doccla

White Paper

Responding to the Darzi Diagnostic

How digital solutions can help create the new NHS



Executive Summary

The Darzi Review describes that radical change is required to recover the NHS. This paper outlines opportunities to use technology as part of this change, with policy shifts to enable the benefits to be harnessed. In many ways, the solutions are in plain sight - every example provided is from an existing NHS deployment - this is about prioritisation, and a commitment to systematically scaling the best of the NHS to the rest of the NHS.

It is also focused around the areas of greatest need; the management of severe and multiple long term conditions, improving working conditions for staff and those unable to work due to ill health, with the aim of providing care at or as close to home as possible. Getting it right for those with the most complex needs would have a disproportionate impact on the NHS as a health system, improving access to NHS care for everyone - with better flow through emergency and acute services and reduced waiting times for all aspects of elective care.

The paper focuses exclusively on candidates for NHS wide scale today, where we have strong evidence of impact. The innovation pipeline is alive and kicking, let us put our energy at this point into getting the best ideas everywhere.

The NHS is also grappling with the same issues that all developed health care systems are. For this reason, many of the solutions listed are deployed already in other nations. However, we do have a number of advantages, that if used well, can accelerate uptake and the NHS' return to health.

We have a single patient identifier in the NHS number and an NHS App with wide uptake - currently being used 33 million times a month - that connects into every one of the over 6,000 GP practices across England. We have an existing infrastructure, in every ICS, of tech-enabled Hospital at Home or Virtual Ward services, an important platform in place from which to build. And we have a range of examples - during, pre and post pandemic - of scale being achieved across the NHS at pace, with the effectiveness of mandates, targeted funding and implementation support, proven.



We have seen continued progress across different parts of the health and social care system in digitising - all of primary care and the majority of secondary care and adult social care are on electronic systems. We have a thriving tech scene from start ups to scale ups to global players, with consistent growth seeing the UK tech industry reach a $1 trillion valuation recently, making it only the third country to do so globally, after the US and China. This means the UK tech industry is ahead of its European peers[1] and is worth more than double Germany's and three times more than France's, with the strongest access to capital outside the US and China[2] making a major contribution to the UK economy.

Another advantage is that in the UK, the public is ahead of us in wanting to use digital methods of care, including technology to keep them out of hospital. A major Health Foundation and Ipsos public survey[3] undertaken last summer asked over 7,000 people their views, with 78% agreeing that they would rather use tech than go to hospital. Among older people, there was even greater conviction; 85% of those over 65, would take the tech over the admission.

So we firmly believe that we can do this. But it requires boldness and focus from health and care leaders at every level. If this was done, and the examples given were scaled, to every part of the NHS over the next three to five years,the impact would be enormous. This is described in the "What would it look like" section.

We have an opportunity in the new NHS plan, to design and rebuild the NHS to be stronger than it has been before. To provide care that is more personalised and in line with what the public want, supporting people back to meaningful jobs, while creating roles that clinicians and other key staff enjoy working in, by harnessing the potential of technology for the NHS. With an emphasis on prevention, and services that are home based and tech enabled. Creating an NHS that is not only fit for today but also tomorrow.



Martin Ratz
Founder Doccla



Tara Donnelly
Advisor Doccla

The Darzi Review

The Darzi Review describes an NHS in urgent need of improvement. Four key drivers are identified: the impact of sustained austerity, the pandemic, not paying enough attention to the views of staff and patients and unhelpful reorganisations. This is resulting in a range of issues from serious delays in accessing care to staff burnout. Lord Darzi assesses that fundamental change is needed to recover the NHS to full health.

Lord Darzi was commissioned by the Secretary of State for Health and Social Care in July 2024 to undertake an independent investigation into the state of the National Health Service in England, reporting in September 2024.
The full report is here[4] and is well summarised in this snapshot[5].



He outlines six areas of focus for this improvement; re engage patients and staff, incentivise the move of care towards home through financial flows, improve productivity, tilt towards technology, clarify roles and direct energy to improving health that improves the economy and gets people back to work.

Keir Starmer's new government, on receiving the Darzi Report, has committed to three shifts across the NHS:

- Hospital to Home
- Analogue to Digital
- Sickness to Prevention

While the explicit inclusion of digital health as a core mission as well as one Darzi's themes is very welcome, we argue that a bold commitment to evidence based technology across the NHS would have benefits across all of the areas for action and that we have a once in a generation opportunity to reset the NHS and strengthen it for future generations.

As HSJ editor Alastair McLellan said recently: "Of the three 'shifts' the government's NHS plan will attempt to supercharge, it is the 'analogue to digital' transition that will prove most consequential. This is because, as well as being significant in itself, it will provide the most effective route for the other two shifts".

The requirement

Darzi describes an over-reliance on hospitalisation in the NHS, and a need to move more care into peoples' homes ideally, or as close to that as possible, through strengthened community and primary care services.

This new model of care can be focused on equipping people with their own health information, using digital tools to support them and to extend precious clinical resources to safely supervise more patients, in new ways. A huge part of health care - around 70% in the UK[6] and 90% in the US[7] - is the management of long term diseases. It is perhaps the most important challenge facing developed health systems globally, and no one has cracked it.

Multimorbidity has emerged as one of the greatest challenges facing health services, presently & in coming decades.

Multimorbidity—a defining challenge for health systems
The Lancet, December 2019[8]

Chronic diseases and multimorbidity are the greatest healthcare challenges facing us today, not only in Denmark but worldwide

Chronic Diseases and Multimorbidity in Denmark[9]

The Health Foundation describe how this will only increase markedly in the years ahead

The number of people living with major illness is projected to increase by 37% – over a third – by 2040. 9.1 million people in England are projected to be living with a major illness by 2040, 2.5 million more than in 2019

A descriptive analysis of health care use by high-cost, high-need patients in England[10]

So completely reimagining how enduring long term conditions are managed and particularly the care of individuals living with several, is crucial to the success of our NHS over the next decade, and beyond. The good news is that tech is getting impressive results in exactly these areas. Scale of evidence-based technology would be transformative for the NHS. We urge the government to look at the best examples across the world and bring these models of care to Britons. The NHS in 2024 has some distinct advantages over other countries in terms of what is already there to support rapid scale; these should be built upon at pace.

Wes Streeting, Secretary of State for Health and Care has launched Change.NHS to invite views from everyone; the public, NHS & social care staff and partners working with health and care services. It is the largest public consultation ever conducted and is a commendable approach. Here are our thoughts on how digital innovation could best be harnessed as we build a national plan for change.

What to do

1. Bring together Health & Social Care
2. Use tech to support those most in need
3. Support NHS staff
4. Build the Virtual Hospital without walls
5. Support people back to work
6. Give patients their record on their phone





1. Bring together Health & Social Care

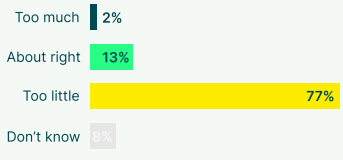
The artificial divide between these services gets in the way of good care. Many people benefit from domiciliary care in the home but it is in no way connected with their health care. As we move to a more home focused, tech-enabled model, we need to bring these services together with the holistic needs of the person at the centre, and take action to encourage more people to join and stay in social care roles which are fundamental to our health and care services flourishing:

Workforce

Increase the standard pay of Social Care staff to match the NHS at AfC3 - as per the Nuffield Trust recommendations[11] - and as part of this uplift, extend roles to blend with home health tasks, with a training package and support. These would include tasks that health care assistants routinely undertake such as health check ins, home testing of blood pressure and liaison with clinical staff providing health care remotely. As one third of social care staff currently access Universal Credit due to how low their wages are, this scheme partially self-funds, helps reduce the exodus of staff from social care to alternative employment and benefits patients and carers. It would also enable the development of greater career progression for staff taking up these roles and support the move to more home based care.

What the public think about care workers' pay

Would you say care workers are paid too much, too little or about the right amount?

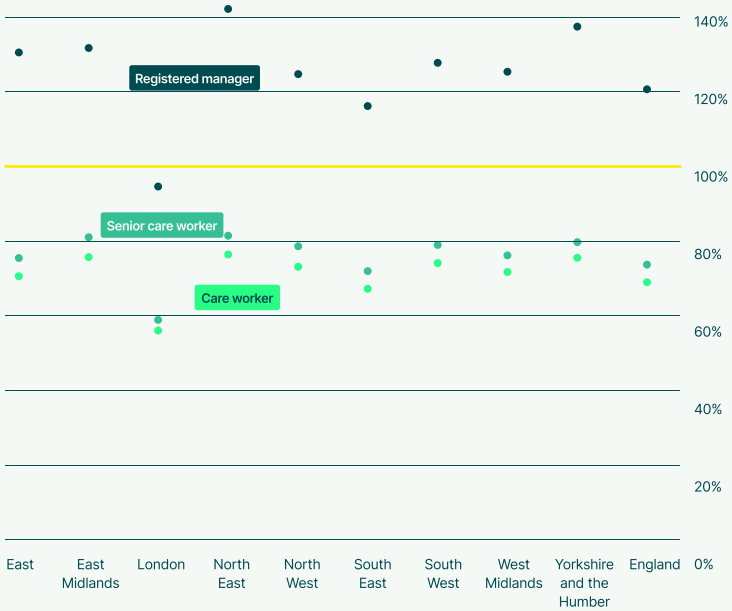


Ipsos survey commissioned by the Health Foundation, 2023

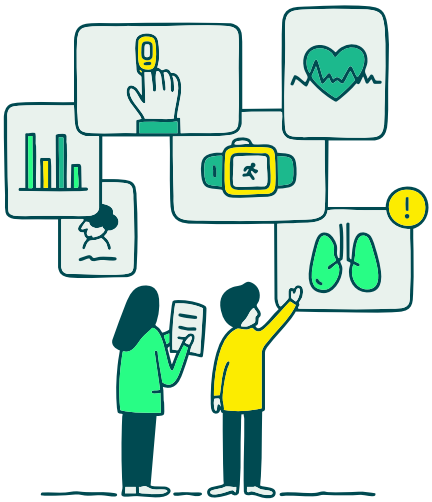
Health in Care Homes

Accelerate the uptake of tech supporting the health of those 400,000 people for whom home is a care home. The Health Foundation found that around 40% of emergency admissions from Care Homes are preventable[12]. There are just under 200k - 192,000 - emergency admissions of care home residents a year, and almost all are taken to hospital by emergency ambulance[13]. If under half - 40% of these admissions - were avoided that would be almost 77,000 admissions avoided every year, 6,400 a month, and a similar number of ambulances freed up, due to journeys not required. Tech that has been evidenced to reduce unnecessary visits to hospital includes remote monitoring of vital signs[14], fall replay technology[15], and fall safety tools such as acoustic monitoring[16]. A programme to support rapid national scale should be established and built into CQC inspection ratings for Excellence for Care Homes to incentivise compliance across the sector.

Median hourly pay for social care roles as a proportion of regional average pay in England, 2023



Skills for Care analysis of the Adult Social Care Workforce Data Set, December 2023
Office for National Statistics Annual Survey of Hours and Earnings, April 2023
Nuffield Trust recommendations[8]



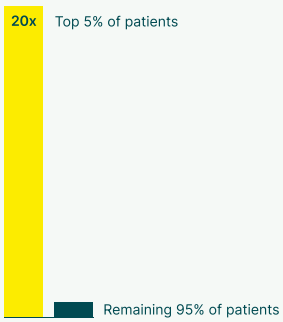
2. Use Tech to support those in most need

We need to pay much more attention to those in the "apex of need" - more NHS resource is spent on the top 5% of patients than the remaining 95%[17]. This Health Foundation research found that the NHS spend on those in the high-cost, high-need group is 20 times that of those outside this group.

Those in the apex will typically be living with a serious and progressive health condition and in many cases multiple conditions (around 3 million people have three or more long term conditions)[18] They will be regularly admitted to hospital in crisis, often by ambulance, attend their GP surgery regularly and have low quality of life, frequently including depression as well as their physical long term condition, spending lengthy periods in ill health. They are also likely to be deprived and older.

The NHS does not currently serve these patients well, they have episodic care, frequent hospital admissions that are preventable and multiple handoffs between specialists. To do better, we need a new model of care that is personalised, holistic, links mind and body and picks up deterioration when action can be taken. Tech-enablement allows us to do this at scale as we now have tools to better support people in most need and we should systematically deploy them, including provision of devices and data in the home to ensure that those facing deprivation can reap the benefits of such a service.

More NHS resources are spent on the top 5% of patients, than the remaining 95%.



A descriptive analysis of health care use by high-cost, high-need patients in England October 2019, Kathryn Dreyer and colleagues, The Health Foundation

→ Support for people most at risk of hospital admission

Define the cohort

All ICSs should be mandated to define initially their top 500 patients most at risk of hospital admission and give them additional support for their physical and mental health, with this increasing to their top 1% over time. ICSs will need to build the capability to risk stratify on an ongoing basis.

Provide home monitoring

This support should take the form of home or remote monitoring to track health, with clinical supervision to enable action and intervention prior to a health crisis.

This will provide extra help to vulnerable cohorts living with serious progressive diseases such as COPD and Heart Failure. Evidence from NHS programmes that have tested this model for Heart Failure also demonstrate a reduction in emergency admissions of one-third[19] alongside significant reductions in symptoms and increases in confidence of self management and for COPD reductions in emergency admissions of 41%[20]. Denmark is extending Remote Monitoring to every citizen with COPD[21] and we believe that the UK should do the same, and also include Heart Failure.

Stratify and provide Health Coaching

It could also provide health coaching to the very top of this at risk cohort, another key element of proactive care that has proven impactful. Research indicates that remote Health Coaching reduces emergency hospitalisation rates by 12%[22]. These services are also very well placed to link people into local services that can support their wider mental and physical health such as social prescribing to reduce social isolation and local charities.

→ Support from the point of diagnosis

Companion App for the Newly Diagnosed

Lighter touch support should be provided at the point of diagnosis, with all patients newly diagnosed with a long term condition provided with Digital support to help them to self manage successfully for longer, avoiding a rapid trajectory into severe disease. This can include referral to the Better Health range of free NHS Apps and Digital companion apps specific to their condition such as Diabetes, Asthma or COPD, which already exist across the major long term condition cohorts.



3. Support NHS Staff

As part of the strategy to listen more to staff needs and avoid clinical burnout we should prioritise the uptake of tools evidenced to impact on this. We need to focus on making these clinical roles as attractive as possible, provide greater flexibility and accelerate the routine uptake of digital tools that save clinical staff time.

As a country we spend £5bn a year training clinical staff, only to see a high rate of attrition from both training and posts. For every 5 nurse training places, only 3 full-time nurses join the NHS[23]. Many who do complete training have to leave clinical practice to find the role that offers them sufficient work life balance. We need to address that head on with national recruitment options and loan forgiveness schemes that will attract and keep people in clinical roles for longer.

26.3%
Time saved using dictation

20%–30%
Cost savings in back office automation

30%–50%
return on investment with RPA projects

20%
reduction in both agency fill rates and unfilled shifts

→ **Ambient documentation**
Transcription technology has improved dramatically over recent years and there are a number of strong products that reduce the time that particularly medical staff; GPs, consultants and resident doctors, spend in documenting clinical episodes, with evidence of this saving a quarter of their time[24], from a UK study in September 2024.

→ **Automation**
The NHS should fully automate its back office at pace. The ROI is extremely straightforward, according to NHS England figures, as most organisations report 20% to 30% cost reduction and 30% to 50% return on investment with RPA projects[25].

- **Staff engagement**
  The way that the NHS change programme is being conducted is exemplary in its inclusion and encouragement of staff ideas. This is replicated in some NHS organisations but not all and in order to make the most of staff innovation and suggestions, needs to be the way of working for all, with an emphasis on staff being able to action their own ideas locally, and have good access to improvement support. Additionally there are a number of excellent digital tools for capturing staff ideas and feedback and then tracking implementation of suggestions.

- **Easy reporting**
  Equally there are tools enabling busy NHS staff to quickly report issues such as door repairs, IT and logistics issues through a single service on their phone. These demonstrate reduced staff burden and improvements in safety[26].

- **Rota planning**
  For all NHS staff it should be easier to work extra hours at their own place of work than for any agency. This is currently not the case. Studies have shown that sophisticated rota planning and locum shift requesting systems can lead to substantial improvements in staffing efficiency. Some Trusts have reported a 20% reduction in both agency fill rates & unfilled shifts[27]. This shift away from expensive agency staffing not only helps control costs but also promotes a more stable and familiar workforce, improving patient safety.

- **Student loan debt write off**
  To enable a better return on the £5 billion direct investment from taxpayers in training clinicians, provide incentives to stay, including write-off of student loans after a number of years in the NHS for staff in clinical professions. Costings for nurses and midwives have been assessed in this review[28].

→ **Virtual clinical work options**

A scheme in place called NHS Emeritus provides a virtual option for surgeons and other senior medical staff to continue to contribute to the NHS post retirement or post leaving the NHS early. These doctors are providing virtual consultations for patients awaiting outpatient appointments and some are also providing hands-on care in undertaking operations as part of the drive to get the NHS waiting lists under control. This should be extended to all staff, initially nurses and non-consultant doctors, then other AHPs, such that anyone seeking to leave the NHS has an option to undertake virtual clinical work instead. This route can help build the workforce capacity for many activities, including the Virtual Hospital in the next section.

→ **Give NHS Staff the tech they deserve**

Hardware

A highly competitive deal should be struck at the national level to replace those aspects of the NHS IT estate that are out of date, with modern data enabled laptops, tablets and smartphones, enabling NHS staff to deliver great care wherever they are.

Software

Electronic records - Progress on electronic records in social care has been rapid and with investment in the final provider sites without an EPR there should not be sites lacking a central digital infrastructure by 2026. The focus should now be on optimisation, that is achieving the benefits of this investment, including cloud, network and cyber resilience, with future major investment reserved for digital innovations such as those outlined within this paper, and as far as possible as revenue rather than capital allocations.

AI to exclude the “normals”

In a number of clinical settings such as dermatology, imaging including brain scans for strokes, breast cancer screening, chest xrays and eye care and pathology there is strong evidence that products that can help clinicians exclude normal results gives them more time to review the abnormal results. Those that meet the NHS’s evidence bar, on impact and price, should be accredited and brought into routine use across the NHS[29].

Apps for Patients

Apps supported by the NHS due to strong evidence of efficacy (NICE assessment, DTAC and clinical recommendation) should be purchased at the national level and deployed on a one click basis onto EMIS and SystmOne as well as Provider EPRs to make it simple for clinical staff to refer in moments.



4. Build the Virtual Hospital without walls

Use digital to bring diagnostics and care closer to home and increase our ambition about what can be delivered in the home, with tech enablement. This could revolutionise the delivery of outpatient services, with followup consultations on a need rather than timing basis, and the following aspects would further augment the virtual hospital.

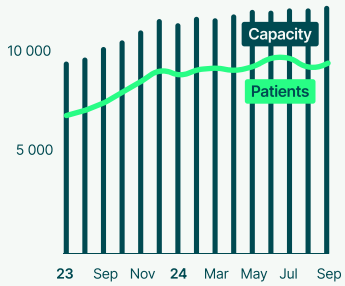
→ **Wound care**

50% of community nursing time is spent on wound care at a cost of £8.3bn per year[30] – and 80% of this cost sits in the community. A range of digital tools have been evidenced to more than halve the speed of wound healing, saving substantial nursing time. Digital wound tracking was associated with significantly shorter healing durations (15 vs. 35 days) and fewer clinic nursing visits (3 vs. 5.8 visits) compared to standard nursing monitoring[31]. Implemented robustly in all services, this would liberate substantial community nursing time that can be dedicated to extending their reach and providing more home based care to other patients

→ **Digital services such as dermatoscopy**

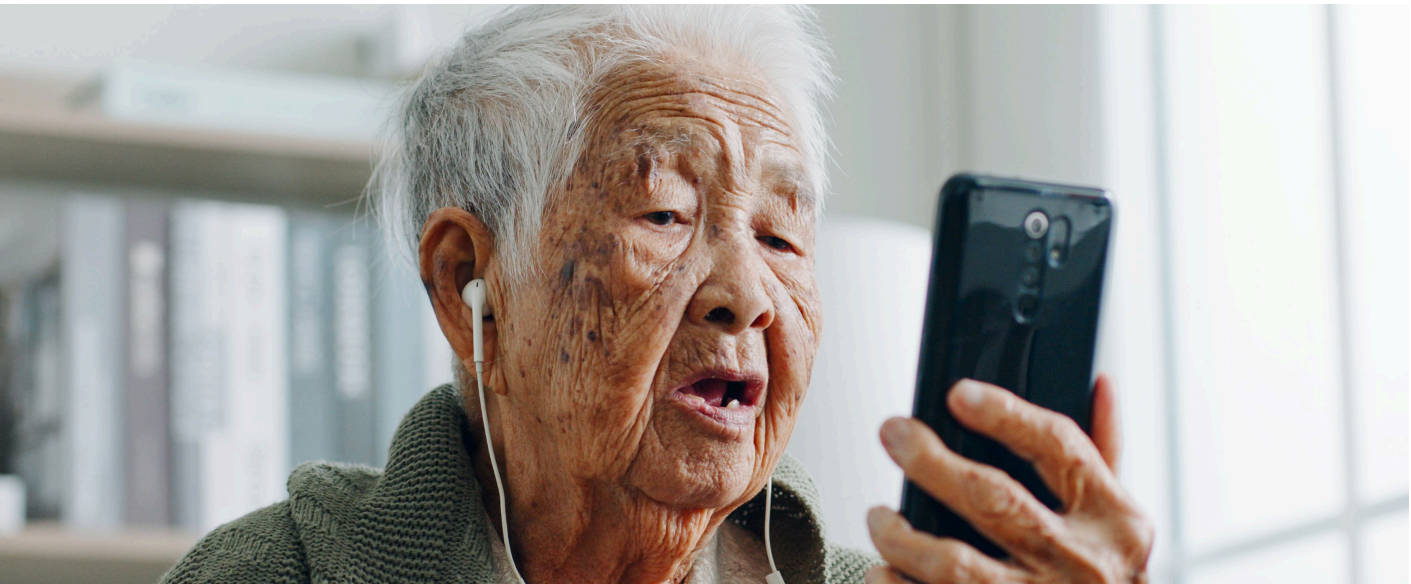
Additional digital services should be added to Community Diagnostic Hubs, GP practices and PCNs such as routine digital dermoscopy to view suspicious moles and provide a specialist dermatology view in days, improving speed of access to patients with a suspected skin cancer and helping reduce overall dermatology waiting times[32].

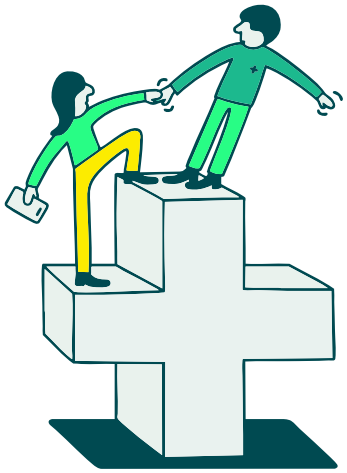
Virtual ward growth



- **Virtual ward expansion**
  The NHS in England has deployed Virtual Wards in every ICS[33]. They are currently providing around 10% of additional acute bed capacity (an additional 9,896 virtual ward "beds" in October 2024 when the total number of acute general beds is 100,000) and this should be increased to around 30,000 beds providing an additional 30% bed capacity, with every patient being offered care at home that is tech-enabled. This would extend the programme to many more conditions, including patients pre and post surgery to ensure patients are fully optimised for surgery and any reasons for cancellation on the day are known in good time to find a replacement patient. Currently the Virtual Ward offer is restricted and often only to acute medical patients when many more could benefit either via admission avoidance or early discharge. The benefits to inpatient flow in acute hospitals would then be marked as occupancy rates reduce. This would enable a ramped up elective programme that would operate effectively including in winter months.

- **Diagnostics at Home**
  Innovative home lab devices are reducing in price and size such as an ECG machine which is smaller than a credit card that is in regular use in home based services. Innovators are working on lateral flows that will detect Neutropenic sepsis, the most serious complication of chemotherapy, as well as home blood test systems. There should be a national horizon scanning service that fast tracks the best emerging innovations through NICE/MHRA/DTAC and completes NHS wide deals for products that demonstrate ROI to then be provided at home, as part of Remote Monitoring services, or in local CDCs or PCNs. With the innovation infrastructure backing their scale - the AAC and the national Health Innovation Network.





5. Return to work support

→ **Provide Digital Tools**
to those unable to work for health reasons

There has been a huge increase in the number of people not at work due to health reasons, hence Pathways to Work[34], the review that Alan Milburn has led. The most common two reasons for this are muscular skeletal issues, particularly back pain, and mental health issues - mainly anxiety & depression[35]. Evidence-based digital health programmes exist for both of these issues and should be made available to people to support a return to health and work.

Britain has a sickness problem. Since 2020, economic inactivity in the UK has risen by 900,000, and now stands at 2.8 million people with 85 per cent of this increase down to those who are not working due to long-term sickness. [...] It does not take a mathematician to work out this is impacting the economy. Yet if the trend could be reversed, our estimates suggest a potential £35bn dividend to taxpayers over five years and that's just from halving the post-Covid inactivity increase."

Matthew Taylor
Chief executive
NHS Confederation

Improving our Nation's Health: A Whole-of-Government Approach to Tackling the Causes of Long-Term Sickness and Economic Inactivity
BCG Centre for Growth and NHS Confederation
Sept 2024

Evidence-based digital health programmes exist for back pain, wider MSK issues, depression, anxiety and insomnia.
A recent NICE review (March 2024)[36] found that "Five digital technologies can be used in the NHS while more evidence is generated to manage non-specific low back pain in people 16 years and over". In May 2023 NICE[34] identified "Two digitally enabled therapies can be used as treatment options for adults with depression while further evidence is generated on their clinical and cost effectiveness."
And additionally "Five digitally enabled therapies can be used as treatment options for adults with anxiety disorders"[35]
They have also recommended one digital therapy for insomnia[36], a common symptom of anxiety and depression.
Currently none of these 13 technologies are deployed at any real scale within the NHS.

Following a personalised assessment, non-clinicians, potentially based in Job Centres, should under protocol be able to "prescribe" these tools to people as part of their return to work journey, keeping their GP informed. In addition, people on the cohort should be signposted, or helped to download the most relevant free NHS Better Health Apps for their health goals, for example to help increase activity, reduce drinking or quit smoking: www.nhs.uk/better-health

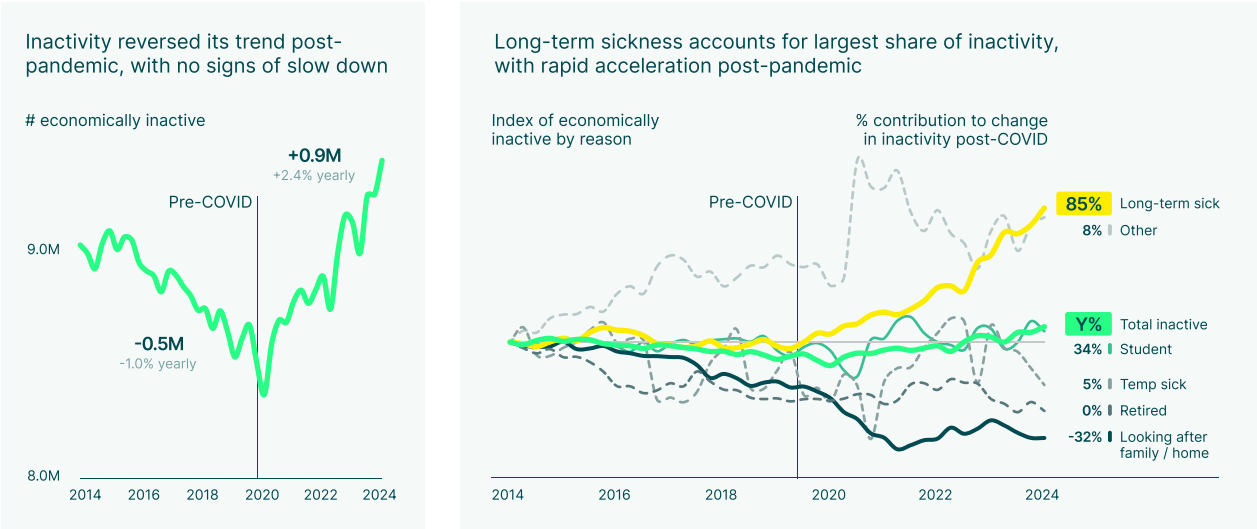
Following an evaluation of impact including cost effectiveness, the programme should then extend beyond these two initial areas if the data is as clear as we would expect.

→ **Keeping NHS staff healthy**

Health and social care account for 12% of the UK economy[41]. Extending this programme to the health and care workforce where overall current sickness rates are 5.5%, well above public sector averages, and last year hit an all time high with around 75,000 staff[38] impacted by sickness in the year. Mental Health issues being the leading cause accounting for 24% of all absences[42].

This could initially be targeted at those on long term sick leave with MSK issues, anxiety or depression, mirroring the public back to work support, however if access was extended to the whole NHS and social care workforce, the tools could also be used proactively at an earlier stage. This NHS and social care staff group could also usefully act as a test bed for digitally-enabled pathways for other health conditions for evaluation ahead of being launched to the wider public as a Return to Work scheme.

Long-term sickness accounts for the largest share of economic inactivity in the UK, contributing >80% to its post-COVID growth



Source: BCG analysis of ONS data (INAC01 SA: Economic inactivity by reason (seasonally adjusted).
Notes: "Other" additionally includes "Discouraged workers" category; quarterly changes are compared using non-overlapping three-month time periods per ONS recommendation; yearly growth rates for economically inactive calculated as Compounded Annual Growth Rates (CAGR) for "Sep-Nov '19 vs Sep-Nov '13" and "Dec-Feb '24 vs Sep-Nov '19" respectively
Improving our Nation's Health: A Whole-of-Government Approach to Tackling the Causes of Long-Term Sickness and Economic Inactivity
Sept 2024. BCG Centre for Growth and NHS Confederation



6. Give Patients their Records on their phone

33 million
NHS App logins
June 2024

20 million
results & records
viewed

7.5 million
hospital outpatient
appointments
viewed/changed

9 million
messages sent

1.4 million
online consultations

+50%
NHS App use
vs same time last year

How we scaled up user research in the NHS App at speed[43]

→ **The NHS App**
Is now the front door to the NHS for millions - 33 million transactions were made through it in the month of June 2024. In addition to providing an easy route to repeat prescription and appointment booking it needs further functionality developed to make it the preferred first contact point for all health related needs. In parts of the country people can access their full hospital medical record and GP record and this needs to be the case for everyone as soon as possible.

→ **Records and Results**
All results, records and letters should be available via the NHS App and be presented intuitively highlighting results out of range, trends and recommendations for action.

→ **Navigation**
The NHS App and NHS.uk should provide visibility of all aspects of the local service offer to help people better navigate the NHS including extended hours primary care, Pharmacy First treatment services and comparative waits.

→ **Communication**
Should be two way. It should be possible for patients to message the health organisations they are interacting with, at any time of day or night. Clearly this needs to be organised in an intelligent way that is responsive for patients without creating email overload for individuals.

→ **Appointment changing**
They should also be able to make and change any health appointment via the NHS App for health screening, vaccinations and all types of appointments. Notifications for all health interactions should come this way.

→ **Personalisation**
Over time, all companion and prescribed health apps should feed in through the NHS App too. People should have the option to link in information from wearables and home monitoring from their latest blood pressure and heart rate to step count and workouts into their personal health record. This will provide everyone with their own NHS passport in their pocket and considerable empowerment in their health management as a result.

What would it look like

As Integrated Neighbourhood Teams are developed, they can be supported by ICB teams running the data on who is most at risk of admission locally, in the first year supporting the top 500, then extending in future years. Existing Remote Care and Virtual Ward hubs can be extended to take on this caseload of patients, working closely with existing teams, particularly Frailty, Respiratory and Cardiology community and acute specialists. Those eligible to join can be approached by text message invites and phone calls and recruited to the digitally supported pathway. Integration of records and regular MDTs will ensure all are kept informed of progress as staff work in new ways, across traditional boundaries with the patient truly at the centre. The same technology will be accessible to people living in care homes, as well as additional digital tools that protect against falls and other preventable harms.

The care of these patients who are currently high-risk, will become much less crisis driven in future, with a reduction in urgent GP visits, calls to 111 and 999 and visits and admissions to hospital. Instead those involved in their care will be able to see at a glance how a patient is doing, and any readings of concern will alert so that the person is contacted by the nurse advisor and support team to take appropriate action as needed. Patients will be connected to various support mechanisms such as the weekly virtual singing club run by Asthma + Lung UK or to heating vouchers for their home or a gardening group through social prescribing. Those at exceptionally high risk of admission will be given a dedicated Health Coach to help them complete the activities most evidenced to keep them well. This could be steadily increasing activity, reducing drinking or quitting smoking, with the connection and support of a Health Coach helping people build a realistic health improvement plan and stay motivated.

Changes in Social Care pay and areas of scope will mean that in the future, domiciliary care workers can be part of this circle of care around a person at home, and support them as they seek to live as well as possible with their progressive disease. Benefits will be felt in improved ease of recruitment to posts in care homes and how long people stay in their role. The introduction at scale of digital innovations that support NHS staff is returning joy to their work and creating more time to care. We are seeing a reduction in absence rates and rate of staff leaving the professions, providing increased continuity to patients and greater team cohesion.

The scale of these digital solutions is being led by Transformation teams locally supported by a National improvement collaborative run by NHS Impact, establishing a community of practice and shared learning, with local accelerated adoption support through the relevant Health Innovation Network. Beyond the NHS they are working with the DWP providing assistance in the rollout of Health App prescribing for MSK, Anxiety and Depression via Job Centres, to help people return to work and with Social Care to embed tech in Care Homes. Robust, independent evaluation programmes are in place to enable real time learning and impact assessment across the country.



How it can be achieved

Mandates, incentives and funding streams will need to follow this policy direction and are under consideration by working groups currently.

Short term immediate

However, very rapid benefits (within 12 to 24 months) could be achieved by the following, to kickstart the change

→ **Setting ambition**

- Set the strategy outlining the target care models and digital solutions to scale
- State the requirement in planning guidance to the NHS for the next year (April 2025 onwards) that the high profile Care at Home & Support to Staff change programmes will be delivered across ICSs with central support
- Make the key policy changes in support of the three shifts (Social Care pay, clearing Loan debt, back to work support)
- Set the national work underway (NHS App enhancements, AI accreditation, integration of patient support apps in clinical systems)

→ **Creating an immediate fund**

- Establish the funding pot to invest in the Care at Home, Support to Staff and national programmes in the immediate term, make the route to access this simple so that oven-ready sites can progress at pace, start now and make a difference by next winter
- Track progress as an integral part of routine performance management

→ **Providing support**

- Align the improvement infrastructure behind this change, the NHS England and DHSC teams in Transformation, including Digital, Community services, Urgent care, Social Care. Establish this as core adoption challenge for Health Innovation Networks, use NHS Impact and GIRFT capabilities
- Create a national community of practice to accelerate uptake and learning

Longer term
18 months onwards

→ **Future tariffs**

- These would kick in from April 2026 onwards.
- New tariffs would reflect the desire to move care out of hospitals into community and home settings.
- Where secondary care clinicians continue to supervise patients in their own homes, acute providers would be reimbursed for this.

→ **Policy changes as enablers**

- Some of these may have a longer implementation period

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Conclusion

The stark diagnosis outlined by Lord Darzi needs a comprehensive response, with real change to the NHS to return it to health. We believe that the opportunity is here, to focus on a limited number of evidenced, scalable solutions to support new models of care and NHS and social care staff in new ways.

The examples listed already have a good evidence base, both in the UK and across the globe. Leading ICSs are doing work in a number of areas described, but none have yet brought all the components together. There are opportunities here for local leadership to drive progress tomorrow.

We also believe that it is the time to be bold in our ambition. We need a national strategy outlining how we will scale the most evidenced digital innovations. National support, mandate and investment programmes make sense when the goal is national scale, designed such that all in the system can work towards a shared ambition, with rewards and incentives in line with this.

The “three shifts” point to care that is much more home based, far more tech enabled and preventative and much closer to what our patients and the public are asking for. The examples in this paper focus on these areas where there is already good evidence of impact.

Energy should now be dedicated to systematically scaling these across the NHS so that everyone can benefit, not just a few, such that they soon become part of the routine delivery of care on the NHS. This work could start rapidly in the ways outlined above and could then have impact in time for next winter, and be part of mainstream NHS care over the next 3-5 years.



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    This is a huge pool of unused talent. The research undertaken for this Report suggests that seven in ten people who are currently economically inactive would like to take a job that is aligned to their skills, interests and circumstances. If our research findings in Barnsley were applied nationally, it would suggest there may be over 4.5 million economically inactive people who could be in the market for a job now or in the future."

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