HOUSE OF COMMONS

# Health and Social Care Committee

## Oral evidence: The work of NHS England, HC 137

Tuesday 14 November 2023

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Watch the meeting

Members present: Steve Brine (Chair); Paul Bristow; Mrs Paulette Hamilton; Dr Caroline Johnson; Rachael Maskell; James Morris.

Questions 1 - 63

### Witnesses

I: Amanda Pritchard, Chief Executive Officer, NHS England; and Professor Sir Stephen Powis, National Medical Director, NHS England.

# Examination of witnesses

Witnesses: Amanda Pritchard and Professor Sir Stephen Powis.

Q1 **Chair:** Good morning. This is the first session of the Health and Social Care Select Committee in the new and probably final Session of this Parliament. We have one of our special one-off witness evidence scrutiny sessions today, and have started right at the top. We have Amanda Pritchard, who is the chief executive officer of NHS England, and her national medical director, Professor Sir Stephen Powis. I should say that obviously I worked with Professor Powis when I was in office as a Health Minister. It is nice to see you both. Thank you for giving up your time to come and talk to us.

Let's kick off with, I suppose, the headlines on where we are in the NHS at the moment. Amanda, has the new Secretary of State been in touch with you yet?

***Amanda Pritchard:*** I met the new Secretary of State yesterday.

Q2 **Chair:** Excellent. That is very good to hear. Secretaries of State like their projects—they like to have personal projects; but whatever the new Secretary of State wants to do, I presume she has been told that cutting waiting lists will be at the top of her in-tray. We very much hope that in a few weeks when she comes before us we shall see her honouring the diary of her predecessor. With north of 7 million people on the waiting lists, what do you consider the situation to be at the moment? I presume that you discussed this with the new Secretary of State yesterday. Where are we? Of the Prime Minister's five priorities, this looks like the hardest to meet right now.

***Amanda Pritchard:*** I definitely would not want to speak for the new Secretary of State about what her priorities would be, but certainly we had a wide-ranging discussion yesterday. Probably for both of us the area of most immediate focus is preparing for winter, but we covered a range of areas. The Committee will, I think, remember that for elective care the original recovery plan focused on reducing the number of people who were waiting the longest for care. On the activity assumptions that were built into the plan at the time—this was of course before we were aware that we would have industrial action, which was a significant change to the reality in which we have operated for the last 10 months—we would, all things being equal, have been hopeful that the size of the total waiting list would begin to reduce before the end of this financial year. In reality, as colleagues know, over 1 million patients' appointments have been rescheduled as a consequence of industrial action. As a consequence of not just the impact on activity but the financial impact of industrial action, we have now agreed with Government on lower activity expectations for elective activity this year, to 103% of pre-pandemic levels of activity.

My expectation, and what I know from talking to colleagues across the NHS, is that they still want to do everything they can, and particularly to focus on the patients who have been waiting longest and on those whose need is urgent, but the overall level of activity we are now able to carry out puts the overall waiting list challenge into perspective. On the commitment that we had made to reduce the longest waits, in addition to the virtual elimination of two-year waits and 78-week waits, it is worth saying that we have reduced the number of patients waiting over 65 weeks—the next target—by over half from its peak. That is an area where we continue to see progress.

Q3 **Chair:** But the list still keeps going up, of course, because new people come in. It is just the way of the world. Did you catch the piece of work by the think-tank Reform last month, about so-called hidden waiting lists? Professor Powis may wish to pick this up. People coming in for treatment will of course be on a pathway of referral to specialist care. That might be their first definitive treatment, but they may have other follow-up. Reform did a piece of work that talked about the hidden waiting list: "60 per cent. of all outpatient appointments in the NHS are follow-ups. This is the hidden waitlist," they say. Could you comment?

***Amanda Pritchard:*** Yes. To be honest, this comes up periodically. We always find it slightly odd when it does. What we measure is this. People are on a waiting list until their first definitive treatment. That is really important, otherwise, as you say, they could be going through multiple diagnostic steps before reaching that point. They are still waiting until the point when they begin treatment. If, for example, they are on a follow-up schedule to come back in six months' time for a routine check-in, that is part of the ongoing treatment plan. It is not separate: "We are now making you wait an extra six months for that." If they could come in tomorrow, it would be completely pointless because they were seen yesterday.

Q4 **Chair:** It does mean that you are not free of the NHS, and are not therefore back to work and economically active, or getting on with your life looking after the grandchildren, doesn't it?

***Amanda Pritchard:*** Most people with chronic conditions will come in periodically for care, often throughout their whole life, and many of them—the vast majority—will continue to work at the same time. I have a heart condition. I am back in for regular appointments. It doesn't stop me working. I think that perhaps the point you are getting at is that we are aware that not all of those appointments add an enormous amount of value for patients. Therefore, as part of the elective recovery plan we have described moving away from the slightly more fixed model of coming back every three or six months, or every year, to much more patient-initiated follow-up, so that when you are unwell you come back. That is the thing in the elective recovery plan that empowers patients to get access to the care they need when it makes sense for them. That is perhaps the point you are making and it is certainly what we recognise as still being the area of focus. In particular, there are colleagues, led by the

getting it right first time team, who have been supporting the clinical redesign of pathways, so that they really give patients the best value, as well as using the NHS's resources most effectively.

Q5 **Chair:** Can we talk about money? On 8 November, NHS England wrote to ICBs and trusts and said it would be allocating "a total of £800 million to systems sourced from a combination of reprioritisation of national budgets and new funding." Which initiatives are going to be affected by this reprioritisation? What will the longer-term impact be as a result of this decision? Presumably it is also about the significant financial challenges created by industrial action that your letter understandably referred to.

***Amanda Pritchard:*** We were really pleased that we now have clarity on the financial position, such that we were in a position to write. As you say, that has allowed us to release £800 million to the NHS frontline, with a clear message that that is now about protecting patient safety first and foremost, prioritising urgent and emergency care so that we can give patients the best possible care this winter, and continuing to progress existing commitments, such as primary care access. On the point that you were just talking about, we have set out the implications for elective care and restated the focus on urgent care.

The impact is twofold. Of course, in that £800 million there is additional funding from Government, so that is £300 million that has come from Government. The reprioritisation largely impacts things that have not yet been spent on tech—technology—and on capital, but that will be things where we would expect just to be able to reprofile the spend, so that rather than having it coming in the back half of this year we will push it—with the Government's agreement, obviously—into next year. That, broadly speaking, is how the money is made up.

Q6 **Chair:** Does that not worry you? You will be aware of our work on digitalisation in the NHS. Every time we go out and talk about systems they talk about the tech, the digital and the lack of interoperability between primary and secondary care. James Morris may want to touch on this when he talks about productivity later on, but I am concerned that there could be a very long tail to what you just said.

***Amanda Pritchard:*** Would we have preferred not to have to reprioritise any funding? Of course. It is entirely appropriate for Government to make a call, given other demands on the public purse and the wider economic position. It is entirely appropriate for Government to make a decision about what they are able to do and would like the NHS to do, in response to the pressures that have come, particularly from industrial action, although of course there have been underlying pressures in the position as well, particularly from inflation.

We have, with Government, looked to minimise the impact of national reprioritisation, but we have had to accept that to make sure that the frontline has the resource it needs to focus on patient safety, and urgent

and emergency care capacity for this winter will require some reprofiling of spend in those areas. As I have said, it will also require an acknowledgment that we probably won't be able to do as much elective activity as we had previously planned.

Q7 **Chair:** Did you discuss industrial action with the Secretary of State yesterday?

***Amanda Pritchard:*** Yes, we did.

Q8 **Chair:** Is it your hope that a new broom can achieve new outcomes?

***Amanda Pritchard:*** Again, I would not want to speak for the Secretary of State, but it has been our clear position right from the start that we strongly urge all parties to find a way to reach resolution in the current industrial action.

Q9 **Chair:** Presumably that was your message to the Secretary of State yesterday.

***Amanda Pritchard:*** It continues to be.

Q10 **Chair:** And it was the same with the previous office holder, I am sure. How far would you like to go, while you have this platform today? Clearly the industrial action is hurting you financially. Your letter says that in stark terms. Is it hurting patient safety? Is it hurting patient care?

***Amanda Pritchard:*** The point that we have been making, consistently through the summer—I am sure that Professor Powis will want to comment on it as well—is that it is patients who are bearing the brunt of this. There is an obvious impact on them from things like the rescheduling of elective care, but there is also a real impact on resources. That money cannot be spent elsewhere. The hidden cost is what that means for individual patients; some of them have had care rescheduled a number of times while waiting. The other hidden cost is on our staff. The impact on morale of the ongoing industrial action is significant.

Q11 **Chair:** They hate it, don't they? Professor Powis, is it hurting patient safety?

***Professor Sir Stephen Powis:*** The first thing to say is that during all periods of industrial action we have prioritised emergency pathways to ensure that those pathways—the A&E and ambulance pathways—remain safe. The BMA have clearly stated that they wish those pathways to function and remain safe. We have worked hard to do that. With a few exceptions where derogations have been asked for, those pathways have been maintained.

During the last period of industrial action in early October, when, if you remember, there were three days of joint industrial action between consultants and junior doctors working at Christmas day levels of cover, we wrote to the BMA to point out some of the concerns we had. It was the first time that we had written formally to the BMA during the periods

of strike action since the spring. We did that because it had got to the point where we were becoming concerned about the impact on patients and the possibility of harm to patients.

There were three things in the letter. The first was that the construct of Christmas-level cover was not working very well. It was difficult for individual organisations or hospitals to plan around it. We pointed out that Christmas usually occurs once a year, not on three consecutive days. Of course, we did not see the reduced levels of demand that we usually see at Christmas, or the low levels of occupancy in hospitals going into Christmas. We saw high levels of demand during those three days, so they were difficult.

Secondly, the derogation process in which we have on rare occasions—it has been only a handful of requests—asked the BMA to bring staff in has not been working as well as it should. The BMA agreed with us on that, and we have agreed, should there be further strike action—hopefully there won't be—to do more work on that, jointly.

Finally, which speaks to the point that Amanda just made, we have been becoming increasingly concerned about the patients who do not require emergency treatment but who require treatment within a reasonably quick period, typically a month. They might be cancer patients or cardiac patients. The concern, particularly when there is strike action shortly after the previous strike period, with little gap between, is that constant rescheduling could increase those patients' time on the waiting list. That has the potential to cause harm. We have not quantified that or seen that harm yet, but clearly there is a risk and we wanted to highlight that to the BMA and put a flag up, in a sense, that we would need to do more work on it.

Q12 **Chair:** Their response to your communication was that your "planning failures" make it "harder to organise safe striking". They say you are making planning failures.

***Professor Sir Stephen Powis:*** We don't agree with that, and they know we don't. We acknowledge that particularly the consultants have typically been providing six weeks' notice, but even that is not sufficient for planning to be done optimally because, particularly for patients who require urgent treatments, the need can arise very quickly. If the periods of strike are close together it is difficult to organise, so I pay tribute to our NHS trusts and staff. I have been around all the regions recently talking to all the medical directors. I know how hard they have worked to keep services going and to prioritise the patients who need treatment, because their care is needed urgently.

I do not see any failure of planning. I see great difficulties when strike action is called on a regular basis. We do not agree with the BMA there, and, as I said, they know that. Nevertheless, we are committed and we have throughout the strikes worked closely with the BMA on an operational basis to ensure that if we have any concerns they are relayed

to them immediately, as we have relayed them to the Government. If that process needs to continue—hopefully, it will not—it will continue.

Q13 **Chair:** On those concerns, there have been a lot of stories in the press in the last few months, and certainly during the strikes; I get phoned by journalists who ask me to comment on stories that consultants are overseas, if I may put it that way, during derogation cover, when they should be nearby, in case they are needed. Has that ever come across your desk? You know what I am referring to.

***Professor Sir Stephen Powis:*** What I have seen on the ground is a huge effort by staff to ensure that patients who need urgent treatment get it, but it is difficult and, as Amanda has referred to already, it has taken its toll. Clearly we are most worried about patients, but we are also concerned about the constant toll on our staff of having to prepare for strike action, manage it and, in the week or so that follows, deal with the host of stuff that needs to be done to recover from it. It has meant that it is difficult for staff—particularly our clinical leaders, but operational leaders as well, and many staff on the ground—to focus on the things that we need them to focus on, one of which is the elective recovery. They are constantly having to work on organising around strike action. As Amanda said, the best thing that can happen is that the strikes are resolved.

**Chair:** Caroline wants to ask about patient choice, briefly, before I hand over to Rachael.

Q14 **Dr Johnson:** Thank you Chair. This is related to strike action. I should say that I am a consultant paediatrician and a member of the British Medical Association who did not strike. You talked about potential harm to patients and I appreciate that you focused on those who are most acutely ill, but there are examples such as a little boy with cancer who had his operation delayed by, I think, 16 days because of strikes earlier in the year. I am aware of a patient who had a two-week urgent scan, which, thankfully, was normal; but it took a further two weeks to report, because the consultants were not available to report the scans. There are actual harms, aren't there? I was wondering what you have done to quantify those and whether you feel that things like reporting radiology scans, and suchlike, have been caught up, or not.

***Professor Sir Stephen Powis:*** That is exactly the sort of example that we are worried about, and it is exactly the reason we highlighted that group of patients in the letter to the BMA. We are looking further at that group. It is difficult, as you probably know, to quantify harm, because there is a host of things that clinicians do to try to minimise it. Nevertheless, it is work that we want to look at. We want to understand the impact on the group of patients who require urgent care—cancer and cardiothoracic patients, for example. That work is ongoing at the moment.

**Dr Johnson:** Thank you.

Q15 **Chair:** Finally, Amanda Pritchard, on patient choice, last month you and the Department announced a package of measures to tackle waiting lists. You said that for patients who have been waiting more than 40 weeks for treatment and do not have a date confirmed, there is the opportunity to travel for care at a different hospital if that means they can be seen sooner. Patients who are eligible will be contacted by the care provider and you estimate that some 400,000 patients will be eligible to benefit from the offer. What you are talking about is a truly national health service, for once, where you use capacity around the system. Where did you get that figure of 400,000? What evidence do you have that people want, and are prepared, to travel for elective care?

***Amanda Pritchard:*** That figure was a snapshot of the number of people at that time who were over 40 weeks and did not have an appointment booked. We did a couple of pilots looking at the enthusiasm for travel. You are right that it is not huge numbers. About 3.5% of the people in the pilot who were offered the opportunity put their hands up to say, "We would be interested," and the majority of those wanted to travel within a relatively small geography, but we had a reasonable number who said they would be prepared to travel up to 50 miles, and a few who said they would be prepared to travel nationally.

That told us that, even if relatively small numbers are involved, for those individuals it is an important offer, and the volume is still sufficient to make a difference, potentially, to some of the places that are particularly challenged at the moment, if some of their patients chose to go elsewhere. We have, in the past, very successfully moved people between the south-west, for example, which last year had some particularly challenging positions with longer waits, into London and more widely.

Q16 **Chair:** You mentioned the south-west. If you live in, say, James Morris's constituency, there are big conurbations relatively near you. If you live in Cornwall, the sheer geography means that exercising any form of choice would mean huge travel. I can see how it could potentially help on a small scale, but it is not a panacea, is it?

***Amanda Pritchard:*** As I say, in percentage terms it is not a huge proportion of patients who want to take up the offer. That is why it is an offer. It is not a requirement. It is only for people who would say that it makes sense for them in their personal circumstances. Equally, the reality of where we are at the moment is that the NHS is pretty capacity-constrained, so it is great if we can, as you say, make use of the benefit of being a national health service, and use the capacity that we have to make offers to patients who want the opportunity to move. It is certainly not a silver bullet for our waiting list challenges.

Q17 **Chair:** How would it work practically? Would your referrer, your GP, turn the screen round and say, "Look, you can have it here, if you are prepared to travel, or here, or very locally with a wait that is a little bit longer," or would it be via the NHS app?

***Amanda Pritchard:*** There are two parts to choice. The choice at 40 weeks is being managed through a national process. There is an online version. There is also a telephone system where you can indicate that you have an interest in expressing the desire to explore the choice to move elsewhere. Then there is a process that includes a clinical review, and a matching process. The other bit that is hugely important is choice at the point of referral. At the moment it is something that we know most people have, and it is a right that patients have, to express choice. That is where you would expect, as part of a GP appointment, to be given a choice of a number of providers, which would include those close by, but could also include those further away if they have more availability, and the independent sector as part of that.

Q18 **Chair:** Crucially—exactly—the independent sector: the Independent Healthcare Providers Network recently wrote to this Committee in formal correspondence published on our website and expressed concern about that principle of choice, which, as you know and referred to, has existed in the NHS for a very long time. Referral management centres at ICB level, the network contests, keep that work within the NHS and it is the patients who lose out. Discuss.

***Amanda Pritchard:*** The same rules apply. A referral management centre is required to offer patients choice if that is the arrangement that has been set up locally. We have made it very clear, and have reinforced it through all the recent work we have been doing on choice, that, assuming that an independent sector option that is clinically appropriate for the patient is available locally, the independent sector should be offered, whether by a GP or a referral management centre. Of course, we have seen a significant increase in the use of the independent sector in the last couple of years particularly. It is running at significantly higher levels than pre-pandemic. It seems that patients are choosing to go to the independent sector where that is clinically appropriate and convenient. We are particularly keen to support choice at the point of referral, which is where independent sector colleagues would like to focus as well.

**Chair:** Yes, I think more work needs to be done on choice at the point of referral, because once that choice has been made for you and you have an appointment at Winchester hospital, you can see how someone might be reticent about changing it. Would the appointment end up not being cancelled and therefore not being fulfilled? You can see how it can get messy. The point of referral is crucial, so I will leave that with you and turn to Rachael Maskell.

Q19 **Rachael Maskell:** Thank you. Can I go back to the point on industrial relations? Clearly, the £1 billion spent on the strikes, as we hear from NHS England, is a significant cost, and the money would probably be far better placed in the pockets of clinicians, and in putting in the solutions that they call for. Is the model for industrial relations right, and should it change to avoid future strikes, to support staff, to prevent the burnout that certainly seems to be happening, going by my experience of talking

to staff on the picket lines, and to do better at providing for staff wellbeing and meeting their needs?

***Amanda Pritchard:*** At the moment, as you know, pay is a matter for the Government, and the way the pay settlement is developed every year is part of what the BMA is in discussion about with the Government. The independence of the pay review bodies is part of what they are discussing. As a separate but clearly linked thing, one of the things that we would see as crucial for the longer term as well as for now is the long-term workforce plan that was published earlier this year. It has three elements: train, retain and reform. It is the retain element that speaks to some of the points that you are making about staff experience at the moment: how they feel, the support that they get locally and whether they feel sufficiently valued in their professional roles and more widely as part of an NHS workforce.

Things that we have already begun to do on the retain part of the plan are making a difference. Retention rates have improved significantly. In August last year, the leaver rate was 9.4% and it is 8.1% now, a year on. A combination of things made a difference. The Government made a decision about supporting people's pensions, which definitely played in. Equally, there are 23 trusts that have been rolling out a package of measures to support staff—a retention package; we can see that they have improved more quickly than other organisations. They were not the best. They were a general cross-section of organisations. We are now planning to roll that out much more widely.

We have pushed a lot of flexible working, because we know that that matters to staff. Some of the things that are in the plan are also important because they speak to what is really the train and reform element—having the right workforce longer term. You spoke about burnout. One thing we have nationally, which started in the pandemic but continued, is a focus on occupational health support, and health and wellbeing support. Some of that is national. Most of it is local, to really make a difference. Making sure that we have a clear line of sight to having sufficient staff with the right skills is a big part of enabling the people we have now to feel that they can do their best work and that they will be supported to do it.

Q20 **Rachael Maskell:** One of the reasons I am asking is that I want to probe into winter pressures, and of course that is the very workforce that will be at the forefront of delivering the targets that have been set on category 2 waits—the ambition is for them to be reduced over the next year to 30 minutes—and ensuring admission, transfer or discharge of 76% of patients within four hours. Incredible pressure is to be put on to parts of the NHS when sickness levels are at their highest and challenges are some of the greatest. How are you going to deliver against those targets?

***Amanda Pritchard:*** Do you want me to kick off? Steve is tapping, suggesting he wants to come in, but I will kick off if that is all right.

**Chair:** Is that what he does—tap? It could be a new strategy for my members to just tap at me when they want to come in.

***Amanda Pritchard:*** First, there is absolutely no doubt that we once again face a really challenging winter. That is partly because of the unknowns. We don't know what will happen with flu or covid. On the positive, we have had the fastest-ever start to flu and covid campaigns, particularly in care homes, so we are doing what we can to keep people safe. None the less, there is a set of variables about what will happen over the winter that we do not yet know. We have also had, as I have already talked about, a big impact from industrial action, which is why it is really good that we are now in a position to provide certainty on funding, so that we can push on with putting in place the services and capacity that we had planned for the winter, to give us the best possible chance of providing the best care for patients.

The earlier planning that we started this year has already made a difference. Although there is enormous pressure, as you rightly say, category 2 ambulance response times are 20 minutes better than they were this time last year. That is against a backdrop of the busiest month so far for attendances. Admissions are up 8% on last year, so we can see that pressure has been building. We have had industrial action, yet we have still seen reduced response times for ambulances. That is because we have more ambulance hours on the road than we did last year. It is because we have already been able to invest in things like virtual wards to put some extra capacity in and to respond to the needs of patients.

The other thing that is happening, even now, is that people are innovating across the NHS. We have some brilliant examples of people using AI in practice. In Somerset, we have four practices actually using AI to identify complex patients who are most at risk of admission or who do not have much contact with primary care, so that they can proactively contact them and make sure they have the support they need. It might be specialist support or it might be volunteers—people to support them with other needs to try to keep them safe over winter.

It is a combination of recognising the reality of where we are with the challenges we face, and the value of the fact that none the less we were able to start early by putting those plans in place. The fact that we now have clarity on the funding position means we can work with colleagues across the NHS to make sure that we focus on getting the capacity in place to support our patients over winter.

Your point about making sure that we look after our staff—to come back to that—and therefore the importance of seeking a resolution to industrial action as we head into the next few months is absolutely top of the list.

***Professor Sir Stephen Powis:*** To build on what Amanda said, of the six years or so I have been at NHS England, I think this year we started planning for winter earlier and more comprehensively than previously. In fact, we started with the urgent and emergency care recovery plan

almost before last winter had finished. Of course, we built on that in July with the winter plan.

When I talk to clinical leaders across the country you very much get the sense that this is the right combination of things. I do not think there is any debate that we do not have the right plans in place. This is all around the ability to deliver on those plans. We are making really good progress. Amanda mentioned virtual wards, where we have already hit our ambition of having 10,000 virtual ward beds available.

When I talk to clinicians, I sense real enthusiasm about the model of virtual wards and hospital at home, both for preventing people from coming into hospital in the first place, because the care can be delivered at home, and for getting patients home earlier because you can deliver the last bit of care at home. I see many schemes across the country with enthusiastic clinicians working with that new model enabled by technology and a different way of working. There are many things in place for this winter, building on previous winters but allowing us to go in with a bit more resilience. Nevertheless, as Amanda said, we still have to see what flu and covid do this winter. We very much hope that industrial action is resolved. It would certainly be better if that was out of the way.

Finally, always in the background, we must remember the demographics of the population. We see the population getting older. The proportion of over-80s is set to increase. That has been happening for a number of years. Of course, those are the individuals in society who usually have multiple conditions, multi-morbidity. Year by year, that puts a pressure on the NHS, particularly as we go into winter. Great work is being done to identify those patients, some of whom are our frailest patients. We are doing work to prevent them from coming into hospital, but there is no doubt that those pressures have been building and will continue to build as you look at the demographic make-up of the population.

Q21 **Rachael Maskell:** Last year, the line shows that funding went into secondary care. However, we know that primary care is where the game changer takes place and where the opportunity comes. It is also around prevention. With regards to the way your budget is deployed, is there more that could be going into primary care as opposed to secondary care on the innovation that is required to bring about prevention? I am particularly thinking about vaccination rates. I understand that they are not great this year. I am certainly concerned about that, both for covid and flu. Hand, face, space is drilled into us, and of course ventilation. They are real, prime game changers with regards to infection rates.

Is there more we can do around the spread of communicable disease and around prevention of slips and trips, another area where an ageing and frail population is particularly susceptible? In that vein, is there more that can be done to ensure that there are better relationships with social care?

***Amanda Pritchard:*** I will start, and then I know Steve will want to come in. It is a really important point. When we talk about urgent emergency

care, although the targets often look like they are focused on secondary care, what we said in the recovery plan is that it is clear that there are three elements that all have to happen if we are to provide the access and quality of care that people need. The first thing is absolutely about trying to avoid the need for people to come anywhere near hospital. That is all about community response and primary care. Then it is what happens in hospital, and then it is discharge.

At the community primary care end, we have protected the investment in primary care and community care, and continue to do so. You are absolutely right, of course, that catching up with the backlog in elective has meant that more funding has gone into secondary care, particularly over the last couple of years, but we have none the less continued the commitment that was made in the long-term plan back in 2019 to continue the investment in community and primary care. This year that has been particularly around things like urgent community response. Again, we are ahead of the targets on seeing 70% of people within two hours. We have also invested in virtual wards, which we have talked about already. There are things like same-day emergency care. That sits in secondary care, but it is often managed in a joint way with community colleagues. I was up in Hull the other day at the Jean Bishop centre, seeing how they have moved services out into the community for older, frailer people. A big investment in frailty has gone in nationally as well. All of those things will be crucial pieces of the jigsaw to help keep people well and out of hospital.

You mentioned slips and trips. That is another great example of where we are now using AI in real life. We have places that have put sensors—obviously in agreement with patients—on things like kettles, doors and fridges to flag where people's behaviour has changed, as well as things like slip mats. There is a much earlier response to people. We had community falls response services set up last year and they have expanded this year. All of that package is crucial, as is the continued investment in primary care access. This year a lot of the focus at the moment is on things like cloud-based telephony. We now have 80% of practices with cloud-based telephony in place; it was 50%. We are just trying to continue to make it easier for people to access their GP when they need to.

You also mentioned social care. That is the other big part of our plan for winter. The Government have put additional funding into social care. We continue to work really closely, which is what integrated care partnerships, in a sense, are uniquely well placed to do. They bring together not just social colleagues but voluntary sector partners as well. The focus on discharge remains. Earlier, we were talking about some of the pressures on the health service. We still have 12,000-plus people in hospitals who do not have a medical need to be there. We are continuing to focus, in partnership, with colleagues to make sure that when people are able to leave, they have the right support to be able to do so. That is an absolutely crucial part of our plan.

***Professor Sir Stephen Powis:*** Taking prevention a little bit wider, I am absolutely certain that an increased focus on prevention in its widest sense will be one of the key ways that we address the demographic challenge that I mentioned earlier. There is no doubt that preventing ill health is much better than treating ill health. The more that we can extend healthy lives and squeeze the years of ill health into the later part of lives, the better. There will be less pressure on the NHS and, of course, it will be better for the individual. In cardiovascular disease, focusing on blood pressure control, detecting atrial fibrillation and treating, where appropriate, with blood-thinning medication will prevent strokes and heart attacks. It will prevent in a relatively short period of time. You do not have to wait years to see an effect.

There is much to be done in the prevention field. It is not just about primary care. The chief medical officer and I have, for the last 18 months, been banging on that this is everybody's business. It is not just GPs. It is secondary care doctors as well. Of course, within primary care it does not have to be just GPs. There are many members of the multidisciplinary team who can focus on prevention. Indeed, community pharmacies are increasingly focusing on blood pressure control and on detecting ill health earlier. There is an awful lot that we can do in this space. As I say, I am absolutely convinced that it is one of the things that we need to completely focus on. For instance, the Prime Minister's recent announcement to bring forward legislation on smoking is welcomed in this space. Smoking still has a huge impact on ill health. I obviously urge parliamentarians to vote for that legislation when it comes through.

Q22 **Rachael Maskell:** We certainly will. My final question is about ICBs. Clearly, they run and they are embedded. Are they delivering to your expectation, or is the tug of war continuing between NHS England and the commissioners and partners out in the area? In particular, is the strategy and accountability around the governance in the right place to ensure strong accountability and strong delivery?

***Amanda Pritchard:*** We recognise that ICBs are still relatively new organisations. They have only been in existence for a year and a half. What they have enabled is a real tidying-up of the commissioning landscape. We have gone from 150 CCGs to 42 ICBs and ICSs. We have a structure that bakes in partnership at ICS level as well as at ICB level in the NHS family.

Nationally, that has enabled us to work really closely with the 42 ICBs. I would not recognise any conflict between what we are trying to do nationally and what they are trying to do locally. What they do, though, which is important, is to provide real local ownership of a population-based strategy, which of course gives them the important multi-year view—speaking to your point exactly—about prevention and what things will address the longer-term needs of a population, as well as working with partners on the things that will make the biggest difference now.

Q23 **Rachael Maskell:** To draw on an example in NHS dentistry, which is a

particular issue for my constituents, certainly speaking to the LDC as I have done recently, they say that they are very restricted in what they are able to deliver through the ICB. The hand of NHS England is still hovering above the ability to deliver a comprehensive service locally. Do you recognise that picture? What more needs to be done to release the ICBs so that they can fulfil their requirements and deliver the service that is needed?

***Amanda Pritchard:*** Dental commissioning is one of the things that is delegated to ICBs, but they have to operate within the dental contract, which is mostly subject to Government regulations. We agreed with Government a set of changes to the dental contract last October/November. I would not want to overclaim—they were incremental changes—but they allowed some of the things to happen that the dental profession had told us really mattered. There was a change in the weighting of some of the UDAs, which allows more of the dental team to do more of the work, and various other measures.

We can see clearly in the data that that has led to an increase in dental activity this year. It is disappointing though, I think we would all recognise, that the dental budget is still underspent. The way it works is that the dental budget is given out to the providers of dental services. It is then given back at the end of the year if it has not been fully utilised. At the moment, it still looks like we are on track to underspend that budget. We would very much like to see it fully utilised. We know that there is a lot of demand out there which at the moment is not being met.

We are working with Government on a next round of reforms that will, hopefully, make things easier in contractual terms. Obviously, the other big thing for us, as you have seen, is to make sure that the workforce plan speaks to the future of the dental profession, training more people and working as part of an oral health team, rather than the way things have perhaps worked in the past. There should be a focus on making sure that we encourage dentists and oral health teams to the parts of the country that are currently under-served. All of that is a really important part of the long-term workforce plan as well.

**Rachael Maskell:** Before I hand back to the Chair, I plead that the underspend is not clawed back but can be invested in greater flexibilities for the dental service.

**Chair:** I echo that. We said that in our dentistry report. The new Dental Minister—I am not entirely sure where the shakedown lays that at the moment; he or she will be delighted if it is them—is going to have to solve this. They are going to have to solve it with the Treasury. Alongside the waiting lists, access to NHS dentistry is probably the biggest issue that faces all of our constituents right now. Anyway, sermon over.

You mentioned the workforce. This is the perfect moment to bring in James Morris, who is going to talk about that.

Q24 **James Morris:** We have been talking a lot about the short-term

pressures in the NHS. Obviously, the Government published a long-term workforce plan which they have championed a lot, but we have heard about having to reprioritise spending on digital, and so on. The underlying assumption in the long-term workforce plan is a productivity improvement of between 1.5% and 2% per year in the NHS. Is that remotely deliverable?

***Amanda Pritchard:*** Yes. You are absolutely right that the long-term workforce plan bakes in an ambitious level of continued productivity gain. It was also explicit in the plan that the things that would be required to deliver that were, particularly, a continued commitment to invest in technology and digital data and, secondly—

Q25 **James Morris:** But is it deliverable? Is it realistically deliverable in the context of the short-term pressures we face? At the moment, digitally, the NHS is a long way from where it needs to be to deliver that productivity improvement. Isn't that the real case?

***Amanda Pritchard:*** To finish my sentence, it is the estate, the state of buildings. Both of those things were important.

It is worth saying on productivity that we have a fairly blunt tool at the moment in the way that productivity is measured. It is particularly focused on measuring what happens in acute trusts. Even then, it does not fully measure everything that happens. For example, it does not fully take account of critical care or diagnostics, where activity is up. It does not take account of all the activity that happens. It does not take account of where investment has specifically been made to improve quality; for example, this year we have put in £165 million for maternity staffing on the back of Donna Ockenden's work.

Q26 **James Morris:** I understand that. What is actually in the long-term workforce plan as an assumption is an improvement of 1.5% to 2%. What I was asking is, is that remotely deliverable? Whatever way you measure it, that is in that plan.

***Amanda Pritchard:*** That is why I thought it was important to say how productivity is currently characterised. At the moment there is a misunderstanding about the state of productivity in the NHS because it is measured in a way that does not fully reflect either what happens in acute trusts or the quality of investments. Crucially, it does not reflect what is happening in community care. It does not count things like virtual wards. It does not count all the community activity that we were talking about a moment ago. It does not reflect some of the innovation and the ways that we have evolved services for the benefit of patients, using things like technology. The start point would be to say that the way that productivity is measured in the NHS does not reflect the way that activity is provided, or services have evolved.

Q27 **James Morris:** What is the definition used in the workforce plan? Is it the one that you are challenging?

***Amanda Pritchard:*** At the moment the productivity challenge for the NHS, if you take into account all of those things, has the start point of an NHS which is doing far more work, and differently, than it was pre-covid. That does not mean there are not still productivity challenges, but it is just a very different baseline from which to build. But the build is dependent on continued investment in those areas.

Q28 **James Morris:** The reason I am pressing you is that, if it is not delivered, whatever way you may define it, we are just going to be running to stand still. Even if you add additional people over the period of the plan, you are just going to find that the plan unravels because we are not achieving what we need to achieve, particularly with the state of digital transformation in the NHS, which, as our recent report made clear, is not in great shape. If we are cutting digital transformation in order to deal with short-term issues, how are we going to deliver on this plan?

***Amanda Pritchard:*** On digital it is worth saying that the amount of funding that is being reprioritised into next year is comparatively small compared with the total amount of investment that is going into digital services. Some of the really big things that have been driven forward this year have been the NHS app, which now has massively more functionality. Just last month over 3 million people changed their appointments using the app. It is not just about the things we often talk about, like repeat prescriptions. It is being used much more than that; 90% of trusts have now reached frontline digitisation. We have an EPR challenge which was crucial if we were going to be able to build from it and do things like data sharing off the back of that. Similarly, we have some important but less obvious things going on around shared care records and things like that.

There is a strong story over the last few years of investment and delivery around digital infrastructure. There is also a strong story over digital innovation. I have talked about some of the AI things that we are putting into practice just for this winter. Again, Steve might want to talk about them. We have examples across the NHS of where we are really embracing innovative technology, everything from bed management systems to AI. But your point is right. We are going to need to continue that level of investment and focus on digital. We are going to have to recognise that often the implementation of new technology creates a hiatus and causes short-term challenges before you see the medium to long-term productivity benefits.

Q29 **James Morris:** Professor Powis, can I ask you the same question? Is it deliverable? Is what is currently in the long-term workforce plan deliverable, or is it not?

***Professor Sir Stephen Powis:*** It is perfectly possible to make productivity gains.

Q30 **James Morris:** Of 1.5% to 2%?

***Professor Sir Stephen Powis:*** With the caveats that Amanda has given. Sometimes where we are making those productivity gains is not where we measure productivity, but we would all recognise that things like virtual wards and the transactional costs that are removed from using digital to interact with your GP or the hospital are productivity gains. They do not sum up in the way that we would want them to sum up into the figures that we produce.

The better point is to ask, "Where is it possible to make those productivity gains and how can we work with clinicians and systems to drive that productivity?" There is a perfectly legitimate debate as to how you measure productivity, which, in a sense, could possibly become a distraction. What we need to focus on is what are the areas in which we can quite clearly see that we can do more for the same, or for less.

People think of this much more in terms of a value equation—quality over cost. Clinicians will buy into the productivity of providing high-quality care at less cost. Sometimes it turns them off a bit because it feels a little bit too industrial, but every clinician will want to deliver higher-quality clinical care. None of them will argue that doing that at a higher cost is better than doing it at a lower cost.

Q31 **James Morris:** I understand that. What I am trying to get at is this. In the long-term workforce plan, particularly around digital transformation, it clearly states and envisages a transformation in digital productivity in the NHS in order to deliver. Is that really going to be delivered? Has it got a remote possibility of being delivered?

***Professor Sir Stephen Powis:*** Productivity gains are possible with the right enablers in place. The broader enablers are technology and estate. They are not the only enablers. There are other enablers as well. Simply having a workforce that is more permanent is an enabler to better productivity. We can get caught up on the headline figures. Productivity, of course, is challenging but it is the right challenge to have. There are plenty of opportunities and plenty of examples of where we can drive productivity. There are plenty of examples where clinicians, even if they might not realise that they are actually driving better productivity, are driving better productivity by innovation.

**James Morris:** I will leave it there, Chair.

Q32 **Chair:** A brilliant line of questioning. It is a very key point. It is why this Committee under our previous Chair, now the Chancellor, was very clear that we felt there should be an independent verification of the workforce plan. Going forward, where will its staging posts be on you judging its effectiveness? It has now been out for a while. Will it be a year on that somebody will do a verification of progress?

***Amanda Pritchard:*** We have very clear milestones for this year, next year and the year after. We expect to be able to be transparent. Much of that is about the numbers of people we would be training, but there are sets of outcomes against all three areas.

***Professor Sir Stephen Powis:*** It was four months in July/August that we were into a 15-year plan. It is always worth remembering that it is deliberately a long-term workforce plan. The Prime Minister was quite clear when he announced and introduced it that it was looking across multiple parliamentary cycles, and that it was the right thing to do. It is important that we should not lose sight of that. Some of the things in it will take time to deliver. It takes time to deliver new medical school places. We will make a start next year. If we are to create new medical schools, you cannot create them overnight. It takes time to create extra capacity. It takes time to train people.

Amanda is quite right and you are quite right to challenge some things, particularly on the retention side, that we need to get on with, but there are some things in the plan that will take a number of years to come to fruition. I don't think we should be backward or apologetic in saying that that is the case because it is deliberately a long-term plan that will take multiple years to deliver.

We have made a good start. Of course, one of the key features of it is the ask from the Treasury, which we entirely agreed with, to iterate it and refresh it every two years. As you know, the practice of medicine is going to be different in 50 years' time than it is now, for all the reasons we have been talking about around innovation and technology. It is right that we continue to refresh and redesign bits of it as medicine evolves, but the key thing is to have it, as this Committee has pushed for over many years. The key thing is that we have it.

**Chair:** We are going to go off in a different direction now with Paulette.

Q33 **Mrs Hamilton:** Good morning, both. This morning I will be asking questions around leadership and whistleblowing. As you know, the leadership of the NHS has come into the spotlight, especially over the last year, with some of the things that have happened. My first question is about the Kark review and the fact that it had the power to disbar directors for serious misconduct. What is the scope and the timeline for this work? What progress has so far been made relating to this piece of work?

***Amanda Pritchard:*** This is hugely important because we recognise, as people who have been in the health service for a very long time, that people do not always get it right. We need to have appropriate accountability and safeguards as well as the appropriate support, training and investment in our leaders to make sure that they are able to do the very complex roles we ask them to do. We recognise, of course, that the NHS is far and away majority-led by clinicians. At last count, 19 out of 20 of our leaders were clinicians. It makes the importance of on-the-job training even more apparent.

As far as Kark is concerned, there were five recommendations particularly related to the NHS, not including those relating to social care. We have now implemented four of them. This summer we launched an updated

version of a fit and proper person's test, with a whole range of additional asks around it. That includes an annual refresh and an annual attestation. We have also introduced things like a reference that the chair will do for a chief exec and a formal reference for board members that will stay on a permanent record until they are 75.

We had agreed that range of things with Government. It meant that as far as disbarring was concerned, which will need additional legislation because it needs a level of regulation to be introduced, the right thing to do was to get on with the four that we could do, and which should have the same impact. If you have done something so heinous that you would be disbarred, that would be picked up in the reference which should prevent you from then moving to another senior role in the health service. That would then be reviewed once the package had had a chance to embed.

In light of the truly horrific crimes that Lucy Letby carried out at Countess of Chester, and the questions that were raised about the strength of leadership, we have certainly undertaken, with the Government, to ask whether we should bring forward regulation of managers and look at that again in light of what has happened. My sense from roundtables—we have had a number of conversations about it—is that while it is very complex and would ultimately require legislation because it is a matter for Government, actually it is the right time for us to look again at whether there is value in a more formalised regulatory approach.

Q34 **Mrs Hamilton:** Do you want to add anything, Professor Powis?

***Professor Sir Stephen Powis:*** Both Amanda and I have been on the record to say that we would support looking to go further in regulation for management and leadership in the NHS. Amanda has already made the point that many of the managers and leaders in the NHS have a clinical background and are therefore already in regulated professions. I am in a regulated profession. I am regulated by the GMC. As I don't see patients any more, the entirety of my regulation by the GMC pertains to my role as medical director of NHS England. It is my management and leadership roles that are subject to regulation by the GMC. They can scrutinise those at any time. My annual appraisal is based on my performance as NHS medical director. Many of us in leadership positions are already used to working within that regulatory framework and I support its being extended to those managers and leaders who are not already in regulated professions.

The other point is that you started with a disbarring question, which is really important, but regulation is so much more than the ability to disbar. It is around setting codes of practice and standards. It is around providing professional support; the GMC revalidation in the case of doctors provides a supportive professional development framework for me to feel each year that I am having an appraisal and that my professional development is being taken account of. This is about helping managers become better managers, both at the entry point into

management and throughout their career, as much or even more so than the disbarring element, which is the minor part of the role of any regulator.

Q35 **Mrs Hamilton:** Do you not think it is an important part?

***Professor Sir Stephen Powis:*** It is a very important part.

Q36 **Mrs Hamilton:** I shouldn't really be thinking about these incidents, but the ability to disbar somebody who is not good enough should be there.

***Professor Sir Stephen Powis:*** It is a very important part, but the point I am making is that regulation in its totality is much more than that. In fact, regulation done well should minimise the risk of people getting to the point when they are in a position where they face the possibility of being disbarred. It is about supporting managers and helping them be better managers so that they do not get into that position.

***Amanda Pritchard:*** The strongest single thing I have heard from multiple conversations with colleagues across the NHS about this is that standard setting, continuing professional development and education and support, as well as clarity of accountability and consequences, would be the real benefit of a regulatory approach.

Q37 **Mrs Hamilton:** Thank you. Moving forward a little bit, Sir Gordon Messenger did a review in June 2022, which had seven recommendations, with impacts on training, staff development and management. Do you have any further plans in that area? I felt that the review was very important, but not a lot seems to have happened since.

***Amanda Pritchard:*** We have absolutely continued to work on implementation of Gordon Messenger's review, despite the fact that there have been various changes of political leadership since then. Not a single one of the Secretaries of State who has come in has said that it is unimportant. We have continued to have Government support for the implementation of the work. At the moment, we are working on things like the induction. That is one of the specific recommendations, as well as the competency framework. That is another of the early priorities.

Where it links to regulation—Steve has heard me say this before—is that if you are a clinical professional, part of the commitment that is made, and is partly required because of the regulatory framework, is to your ongoing professional development. There is an allocation of funding that is theoretically available every year to do that. If you are moving into a more formalised management role, actually you may or may not get ongoing development funding to gain the skills that would take you from being an expert consultant to a medical director or a chief executive. Coming from a non-clinical route, you may or may not get any support at all. Part of what we need to link between the work that Gordon Messenger described in his review and the potential for regulation is recognising that, if we are to get the calibre of leaders that we need in the NHS, investment in their education and training, as well as the

standard setting and the accountability, is crucial. I would very much like to see that work prioritised.

Q38 **Mrs Hamilton:** There is something there that leads into my other question, so I am going to ask it now. With the pressures on the budget in the NHS, will there be some sort of protected budget to ensure that if you are bringing through your leaders, you are training them, developing them and ensuring that they are monitored so that they do not become rusty or feel they are acting within bubbles, not being challenged re improvement? Do you feel that the budgetary restraints in the NHS will cause a problem in this area?

***Amanda Pritchard:*** As it stands at the moment there is no protected budget for that. Again, that is potentially one of the reasons why it makes sense to look at regulation. That moves us from something where it is optional, to something where there would have to be an ongoing commitment. It is none the less, with the team that I have at NHS England and with the commitment of colleagues across the NHS, still something that we seek to prioritise despite those financial constraints.

Q39 **Mrs Hamilton:** My last question in this area is again about money. If you want quality, you have to have a programme in place. If that programme is in place, it has to be budgeted for. If, at the moment, you are struggling to have the budget to put the programme in place—I will ask the question again—how are you going to get the best leaders we can have in that area in the 22nd century and ensure that they are going to be up to speed on things like AI, and everything that is coming on board, to manage that work? There is equality, inclusion and diversity. We have to ensure that our leaders are up to speed. How will we do that when, at the moment, it is good will, Amanda? If you are no longer there, the priorities of the next chief might be completely different.

***Amanda Pritchard:*** This is hugely important to the NHS. I think you have put it brilliantly. My view at the moment is that we do not do enough to bake in a continued expectation. We should have high expectations of our leaders, but if we are to have high expectations, we have to bake in an expectation that there will be ongoing training and development and that it will be high quality, assessed and give people the skills that they need to do the jobs well. These are big jobs that we are asking of people. What Gordon Messenger said in his review, which again I strongly believe is right, is that it has to be career course, not just people at one end, either entry or really senior. It has to be something that is career life course.

I would not be surprised if the Thirlwall inquiry into what happened at Countess of Chester and beyond focuses on this as part of their work. Equally, it is something that Gordon Messenger has already highlighted. Within the resources that I have at my disposal, we are making sure that we continue to prioritise the implementation of the Messenger review, but I would like to see that go further.

***Professor Sir Stephen Powis:*** Can I say one thing about medical leadership?

**Mrs Hamilton:** Yes.

***Professor Sir Stephen Powis:*** Anybody of my age and generation in medical leadership will tell you that we did not go through any structured training programmes to become medical leaders. We had to work our own way through. We are all determined that that does not happen for future generations of medical leaders. We are absolutely determined to put in place the sort of structured training programmes that young doctors can go through and look to, to become better medical leaders in the future than we are.

A wonderful example is the national medical director's clinical fellow scheme. Many hundreds of people have gone through that scheme; there is one clinical fellow in the room with us today because you, as a Committee, host a clinical fellow every year. I am very grateful to the Committee for doing that. It is infinitely better for the next generation of medical leaders than it was for us. It is that sort of commitment from the leadership of today to put in place those sorts of schemes and support them that will ensure that the people who follow us will be even better than we are.

Q40 **Mrs Hamilton:** My last couple of questions, quite quickly, are around whistleblowing. I am a nurse. I will be honest that when I was a jobbing nurse you were virtually seen as a leper if you were a whistleblower. It was a difficult position to be in. What is your assessment of the effectiveness of provisions at the moment for people who want to whistleblow but also to protect patient safety?

***Professor Sir Stephen Powis:*** The first thing is that raising concerns is really important, because this is around the ability to raise concerns, whether through a whistleblowing route or simply to a colleague or somebody who is managing you or managing a team. First and foremost, it is cultural. It is about creating an environment where everybody feels comfortable to raise a concern, such as a nurse in theatre who believes that a swab is missing and needs to raise it with the team. It is creating the culture where nobody is afraid to come forward and say, "Hold on a minute, I think there's something that isn't quite right here."

There are many ways that that can be done. One of them is through the more formalised whistleblowing route. The freedom to speak up guardians that we have introduced in recent years are an important component of that. They are still evolving and developing, but wherever I go I know that they are valued; they are in place and people are increasingly using them. The ability to speak up, confidentially and at times anonymously if you need to do that, is really important. As a senior leadership team in NHS England, as I know are our colleagues throughout the NHS, we are determined to ensure that that ability is in place but, more importantly, that we create the culture where people are not afraid

of speaking up and see it as the right and normal thing to do. It is only by doing that that safety issues can come to light. It is only when people feel that they are supported in doing that—we know this from many other industries—that we can avoid harm.

Q41 **Mrs Hamilton:** This is absolutely my last question. You have talked about culture. We know that there are sometimes some systemic weaknesses in the system. How would you protect a doctor, nurse or physiotherapist? How would you encourage them to speak up? You have talked about the management side of doing it, but I would like to know how you would protect them and support them. What are you encouraging your leaders to do in hospitals, ICBs or wherever to ensure that they implement some of these new ways of thinking?

***Professor Sir Stephen Powis:*** A lot of this overlaps with the leadership conversation that we have just had. I think one of the most important things about leadership is role modelling. Leaders who create the environment within their organisation, whatever that organisation is, and of course there are many different constructs within the NHS, create a leadership culture and a role model encouraging people to come and speak up, both through informal routes and formal routes when required. That sets the tone. I don't think you can dissociate the leadership question that we have just been discussing and the role of good leadership from the cultural discussion that we have just been having. Within that sits the ability for people to feel that they are supported in speaking up.

**Mrs Hamilton:** Thank you both for that. Thank you, Chair.

Q42 **Paul Bristow:** Good morning. I direct the Committee to my entry in the Register of Members' Interests.

Do you think NHS England has been an effective commissioner? I am thinking around specialised commissioning.

***Amanda Pritchard:*** In terms of specialised commissioning?

**Paul Bristow:** Yes.

***Amanda Pritchard:*** I am not sure where your question is going in terms of the specifics, but specialised commissioning is one of the areas where we have probably had the most obvious track record of making a difference to patients' lives. Specialised commissioning in particular is often the area where very small numbers of people are impacted by some really life-changing—

**Paul Bristow:** I don't disagree with you.

***Amanda Pritchard:*** —abilities to roll out new services at scale across the whole of the country. It has been something that specialised commissioning teams have done very well.

Q43 **Paul Bristow:** I don't disagree. I just wonder whether you think it is the right thing to be handing specialised commissioning functions down to

ICBs.

***Amanda Pritchard:*** Ah. Okay. We are still in the process of working through whether or not now is the right time to go for a model with devolved commissioning responsibility. Where we might end up, although we have yet to fully work it through, is potentially a mixed model. Some ICBs have very advanced plans, are very clear and have a lot of strength in local commissioning arrangements, which would still of course be bound by national service specifications and national oversight. They are keen to go further because they believe that they can make a difference to patient pathways. I used to work in south-east London, and I know their arrangements well. South-east and south-west London are areas that would be keen to go faster.

There are other ICBs where they have already said to us that they do not think they are ready. One of the things we are working through at the moment is what the right balance is between where there is local expertise and people having advanced skills and plans. We want to see them able to drive things, but what we definitely do not want to do is introduce a level of unwarranted variation or risk at a point which would not work for patients.

Q44 **Paul Bristow:** If you feel that NHS England has been an effective commissioner, why are we changing specialised commissioning? Why is there the need to do that?

***Professor Sir Stephen Powis:*** There is a group of conditions in specialised commissioning that have always been at the margin of local commissioning and national or regional commissioning. In my many years of career in the NHS—I am a renal physician by background and a kidney specialist—for instance, dialysis provision has been one of those areas where I remember many debates and conversations about whether it should sit at local level or at a higher level, whether that is regional or national.

That is the right debate to have. There is a strong argument for those services to be commissioned at a local level because of the nuances and the importance to the local community. There is a set of specialities, predominantly those at lower volume and which are much more specialised, such as liver transplantation in my field, for instance, where you would always say, "This is much better set at a much higher level."

This is the approach we are taking at the moment. We are focusing on the conditions at that boundary. If the conditions are right and the construct of ICBs is obviously structured so that they sit at that local interface, bring providers together and have the right interactions with local government, under the right circumstances those sets of conditions mean it is perfectly plausible for them to be commissioned at local level. Remember, we still hold the legal accountability for these services as well. We are devolving the commissioning, but we still hold accountability.

Q45 **Paul Bristow:** You will be aware that patient organisations, clinicians and industry have significant concerns about regional variation.

***Professor Sir Stephen Powis:*** Yes.

Q46 **Paul Bristow:** We have seen it with NICE guidance and all sorts of other things. Huge regional variations exist in access to treatments and therapies. How are we going to prevent that?

***Professor Sir Stephen Powis:*** That is always the tension between doing one size fits all nationally versus local accountability. The key is to get that balance right. It is one of the reasons why it is important that we still maintain the accountability for specialised services. If we feel, in the case of specialised services, that that variability is too great, we would not be getting the balance right.

Q47 **Paul Bristow:** Are you saying you do not think we have the balance right at the moment?

***Amanda Pritchard:*** In my earlier answer, I said what I think we have done well on specialised commissioning. If I was to give you the shortcomings, it is clear that at the moment you are more likely to get access to specialist services if you happen to live near a provider of specialised services. If you look at it on a population basis rather than a geographical basis, that cannot be right.

For example, if you live in Lambeth and Southwark your chances of getting highly specialised cardiac care are greater than if you live in Kent and Medway. That is not likely to specifically reflect the population who live in Lambeth and Southwark. It is more likely to reflect the fact that Guy's and St Thomas's are right in the middle of that patch. There is definitely something for us about how we make sure that networks are as effective as possible so that they serve the population. Some of that is about the join-up between the highly specialised service and the less specialised service, so that it is done as a continuum of care. That is the thing that over recent years some of the specialised networks have done really well. They have made huge progress. That is one of the areas where you would hope to be able to go further down that road, to answer your question on what would be one of the benefits to moving to the kind of model that we were describing a second ago.

Q48 **Paul Bristow:** You've got a job to bring patient groups and clinicians in industry with you in that regard. Further to that, I understand you would retain the responsibility for drafting service specifications, commissioning policies, and so on. How do you intend to ensure that the process is much more transparent? I think NHS England has been accused in the past of not being very transparent about the criteria it uses. Previously, I don't think local commissioners were necessarily transparent about the criteria that they use. If you accept that, how would you intend to improve that transparency?

***Amanda Pritchard:*** Steve, do you want to talk about the clinical groups?

***Professor Sir Stephen Powis:*** Obviously, we have clinical reference groups at speciality level that will oversee that. I think we are progressing very carefully on this route. I know that our specialised commissioning teams are taking the position that we will only devolve the commissioning of this when we feel that the ICBs have reached a point where they are in a position to take it on responsibly and deal with that variation.

To give you one example, you were talking about clinical buy-in. I recently undertook a review of transplantation services for the Secretary of State. In that review the issue of commissioning for transplant services and dialysis services came up. What I heard from my clinical colleagues, having been out of renal medicine for a number of years, was that on the dialysis side and the chronic kidney disease side there was a real appetite for moving it back down into local commissioning at ICB level. There was a bit more reticence on the transplant side, to be honest, but I did not hear a set of clinicians who said that it was the wrong thing to do. I heard a set of clinicians who said, "Under the right circumstances we see there is value in this particular area of moving this once again into a much more local commissioning framework."

It is our job as NHS England to ensure that it is done correctly, properly and with the appropriate safeguards in place. One of them, which you have absolutely highlighted and is right, is that if we begin to see too much variation in the application of commissioning and the way that services are delivered, we would reserve the right to step in.

Q49 **Paul Bristow:** My concern is that innovation is often supported through one-off funds or it depends on the particular interest of a clinician. It is often iterative in devices. My concern is that quite often procurement leaders and commissioners are making short-term decisions to save money in the short term. That does not really give a saving in the longer term if you are changing a pathway. There is concern that by transferring this down to the local level you will get more of that. Do you think that is a concern, or do you think it is ill-founded?

***Professor Sir Stephen Powis:*** Not necessarily. In some of the conditions we will be working on a lead commissioner, so it will not all be devolved to 42 commissioners. There are different models in how you can work it. Some of these conditions have been under the auspices of local commissioning before.

I acknowledge the risks that you are highlighting, but I think it is manageable. I think the approach that we have been taking with our specialised commissioning colleagues within NHS England is one of doing this cautiously, properly and ensuring that we are confident that ICBs, which, as Amanda said, are still relatively young organisations, have

reached the stage to accept the specialities for local commissioning. We retain the legal responsibility for them, so we will retain an oversight role.

Q50 **Paul Bristow:** I have two more quick questions. Do you think that all NHS bodies should have multi-year funding settlements?

***Amanda Pritchard:*** I will answer, but to re-emphasise what Steve said, we are being really thoughtful about specialised commissioning. We do not want to do anything that is going to destabilise current services or, as I say, introduce unwarranted variation or risk. I leave you with the reassurance that we are not going to be rushing into this, and we are certainly not ideological about what the right answer is. We are understanding where the strengths are and what we can do to continue to develop services. The transparency point is incredibly important to us, which is why the clinical groups play such an important role.

On multi-year funding, we would always welcome—I know I speak for colleagues across the NHS—as much certainty as possible, not just in revenue funding but on capital as well. We recognise where we are at the moment in the spending review cycle, but certainly the more that we can move towards longer-term planning, the better.

***Professor Sir Stephen Powis:*** The long-term workforce plan is a great example of that. Again, thank you to the Committee for pushing that over a number of years. Over and above the workforce element, there is the principle of looking sufficiently far ahead to give certainty. There is a five-year funding envelope to start with, but we would all agree that having the workforce plan in place commits subsequent Governments to take account of it. We would very much welcome conversations around capital expenditure and tech expenditure, of course, which is part of that. It goes back to the discussion we had earlier about tech funding. Having the certainty that that funding is going to be in over multiple years would be a great step forward for the way that the NHS works.

Q51 **Paul Bristow:** I have one final question. Some therapies, approaches or patient pathways are no-brainers. What are we going to do to ensure that mechanical thrombectomy is offered across England 24/7?

***Professor Sir Stephen Powis:*** That is where we are making progress in some areas but not in all areas. In London, for instance, our ambition to achieve 10% of patients with thrombectomy is pretty much there, but in places like the east of England it is not at the moment. Part of it is around workforce because mechanical thrombectomy requires somebody with the skills to be able to put a catheter into the artery to the brain and fish the clot out. That is a technique that interventional neuroradiologists are trained to do. That is a limited workforce. We are growing that workforce. We have increased training numbers—

Q52 **Paul Bristow:** Interventional cardiologists do that job as well.

***Professor Sir Stephen Powis:*** I am incredibly keen for us to put in place systems for interventional cardiologists to do that as well. I know

that there are interventional cardiologists who wish to do that. We have been working hard with the Royal College of Radiologists to put in place a system of credentialling, again with the General Medical Council, so that we have a process in place that would allow cardiologists to be trained. It is a little bit different. Cardiologists obviously put catheters into the heart, but the anatomy of the brain is a bit different, so you have to do the training. That credential is now in place. This a four-nations approach. The next step is to get in place the programmes and get cardiologists on those programmes.

It is a combination. It is growing the interventional radiology centres with interventional neuroradiologists, but it is also allowing other specialties—cardiology is the prime example—to extend their skills. That is absolutely the solution and is absolutely what we are doing at the moment. It is also around the commissioning process. It is about us ensuring that we have commissioning in place that will support those neuroradiology centres.

Q53 **Paul Bristow:** I just want to leave you with this. It is not a question. I find the development of mechanical thrombectomy services across the country to be a must. There is a comparison to primary PCI, which happened more quickly and with much more political focus and backing. I find the development of the two very striking and very similar.

***Professor Sir Stephen Powis:*** I am frustrated that it has not occurred as quickly as it should. It was an ambition in the long-term plan. It is still an ambition. Clearly, we have had a pandemic in the middle of it. I would have to say that that has set us back a bit, but we are completely focused on achieving the thrombectomy rates that we need for the population. Of course, the evidence base for mechanical thrombectomy is improving all the time. The window in which you can do it is now longer than the window when we first looked at this five or six years ago.

***Amanda Pritchard:*** Could I use this opportunity to give a shout-out to the team in Hull that I visited last week? They are a blended team doing exactly what you have just described. They tell me that they are now doing the second highest number of mechanical thrombectomies in the country.

Q54 **Paul Bristow:** If you are going to have a stroke, go to Hull.

***Professor Sir Stephen Powis:*** I oversee the stroke problem at NHS England. We do that in partnership with the Stroke Association. The chief executive of the Stroke Association is holding my feet to the fire on this. I am determined to move ahead with thrombectomy for the reasons that you have stated.

**Paul Bristow:** Thank you.

**Chair:** Very interesting; thank you. For the final 10 minutes we will go to Caroline Johnson.

Q55 **Dr Johnson:** I want to bring you back to a couple of things that have

already been raised today—productivity and training. Of course, training and productivity are welcome, but I want to take you back to when the covid vaccination scheme was first brought out. There was a bit of an upset because people were asked to do a whole load of mandatory training schemes. It was highlighted how not very useful much of that stuff was. It was ultimately decided, I think by the Secretary of State at the time, that it would not be necessary for people giving covid vaccines to go through the full suite of mandatory training.

Currently, looking at my ESR profile this morning, I have to do 29 different mandatory training programmes, some of which I have to redo every single year. I want to read you a couple of questions. I read them to my eight-year-old and he could answer them. Questions that we would be asked are things like, "What must you do if you receive a phishing email? Choose the correct option." Options include: "Reply. Open the attachment. Forward it to your colleagues. Follow your organisation's procedures." Another question we received was: "It is important to lock your computer or mobile device when you are not using it. True or false?" We are shown pictures of someone sitting back in a chair as I am doing now: "Is this the correct position to put someone in for recovery?"

There are consultants doing these training programmes. There are pictures of two defibrillator pads on a gentleman's abdomen: "Is this the correct position to put defibrillator pads?" Why are we wasting consultants' time with this nonsense? For example, there are fire lectures. A fire lecture on the face of it makes a lot of common sense. If it was teaching me how to evacuate patients in a fire, how to keep children's safeguarding levels high in such a situation or how to manage an oxygenated patient, maybe it would be useful. I have on several occasions sat through videos that included a bonfire in a field and someone watching what happens when petrol is poured on to it. It is not a good thing to do, but it is not at all useful to anyone working in a hospital.

I am interested to know what you are going to do about it. I notice that NHS England commissioned a review. That was the CSTF review published in March 2022 in which you found that 30% of staff thought that much of the training could be merged and that for at least one course two thirds of people thought it was not useful at all. I cannot see any evidence that it has changed; I just see more and more being added to my list on my ESR.

***Professor Sir Stephen Powis:*** Even I do mandatory training at NHS England. I am completely up to date and compliant with my mandatory training, just to put that on the table.

**Dr Johnson:** So am I, 100%.

***Professor Sir Stephen Powis:*** I am going to push back a little because I think there is a balance to be struck. I think there is a need for members of staff—of course, it is not just the consultant workforce or medical workforce—to be aware of many of the issues that are covered in

mandatory training. For instance, you mentioned safeguarding as one and cyber-security. We can discuss the quality of the questions and how they are delivered, but I don't think anybody around the Committee today would disagree that cyber-security is one of the greatest risks that we face in the NHS and in wider public bodies. Ensuring that staff are aware of some of the risks around cyber-security and the dangers is perfectly legitimate. It is correct that that is part of mandatory training.

We give a fair amount of latitude to organisations in how they deliver mandatory training and what they put in. What you are getting at is around the balance. I talk to many consultants who undertake mandatory training, and I did when I was the medical director at the Royal Free, who think, "Well, what was the point of that?" and who think the questions are too simplistic, but I do not think any of them would argue that it is not right that people should understand safeguarding and some of the legislation behind it. Of course, as a paediatrician you would recognise that as well.

It is always about getting the balance right. It is not about no mandatory training. It is about ensuring that the mandatory training that is delivered is the correct mandatory training and that it is done in the best possible way and the most effective way. I tend to do an online course once a year, or whatever it is. At the Royal Free, I remember that the fire training could be done face to face. There are many ways of doing it, but I think it is about getting the balance right.

Q56 **Dr Johnson:** It is certainly true that I watched the fire lectures face to face. I remember watching that video of the bonfire with the petrol being poured on it by a couple of young lads in a field for the second time and looking around at the lecture theatre, with perhaps 100 people in it. There were certainly more than 80 people in it. I was thinking, "The NHS keeps saying it is short of money and short of workforce, yet we are all sat in a room wasting our time while we could be seeing patients."

Consultants' time is very expensive, and they are very useful at bringing down waiting lists. When a new training scheme is brought in, does anybody actually sit down and say, relative to a little bit of common sense, "Is this stuff actually useful or would these people be better off seeing patients instead?" I cannot see that that report has done anything other than gather dust.

***Professor Sir Stephen Powis:*** There is a balance to be struck. My other reflection, again from my time in a trust, is that sometimes it was clinicians who were asking that their particular area was included in mandatory training. It can be the case that groups, for very particular reasons, want things included in mandatory training because they quite rightly recognise its importance. It is about striking a balance. A world where we did not ensure that people were cognisant of the risks of cyber-security would not be a world that we would want to be in. Equally, we need to make sure that it is done at a frequency which is the right

frequency and that the time spent doing it is the right time and not excessive.

The safeguarding issues, cyber-security issues and health and safety at work that mandatory training generally covers are important. I think we have a duty as a set of collective employers to ensure that our staff are aware of them. I absolutely agree that it is about getting the balance right.

Q57 **Dr Johnson:** If you can give this to an eight-year-old boy and they can do it, you have probably set it at the wrong level.

***Amanda Pritchard:*** It is, of course, entirely right that organisations need to take responsibility for the quality of the training.

Q58 **Dr Johnson:** It is NHS England training. It has the branding at the top.

***Amanda Pritchard:*** I will absolutely undertake to review anything we are doing nationally to make sure it is appropriate. Anything that is designed for all staff obviously also has to be accessible and has to work for everybody, but I take your point on fire training. I have to say that when I was working at Chelsea and Westminster and there was a fire at the neighbouring Royal Marsden Hospital, they were very pleased that they had done their fire training. I don't think they spent much time watching bonfires. I think they would have pointed to exactly the point you have just made about relevant in situ training being invaluable.

Steve is right. We will undertake to ensure that we follow up on the actions from the review that you have mentioned. Perhaps we could write back to the Committee and give you an update on what has happened.

Q59 **Chair:** We would like that.

***Professor Sir Stephen Powis:*** Typically, the question element of mandatory training is the bit at the end to complete the course. The important bit is the body of information that is provided prior to the questions at the end.

Q60 **Dr Johnson:** Which most NHS England stuff, thankfully, allows you to miss. One of the other challenges with it is that, because the questioning is so banal, quite a lot of people just do the questions and do not read the things, so because the quality is so poor the training is not being delivered as you would wish. Fire training for someone whose job is to press the button and make sure no one else goes in there is very different from the fire training of the medical staff who are going to be leading the evacuation of patients. It should be different, depending—

***Professor Sir Stephen Powis:*** I entirely agree that we should constantly review the quality of the training and how it is delivered, but I think it is important that we deliver some mandatory training to staff. That is what a responsible employer would do. It protects all of us.

Q61 **Dr Johnson:** My other question is about community paediatric care. My

feeling as an acute paediatrician is that it has been a Cinderella service. It is struggling, I think it is fair to say. One of the effects of its struggling has been the development of these referral management structures, where consultants cannot just refer any more but have to fill in lots of forms with all sorts of information administratively that they would not normally have needed to do. The delays in appointments mean that patients are ending up in the acute paediatric sector, using acute paediatric appointments, which in itself is not the right place for those children to be assessed. The appointments are not long enough for the children to get proper assessments. There is obviously an effect on the demand in those services as a result. Are you aware of the challenges faced in acute paediatric care and the knock-on effect on acute paediatrics, and what are you doing about it?

***Professor Sir Stephen Powis:*** I will give you chapter and verse on community paediatrics, although I am happy to write with more information. The wider point of community services in the round is something that we recognise is an area on which we must provide more focus. The opportunities that you have just described are in the context of children. I think there is a lot of opportunity in adults as well for better management of patients in public and community settings. In a sense, that is often the bridge between acute care, primary care and social care. Amanda and I agree with colleagues at NHS England that community service is something on which we need to place more focus. I am very happy to provide more information specifically on community paediatrics.

Q62 **Dr Johnson:** Thank you. If you have an infant, a new-born baby, with a syndromic condition, for example, who is going to have developmental challenges, and you wait 18 months for the community paediatric support and end up in the acute paediatric sector for an appointment because the GP does not know what else to do, and then you cannot provide those services because you are in an acute paediatric service, the child's ability to get all the speech and language, physio, OT, development and parental support, and so on, has been missed for a huge period of time relative to the child's developmental windows.

***Professor Sir Stephen Powis:*** Those time-sensitive conditions, which of course are particularly pertinent in childhood and young adults, are something that we absolutely have a focus on for all the reasons you have just stated.

Q63 **Dr Johnson:** My final question is about theatres. One of the longer waiting times that you have are for things like orthopaedic surgery. There are a lot of people waiting for operations. Some of them, as we have heard, are going private as a result.

I was talking to a consultant orthopaedic surgeon about that. He works mostly in the NHS sector and does a day a week in the private sector. He does knees and hips. He told me that in an ordinary day at his NHS practice he does four operations. In a similar length day at the private practice, he does six or seven. That is a huge productivity gap. I know

there will be arguments made about patient case mix, but there clearly is not enough difference in patient case mix to warrant that level of productivity difference. Are you aware of those challenges, and what are you doing about them?

***Professor Sir Stephen Powis:*** Yes. It is back to the productivity question. It is one of the areas where there is huge focus on theatre productivity at the moment. Our GIRFT teams are particularly focused on driving theatre productivity. Sitting underneath it is a whole host of things. You mentioned case mix as one. There is also flow into theatre. I was in Weston General Hospital in the south-west a few weeks ago. They had changed the way that they were managing the transport of patients from the ward into theatre so that there wasn't a gap between cases any more. Simple things like that can make a difference.

Clearly separating theatre activity into cold sites rather than acute sites helps as well. There is a whole bunch of things on theatre productivity, but you are absolutely right that it is one of the areas where we think there are additional productivity gains to be made. We have teams providing support. This is around providing support, particularly to hospitals. As often in the NHS, it is showing people where it is being done elsewhere at a higher level of productivity. Usually, when you do that, clinical teams take it on board.

I know from experience, as you will, that it is often very frustrating for surgeons, and anaesthetists, that they cannot get their next case in as rapidly as they want. I agree with you and can reassure you that we have a huge amount of focus on that at the moment.

**Dr Johnson:** Thank you.

**Chair:** That's brilliant. We have really covered some detail. If you were looking at the themes of this session, it would be around the workforce and waiting lists and productivity. James Morris and Caroline Johnson have really dug into that.

We have a couple of pieces of correspondence coming back from you in response to Dr Johnson. I guarantee you that she will follow up on it if you do not, particularly around the mandatory training point. Her point was that you have a lot of balls in the air and a long waiting list. You have to prioritise your people, as any organisation does. Is that the best prioritisation of them? She put it better than I could, but I think that was her point and it was well made.

Professor Sir Stephen Powis, national medical director at NHS England, and Amanda Pritchard, the chief executive of NHS England, we are really grateful to you for your time. We look forward to hearing from you again and to working with you. Thank you for your time today.