Midlothian Integration Joint Board

Independent Investigation of the National Health Service in England Report (The Darzi Report)

Thursday, 19th December 2024, 14:00-16:00

Item number: **5.11**

Executive summary

This report considers the recent Independent Investigation of the National Health Service in England and presents some of the key themes as they relate to Midlothian IJB for discussion.

Lord Darzi was commissioned by the UK Government Secretary of State for Health & Social Care to undertake a rapid investigation of the NHS in England that considered patient access, quality of care and overall performance. The report considers how demand for healthcare has changed, the reasons why it has risen, and examines the challenges faced across the system (appendix 1). A summary of the report produced by Carnall Farrar is also provided in appendix 2.

Although the report was written in regard to NHS England, there are many similarities to the Scottish position including challenges with integration and issues of capacity and demand. Additionally, the report raises some key themes that Midlothian IJB may wish to discuss.

Members are asked to:

- Review the Independent Investigation of the National Health Service in England (appendices 1 and 2).
- Consider some of the key themes as they relate to Midlothian IJB.
- Discuss and consider if the Board wishes to take any action in response.

Independent Investigation of the National Health Service in England Report (The Darzi Report)

1 Purpose

1.1 This report considers the recent Independent Investigation of the National Health Service in England and presents some of the key themes as they relate to Midlothian IJB for discussion.

2 Recommendations

2.1 As a result of this report, Members are asked to;

- Review the Independent Investigation of the National Health Service in England (appendices 1 and 2).
- Consider some of the key themes as they relate to Midlothian IJB.
- Discuss and consider if the Board wishes to take any action in response.

3 Background and main report

3.1 Lord Darzi was commissioned by the UK Government Secretary of State for Health & Social Care to undertake a rapid investigation of the NHS in England that considered patient access, quality of care and overall performance. The report considers how demand for healthcare has changed, the reasons why it has risen, and examines the challenges faced across the system (appendix 1). A summary of the report produced by Carnall Farrar is also provided in appendix 2.

3.2 Although the report was written in relation to NHS England, there are many similarities to the Scottish position including challenges with integration and issues of capacity and demand. Additionally, the report raises some key themes that Midlothian IJB may wish to discuss.

3.3 **Aligning strategy and resources**
Darzi notes that strategic ambitions have not been followed with the appropriate allocation of funding steams and that poor productivity in Acute services has continued to drive increasing expenditure. Despite hospital funding increasing from 47% to 58% of the NHS budget since 2006 and a 17% increase in hospital staff since 2019, Darzi notes there are 7% fewer out-patient appointments per consultant and 18% less activity per emergency department clinician. This contrasts with over 60% of all healthcare activity taking place in primary care and Darzi recommends

that financial flow is changed to sustain and expand GP, mental health & community services at a local level.

3.4 Midlothian IJB have already commissioned the Strategic Planning Group (SPG) to scope out viable opportunities to support General Practice in Midlothian and work in underway to consider a set of proposals for the Boards review. Seeking opportunities to divert resources appropriate from secondary care and ensuring people receive safe, efficient, and person-centred services close to home from the services best placed to deliver this care and support is a priority workstream to support local ambitions and national strategy.

3.5 General Practice provides General Medical Services to every person in Midlothian whenever they need them. Practices are a key first point of access for a range of health and social care issues, at relatively low cost per capita. The independent contractor model allows practices to maximise local productivity by being in control of their own resources and matching them to demand and workload as needed. The Health and Care Experience Survey (HACE) 2024 shows that access to a GP in Midlothian has improved in the last 2 years and data from the Tableau and Discovery dashboards that self-attendance at A&E with subsequent discharge home (suggesting low acuity problem) has not increased.

3.6 However, this should be viewed as a temporary position only and the Board may wish to consider how to plan for the significant pressure on health and social care that lie ahead. The rate of direct clinical activity in general practice in Midlothian is already higher than in the other Lothian HSCPs and this is unlikely to be sustainable in longer-term with appropriate review to funding. Increased primary demand from disproportionately high morbidity across a range of long-term conditions and the demand cumulating from long waiting lists for hospital services coupled with a predicted 22.9% growth in the Midlothian population over the next 10 years (and 40% growth in the over 75 years population), creates a risk to the sustainability of community services including General Practice and the provision of general medical services locally.

3.7 **Planning ahead**

Darzi highlights 3 areas of emerging increases in mortality: cardiovascular disease, cancer, and dementia. Local and national public health approaches and re-designed pathways of care emphasising the significance of preventative care and early intervention strategies will be required to improve long-term health outcomes and maximise available resources.

3.8 Although prevention is a focus of Midlothian IJBs strategy, the Board may wish to consider increasing support and resources specifically for preventative strategies that could significantly improve health and care within the community. Although it is unhelpful to evaluate prevention intervention by what they cost, there is a risk that this approach will require a range of reallocated or new resource commitments and result in agreed disinvestment in other areas or exacerbate the current financial challenges.

3.9 Additionally, the appropriate use of evidence-based medicines for the prevention and treatment of these conditions is also likely to create increased pressure on the local prescribing budget, and this should be noted as a risk.

3.10 **Wider Perspective**
The review is written from the perspective of the NHS and its underlying and underpinning principles. This leads to some useful insights, but also highlights a number of noteworthy omissions. Darzi mentions the need for accountability but does not address how the system frequently discourages ownership. The report also highlights the need for people to work together but makes no mention of the leadership styles that predicate how the system behaves and can prevent people being able to work together. Most importantly, the report notes that the focus of managers and leaders is predominately cost and measures, rather than recognising the causes of cost, and where there is value.

3.11 The mechanisms of the NHS are underpinned by the principles of New Public Management. In this context, no matter what improvements are desired, the principles of New Public Management will ultimately dictate their design and behaviour. We know the workforce will collectively behave as the 'system' drives them to with any attempt to shift this met by pressure to comply. The only solution is to remove systemic barriers and to allow the new to replace the old.

3.12 **Data quality, planning and intelligence support**
Darzi notes a step-change improvement in data quality is required and, while there are some examples of good practice, the NHS has struggled with data-sharing to improve the quality of care.

3.13 However, without well designed integrated data sets and solutions, attempting to tie pieces of the system together when they are not designed to do risks a much bigger challenge. This approach risks embedding processes that are highly inefficient and ultimately make change more difficult.

3.14 In Midlothian, data sharing across health and social care continues to be challenging. Faster progress is required to ensure data sharing agreement are in place to support the creation of an integrated health and care data dashboard with the potential to generate new insights across the system that can truly transform service delivery. Darzi is unequivocal in support for integrated, multidisciplinary team drawing insights from integrated datasets. However, without the ability to integrate data and have confidence in their interpretation, progressing the wrong initiatives remains a risk.

3.15 The Board may wish to consider how they are able to support the ambition to the and effectively utilise integrated datasets, and create population level insights that inform strategic planning, operational service design to improve outcomes.

3.16 **Opportunities for new outlooks**
Midlothian IJB has an opportunity to consider the disproportionate level of attention on data collection and analysis within the acute hospital sector. The Board may wish to consider if reporting using acute hospital metrics e.g. delayed discharges, readmission rates has contributed to a culture of “what gets measured gets managed” and the risk of what gets measured, gets funded.

3.17 There is an opportunity to consider the need for both effectiveness and efficiency, the concepts and actions we apply to understand these concepts and understand how they are distinctly different from each other.

3.18 Efficiency is easier to identify and measure, most often aiming to cut costs, or improve, but whether an efficiency is effective is more difficult to determine. Effectiveness is about understanding how well we are working, and we rarely focus on measuring this.

3.19 However, if we did invest in understanding effectiveness, we would better understand the causes of cost. If we better understand effectiveness and what creates cost, we can also reduce costs. Understanding and evaluating effectiveness also considers value, waste, variation, and outcomes (not outputs) and supports the systemic change required to drive improvement or innovation. In this context, a reductionist approach of solving individual problems is not how to either understand these concepts or drive innovation in a complex system.

3.20 There is an opportunity to consider how the Board wishes to address the challenges of working within complexity and the means by which to approach this.

4 Policy Implications

4.1 There are no implications for policy as a direct result of this report.

5 Directions

5.1 There are no implications for Directions as a direct result of this report.

6 Equalities Implications

6.1 There are no implications for people with protected characteristics as a direct result of this report.

7 Resource Implications

7.1 There are no implications for Best Value as a direct result of this report. However, should the board wish to consider any action in response to this report, identified resource and capacity and for any action must be considered and agreed by members.

8 Risk

8.1 There are no direct risks to Midlothian IJB as a result of this report. However, there are key similarities and parallels to be drawn that create opportunities to reframe the IJBs response to system pressures.

9 Involving people

9.1 n/a

10 Background Papers

10.1 None

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Appendices:

Appendix 1: Independent Investigation of the National Health Service in England

Appendix 2: Darzi Investigation of the NHS In England Summary