Independent Investigation of the National Health Service in England

The Rt Hon. Professor the Lord Darzi of Denham OM KBE FRS FMedSci HonFREng

September 2024

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

Dear Secretary of State,

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

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

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

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

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

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

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

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

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

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

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

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

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

Performance of the NHS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Drivers of performance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

* * *

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

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

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

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

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

ARA DARZI
Paul Hamlyn Chair of Surgery, Imperial College London
Consultant Surgeon, Imperial College Healthcare NHS Trust
and the Royal Marsden NHS Foundation Trust
Independent Member of the House of Lords