be good for them, society and the NHS. The point you made about the issues around reasonable adjustment is important. If you were to think about the NHS of the future, what would you want it to be able to do? If you believed in a more preventive NHS, you might believe that one of the things it could offer—I am not sure that it does so much today—would be assisting employers to make reasonable adjustments, or providing evidence and guidelines or options for reasonable adjustments.

There is another thing, which connects back to some of the basic questions of responsiveness. All of us have probably experienced for ourselves the problems in accessing care. That expresses itself in a couple of different ways. One of those ways can be long waiting times, but the other can be in the slightly chaotic way in which things tend to get organised. Before an appointment on a Monday, I first received notification of it on Friday through a text message. I then got a further four text messages that changed the time three times over the weekend. The final one said it would be a different time from the original, but they called at the original time on the Monday, as it happened. Three weeks later, I got a letter through the post saying I would be having an appointment in what was then the past. Naturally, for anyone, that is quite hard to plan around a job.

Part of it is about whether the NHS could do more to assist employers on reasonable adjustments, but there is something about getting our own house in order first and getting some of the basics right, so that waiting times are reduced, it is easier to book an appointment and those appointments are honoured—because we record the “did not attend” rate, but we do not record the “how many times did we cancel and move it around?” rate. That would go a long way to helping people who have long-term conditions to stay in work. It would be good if the NHS in its core activities were able to be more responsive, rather than necessarily thinking about these new frontiers. You make a very good point that there could be a contribution for the NHS there.

Q32 Dr Cooper: Thank you for giving up your time to come along today. Lord Darzi, as a public health consultant I do not hold it against you that you chose to become a surgeon, but I am glad that you have seen the light. Welcome to the good side. As Deirdre says, I wanted to pick up the point around the prevention agenda and some of the more strategic aspects of it. In your report you refer to the break-up of Public Health England during the pandemic. The wording of your report suggests that you do not think that this was the most beneficial action for public health in the UK. Could I ask for your thoughts on the subsequent set-up of public health departments in the UK? You have referred to the Health Security Agency already, and we have the public health teams in local government and OHID sitting in the Department of Health and Social Care.

I hear you when you talk about Sir Chris Whitty; he is absolutely excellent, but the chief medical officer does have a specific remit. That



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remit aside, do you think we are now well served with the strategic public health leadership? Does your report give any insight as to how we might improve going forward?

Lord Darzi: My report was diagnostic and did not give any sets of recommendations. I am sure that the 10-year plan will have its own recommendations. The point I was making was about dissolving a structure in the midst of a pandemic, and I will just say that I was being a bit cynical. I do not understand what the reasons were at the time, but I am sure there were good reasons for it.

The Health Security Agency is doing its job very well. What I was trying to say is that we have the Department of Health and Social Care and we have the NHS. We need to think through what are the powerful levers we can use at a time when we have a chief medical officer with global public health expertise. How do we use those levers to drive the public health agenda within the national health service, considering all the strains and challenges we have just been discussing? Secondary prevention is critical, but that is never going to happen if we are constantly chasing the big other challenges—that is, the long list of challenges facing the national health service at the moment. We need to find a way of prioritising secondary prevention and the public health agenda. I would love to see more of that, and I am sure it will happen in the 10-year plan. I have no doubt that we will see much more reinforcement of the contribution of public health.

Q33 **Dr Cooper:** To be clear, do you see strategic public health leadership currently sitting solely with the CMO? I know that there are leaders in OHID, the Health Security Agency and the Association of Directors of Public Health. Or do you see the need for, to coin a phrase, a “truth to power” leadership that might need to complement the CMO’s role?

Lord Darzi: I have no opinion about this. I really don’t. The only thing I could say is that you have an amazing leadership in the CMO to drive this and I would use him rather than create a different organisation.

Q34 **Dr Cooper:** Thank you, that is really useful. Moving on to look at the general funding set-up, Tom has already talked about this when discussing the inequalities and health resource allocation. Reading through your report, I wondered if you wanted to comment on whether you think there is a better way to distribute funding through our health system. Specifically, perhaps picking up on a couple of Ben’s points about local government, do you have any thoughts on more fully devolving resources and responsibilities for health services, perhaps to run in parallel to the planned devolution agenda for local government?

Tom Kibasi: There has been some experimentation in this area. There was obviously the effort—“Devo Manc”, as it is called—to devolve health and social care budgets to Manchester. That has been through various different evaluations. I suppose the question is whether you would want to devolve health budgets to local authorities. I think that is what you are getting at and there has been a long tradition of people arguing for that.



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In this report, we look very closely at the distribution between different parts of the health system. Take the shift from hospital to community. Having said that very loudly in 2006, for the next 18 years we have gone in the opposite direction. In 2006, the hospital sector accounted for 47% of spending, but by 2021, which was the last year that the data was available for, it accounted for 58% of NHS spending.

One of the notable changes that I think has had a very positive impact has been the mental health investment standard. What that has done is to protect mental health budgets. If you look at the report, you will see that in the first period of the 2010s there were very deep cuts to and reductions in mental health expenditure. That process was then reversed from 2016 onwards. You see that there is a kind of U-shaped curve, so that by the time you get to the end of the period, we have recovered back to where things had started in 2010.

Basically, the mental health investment standard says that mental health spending will increase at the same rate as the wider NHS budget, plus a very small percentage—I think it is 0.6% or 0.7%—each year. It seems to me that one of the recommendations around locking in financial flows in a particular direction is that if we really believe in this idea of shifting from hospital to community, then we ought to consider expanding the scope of the mental health investment standard, so that we create a similar investment standard for community services and primary care, in order to stop this long-term drift of more and more resources going into the acute sector.

I think that would have a much more significant impact on the overall pattern of services than something that was aimed at somehow changing the way that they are distributed among ICSs to involve local authorities. Ara is very clear in the report that reorganising the system again would be detrimental to its performance, so we would see that kind of radical reorganisation, to hand it over to local authorities, as a largely harmful activity. However, changing the financial flows to lock in the shift of resources, so that we match our words with our actions, could be very powerful, and hopefully the 10-year plan will consider that.

Q35 Dr Cooper: To be clear, I was not thinking about the old regional health authorities—we could just keep going round in circles—but perhaps the integrated care partnerships could consider what they are able to do and what perhaps they are not doing now. If we are going to be serious about decentralising health alongside social care, we should give parity of esteem to those two areas. Is that something we should consider?

Tom Kibasi: Also, NHS England has just devolved the specialised commissioning budgets to ICSs, so ICSs are taking on a greater and greater share. It is quite complicated, but each of them contains an integrated care board, or ICB, which is an NHS body that is part of an integrated care partnership with local authorities. That structure already exists. So, as the scope and scale of ICSs expand, hopefully that will also be a good basis for closer working with local authorities.



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- Q36 Josh Fenton-Glynn:** Thank you so much for the report that you have produced; it is incredibly detailed and, as you say, an incredibly good diagnostic starting point.

The report details the 2012 reforms and how they took away a whole layer of management. What we have essentially seen since then is that layer of management being rebuilt and restructured through the ICB setting. In your opinion, are the management lines now sufficient for the running of the health service? And if you were to draw them on a blank page, is that what they would look like now?

Lord Darzi: The management lines, or at least the management structures, have matured since 2012, with a process of iteration—mostly Darwinian, if I could just say. I think we have what we have at the moment. The report was not really about looking into the future, and I do not think there are any suggestions of change again. As Tom just said, it is about getting them to execute their roles and responsibilities through better commissioning, managing provision and whatever else goes into their portfolio.

- Q37 Josh Fenton-Glynn:** I guess that a big part of the report is the failure of left shift. One of the things you put in the report is the number of community nurses being 87% lower than the OECD average, but I know that statistic is not exact because of how they are measured when attached to hospitals. I have used this phrase before in other circumstances: what gets measured gets mended. Do you think that, to do community care and left shift better, we would be better doing some more measuring in that sense?

Tom Kibasi: Absolutely—the first thing we have to do is start counting it properly. If we do not, how can we know whether we are succeeding or failing? You are absolutely right about that figure of 87% versus other countries. We know that that is not right because we know that there are enough hospital trusts that also provide community services, like the example of Guy's and St Thomas' across the river. Having said that, we also know that even if you were to account for all of those, we probably still have significantly lower levels of community provision compared with the OECD. However, your first point was absolutely right—what gets measured gets mended. If we do not start measuring it, we will never know whether we are fixing it.

- Q38 Josh Fenton-Glynn:** To follow up on that, what does good look like in your opinion? What does a good, devolved health system look like with proper left shift? Is there an international example? Are there particular boards where it is done well? Is there anything else that you point to?

Lord Darzi: That is exactly what we are going through in the 10-year plan with quite a big consultation.

- Q39 Chair:** But you have not seen it elsewhere is the question.

Tom Kibasi: You certainly see it in Scandinavian countries, for example, where there are much higher levels of out-of-hospital provision. You also see it in a number of other different systems. In France there is a greater



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level of out-of-hospital provision, and there is also a greater level of hospital provision at the same time, but then they spend significantly more on healthcare than we do. I think there are plenty of examples that you can look at internationally where people have made these kinds of investments. Also, here in the UK you can see the impact of greater investment in out-of-hospital services.

Q40 Chair: You mentioned north-west London as an example. Is there anywhere else that we should be training our eyes on?

Tom Kibasi: I think Whitstable is a very good example, and there are some other parts of the country too. I am sure we could come back to you with suggestions of where is doing it well already. Most of the time with the NHS, you can usually find that there is some place somewhere that has cracked it already. The problem is doing it with sufficient scale and consistency in other parts of the country.

Q41 Paulette Hamilton: Good morning, Lord Darzi and Tom. I read the report with great interest. I have read or seen lots of it before, but it seems to have brought things together, like a bible, where people can go from start to finish, so I thoroughly enjoyed it—I will start there. My question is about ICBs and whether they are fit for purpose. In the report, you said that you felt that they were fit for purpose, but you highlighted, “The function...of ICBs remains unclear and in some important respects.” You also said, “There are duplications of functions between ICBs and providers”.

I have been involved in this issue since the days when Simon Stevens was head of NHS England, and in 2014 when STPs came in. I cannot remember what STP meant, but I have been involved from when it first started up until now, so I was interested. Lord Darzi, how would you want to see services standardised with all that work that has gone on in the past?

Lord Darzi: What you just described was a process of maturity for the ICBs. If you look at the early days, there was a lot of duplication. That is the problem of reorganisation. You are giving birth to new structures, with probably the same people, but without knowing what their powers or tools are. That is where you will see some of wastage as they reach a stage of maturity. I think they are doing better than they would have done, but there would have been overlaps. We just gave the example of ICBs appointing provision of community services at the same time that NHS hospitals might be providing the same. Who should be regulating? I do not know who does. Absolutely, NHS England should be.

Tom Kibasi: The issue is that there is some duplication of functions. The duplication is on the provider’s side and on the commissioning side. As an example, some ICBs employ a lot of people in infection prevention and control. Quite why is a bit of a mystery, because the providers also have infection prevention and control functions, and the boards are accountable for that. There is a situation where sometimes hundreds of nurses are employed in ICBs, in infection prevention and control functions, but their only function is checking that the providers are doing their job. Given that



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the providers have boards that are meant to be accountable for that activity, it is unclear to me why you would then need another set of people ensuring that the original set of people are doing their job. Why would you not hold the board accountable for fulfilling its functions? That is a tangible example.

The stuff on performance management has also been relatively unclear. Is that the responsibility of the ICB or the region? Similarly, there was a whole thing about abolishing the commissioner-provider split, but there are still commissioning functions that need to be done. More and more of that is getting clarified, so in the past few months we have seen some clear positions communicated by the Secretary of State and NHS England on who is going to be responsible for what tasks. Where the report says that there are duplications and a lack of clarity, it is about getting at those things that are now in the process of being clarified.

As Ara says, when you create a whole set of new institutions, everybody has a different interpretation of how to do the job and what the scope of the job involves. The trust that I chair operates in five different ICSs, and I can see from that experience the diversity of approach taken in different places. As an example, one of the ICSs has a strong conviction that it should be involved in primary prevention and puts a lot of time and energy into employment issues because it believes that employment is a route to better health. Others see themselves in the more traditional intermediate tier of managing NHS providers. There is much more work to be done to get consistency and clarity around what exactly the functions of an ICB are, and how it executes them.

Q42 Paulette Hamilton: I have a final question to round off this section. ICBs have lots of targets. I have asked you about standardisation. My personal view is that there are far too many targets within ICBs. They have got a sum of money, they are told they can be quite innovative, but they are set quite a lot of targets, which means they cannot be as innovative as they want. While doing the report, was there anything you saw in that area that we could improve on, and to be honest, that would help to shift the money?

Lord Darzi: That would have required a qualitative piece, to go and talk to them and establish exactly what they are doing and why, and why there is duplication. With eight weeks we did not have the time to do that. It will be part of the themes in the NHS 10-year plan. It is a very good question to ask. Another element is what happened since the creation of these, and what happened to them during covid. During covid there were all sorts of changes in roles and responsibilities.

Paulette Hamilton: A lot of those targets slipped, which meant that lots could happen. Going back, that has been the problem: the targets have quietly escalated again. I will leave it there, because I have had my time. Thank you, panel, and the Chair.

Danny Beales: Thank you, both, for the exceptional and helpful report and for bearing with us today. It has been a long session. You will be



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pleased that Greg and I are the penultimate questioners, so we are almost there. I will ask specifically about the productivity issues raised in your report and will focus on capital spending and technology. On capital spending, in the report you tell of a stark situation with significant capital needs gaps right across the health service, whether in acute trusts, secondary care, primary care or community services.

It is difficult to know where to start with this massive and increased financial need for investment. You talked specifically about how, relatively, the NHS was performing fairly well in the early 2000s to 2010 period, in terms of capital investment, relative to Nordic countries and the EU15, but that has completely shifted. We now lag very far behind those comparators on capital investment. First, on prioritising capital investment going forward, did you have any sense from our comparators of where that capital investment we have missed out on relatively has gone, and of any impact it has had on our comparators' relative performance? Secondly, on prioritising where we go forward with capital investment, where do you feel capital investment would have the biggest impact on productivity?

Lord Darzi: I will start, and Tom will go into the detail. For me, that was one of the troublesome components. We could not explain the productivity drops that we were seeing—as you might know, a 17% rise in staff in the past three years, yet productivity has crashed. That is in both, including infrastructure—you put that eloquently. I work in one hospital, St Mary's, where we still have a ward in the Mint wing, which was the old Victorian stables. It is a listed building.

When I was appointed, I would have been part of a team—I do not know how many surgeons we would have had, but in general cancer surgery it would have been about five or six of us. That has now doubled, but we still have the same number of operating theatres. How we are going to improve productivity is very obvious. We are also trying to sweat the asset, but as I said earlier, we are waiting for three hours in the morning to see whether the patient is admitted. That is another reason.

There is infrastructure investment, but also there is technology. Look at our MRI and CT scanners—per head of population, the numbers are well below what the average is in many of our comparator countries. Most of them are really dated, so servicing them is costly. Diagnostics is critical, let alone the IT structure. When I see many of my younger colleagues who are in training spending about 20 to 30 minutes just to log into the computer to start entering data, that is so disheartening. We have to do this, and that is the reason why our productivity has dropped dramatically. It is a significant challenge, and we need to do something about it. More detail from Tom.

Tom Kibasi: The backlog maintenance alone is now nearly £12 billion. What is the practical effect? Services were disrupted at 13 hospitals a day, every day, in 2022. That gives you a sense of the scale of the disruption caused by those kinds of problems. Sometimes, it is problems of the building literally crumbling—water coming in to flood a ward and those



kinds of issues—and other times problems are more directly with equipment. For example, I was talking to someone at Ara's trust, St Mary's, and the MRI scanners are now so old and decrepit that they cannot be run for three shifts, so they have to be run for two. That massively impacts on productivity—you would get a 50% increase in the productivity of MRI scanners if you could run them for three shifts a day, rather than two shifts a day. There are those kinds of issues across the service.

There is obviously an immediate call for the backlog maintenance, which has to be prioritised and dealt with. Had we spent that money, the 40 hospitals that have been talked about would have already been delivered. Then there is a bit that gets much less attention, just because it is on a smaller scale, but it does not mean it is less important. A lot of the primary care estate is absolutely not fit for purpose. In many cases, it pre-dates the founding of the NHS. There are plenty of examples of primary care facilities that are not in purpose-built buildings. They are not accessible to people with disabilities. There is a clear call for capital there.

Another area that is important to emphasise is mental health. Ara did a visit into a locked ward during the investigation, which you see in the report. The conditions were atrocious. There is a particular moral responsibility for people who are detained against their will to be living in a reasonable set of conditions, not least because for some of these people who are there for quite long periods, that is their home—that is where they are living. Having tiny rooms, 17 people sharing a single shower, and problems with vermin that cannot be resolved should be unacceptable to all of us. When we think about prioritising capital expenditure, yes, we can look at the big shiny new hospitals, and everyone will pay attention to that, but there is a very important obligation to sort out mental health and primary care facilities, many of which are stuck not just in the pre-NHS era, but actually before the 20th century. We have a lot of work to be done to sort that out.

Q43 Danny Beales: Thank you. You have put the challenges ahead very starkly. In terms of addressing them and securing investment, you describe quite a dysfunctional system for capital investment allocation. You describe the approach to how business cases are developed and how NHS managers approach and deal with capital investment bids as byzantine. My local trust at Hillingdon hospital would recognise that, having waited many years for help with flooded wards—it might have been that exact trust you referenced. From your discussions with stakeholders, and elaborating on the byzantine nature of the process, what specific problems are there with how capital investment is managed, and what reform to that process have people told you would be helpful in addressing those challenges?

Tom Kibasi: The first problem is an insufficiency of the sums of money. There is simply not enough capital going into the system at the moment. The big problem for the health service at the moment is low productivity. Productivity is very significantly down and, in the end, productivity is the name of the game, in that it is what you get out for what you put in. At the moment, in the acute sector, overall productivity is down 14.3%



compared to a 2019 baseline. That means that fewer patients are being treated than would have been had we stuck to a pre-existing level of productivity. Capital is crucial to that. If you reduce your capital investment, you are likely to lower your productivity, because the ratio of labour to capital goes in the wrong direction. If I asked beforehand, "If I were to reduce capital intensity and increase the amount of labour, what outcome would I expect?" I would probably expect to have lower productivity, because the whole dynamic of capitalism—the clue is in the title—is add more capital and you will get higher productivity growth. If you crash capital spending and see capital assets deteriorate, it is not then surprising that productivity falls by such a significant degree.

On the specifics of the process, creating a business case and consulting on it is an unbelievably painful and difficult task. On top of that, to take the local authority point, the rules for NHS capital are totally different. In local authorities, there is much more freedom around capital. In the NHS, the Treasury insists that all receipts return to it and then capital is redistributed out. There is very little incentive to dispose of assets that are no longer fit for purpose, partly because the trust that does the disposal will not see the benefit of having done that. It will go through the pain of the business case process and the consultation, only to find that the receipts it gets from that asset disposal go back to the Treasury rather than the trust. That is a very tangible example, but the first problem is that there isn't enough capital.

I will turn to the final problem. On page 102 of the report, you can see that in this environment where there was not enough capital going into the NHS and a significant accumulated backlog of maintenance, the NHS none the less produced a series of significant capital underspends. If there is a desperate need for capital and the budget isn't being spent, that already tells you that the system isn't working. In practice, in that period, those capital underspends acted as an informal reserve for the Treasury, so not spending the capital meant that those capital budgets could be raided to plug the holes in the unrealistically low spending settlements. That dynamic is possibly part of the explanation as to why nobody has fixed the very well-known and well-described problems that exist in the NHS capital regime.

Lord Darzi: Could I add to that? I did another piece of work many years ago in London. The unutilised NHS estate in London is three times the size of Hyde park's footprint, so we are sitting on a lot of land and infrastructure that we need to start mobilising to help us. Even within the same hospital, you have a lot of assets that you are not using clinically for whatever reason, and you can dispense them. Generate your own capital, let alone getting capital from the NHS.

- Q44 **Danny Beales:** That is really helpful. I think I have one or two minutes left, so I will turn briefly to technology. Again, there are stark issues, but it struck me that you described cases of GP practices adopting technology—often quite routine—that drives innovation, such as automated route planning or texting patients to reduce DNA rates. They



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are quite simple interventions, but they are still not universally adopted. Is it the case that we need to chase big shifts in technology—you talk about the use of AI—or would productivity be driven by the standardised use of quite simple technologies? What are the factors behind those who do adopt those technologies that others can learn from?

Lord Darzi: For me, this is all about innovation. Innovation is a pull, not a push. As you say, you see the two extremes. You see amazing innovation really transforming whole pathways of care. That is where you start, and you create the pull. We worked on the stroke pathway in London in 2007, and transformed it from 32 hospitals into five comprehensive stroke centres. It became a published Harvard Business School case study: the NHS at its best. We really reconfigured the stroke pathway. That was based on innovation, because we wanted 24/7 imaging, radiologists available to read it, someone to put the catheter in and dissolve the clot, and the patient to walk out the hospital within 48 hours, completely without any deficit. That is what we need to aspire to. The 10-year plan will only work if we really drive innovation through it, and it needs to be in every pathway of care from the cradle to the grave.

You also asked whether technology should be one size fits all. I don't believe so. You are talking about intelligent, highly educated people. Give them at least the heterogeneity of the different tools available to do what needs to be done. I really believe in this, and we are not good at it. We have to improve.

Tom Kibasi: I think you are absolutely right about the common-purpose technologies. Getting them applied more consistently would have a big impact. I will give you an example. For any of you who use Amazon, imagine that from tomorrow, the way in which Amazon delivers parcels to you is that all the parcels are thrown into the back of the van, and the Amazon delivery driver gets a printout of names and addresses listed alphabetically by surname, and then gets told, "Off you go. Do your best." How long do you think it would take to get a package? Every day we send 300,000 or 400,000 people out with a list of names alphabetically and say, "Do your best. You work out which order you see people in." As long as we don't adopt even some of these basic technologies around automated route planning, having some of the data to hand and figuring out some of those basic things, we will have the NHS persisting in this kind of low productivity equilibrium. But it's not that you need these radical breakthrough technologies that don't exist someplace else; you actually need things that are in common use in other sectors of the economy to be taken into the NHS.

Separately, the potential from new innovations, particularly in AI, are enormously exciting. There is passive data capture, for example, where AI can capture what the clinician is saying to the patient and record it and summarise it. Instead of the clinician focusing on the computer and data entry while talking to the patient, they can be looking and speaking to the patient directly and the system is capturing it. That presents an enormous opportunity to improve productivity in almost every setting of care. There is something about being able to capture all those opportunities that are



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really at the technological frontier, but there is also something about making sure that we get some of the basics right that simply do not exist in the NHS.

- Q45 Gregory Stafford:** I am going to ask a couple of questions on productivity. Before that, I want to bring it back to something you said earlier. In response to a colleague you said, "I'm just a surgeon who works in a hospital." But you are clearly more than that. You have been a Labour Government Minister, you have been commissioned by two Labour Governments to write reports, you are a peer of the realm, and in this report and previously you have criticised directly and by implication Governments prior to July this year, so I do not think it is unreasonable to ask you to comment on the current Government. On the point raised by Mr Robertson, do you think the current Government has got it right on overall spending and the balance between health and social care? Do you think the current Government has the reforming zeal to really enact some of the stuff that you highlighted in the report?

Lord Darzi: Could I correct you there? I have also worked for the Conservative Government. You might not be aware of that, but I was appointed by Lord Cameron as his health and innovation ambassador.

Gregory Stafford: That makes it even more—

Lord Darzi: I also chair the accelerated access collaborative board—as we are talking about the innovation side. And I am independent. So, back to your question: is the Government fit to deliver what you asked about? Absolutely. The vision is there. The determination is there. The Budget announcement was a critical part of it. My interaction with the new Secretary of State started around the time when I was asked to do the NHS investigation. I was given complete freedom to do this. I had access to all the data from the NHS and also a lot of the analytical support that you see in the report. If this was a clinical case, you need to know your facts before you plan the treatment with the patient. That is the way I will approach this. I hope I have given the doctor who is going to fix the NHS the plan or what the problems are and, through the next process, how you really try to address the significant challenges that are facing us. By the way, we have done this before—you are correct—and it has worked. I do not see any reason why it should not work this time.

- Q46 Gregory Stafford:** I hope you are right. Moving on to workforce, clearly staff morale has an impact on productivity; allowing managers and clinicians to have the autonomy and freedom to be able to do their jobs properly is part of that. How do you see the balance between the clinical leadership and the managerial leadership within the NHS working in order to improve morale and productivity?

Lord Darzi: There are a number of other reasons why the morale might be low beside productivity, but downstream that is the endpoint.

- Q47 Gregory Stafford:** Sorry—it is not that productivity is affecting morale, although I am sure it is; it is how we improve morale from a clinical and managerial point of view in order to increase productivity.



Lord Darzi: The frustrations are what we described earlier. I am talking about a surgical case again as an example: you come to your theatre in the morning; you are waiting; there are no patients; you have seen the patient; you have tried to consent the patient; the patient is not ready; you are wasting a lot of time. That is not just from a clinical perspective—your managerial colleagues are also frustrated by that. They are doing their best from the night before to see who is physically able to be discharged in the morning. I think those two are aligned. They should work, again, hand in glove because at the end of the day, clinicians have managerial skills. Managers working in the national health service also fully understand what the clinical challenges are.

- Q48 **Gregory Stafford:** You were critical of the overall reforms, but the outcome of the 2012 reforms was to give clinicians more leadership roles. Is that something you approve of, or do you think clinical and managerial needs to be separate?

Lord Darzi: Absolutely not. I championed and fought for empowering clinicians to deliver what was understood to be the right thing. I agree with you—that was the thesis of the 2012 reforms. What I did not understand was the major restructuring. That is the distraction that took a number of years.

Tom Kibasi: And it did it on the wrong side, in the sense that it tried to get GPs involved in commissioning services. The scope and opportunity for more clinical leadership is in the provision of services. It tried to take GPs away from their provider roles, which is what was so unusual about the 2012 reforms and why no other health system has attempted anything in that direction, and essentially said that a set of highly technical planning skills and capabilities should now be taken on by people who have been to medical school. That is a slightly peculiar thesis. Saying that the frontline clinicians should be leading and managing the services that they themselves have been involved in delivering is a much more reasonable and logical conclusion to arrive at.

- Q49 **Gregory Stafford:** Let's move back to where we started the whole session: data. The questions at the start were about the macro level and how we look at data to make big decisions across populations. What was your assessment of the quality of the data that trusts, ICBs or any of the providers or commissioners look at? How can you improve it? How can it be shared better between systems? Do you think there needs to be a lot more investment in clinical coders and coding to ensure that the data is correct at the starting point?

Lord Darzi: It depends what you are using the data for. For what we used it for, it was more than adequate. We looked at a stretch of data sets. We wanted to see trends and what happened. If I was a cancer surgeon trying to see the outcomes of a specific cancer over a period of time, then I would love to have much more accurate data to tell me not just that it is cancer—what type of cancer? What stage of that cancer? When was the presentation? Then you would get much more granular data to look at very specific outcomes. For example, stage 1 bowel cancer will have a



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significantly better outcome, so you will be surprised if it does not, and you can deal with that. We have not gone into that level of granularity, but we could do that. We could and should be doing that because that is one of our strongest, most powerful assets.

- Q50 **Gregory Stafford:** I was pleased that you mentioned the Getting It Right First Time programme, which I worked for until becoming a Member of Parliament. Just to push you on that, do you think the sharing of data at a local level, either within or across organisations, is good enough?

Lord Darzi: I do not think so. You know from your role before that we could do much better. The data is one way of integrating organisations, not just structurally, but data flows could be—

Tom Kibasi: Real-time data would make the biggest difference. If a patient shows up at A&E, it could be a total mystery as to what medications they have been prescribed in primary care. If you could share the data across settings, you could improve the quality and safety of services in a very significant way.

Gregory Stafford: Thank you. That was really helpful.

- Q51 **Chair:** To follow up on that, counting things in the community has been a consistent theme through these two hours. Thank you for answering so eloquently throughout that time. What barriers to getting the data from those settings have you observed?

Tom Kibasi: The first thing is that you just have to choose to count it. It's as technical and simple as this: you need to put a flag as to whether a nurse is working in the community setting or a hospital setting, or are they working in both—in which case, what is the division of their time between the two? So, it's very technical—are we flagging in existing data systems?

However, the area that is a data desert remains all of care that exists outside hospitals. Hospital datasets are much more advanced than out-of-hospital datasets, and that is partly a reflection of the fact that hospital data systems are also much more advanced than the systems that exist outside hospitals.

- Q52 **Chair:** I am trying to get under the skin of something you said. Is it about the technology, or is it about the culture? Is it that the culture of counting doesn't exist?

Tom Kibasi: It is both. One of the reasons that the culture is not there is that the hospital trusts have got very good at counting things, as a result of the introduction of the national tariff, which meant they got paid for activity. If your income is dependent on you counting things accurately, then, not surprisingly, the degree to which you accurately count things increases. Because community and mental health services have been paid largely on block contracts, it has meant that the data completeness levels have always been much lower, partly because there has not been a significant financial incentive for the datasets to be complete. If you take the most detailed data that exists in primary care, it is all the datasets



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that exist around the quality and outcomes framework, on which part of GP pay is based, because recording is deliberately financially incentivised.

Where there are financial incentives for data recording, the datasets are pretty complete and much further advanced. Where there are no financial incentives for data, the datasets are much less complete and much less advanced. As a result, it is fairly clear what drives the disparities in data.

Chair: There is a natural tension, potentially, between counting and quality, and quality is one of the key themes that comes through in the report.

Tom Kibasi: Measuring quality is part of that. It is not just about measuring activity; it is about measuring quality.

Chair: That is very important; thank you.

There is one question that we haven't got to at all yet, and that is about pharmacy. Jen Craft, would you like to ask about that before we draw to a close?

Q53 Jen Craft: You mentioned that community pharmacy has a key role to play in reducing the burden on primary care services. How do you see that going forwards, and what further, more clinical, role could community pharmacies potentially play?

Lord Darzi: First, there is a serious challenge when it comes to pharmacy at the moment. There is a lot of anxiety out there about pharmacies remaining. A lot of those businesses are deciding to shut down, for whatever reason. I think that is something you should look into, because it is of great concern. I personally believe—and perhaps Tom does as well—that pharmacy could provide significantly more, in terms of both health and wellbeing, and healthcare. It is an opportunity missed, because if we really want to reduce the burden on our general practice and community services, pharmacy has a huge role to play. We saw that during covid—pharmacies had a huge role to play.

Tom Kibasi: We want pharmacists not to be counting and dispensing pills; we want community pharmacists to be involved in managing complex regimes of medicines. What we want is a pharmacist who is in an integrated team, who is helping the GP or other clinicians to get the medication right, rather than literally just making sure the packet is filled correctly. In the future, how do we delineate between the higher skillset that pharmacists have, and the more mundane tasks? Those are still important to get right, but as more technology comes into the sector, more dispensing could be done in an automated way, which would free up the pharmacists to work out the nature of the possible drug interactions for people who have multiple long-term conditions. It is striking, as the report showed, that the rate of increase of people with two or more long-term conditions is growing at 6.6% a year. That community pharmacist role, in terms of medications management, will become much more important than the role of dispensing and selling beauty products. The latter, fundamentally, is not a hugely value-adding activity, compared with



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being able to work out how to use medication in the correct way to keep a patient as well as possible for as long as possible.

Q54 **Jen Craft:** Is there an appetite in the pharmacy sector to do more work on preventing ill health?

Lord Darzi: Yes. I have had a lot of people lobbying me about it.

Tom Kibasi: Yes. They are very excited about it.

Lord Darzi: However, we need to make it happen. Pharmacists are very threatened by things that have been happening recently.

Chair: That brings us to the end of our two hours. I hope it has flown by for you, as it has for us. We could have kept you and continued the questions for another two hours—don't worry, we won't put you through that. Thank you for coming, Lord Darzi and Tom Kibasi. Your time is much appreciated, as was the report. We will continue to draw on it, and with permission, we will continue to be in touch as a Committee. We thank you for your time, and we thank those in the room and those watching.