

Public Accounts Committee

Oral evidence: NHS Financial Sustainability, HC 350

Monday 25 November 2024

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[Watch the meeting](#)

Members present: Sir Geoffrey Clifton-Brown (Chair); Mr Clive Betts; Mr Luke Charters; Anna Dixon; Peter Fortune; Rachel Gilmour; Sarah Hall; Lloyd Hatton; Chris Kane, Sarah Olney, Rebecca Paul.

Gareth Davies, Comptroller and Auditor General, National Audit Office, Tim Phillips, Director, NAO, and Marius Gallaher, Alternate Treasury Officer of Accounts, HM Treasury, were in attendance.

Questions 1-81

Witnesses

I: Andy Brittain, Director General for Finance, Department for Health and Social Care, Julian Kelly, Chief Financial Officer, NHS England, Amanda Pritchard, Chief Executive, NHS England, Antonia Williams, Director of Public Services, HM Treasury, and Sir Chris Wormald KCB, Permanent Secretary, Department for Health and Social Care.

Report by the Comptroller and Auditor General
NHS Financial Management and Sustainability (HC 124)

Examination of witnesses

Witnesses: Andy Brittain, Julian Kelly, Amanda Pritchard, Antonia Williams and Sir Chris Wormald.

Chair: I thank everyone for attending, in particular our witnesses. This will be a big and comprehensive session, so we have a lot of questions and answers to get through.

I extend a warm welcome to Sir Chris Wormald KCB, permanent secretary at the Department of Health and Social Care—Sir Chris, you are very welcome. You have a long-term season ticket to this Committee.

Sir Chris Wormald: I think this is No. 75, scarily.

Chair: You must almost dream about us in your sleep—hopefully you don't.

Sir Chris Wormald: It is a pleasure, as always.

Chair: Sir Chris is joined by—on my left, his right—Andy Brittain, the director general for finance at the Department of Health and Social Care; on his right, Amanda Pritchard, chief executive officer of NHS England; on her right, Julian Kelly, deputy chief executive and chief financial officer at NHS England—welcome to both of you. A particularly warm welcome goes to Antonia Williams, who is the director of public spending for HM Treasury; it is her first time before the Committee, so she is especially welcome. Thank you. *[Interruption.]* Sorry, Antonia may be director of public services—my piece of paper says “director of public spending”; Antonia, please tell us what your role is.

Antonia Williams: It is Director of Public Services. Thank you for the welcome, Chair.

Q1 **Chair:** Brilliant. I am glad you have clarified that. Thank you.



HOUSE OF COMMONS

Without any further ado, let us move on to our first question, which is from me. I come to you, Amanda Pritchard, if I may, with a very simple question. Why has it been so difficult for NHS systems to break even in recent years?

Amanda Pritchard: Thank you, Chair, for the opportunity to come here to talk about NHS finances and, no doubt, broader topics as well. The backdrop to the place that the NHS is in is important. Obviously, as the NAO Report set out, covid was a massive shock to the NHS, not just in relation to finance, but in so many other ways. In the recent period since covid, we have seen a story of gradual recovery: productivity took a huge hit through covid. It bounced back quickly, but we still have a gap between where the productivity of the NHS was pre-covid and where it is now. It is improving year on year, but we are not back to that level yet.

Similarly, huge efforts have been going on to recover the backlog in electives, and we can see progress being made, particularly in reducing long waiting times. We have huge challenges with urgent emergency care, but again we can see progress being made, particularly on things like reducing ambulance response times, which was the big focus last year that has been sustained into this year. But we have much further to go on all those things.

For the financial position—I am sure Julian will want to say more about this—some of that translates into what local leaders are grappling with in the ICBs and in the systems. They have been trying not just to deal with that big recovery challenge, but to manage the impact of inflation, which we have had over the last few years, and of industrial action, which has happily ended, at least for now. They have also been trying to do that in the context of what has in practice been the task of reducing those covid costs out, such that they can focus their resources on doing what patients need now and on planning for the future.

The bigger backdrop to all that remains—Lord Darzi was very clear about this in his report—the fact that, for many colleagues, local NHS leaders are doing that without necessarily having the capital estate that facilitates it. We have talked before in this Committee about backlog maintenance, and the day-to-day impact that that has, for example, on being able to run efficient services. The very welcome increase in capital funding that has just been announced speaks directly to addressing that, as does the investment that has been made in technology to try to get to a place where we are giving the NHS the best chance of being able to use its resources as effectively as possible to meet the growing needs of our population.

This is the last thing I will say: all this is against a backdrop of ever-increasing levels of demand, partly because we have a growing and ageing population with multiple conditions, and partly because—as I said, coming right back to the impact of the pandemic—we have seen some of that pent-up demand come through in recent times.

Q2 **Chair:** Okay. I will come on to Mr Kelly, too. Thank you for that



HOUSE OF COMMONS

introduction. I think we will be probing all the areas that you mentioned, but thank you for covering that. Mr Kelly, why do some integrated care boards overspend, and others do not? Why is there such a difference in performance?

Julian Kelly: There are several factors. They actually start in different places, historically. As the tide of covid has receded, we have seen some problems that existed before the pandemic re-emerge. Some have had more significant issues dealing with covid and, to some degree, industrial action. As we have grown the substantive workforce—I would say successfully—over the last few years, we have seen that some have not taken as prompt action to take out the temporary staffing costs as others have. There are a variety of factors: structural, historical and, in some cases, absolute local leadership and management grip. It is a combination of those factors in different places.

Q3 **Chair:** That is helpful. What activities did NHS England cut in order to reduce spending against central budgets and bail-out systems in '22-23 and '23-24?

Julian Kelly: In '22-23, we were not spending as much as we thought we were going to, centrally, on certain things. We might have recycled that investment to do more, but because places were overspending, we could not—we had to put it to covering those deficits. Going into '23-24 and '24-25, we would have had ambitions to invest more in increasing mental health capacity, supporting community services and doing more on technology. We have still managed to make progress on those investments, but we have not done it at the scale and pace that we originally thought and envisaged we would.

One thing underlying the last three years in particular is that inflation has turned out to be much higher than was forecast at the beginning of each of those years. In each of those three years—certainly '22-23 and '23-24 and, I think, even in the latest forecast for '24-25—inflation has turned out to be much higher than the basis on which we agreed budgets with the Department and the Treasury, which was based on whatever the OBR's inflation forecast was. That accounts for an unfunded pressure of about £1.6 billion. That is, to some degree, not coincidentally, about the level of the aggregate deficit that the system has experienced in the outturn for '23-24.

Q4 **Chair:** Thank you. What is the expected final position of NHS systems against financial plans for '24-25, and will this again require NHSE to reduce spending against the central budget?

Julian Kelly: At the moment, our month 6 report to our board said that we, or at least systems, were—I will not get the precise number absolutely right—about £650 million off-plan, so worse than plan. By the way, that is about 0.7% of their spend. In percentage terms, it is quite small, but clearly, in cash terms, it is a big number. That is better than last year, so although it is not where we want it to be, you can see the progress people are making. At month 6, people are still forecasting to get back to plan. We are working with every system across the country to see how close to



HOUSE OF COMMONS

those plans we can get. I think there is a fair risk that we will not hit plan, though I think there is a fair chance that even at the end of month 7, we are still in a better place than we were last year. We will still work to get as close to plan as possible.

I do not have an updated forecast that can tell you precisely where—between nought and a deficit—we will be, but systems are currently forecasting to get back to plan.

Chair: When you have that forecast, could you let the Committee have a note? We would be very grateful. Blame this on me as a new Chairman—I am sorry. Anna, you had a question at the top of the session, so let's rewind. I do not know who you are going to ask it to, but you have a question on medicines, so over to you. I think you have been notified Sir Chris—a question on medicines at the top of the session.

Q5 Anna Dixon: Thank you, Chair, and good afternoon. Before I get into my question, I need to declare interests, including that I previously worked as a civil servant in the Department of Health and Social Care. I am also currently the chair of a charity called Helpforce, which promotes the use of volunteers in the NHS, and I have family members who worked for the NHS.

On my topical question for this afternoon, I have had various constituents write to me expressing the difficulties that they face in accessing essential medicines. Julie from Menston struggles to get her HRT medication, and other constituents are desperate because they cannot get ADHD medicine, either for themselves as adults or for their children. Doreen could not get reliable supplies of CREON, and she has an enzyme disorder. There are huge impacts on each of those constituents and their quality of life. I understand from data—according to the NHS Business Services Authority—that nationally the proportion of HRT items affected by shortages has increased sixfold in the last year. I do not know whether this is a question for Chris or Amanda, but can you update us on what actions you are taking to secure reliable access to essential medications such as those?

Sir Chris Wormald: Yes, I will answer—Amanda can then add to it from the NHS perspective, if she wants to. As your question suggests, at any one time we are, for a variety of reasons, short of an ideal position on a number of essential drugs. The NHS uses thousands of drugs a year, and we are susceptible to a whole range of shocks to that system. Normally, those are manufacturing problems, and in some cases that you quote, that is the root cause. These are world markets that work by supply and demand as usual, and when there are world shocks, we have to deal with the consequences.

The first thing to say is that it is of course very distressing for the individuals affected, and our answers tend to be about what we do at a macro level, but as your question suggested, we always have to remember that there are individuals at the end of this challenge. Our



HOUSE OF COMMONS

message to individuals is always, "Go and talk to your clinician, who can discuss your individual circumstances and what is best to be done."

What do we do in that situation? We have a series of protocols that we follow with our NHS colleagues, but there is no one silver bullet. We seek to secure extra supply where that is available, including paying a higher price in some cases. We seek to ensure that the supply that we do have is used where it can have most impact with the people on whom the challenges are greatest. We also look for alternatives. We have a series of clinical panels that we run with the NHS to recommend alternative treatments, where the original treatment is not available, and that is the case in some of the examples that you described. We then look at whether there are other mitigations, which can be agreeing with the medical regulators and manufacturers that stock is in date for longer. You may remember that we had a lot of challenges with EpiPens where that was part of the solution. There are also things like agreeing that different dosages may be used, such as dosages usually available for children being available for adults.

There is a whole series of things, and we seek to attack the problem from all those different perspectives. We seek to mitigate the effects until we can get to a position where supply equals demand again globally. As I said, it is normally a manufacturing or distribution problem that is being sorted. That is what we do in general. We can write to you on any of the individual cases, but it will be a mixture of those techniques. Do you want to say anything about what the NHS does, Amanda?

Amanda Pritchard: I think you have done a really good job of explaining.

Chair: We have a lot to cover. The only thing that I would add is that some of the examples that Anna Dixon has mentioned are actually dangerous if you were to run out.

Sir Chris Wormald: Absolutely.

Q6 **Anna Dixon:** Could you follow up with data to show how significant and frequent these shortages are?

Sir Chris Wormald: We would be delighted to do that. As I say, the fact that such situations are dangerous is the reason that it is so important for people to discuss the situation and their individual circumstances with their clinician, because it is obviously not something we can deal with at Government level.

Q7 **Chris Kane:** Can I move on to paragraph 1.10 of the Report, which talks about funding in relation to covid-19? This is a general question for Amanda and Julian—a big one at that, I grant you. How well would the NHS cope financially in the event of another pandemic? That is to Amanda, Julian or both of you.

Amanda Pritchard: I am happy to start. I am sure Julian will want to come in after. It is worth saying that the Government were very clear at the point of the previous pandemic that the NHS would have the funding it



HOUSE OF COMMONS

needed to respond to the pandemic. In the main, that was absolutely the case. There were not the usual processes around setting budgets that we are now back into. A move was made that was about estimating, while moving at huge pace, what we thought things would cost and then setting appropriate joint processes between the Treasury, NHS England and the Department. Then there was rapid sign-off to access those funds as needed. But that meant that there was an awful lot more funding available in the particular period of 2019-20 and 2021 to deal with the pressures of covid.

Part of what we did was to suspend some of the normal financial rules at that time for the NHS to reflect the fact that there was a need for everybody to do the most unbelievably extraordinary things in response to a brand-new global pandemic. The last thing that anybody in the country wanted was for lots of process to delay that. In the last few years, we have been working to try to then put back some of those processes and appropriate checks and balances and to have good governance around that. The answer to the question "What would happen next time?" is a bit dependent on what the nature of the pandemic would be and what the nature of the financial arrangements would be. Sir Chris and I have both been at the covid inquiry recently discussing this, and I would say that we clearly still have some of the same constraints we had going into the last pandemic—for example, the state of the estate and the pressure on our workforce. We do not have a lot of headroom in the NHS at the moment, and occupancy levels are at 95% of our in-patient adult bed base at the moment. Similarly, pressures on intensive care for both adults and children remain.

I would say that it would probably be less about funding. The thing we can be absolutely certain of is that it will not be the same as what happened last time, but if we did see the same again, and the same financial arrangements were in place, I do not think we would be worried about the money. But we would be worried about a lot of the same things we were worried about last time, including our resilience, capacity and the ability of our workforce to step up again to deal with something as challenging as last time. Equally, we have learned a huge amount since covid, and we now have a lot that we did not have last time, and that would enable us to be more resilient. That includes everything from remote monitoring and the ability to treat people more effectively in their own homes, through to much more tried and tested EPR processes to help us respond in an emergency.

Sir Chris Wormald: The only thing that I would add is that it is very dependent on the type of pandemic. The previous pandemic to covid—HIV—had nothing like the same financial pressures, partly because of the timescale that it plays out in, and partly for very bad reasons; there were no tests to buy, no vaccines to buy, or PPE that helped you. There is a big thing about the sort of pandemic you are in and the sort of financial pressure that that therefore puts on your health and care system.

Chair: I think that this Committee will be returning to the whole subject of



pandemic preparedness, particularly after the lessons learned from the covid inquiry so, if you are happy, Chris, we will move on.

Q8 Anna Dixon: I would ask the witnesses to refer to figure 10 in the NAO Report, which shows historical data for healthcare productivity. Over the period from 1996-97, right up until pre-pandemic 2018-19, I think the average change was about 0.6%, with sometimes a couple of percentage points up or down. We have had the pandemic, so that explains the exceptional bars at the right-hand side. First of all, Amanda, could you explain why NHS productivity continues to be so much lower compared with before the pandemic?

Amanda Pritchard: As I say, actually, what we have seen—this chart illustrates it really well—was this very significant drop and significant bounce back. Since then, we have not had official ONS statistics that allow us to say, definitively, “These are the numbers”. What we have been doing, though, is developing what I think is a pretty robust internal analysis of productivity to help us track that, as well as paying attention, as you would expect, to people like the IFS, who produce their own reports. All of those are saying the same broad thing, which is that productivity continues to improve in the NHS, and, in fact, has improved a lot faster than we were seeing pre-covid. This year—I think we are about to officially tell the board this next week—we are running at about 1.8% improvement, and that is, as you say, against a historical rate of somewhere around 0.6% to 0.9%, so it is at least double what we were doing pre-pandemic.

That is from a combination of a lot of things that colleagues are doing on the frontline which, I have to say, are really tough. That is everything from seeing significantly more patients—the IFS pointed to this in their report last week—than not just the last year but pre-pandemic, to doing so while paying particular attention to reducing agency costs. We will have reduced agency costs by about £1 billion over the last two years—those are now running at about 2.5%. Julia can correct me, but I think that is pretty much a historic low for the NHS. There is a combination of more activity while really bearing down on agency staffing. There is also something that bears slightly on the conversation we have just been having, which is that people are really leaning into the opportunities with things like biosimilars and generic drugs, and using Supply Chain really effectively. All of those things are contributing to our ability, at the moment, to run at a higher level of annual improvement.

We have still got further to go to get back to where we were pre-pandemic, which I think is the final bit of your question. There are some things that are going to be really difficult to shift, and that is partly because some of the gap is now accounted for by things that are either driven by covid or driven by other broader changes in society, which I think are worth calling out.

First, there is the fact that we have this more complicated older population, which means we are seeing lengths of stays increase from pre-covid periods, and that does not look like it is changing any time soon.



HOUSE OF COMMONS

Some of that is acuity and complexity, and some of it is the pressure on social care. We can see that the difficulty in getting people discharged contributes to that.

Secondly, it is worth saying that, despite the fact that sickness levels have reduced from the peak quite significantly—they are about 1% down now, and consistently down—staff sickness is none the less higher than it was pre-pandemic. If you look at the single biggest cause of ill health in the NHS, it is mental health—depression and anxiety—some of which is definitely correlated with covid experience. Those are two examples.

A third thing that is worth calling out is that we now have more robust infection-control processes in place, in hospitals in particular. For example—I think this is called out in the report—you would not put a patient without covid in the next bed to somebody with covid, because clearly that would put them at risk. There is a whole combination of things that look like they are more intractable, in terms of the productivity challenge.

The final thing, and I am sure that Julian will want to come in, is that we are really conscious that the figures do not capture the productivity of the system as a whole. That is not to suggest in any way that we are not bearing down on acute productivity, which is what this points to. What we have done, particularly over the last couple of years, is try and invest in out-of-hospital care, with things like virtual wards. We now have 12,500 virtual wards in the NHS. Those are an important piece of our capability to look after people effectively and safely in their own home rather than in hospital—but we cannot count them in our productivity measures. That is just one example of a number of things where we are conscious that there is work to do to ensure we have a way of capturing productivity—as the NAO says—that does justice to not just the acute part but everything.

Q9 Anna Dixon: To clarify, they are not currently captured in your productivity measures, even the ones you are using internally. You mentioned the limitations of measures of productivity. The other thing is that it is very sensitive to pay, so are you anticipating that with pay rises productivity is going to fall? Linked to that, and to some of the points that you made about social care interdependencies—I am sure we will come on to the workforce separately—how are you going to secure the projections in the Long Term Workforce Plan, which suggest 1.5% to 2% productivity improvement? Maybe that is a question for Julian.

Julian Kelly: We think that it is absolutely possible to do over the next couple of years, because we still think there is further recovery. It is worth clocking that this is the first year that we have not had some major, enduring, ongoing disruption. In 2022-23 we had more people in hospital with covid than we did in the previous two years, and last year we had significant industrial action. In one sense, this is the first stable year that we have had, so we still think there is further recovery to be done.

With the possibility of technology-enabled change we are in a different position from where we have been in any of the last 10 or 20 years. I will



give one example. There was publication last week of some work we have done in London, looking at a large-scale trial of the use of a thing called ambient documentation. It basically uses large language models to record conversations and turn them into medical notes and discharge letters. The evidence is that it is transformative. If you are a GP, it means you can be talking to a patient face to face without having to be tapping on your keyboard. It improves the use of your time in the appointment and saves material time after in terms of you having to write medical notes and letters. There are things that are possible to do now that were not possible previously. If we can get the right plan and the right investment consistently delivered, we honestly think that we can materially improve, and make an improvement in productivity.

Q10 Anna Dixon: To challenge that a little further, I was a rep in the NHS for some of those last 20 years, and the promise of technology delivering productivity improvement has always been there. I believe the NHS is still the largest user of fax machines. We had not even adopted the technology that people use every day for many of those last two decades. Have you got well-developed plans that are clear on how the adoption of those technologies is going to deliver? Are you being an optimist or a fantasist?

Julian Kelly: You need to remain an optimist, but you need to plan with some pretty critical realism. We have been rolling out the adoption of electronic patient records at a scale we had not achieved before, with the aim that by the end of March 2026 every provider in the country will have one. The evidence is that those providers who have them and have implemented them well have a level of productivity that is about 13% better than those that have not had them.

We have our first national programme to roll those out and implement them; that is well under way. That gives you the critical building blocks—the promise of some of the things that technology can do, which people have been talking about for 20 or 30 years, is now at the point where things are not just in research and development. We are in actual delivery.

As I have just said, we have done a large-scale trial of the use of ambient documentation. We can see where it will work. We have just made a massive investment in technology in primary care, which we think is yielding results now. The public polling we do—we are only on about wave 3 over the past three months—shows that we are seeing improved public experience and patient experience with GPs. Is it where you want it to be? No. We know these things can make a difference; we can see the signs of success, where we go at it with a concerted plan over time. The trick will be—it will be all through the conversations we have with the Treasury, no doubt, over the SR—is getting the right kind of investment that we can consistently apply over a number of years.

Q11 Peter Fortune: I will just follow up on some of those figures and I am looking forward to when you release the figures about productivity. You think that is imminent, do you? I think you said you were giving them to the board next week.



Julian Kelly: We will do an update on where we are, yes.

Peter Fortune: I appreciate that it is very difficult, because of covid over the last few years, to assess these things linearly. I went back to an IFS report from November 2023 that looked at staffing versus treatment volumes; it compares 2019 with 2023, so I hope it misses the sort of heat of covid. The comparison from then to now is that there are 25% more junior doctors, 20% more nurses, essentially 20% more clinical staff and 16% more consultants. However, in terms of treatment for emergency admissions, the figure is down 4.3%; looking at non-emergency, it is down 1.3%; outpatient appointments are up 1.8%; and treatments from the waiting list is up 0.8%. It was pretty flat at that point, but with all the extra staff. I guess the question is that, with the injection that is coming up—?

Chair: We are asking a different question, Peter.

Q12 **Peter Fortune:** Sorry—what will be done differently now from what was happening in 2019?

Julian Kelly: Clearly, where we are today is that we are seeing non-elective volumes above where we were pre-pandemic; we are currently doing 15% or more elective activity than we were doing pre-pandemic. If you look overall at the NHS—within which I include mental health trusts, community trusts and GPs—it is still true that we have a gap. We have about 19% more staff in aggregate and we are currently seeing about 14% more patients than we were pre-pandemic, so there is still a gap to recover.

Peter Fortune: What was that figure again on patients? Sorry—I missed that.

Julian Kelly: About 14%. That gap has closed significantly. As the IFS recognised in its recent report, it can see that sort of rebound and recovery playing out over the last six or seven months. Also, in November 2023, we were clearly in the middle of industrial action. As we have just described, we are seeing further recovery for the NHS overall. It is about 19% more staff; we are seeing about 14% more patients. There is still further to go. There is still some further recovery to be done, which is what we are anticipating over the next couple of years.

Sir Chris Wormald: I will add two points. One is that when we look across the OECD, we see that demand for health services goes up by about 4% a year. So in some ways, the level of increases in staff numbers that you were quoting is not unusual, given that demand growth.

Secondly—it has had one mention already—the Darzi report is relevant, in that it sets out the challenges of the NHS, including on productivity, as being multi-causal. He is very, very clear that there are a whole series of external things, including covid. There are also a whole lot of internal things; there's a lot about the 2012 Act, technology and investment. We think he is completely right and that therefore there is no one answer.

As Julian has set out, there is a lot to do to get the productivity levels that we want, but it is not going to be one thing that we can do. Just as the cause is multi-causal, our solutions will have to be multi-causal as well.

- Q13 Mr Charters:** A quickfire question for Ms Pritchard. Do you think there is a materially significant impact when it comes to staff mental health and staff burnout and NHS productivity?

Amanda Pritchard: As I said a moment ago, that is the single biggest reason why staff are off sick. Sickness rates are clearly playing to the bigger picture around not just productivity; it is much more than that because that is about the quality of patient care. It is about the ability to recover on a range of other things. As part of last year's Long Term Workforce Plan, we are looking not just at training and bringing in the right number of staff that we will need for the future. We are not just looking at the skills that those staff will need. The big pillar of that was under the term "retention", but that was a whole range of different things. We are doing a review now around occupational health services and what the best local support looks like to try to make sure that we provide the best possible advice to the NHS about what the best organisations are doing and how to roll that out locally.

We are doing everything from that through to a bundle of measures that have been proven to work, which will enable people to have the work-life balance that means they can generally stay well, stay at work, really participate and see flourishing careers, which would include things like flexible working. There is a range of things that we can see are collectively helping. As I say, sickness rates are down by about a percentage point. Retention rates have gone the right way. We have seen improved feedback in the staff survey, but there is much further to go on all of those things.

Chair: If we are not to be here till midnight, we will need short answers and short questions. An example of that is now going to come from Clive Betts.

- Q14 Mr Betts:** Thank you very much, Chair. First of all, to Amanda Pritchard and Julian Kelly: the NHS is a very centralised organisation, and the various parts tend to respond to central direction. Are you responsible for the maintenance backlog that has now developed?

Amanda Pritchard: It is an interesting point, because I think the NHS is an extraordinarily decentralised organisation if you look at the number of different organisations with their own boards. As you know, primary care is mostly independently provided, with 6,500 GP practices. We have a range of things that, as national bodies, we can do to try to provide direction to the NHS: set standards through the mandate that comes from Government; translation into planning guidance; and we have various statutory and other levers. Ultimately, the NHS is rightly run very much by local leaders as part of their own structures, and now collaborating through ICBs.



HOUSE OF COMMONS

Part of that structure means it is for local organisations to make sure that they are on top of their maintenance requirements and backlogs, and that they are then distributing and making decisions about capital in a way that balances the need locally to meet the critical high-risk backlog, and also to invest in developing new capacity and expand where they want to. The thing that they have to do, which, again, my colleagues might want to talk to, is live within the capital allocation that comes from Government. The process of then making decisions locally about how you choose to spend it is where the national and local meet.

- Q15 Mr Betts:** I will come on to that in a second. I do not think that most of the organisations that I talk to in the NHS would recognise that description of the amount of freedom they are supposed to have. Most of them say that the pressure is on to balance the budget by the end of the year, do whatever it takes, and if that means stopping doing some maintenance because that is the easy way to do it here and now, that is what tends to happen. How do you get out of that cycle? Maybe that is for you to answer, or Sir Chris.

Amanda Pritchard: You are absolutely right. In a national health service there is a national mandate that is translated through planning guidance to local systems. What is true is that there are national expectations set around priorities and budgets. We all have to live within the reality of constraints. That is also true for the NHS. But in practice, there is more flexibility. If you can balance your plans locally and financially and deliver the things being prioritised by Government—

- Q16 Mr Betts:** But that is not happening, is it? Just look at the maintenance backlog: it has gone up to £11.6 billion. Don't just say it is all down to covid, please, because it was £6.5 billion in 2018-19.

Amanda Pritchard: You might want to take that from a capital perspective, Andy.

Andy Brittain: Shall I come in from the departmental perspective? Given the size of the NHS estate, it is inevitable that it is ageing and the maintenance backlog will increase; Lord Darzi's report made that absolutely clear. What are we doing about it? The autumn statement gave the Department the biggest capital budget in real terms since 2010, with £1 billion announced specifically for backlog maintenance and critical infrastructure risks such as RAAC hospitals. We are doing it. Investment is increasing. But given where we are coming from, it will take more than one year to fix it.

My final point is that when you have a capital budget, there is a decision to be made about the best thing to do. To take it to extremes, is it to invest it all in the backlog maintenance budget or to try to build some new facilities so you do not have to maintain them in the first place? That is what we are working through now.

- Q17 Mr Betts:** Can we be assured, then, that the capital budget you get will be spent on capital in future?

Andy Brittain: Yes, it will, because the Chancellor has introduced new fiscal rules that prevent transfers from capital to resource funding in future. That has been immediately ended.

Sir Chris Wormald: There is one other important thing in this: there is both the quantum of capital and the timeframe. The other thing the Chancellor set out in the Budget is that there will be longer-term capital budgets. Whatever the quantum, that gives individual trusts and other institutions a much better chance of being able to set a proper capital plan where they are making the right investments at the right period. In my opinion, having a long-term capital budget is at least as important as what the quantum is. Those are the two big changes we are making.

Q18 **Mr Betts:** How much capital have we spent for revenue purposes this year?

Andy Brittain: For this current financial year, at the current point we have proposed a switch of £900 million. That has come from technical things such as the ringfenced budget for leases and the new hospitals programme, where delivery has been slower than anticipated. We have not proactively decided to stop or slow down programmes. That is where headroom has been available.

Q19 **Mr Betts:** That is money that should have been spent on capital.

Andy Brittain: Ideally, yes. In an ideal world, we would have done that. However, it was available for that reason. But as I said, that has ended; it will not happen in future.

Q20 **Mr Betts:** So nothing from the next financial year onwards?

Andy Brittain: That is what the Chancellor said in her statement. That is the new fiscal rule.

Q21 **Chair:** How is the capital hospital programme going? As Clive said, if you do not start to make inroads into the backlog, you will get to the situation the Committee saw in hospitals in West Suffolk and Huntingdon, where the buildings are on the point of collapse. How can people work in the NHS in those sorts of conditions efficiently and productively? This backlog needs to be addressed.

Andy Brittain: Yes, absolutely. I have set out the action we are taking on the backlog. As the Secretary of State has set out, the new hospitals programme is currently under review to put it on a long-term sustainable and deliverable footing.

All the schemes are being reviewed. Some are out of scope: RAAC hospitals and ones that have had full business case approval and are in delivery. They are not part of the review; we are going to get on with them as quickly as possible. The schemes in review will be looked at as part of the spending review and put on a sustainable and deliverable profile. That work is under way and will be set out in due course in the outcome of the review.



HOUSE OF COMMONS

Sir Chris Wormald: The examples you gave, Chair, are exactly right, and they are why being able to have a long-term capital strategy is part of the answer. If you are running a hospital and you have one year's capital with the kind of block you described, you have no choice but to prop it up. If you have a proper, five-year capital strategy, you can decide, "Actually, I will demolish that one and rebuild it in three years' time."

If we have the level of certainty the Chancellor has promised, you ought to be able to get quite a lot of allocative efficiency out of being able to take rational capital decisions at local level about how you manage your estate. That is why the long-term certainty bit is as much a part of the answer as the quantum bit.

- Q22 **Mr Betts:** So £900 million is going to be transferred from capital revenue this year, but apparently in the first third of the year, the NHS estate had spent only 50% of its capital budget on capital projects. It doesn't look like it is going to spend the rest effectively and efficiently, does it?

Andy Brittain: Mr Kelly may be able to chip in on this one, but normally the way it works is that capital delivery increases as the year goes on—as people get contracts approved and signed, for example—so we normally see a sort of hockey-stick approach where a large amount of it is delivered in the second half of the year. Currently, the NHS is planning to spend roughly approximate to its forecast.

Sir Chris Wormald: It is yet another problem with having the money year by year, actually. If you don't know what you are going to be spending in the following year, you wait for that year and sign contracts then, and you get that rather odd profile that you described. It is probably part of the same phenomenon.

- Q23 **Mr Betts:** Can I ask a simple question, then? If £900 million is being transferred, will the rest of it be spent on capital projects this year?

Julian Kelly: Yes, and the NHS is currently on track to spend pretty much all the capital that has been given to it.

- Q24 **Chair:** So could Sir Chris or Julian—one of you—produce a note for the Committee on exactly where we are with the new hospital building programme? Obviously, some colleagues have a huge interest in that.

Sir Chris Wormald: Yes.

Chair: Thank you very much indeed. Sarah Hall.

- Q25 **Sarah Hall:** I want to go back to the extensive usage of temporary and bank staffing, and the variation in usage. I want to know why there is such variation in usage between the ICBs, and what are the roles that need to be covered. What does that tell us about the types of vacancies that there are? What kind of length are they covering for, and has the Department taken the chance to gain a deeper understanding of what those roles are and what we need to do to fill them?



HOUSE OF COMMONS

Julian Kelly: As Amanda set out, we have seen a material reduction in the use of agency staffing over the last 18 months. As we said, we are on track to reduce the total cost by over £1 billion over the last two years. As a share of the workforce, it is as low as it has been since we started measuring it. By the way, that is good, because we are recruiting substantive staff. We know that staff are happier and more efficient, to go back to Anna's point, when you have substantive staff.

We think that more can be done in that area, both this year and in future years. Indeed, we will look at some of the best practice where trusts have basically got rid of the use of agency staffing, but it does require them to get to a level of substantive recruitment before they make that move. We are in discussions about what is a sensible target to set for next year and the year beyond.

We know that we have some specialities with particular issues. Mental health nursing has some of the highest use of agency staffing, because in the previous decade we did not train enough mental health nurses. As we look at the Long Term Workforce Plan, a key issue is whether there are particular specialities where we know we need to keep growing the substantive workforce, and until we have, we won't deal with all the temporary staffing issues.

We are in discussions because, as you said, there is variation between trusts, which comes down to how good they are at managing their total workforce and rostering, and their levels of sickness and absence. It is about identifying those trusts with higher use of temporary staffing and working with them to understand why—what it is in their processes, systems and culture, and the things they need to sort out to improve their positioning to become more dependent on substantive staffing. But we are making real progress in this area.

Q26 **Sarah Hall:** Is that being prioritised? As we have both said, there are disparities.

Julian Kelly: Yes. In the last two years we have set caps on the total amount of agency spending we expect by a provider. I forget the precise percentage, but we are now seeing, in the vast majority of cases, people live within those limits. We will continue to work with them and we are working with trusts to identify where they can do better job planning and better rostering, where technology can help.

Q27 **Sarah Hall:** I would like to move on to the foreseeable future pressures on the NHS. As we know—we have touched on this—the population is increasing and getting older, and that comes with obvious challenges for the NHS, so what actions are being taken to address the predicted rise in demand for health services?

Sir Chris Wormald: I will start and then NHS colleagues can add their comments. As I was saying before, this is not new. Since the creation of the NHS, demand has gone up by roughly 4% a year. From our studies, only about a third of that is down to straight demography. Another third is down to technology—in particular, new drugs to treat conditions we could



HOUSE OF COMMONS

not treat before. And about a third is down to policy—that is, we ask the NHS to do more than it was doing previously.

The Chair will have heard my spiel before. When I used to talk about this pre covid, GDP rose by about 2% across the same OECD countries. The big challenge of western health is how you meet the gap between the 4% and the 2%. That has been a long-term equation—certainly since the creation of the NHS—and to deal with it, you have to hit all three causes.

We must be very clear on this: what is it we as a society are asking the NHS to do, and is that top of our priorities list and affordable? We need to reduce the burden of ill health, which is not really about length of life. As I am sure many Committee members know, it is about the number of years spent in ill health. As we have lengthened life, we have lengthened the period people spend in ill health more, so we have to tackle the drivers of ill health. There is a vote on the Tobacco and Vapes Bill tomorrow. That would be a huge step in doing that, but there are lots of other drivers of health around obesity, activity and air quality—the whole public health agenda. That is clearly part of the answer about how you would bridge the gap between the 4 and the 2.

We have to find those technologies that save money as well as costing money. It is of course wonderful that we create lots of new drugs to treat things that could never be treated before. That is a good thing, not a bad thing, but it comes at huge cost. So, as Julian was describing, what are the technologies that save money?

We have to attack that gap between economic growth and health demand from all those various perspectives, including productivity, which we have already covered in quite some detail. And you are going to make it long-term sustainable—this has nothing to do with the NHS; it is the story of western health—only if we can use all those various measures, basically to close that gap between the 4% and the 2%, unless we are all just prepared to pay more.

Chair: Sir Chris, I want to take you to paragraph 4.10 on page 49 of the NAO Report. Sarah Hall is absolutely right to press you on this. The final bit of that paragraph says: “More widely, the Health Foundation projects the number of people diagnosed with major illness will be 9.3 million by 2040 compared with 6.7 million in 2019, an increase of 39%” when the population is increasingly only by 13.1%. How much are you in the Department concentrating on these long-term trends, because otherwise the health service is going to become completely unsustainable?

Sir Chris Wormald: Well, in exactly the way I have just described. You will know from all the hearings we have had that the challenges of health are necessarily two-speed. It really matters if we are delivering today for the patients of today, those ambulance queues and all those things. We can't say we are going to focus only on the long term, because all those services today really matter. Likewise, exactly as you say, we can maintain a health service that is sustainable—this has nothing to do with



HOUSE OF COMMONS

the NHS; every country faces the same challenges—only if we do the long-term things that I have described.

The measure you will vote on tomorrow, in terms of a smoke-free generation, is exactly the kind of long-term reform we are going to have to make if we are to deal with both the overall health burden and, in the case of smoking in particular, the local variations and variabilities that it drives. Part of the challenge is on our side of the table, to be efficient and productive, and part of it is on your side of the table, to give us the legislative framework that allows us to tackle the various challenges. Is there anything to add to that?

Chair: I think we have got the flavour.

Sarah Hall: That is it from me for the moment.

Anna Dixon: If you want to continue with prevention, I think I can follow on; otherwise, I will move on to expenditure.

Chair: I think we will get back to prevention, and we need to come back to public health. Maybe you will want to come back to public health, Sarah.

Sarah Hall: Yes.

Q28 **Anna Dixon:** We have talked about productivity; my question is about the total expenditure and the allocative efficiency of where we spend the money. Figure 2 in the NAO Report gives some historical data. We know that the long run increase in expenditure historically was 3.6%, probably nearer to 4%. Between 2014-15 and 2018-19 it was between 2% and 2.9%. It has flatlined a bit recently, but obviously there was good news in the recent Budget, which increased the RDEL—the day-to-day spending for the Department—by £22.6 billion over two years. I think that takes you back up to around that 4% growth in expenditure.

We have heard a bit about demand and some of the things you can do in the long run to try to reduce the demand pressures, but what sort of future funding increases do you think the NHS needs to keep pace with some of the rising future demands? I suppose that is a question for you, Sir Chris, and then we might come to the Treasury.

Sir Chris Wormald: There is not a lot for me to say on that question. As you know, a whole series of projections have been done by think-tanks and others. Our responsibility as public officials is to spend, with best value, what it is the Government and the taxpayer decide to invest in health. The Department does not project future expenditure; that is set in spending reviews, in discussion with our Treasury colleagues. As I say, we focus on whether we are spending the resources that we do have as effectively as possible.

As I have just described, we do look at the demands on health. My 4% number is a demand number, not a cash number. The challenge that we set ourselves is how we can reduce that demand, both for the benefit of



HOUSE OF COMMONS

the taxpayer and for the benefit of individuals. Obviously, if we keep people in good health—I do not know why I am saying this to you, because you know it—

Anna Dixon: That is fine.

Chair: And many may not, Sir Chris.

Sir Chris Wormald: Yes. If we are keeping people in good health, there is a double win: those individuals obviously benefit and the taxpayer also benefits. We can then concentrate NHS resources on the people who really need them. There is clearly a massive win in that demand space, which is why we are focused on it in the way I describe. On the funding questions, those are settled in spending reviews in the usual way.

Q29 **Anna Dixon:** In terms of the allocative efficiency of the money you do have, a number of things in the Report suggest that more of that money has gone towards the acute. Some of your central budgets that were cut seem to be related to primary care; the public health grant, for example, has been cut by an estimated 20%; and social care, relative to the NHS, has had a much poorer settlement, historically, even with the uplift in the recent Budget. Do you think there is a reason to shift around the funding to deliver more for the same amount?

Sir Chris Wormald: Yes. The new Government have set out three shifts that they want to see: from analogue to digital, as you were pointing to before; from treatment to prevention; and from acute to community. At one level, if you look around the world, those are not controversial ideas—most health systems are trying to make those changes—but what the numbers you point to show is just how hard that is. It comes back to my point about the two-speed health service: we want to see those shifts over time, but not at the expense of patients now.

The pressures on acute—I am sure Amanda can say more about this—have been intense. Those are real people who need their A&E or elective services, or whatever, and Governments have made their choices about prioritising those people. Over time, however, we see exactly what, as you say, is set out in the Government's three shifts. Do you want to say a bit more, Amanda, about what you are doing?

Amanda Pritchard: Yes, sure. Thank you, Chris. Those three shifts are exactly the answer, certainly in the medium term. You rightly set out the big, existential questions about the very long term—great that we now have a 10-year health plan and the opportunity to describe what that longer-term future looks like—but in the medium term, some of which I have talked about, we have touched on all the things we are trying to do to make the NHS as efficient as possible. Some of that is definitely enabled by technology, but some of it is enabled by the shift from hospital to community.

Even over the past two years, the big investment in capacity has been into community rather than into hospital. Last year, we put more beds in—what are called core beds—to get up to about 100,000 beds in the NHS.



HOUSE OF COMMONS

That only have had the impact that it did because, at the same time, we had this 10,000—now 12,500—virtual ward beds in people's homes, in the community, supported by an infrastructure around single points of access and urgent community response. As we were discussing earlier, given the nature of an ageing population, the only way in which we are going to be able to provide the care that people need, the care that people want, is increasingly by looking to people's homes as the predominant place of provision.

That will require the shift that we have just described to be supported by some of that data and technology, which needs to be able to identify population risk and stratify those people who are most likely to need enhanced levels of care, linked with the sort of frailty services in which we have begun to invest in the NHS, supported by the urgent response services, such that, rather than ever take an older person to hospital in the back of an ambulance if they do not need to go—if they need to, that must happen—we can provide better care in their own homes. I saw, personally, a brilliant example of that in Middlesbrough just last week. That second shift, in the context of our ageing population, is crucial.

Then there is prevention—

Q30 **Anna Dixon:** May I interrupt? Will that not require more funding in social care?

Amanda Pritchard: You are absolutely right to say that we cannot talk about health without talking about social care at the same time. Clearly, I am only responsible for the NHS part of this, but where ICBs have already made a big difference—Chris will want to say more about this, but I would make a culture point, more than anything else—is over the past couple of years, when certainly I have seen really collaborative activity at local level, with people trying to problem-solve together, whether that is on intermediate care capacity or single points of access that properly link up processes. Again, there is loads more to go, but it is interesting that, now, if you were to ask a snap poll of acute chief execs, you might be surprised by how many of them would say, "If there is a spare pound, put it into social care rather than put it into an acute trust", because that interdependency is well recognised.

Anna Dixon: Thank you. The NHS providers that submitted evidence to us definitely made that point. I will make one final brief point and will invite the panel to make a brief response, if that is ok, Chair?

Chair: A very brief point from one of you, please.

Q31 **Anna Dixon:** You are right to say that social care is elsewhere, but the Better Care Fund was very much established to invest in that sort of prevention and early intervention across social care. For continuing healthcare, £6.5 billion has been estimated for 2023-24. That is on your account. What are you going to do to make sure that we are getting value for money through the NHS's role in this integration and spending across health and care?



Amanda Pritchard: For the continuing healthcare assessment process, the rules are set nationally and implemented locally. It is a very skilled but very complex process. We would be the first to recognise that as part of a broader review it would be very sensible to think about how we are making best use of both the Better Care Fund and structures around it and the content of what the money is spent on. It would probably be sensible to look at continuing healthcare as part of that. The emphasis at the moment is very much on what we see increasingly, which is much better system working locally and people working together as part of the annual planning process to ask, "What is working? What do we need to back? Where do we need to do more and of what?" The harder thing is always where something might have been invested in for a period of time but is not a value for money investment, and so it is time to use that funding better elsewhere. We are seeing some good examples of that locally.

Chair: Thank you, Anna Dixon. Back to Sarah Hall to probe the important issue of preventive health, which we are all relying on.

- Q32 **Sarah Hall:** I have had a little break and now I am back. The National Audit Office's 2022 Report on the introduction of ICSs noted that while 77% of senior ICSs start who were surveyed reported that their organisation had an intention to invest in prevention, only 31% felt that they had the capacity to do so at the time. With that in mind, using your two-speed approach, Sir Chris, do you think that the Department of Health and Social Care has been striking the right balance between focusing on the pressures of now and in the long term?

Sir Chris Wormald: It is almost an impossible question to answer.

Chair: A man of your calibre will have no problems.

Sir Chris Wormald: I will have a go at an answer. There are two levels of prevention: primary prevention, which is often not a fiscal intervention but things like what we are doing around smoking, and then secondary prevention, which is frequently done out of NHS budgets—the individual advice GPs give and so on. It is not a simple question of what budget goes where. It is about how a GP spends their time and what an individual consults on and advises a patient to do about their condition. That is the first point. The second is that overall there are three shifts that the Government want to achieve, and one of them is from treatment to prevention, so over a period of time we wish to see more focus on prevention. As I say, the answer to everything is not always cash, particularly in the prevention space. That is why it is very important what the timeframe is. It is one of the reasons why we want a 10-year plan, because of the pressures of today that you have to deal with and the fact that a pound is a pound and can only be spent once. If you need it in A&E for something urgent, that is where it will get spent.

Over 10 years, as part of the 10-Year Plan process, we can begin to look strategically at whether we want to change over time the balance of our investments. That does not necessarily mean taking money out of one budget and putting it in another. It may be GPs changing the balance of



their time between what they do on the prevention side and what they do on the treatment side. Likewise, it is not a question of whether we are taking money out of hospitals but what the role of the hospital is. Is it to reach out into the community and do prevention measures, or is it to treat the people who come in through the front door? It is partly a question of the balance of investment, but it is probably more about what the focus of all our professionals is over a 10-year period? Lastly, I would just say that this is really hard. Everyone has said for many years that we should spend more on prevention and less on treatment. At an individual point, where a person is in need of treatment, of course the pressure is to spend on that. That is the reasonable thing to do in that circumstance. Breaking yourself out of that cycle is really hard, and all health systems struggle with it. I am sure you will only be able to do it if you take that kind of 10-year timeframe that I have spoken about. In terms of cash there is an awful lot we can do on prevention, which is to do with culture, attitude and the legislative environment. That is not always about cash.

Q33 Sarah Hall: Do you think that is why there has been such a lack of progress? Do you think that professionals take prevention seriously?

Sir Chris Wormald: It is an interesting one. Were the chief medical officer here, his answers would be considerably more interesting than mine, as this is what he has spent his life studying. He would point out that we have had a series of prevention triumphs: the whole of vaccines, the whole of what our predecessors did around clean water and safe food and all the things that have caused people to live longer. He would point to the rapid reduction in the number of people who have died from heart attacks and strokes as all being successes of prevention.

What that has done is create a series of new problems about, as you pointed to in your earlier question, people living longer in ill health with completely different conditions, particularly cancer and dementia. If you look over that long period, we have had a series of prevention triumphs, which have left us with a series of new prevention challenges that we now have to meet, which go with the demographic changes that we have all seen. So I am not sure it is about whether we have focused on prevention. As I say, if you looked over 200 years, this is the great success of health. It is about whether we have the right things to tackle our new prevention challenges now, which are different from the ones that I described, which our predecessors were really successful at tackling.

Q34 Sarah Hall: Taking that one step further in terms of tangible action, what action will you take to allow integrated care systems to make progress on the key things that they were set up to do?

Sir Chris Wormald: That one is probably for you, Amanda.

Amanda Pritchard: Thank you. Chris has put it brilliantly. ICSs have two big opportunities here. One is the partnership work on primary prevention, which is less about investment and more about joined-up plans and the NHS playing a support role in delivery of that. The second point is the secondary prevention. Some of the secondary prevention that we do is on



HOUSE OF COMMONS

national schemes that are then implemented locally. Some are very much more about local need and responding to that. In terms of the national schemes, it is worth saying that on vaccination at the moment with this winter vaccination campaign—flu, covid and RSV—we are currently vaccinating more than 300 people a minute. More than 300 jabs a minute are happening in the NHS. That is a huge amount of local activity going on, and that is just across those three types of vaccinations—sorry it is not necessarily people; it is jabs per minute, because someone might have two jabs at the same time.

On the diabetes prevention programme, there have been 1.6 million referrals since it was set up in 2019. On digital weight management there have been 360,000 referrals. We are on track to prevent 175,000 strokes or heart attacks by 2028-29. Those sorts of schemes are nationally designed but locally implemented. We are seeing a huge amount of activity, and, as Chris says, with some real benefit.

The other thing that is a national/local thing is early diagnosis. This is a slightly different point because this is less about prevention, but the earlier you identify a problem, the easier it is to treat, often with better outcomes. Our targeted lung health check programme is currently diagnosing about 200 cancers a month. Lung cancer is traditionally one of the ones that are often diagnosed very late. The targeted lung health checks are diagnosing 75% at an early stage and are disproportionately identifying people from the most deprived quintile. Again, it is a national scheme, but it is delivered and implemented locally. Schemes like that are where the local teams, because they know their populations—this is a great example—and their geographies are much better placed than we would ever be to identify where to base a service like that to have maximal effect.

All of that is to illustrate and pay tribute to how much my colleagues are doing and how hard people are working to try to get the balance that Chris talked about right. It is very much about understanding there is a real need to do some of the heavy lifting on financial position, on productivity and on recovery now; and what we can see, certainly, is a huge commitment both to doing the partnership work on primary prevention and to delivering the secondary prevention schemes that we have got up and running.

Sarah Hall: Fantastic. That's good for me. Thank you.

Q35 **Chair:** Sir Chris, both you and Ms Pritchard are waxing lyrical about the cash and everything else on prevention, but actually the public health grant is about a fifth of what it was 10 years ago. Considering how much money this could save the NHS and how it could save all the individual patients going through a lot of agony that they wouldn't necessarily need to go through, we surely should be paying much more attention to the public health grant.

Sir Chris Wormald: Well, that is a choice. Previous Governments took the choices that they took. They took them very transparently. As I say, as public officials, our job is to implement those decisions to best value. As



HOUSE OF COMMONS

I say, it didn't happen by accident. There were conscious choices about how to balance pressures in the NHS against the pressures on public health. As I say, Governments took the decisions that they took.

Chair: I think you can hear, from the Committee's frustration, that we feel that prevention should be taken much more seriously. On that subject, I am going to bring in Anna Dixon to ask Antonia Williams about the Treasury's attitude to this.

Q36 **Anna Dixon:** Hello, Antonia. As colleagues have said, the shift to prevention has been desired for a long time, but the challenges are always about making that investment—with some pay-off in future years—when the pressures are on people to balance their budget in-year. So is there any flexibility that the Treasury could look at—changes in your rules—that would make it easier for your colleagues to be making those investments, not only in the short term getting in-year waiting times down, but making the investments that are going to see that shift in the health of the population over multiple years?

Antonia Williams: I will start by saying that we have had phase 1 of the spending review at autumn Budget, which the Chancellor has used to reset budgets, in effect, and she has clearly prioritised the NHS through that with the additional £22 billion RDEL and additional £3.1 billion CDEL. We will have phase 2 of the SR in the spring. The Chancellor has been clear that it will be a multi-year spending review—we have talked about five-year capital budgets, which is a real opportunity to look and plan over the longer term—but multi-year for RDEL as well.

This is a conversation that we have very actively and in a lively way in the Treasury: how do you encourage and support more of a shift to prevention and early intervention? We know that you can get better outcomes across a range of public services and better value for money, but it is incredibly hard to do when there are significant pressures on the day-to-day priorities. It is something that we talk about a lot to other Government Departments and to external stakeholders: exactly how do you define preventive activity? There are interesting insights and recommendations from the Committee on this, but it is very difficult to do, actually, when you look right across public services at all the different types of intervention.

Sir Chris has talked a bit about this. For example, when somebody is seeing their GP and they advise them to stop smoking, what do you capture as prevention? Or, for example, someone has a hip operation. That is not something we would see as prevention in an NHS context, but actually it could help somebody get back to work and very much be prevention on the inactivity and worklessness side of things.

I think the multi-year SR does give us an opportunity to look over multiple years at budgets and when the potential pay-off comes through, but we do have a tough fiscal context. Investment can be part of the answer, but we also need to be looking at non-fiscal levers—at regulatory levers and others. The Chancellor made a number of tax commitments at



HOUSE OF COMMONS

Budget about the soft drinks industry levy and alcohol duty—those increasing with CPI. Again, this should make an important contribution to the prevention agenda.

- Q37 **Rachel Gilmour:** I think you are all missing something, and I am famously bad at maths; it took me three attempts to pass my O-level maths. But given that a pitiful 6% of the NHS budget is spent on primary care, are you at all surprised that prevention is somewhere further down the list than you would want it to be? Ten minutes with your GP is probably the best sort of prevention you can do, but the budget is just not allowing for that. You are spending huge amounts of money on hospitals, which is proof that prevention is not working and you are not putting the emphasis that you need to be putting on it, rather than putting the emphasis on providing more primary care, so that our GPs can do the job that they are best at, which is convincing people to stop doing things that are bad for them, like smoking. I do not mind which one of you answers that.

Chair: Who would you like to answer that, Rachel?

Rachel Gilmour: I do not mind—I mean, it is for all of them, really. It is just common sense.

Chair: Amanda, this seems to be in your budget, so it is probably you or Julian.

Amanda Pritchard: I am happy to start. We have discussed some of this already. Clearly, it has been a long-term intention to try to achieve a shift to community and a shift to prevention. This Government have been explicit about that. That means that—and we have mentioned it already—the process through the 10-year health plan is really important to crystallise what that ambition over a 10-year time frame would look like and, perhaps even more importantly, how we would actually get there.

There are good intentions, but there are difficult trade-offs between investing in things that will certainly deliver really obvious long-term benefit and meeting a today priority, and it is very difficult for the Government to make those sorts of decisions in a very short timescale. It is much easier when you can take a longer-term view, and we have seen during pre-pandemic periods a gradual, slow but steady increase in the funding going into mental health services and community services. There has also been big investment in primary care through the additional roles scheme, and the training of additional GPs is now beginning to come to fruition.

All that puts us in a place where we can say, “We know if we can do something over the long term and we do not have a global pandemic to deal with in the middle of it, we stand a reasonable chance of being able to build on some of these early foundations to get to a place where that is a much more sustainable model for the long term.” I do not think that anyone would disagree—in fact, quite the opposite; I think we would all strongly agree—although I dare not speak for all my colleagues—that



HOUSE OF COMMONS

those are the right shifts, but I think it will be a case of leaning into the 10-year plan opportunity to describe how we get there.

- Q38 Mr Betts:** This question is to Sir Chris Wormald and Andy Brittain to begin with. It is very clear, and everyone agrees, that getting bits of Government to work better together is a better way to spend money and that it gets better value for the taxpayer and better outcomes. There was feedback in the NAO Report that some of the local government stakeholders in the process of developing the ICBs and working jointly at local level have said that the objectives do not often align. You have got the NHS, which is very centralised in terms of the requirements coming down, and local government, which has a lot more local flexibility. There is often frustration in local government that they cannot get the same rapport with their colleagues in the health service because of the restrictions on them. How are you going to address that?

Sir Chris Wormald: I will start and then I will hand over to my NHS friends. First, that is clearly right, particularly between health and social care. Trying to get integration between a service that answers nationally to national Ministers and a service that answers to local councils; between one that is free at the point of delivery and one that is means-tested is really, really hard. There is nothing that the five of us here today—the witnesses—can do about any of those things. They are built into the legislative framework and we administer the legislative framework that we have, which is not to say that there is nothing that can be done to make things work better.

Indeed, as I think Amanda mentioned earlier, we have a lot of feedback from local authorities that although there are still lots and lots of problems, the working relations that are built into the ICS-ICB system, into BCF, and the local relations between NHS leaders and local authority leaders, have actually been better over the last couple of years.

There is a lot more to do and it is quite variable across the country. One of the things that we get quite a lot of feedback about, and I am sure that you see this in your constituencies, is that when a trust is dealing with the local authorities that it is used to dealing with, there are often very deep and very good relations. You see the joint discharge teams in trusts and all those things.

Many of our trusts deal with local authorities all over the country; I was at one trust where only 25% of their elective patients come from their local ICS. When you are dealing with local authorities that you have not dealt with before, you see a lot more problems—just intensely practical problems of not knowing systems.

We do think that we have made some progress through ICBs and ICSs. We do not think it is by any means perfect; it is much too variable across the country. And we have that underlying challenge of the different geographies that a trust works on and a local authority works on; there is no way of equalising them. The trust that I was talking to was dealing with cancer and its catchment area was the south of Birmingham to the south



HOUSE OF COMMONS

coast, as it were, and all the local authorities you have to deal with. There will be other trusts that have similar catchment areas—

- Q39 **Mr Betts:** Do you think that you have complicated that by setting up the ICBs, when previously CCGs often worked very well with the local authority? I remember a case in Sheffield where a CCG worked very well with the local authority right through covid. There were brilliant working relationships. Suddenly, you changed all the geography—

Sir Chris Wormald: Yes, you are completely right. For the reason I have given, there is no perfect geography for health. Some health questions are at the level of a street; and then you take the trust that I was talking about and it is dealing with half the country, as it were. There is no perfect arrangement.

Now, with CCGs there were some brilliant ones; I do not happen to know the Sheffield ones, but they may well have been brilliant. There were also a lot of them and they were quite variable. The previous Government took the decision to go with the ICS model and the current Government have no plans to change that.

We take the view that we work with the system we have got and make it as good as we can, and there is a lot of work going on. It is by no means perfect and there is lots more to do, but we do think we have made some progress.

- Q40 **Mr Betts:** Can I follow up on a couple of other points in that case, Sir Chris? You almost gave an impression before that you could do prevention without spending money, and that it is a cost-free zone.

Sir Chris Wormald: It is not always about cost. There are obvious prevention measures that just cost. A vaccine programme has a cost, but—

- Q41 **Mr Betts:** You mentioned clean water before; there was clearly quite a big cost in achieving that in the past.

Sir Chris Wormald: Yes, that was significant.

- Q42 **Mr Betts:** Right. Let's go back to public health grants, then—

Sir Chris Wormald: No, sorry, I want to be clear about what I am saying. It is not all about cash. A lot of those things that are about lifestyle—whether you smoke or not, to what you eat; all those sorts of things—are about Government action and Government advice, and sometimes legislation, but they are not always about money. That was my point. I am not trying to claim that money is not important; it clearly is.

- Q43 **Mr Betts:** Right. So let's go back to public health. It is your job, as you keep saying, to say how much should be spent. Do you accept that if the NHS is going to address prevention better and spend more on it, cutting the public health grant is not the right way to do it?

Sir Chris Wormald: Well, I am not going to pass comment on previous Government policy. They took the decision—

Q44 Mr Betts: I am asking about here and now.

Chair: Do not repeat what you have said in answer to my question. Is there anything else you want to add to that?

Sir Chris Wormald: Clearly, this comes back to the long-term budgets that Antonia was talking about and the 10-year plan. Over those longer periods we will want to look at what is the right balance of investments. As I said, it is also about what professionals do, as well as whether we move money between budget headings, as it were. So yes, we want to look at those questions, but over the timeframes that I have described.

Q45 Mr Betts: I think we will come back to that point at some future date.

Amanda Pritchard, is it important that you look at how your money is being spent and whether it could achieve better outcomes in terms of prevention? I am thinking of the big issue of child inoculations, which we discussed and which the ICB in South Yorkshire is very supportive of. The way it is paid for is that GPs get funded according to the number they achieve beyond a certain bar. That sends more money into the wealthier areas where GPs have patients that are parents who are willing to have inoculations and sends less money to deprived communities where GPs are struggling to get inoculation levels up. Why don't you have a look at those sorts of things? Maybe targeting that funding better would achieve better outcomes.

Julian Kelly: If I can pick that up, we think that is precisely the type of issue we are looking for integrated care boards working with primary care networks to identify. We have got so many lessons to learn from the covid vaccine campaign, with the granular data of where take-up is good and where it is not good, and what we learnt about how you reach populations who are not proactively coming forward. To your point about local authorities, what we learnt about working with local authorities is that most of them probably have better links into some of those communities. We are looking for integrated care boards to do precisely that: identify where in their population that is true, because if the job is done—

Q46 Mr Betts: Okay, are you going to allow flexibility in funding? Currently, they have to fund according to NHS remit.

Julian Kelly: No, they already have the flexibility, and if the job is done, the person will be paid. They have the flexibility locally to work with their primary care networks to work out which are the less well-served populations, and how they reach groups who are not being, in this case, jabbed. One of the things we are looking for is for them to show how they are doing that.

Mr Betts: I might write you a note about that because I am not totally convinced by the answer.

Q47 Chair: I am going to follow up on Mr Betts's question. We are not just talking about jabs; there was quite a narrow focus in your answer. Is it not surely about the flexibility of the ICBs to determine for their local populations how they could best use their money in preventive



HOUSE OF COMMONS

healthcare?

Julian Kelly: And they can determine how they use their funding. A very small proportion of the total funding we have provided—

Q48 **Chair:** You just said it: a small proportion of the total funding.

Julian Kelly: No—that we have provided on a ringfenced basis. We have run and funded certain national programmes that the evidence says are some of the most cost-effective things that we can do to prevent long-term ill health—such as the diabetes prevention programme. In that instance it does not make sense, given we know what works and the long-term health outcomes, to leave it up to every part of the country to decide if they do it or not. Nor does it make sense to allow 42 different places to each buy the programme, because we know we get better value by buying it once nationally. As with targeted lung health checks—we know they work. It is one of the big things that we have done that has shifted the early cancer diagnosis rate when it had been stuck flat for the best part of the 10 previous years. We have worked with ICBs to target it at those areas of the country with the biggest need. It is about the balance between—when we know something works nationally—reinventing the wheel and working out when it makes sense to pay once and get the best value. That does not stop ICBs and local places from using the many billions of pounds that we otherwise give, for which they have the flexibility to determine how to spend and what services they commission. They can still work out what the particular local needs are in their population and how they can commission services to tackle those needs.

When money is tight—and it has been, as shown by the first questions you were asking—clearly the flexibility to pay for and commission new services is reasonably restricted. We have an obligation to live within the money that Parliament approves, and ICBs seek to live within the budget. When money is tight, the ability to commission new services is obviously tight, but they have flexibility as to which services they commission.

Chair: Thank you for that answer. I am sure that is something the Committee will wish to consider and maybe we will want to come back to it.

Q49 **Anna Dixon:** It's me again. We talked a little bit about the short-term workforce, such as things you are doing on wellbeing and tackling agency working. I would like to shift to the long-term workforce planning, if I may. Obviously, securing a workforce over the medium to long-term requires balancing decisions about training new recruits, overseas recruitment, investing in retention, maybe even persuading some people to return to work in the health service, and also managing retirement and maybe persuading a few people to work for a bit longer. Given that you have a long-term workforce plan, could you say how confident you are that the current data and plans will secure the right workforce for the long term? I am guessing this sits with Amanda and Julian.

Amanda Pritchard: I am happy to start, and thank you for that question. It is worth saying that, thanks to a combination of both international



HOUSE OF COMMONS

recruitment and improving retention rates, as well as some of the investment that previous Governments have made, particularly in medical training, we have 70,000 more staff now than we did pre-pandemic. That has been a success story, and clearly it is about keeping people well and at work. The discussion we were having about sickness and continuing all the focus on retention really matters if we are then going to enable people to have fulfilled careers at work.

However, that does not close the gap between the number of people we need and the number of people we have. We still have a very significant vacancy rate in the NHS, so the Long Term Workforce Plan is crucial. As I say, it is about those three elements—training, retaining and reforming are still the three pillars. We made an important commitment at the time. Looking out 15 years is crucial if you are trying to train people, because it takes a really long time. But on the other hand, you know for a fact that whatever you say for a 15-year time horizon will need to change, because clearly an awful lot changes over that time. We said at the time that it would be really important for the plan to be refreshed regularly, and we talked to this Committee about that relatively recently. This coming summer will be the first point at which it hits an obvious opportunity to refresh and update the planning assumptions, and that ties in very well with the timing of the 10-year health plan.

We would want to take it anyway, but we have the opportunity to update the Long Term Workforce Plan in the light of the 10-year health plan to ensure that it will then help support the health service that we are designing for the future. That includes some of the shifts that we have discussed today, such as the shift to community, as well as some of the things that we spoke about in the previous plan. For example, there is the need to invest in primary care, as we continue to see a disproportionate growth in the number of GPs coming through versus other areas, as well as some of the existing gaps. Julian has already mentioned mental health nursing. We would still say that there has to be the right balance between where we have gaps now, and therefore we can see we need to do more, and where we have opportunities with the three shifts and the 10-year health plan to ensure that we have updated the plan in the light of that.

Q50 Anna Dixon: Will you update the cost assumptions when you do so?

Amanda Pritchard: Our assumption at the moment is that the modelling will be refreshed this summer, and I guess we will have to see what falls out of that. We are all very conscious that we are still working within the plan. This is not an opportunity to come back with a completely new plan; it is about refreshing a plan that we already have. We have to ensure that we have the balance right between the different elements of the plan and the different types of training that we were planning to invest in.

Q51 Anna Dixon: Clearly, there is not only this increase in the higher education sector's ability to train people but in the NHS's own training capacity, but then it is also about the ability to actually hire the people we are training. There seems to be some gaps between the number of GPs coming out of training and the NHS's ability to employ them. Will all



HOUSE OF COMMONS

those things be part of what you are looking at in the review of the Long Term Workforce Plan?

Amanda Pritchard: Yes; Julian might want to come in on this, but pace is a really important factor. We were clearly very ambitious about some things—increasing medical training places is a good example. Other things were planned to start slower, with an increase later.

What we have now is more data to go on; we know, for example, that slightly fewer people applied for nurse training this year than during the peak of the pandemic. There are lots of obvious reasons for that, but one of the assumptions that we made was based on the level of interest in joining these courses. If the facts change, you have to update the plan in response.

Q52 **Chair:** Do you just sit there passively and say, “There isn’t a demand for nurse training places this year,” or do you actually go out and stimulate demand in schools and so on? You cannot just passively sit and hope that it will happen—you have to do something about it.

Amanda Pritchard: Indeed—hugely the latter. We have run campaigns such as “We are the NHS”, which I hope you will have seen—although, to be fair, you are possibly not its target audience. It is a more social media led—

Chair: I am a bit old for training, unfortunately.

Amanda Pritchard: We did “Speakers for Schools” last year; I went back to my old school and talked to 1,000 people about careers in the NHS. Literally thousands of people have been out in primary and secondary schools talking about careers as well as all the local activity that trusts do, often in partnership with local schools. We get people in and encourage them to think not just about—

Chair: Okay, brilliant.

Amanda Pritchard: I’m sorry—I’ll stop.

Chair: We have to keep going, as time is rapidly running out.

Q53 **Rachel Gilmour:** My first two questions are about finance. I am going to take them both together; I would really appreciate brief answers, please. Where do you consider the value to be in putting pressure on finance professionals to agree plans that they know to be unrealistic and which are based on unachievable assumptions and savings? That is probably one for Amanda and/or Julian. And what work have you done to simplify annual budgeting processes and reduce the bureaucratic burden on finance directors?

Julian Kelly: On the first question, in previous years and this year of ‘24-‘25, we have clearly set out the money, the expectations, what the ask is and what the rules are. It is a huge system. We have had in-depth, detailed conversations with just about every provider and ICB as a whole system in the country.



HOUSE OF COMMONS

Boards are the ones who sign off the plan and say what they can do with the money that has been given and what their intentions are with respect to their workforce. We personally met every single system in the country—all the leaders—to confirm, over the course of May, that they were serious about doing what they told us.

I do not recognise some of the things said about financial fantasy plans. The leaders have given us a plan and signed it off at their board; we have discussed it in depth and in some cases agreed extra funding to reflect a particular situation and the specifics of individual providers and systems. Our expectation is that if you as a board have signed the plan off, you are serious about doing it and have thought hard that you can do the thing you have given us.

Our expectation is that as long as we honour the things that we have said we will do—which we have done—people will do what they say they will do. If they are off track, we meet them to understand why and what they are doing to get back on track or at least whether something has materially changed. Things can materially change. The cyber-attack in south-east London caused a particular financial pressure and performance impact that was not in the plan. So we adjust.

Q54 Rachel Gilmour: So you are saying that it is the boards that are fantasy planning.

Julian Kelly: No, I am not saying that anyone is necessarily fantasy planning. I am saying that if they have seriously sat down and said what they can do, and we examine that and challenge them on it, they have agreed that that is what they are going to do. We therefore hold them to account to follow it through.

Q55 Rachel Gilmour: Okay, now let's talk about the bureaucracy.

Julian Kelly: Clearly, if you are handing over billions of pounds of taxpayers' money to services, your expectation—witness this session—is that we can give a good account of what that money is being spent on and that it is delivering good value for money. It is therefore not surprising that when we give money to people and the Government set out what their priorities are, we are asking for an explanation of how that money will be spent and whether it is delivering things consistent with the priorities we have been given through their mandate.

We look to make that as simple a process as we can, but for something the size of the NHS, you are clearly going to ask for a reasonable amount of information back. We seek to make that as streamlined as we can. We have worked very hard on that over the last few years and we will continue to. I do not recognise that it is entirely bureaucratic because, as I said, if you are going to give billions of pounds, you are going to expect some explanation of what people are going to do.

Q56 Rachel Gilmour: I do not want to put words into your mouth, but I think you are saying that bureaucracy is a necessary evil in the NHS.



HOUSE OF COMMONS

Julian Kelly: A certain amount of collecting data, understanding how money is being spent, and people proving that they are delivering stuff, is inevitable. We seek to automate it and make it as simple as we possibly can.

- Q57 **Rachel Gilmour:** Great. I will move on to the next question, which is to Amanda and Chris. Why was there such delay in agreeing priorities and a final budget for NHSE for '24-25? Again, a brief answer, please.

Amanda Pritchard: I am sure Chris will want to come in on this. In NHSE, we get a mandate and translate it into a document, which is then sent out to the NHS. We always try to get it out this side of Christmas, because we all recognise the need, as per the conversation we are having, to get into a proper, detailed planning process, and we want to give people the maximum amount of time to do it.

That process is not something we can do unilaterally. We would have a go at drafting and sharing planning guidance, usually in November—that was certainly true last year as well—but then there is a complex process of agreement between us and not just the Department of Health and Social Care, but the Treasury as well. In fact, I think I am right in saying that it goes right around the whole of Government. As we are discussing, how this amount of public money is spent matters, and it is quite right that there is a process of check and challenge as part of that. Chris might want to shed a light on some of what was going on behind the scenes.

Rachel Gilmour: I think that is enough, because we are running short on time.

Sir Chris Wormald: I will just add one thing. That year was particularly complicated because of the very high rate of inflation. That is a problem in itself, and it makes budgets very unpredictable. There was a delay in that year and quite a lot of reprioritisation going on, which was just a fact of a very high inflation shock caused not in this country.

- Q58 **Rachel Gilmour:** So can I take from what you are saying that the date you have all agreed on for releasing the 2025-26 planning guidance to NHS systems is not as delayed as the one for '24-25?

Sir Chris Wormald: We would certainly hope not.

- Q59 **Rachel Gilmour:** Okay, that was a good, quick answer. Do you accept that you should all agree, publicise and stick to a deadline for publishing planning guidance for future financial years as well?

Sir Chris Wormald: It depends on those external shocks. To use your phrase from earlier, there is absolutely no point in going out early with a fantasy budget, so you have a trade-off between how early you do it and how certain you are about what the fiscal and economic situation will be. If you are in the middle of an inflation shock, bluntly, you want to do these things as late as possible. If you are in a basically stable position, then clearly, you want to do it early. I am not going to give any guarantees, but that is how we would think about it, and in principle, you are right that the



HOUSE OF COMMONS

earlier you do it and the longer you give people to plan the better, as long as you are giving them a realistic number.

- Q60 **Rachel Gilmour:** To Julian and Amanda, what are you doing to make sure that things are signed off in a more timely manner well in advance of the financial year? To me, with my background—very briefly, I worked for the Environment Agency, which I found really frustrating—we would never consider starting a budget in November of the year before the financial year. That was a big organisation with complicated needs, and we were subject to the same external rigours as you were. I cannot get my head around the NHS not starting a budget until November.

Julian Kelly: We clearly try to give early informal indications of what people should be expecting, but we actually need to know what our budget is in order to be able to give a budget. If that process does not conclude until October, November—in the case of '24-25 we were still in discussion with Antonia and colleagues on certain items up to the March budget—it is hard to absolutely finalise it, but our aim is to give as much information and certainty as soon as we can. Clearly this year we still have some details to sort out with Antonia and the Department, but we are aiming to do those as soon as we can so that this side of Christmas, let us hope, we can give clear budget allocations and be clear about what the rules and framework are.

- Q61 **Rachel Gilmour:** So you could do better: 6/10.

Julian Kelly: We could always do better.

Sir Chris Wormald: You are completely right. The reason it is difficult is because the number is so huge and the externalities are so great. On that huge element of the NHS which is demand-led, how high is flu? How cold is the winter? Is there a covid spike? All those things we cannot know. A 1% variation on a budget of £170 billion is a size of move that interests our friends at the Treasury and affects how we manage the fiscal situation generally.

- Q62 **Chair:** I am going to cut you off there. I have heard all the excuses.

Sir Chris Wormald: That was the explanation.

Chair: I have heard the excuses. But if you are trying to operate an ICB and you do not get your final settlement till June, two months after the end of the financial year, it must cause inefficiency. Let me ask you a very simple question. For the '25-26 budget, when will you give the ICBs their final allocation?

Sir Chris Wormald: We hope to do it as early as possible.

- Q63 **Chair:** That is not an answer.

Sir Chris Wormald: Given that I do not have a date, it is the only answer you are going to get.

- Q64 **Chair:** So the present inefficient system will carry on.



HOUSE OF COMMONS

Sir Chris Wormald: Clearly, doing it in June is suboptimal. As I say, giving out a fantasy number earlier because you have not worked through the inflation—

- Q65 **Chair:** But you could do what Julian Kelly is suggesting: give them an indicative figure that is as accurate as possible so that they at least have a realistic figure they can plan on at a much earlier stage.

Sir Chris Wormald: I would say the crucial bit of your sentence, which I agree with, is “realistic”. The question is, at what point can you give a realistic budget? The greater the externalities and the more the variability, the later it is that you can give a realistic number. I do not disagree with you at all. It is just those variabilities are—

- Q66 **Chair:** At least give me an aim for when you would like to get the money out to them.

Sir Chris Wormald: Ideally, as I think we have said already, we would do it before Christmas. Whether that is possible is not always entirely in our hands.

- Q67 **Chair:** If it gets later than that, do you agree that you should give them an indicative figure that, hopefully, is as accurate as possible?

Sir Chris Wormald: As long as it is realistic, yes.

- Q68 **Rachel Gilmour:** If you can’t make it realistic, nobody else can.

Sir Chris Wormald: As I say, I am simply being blunt with the Committee. We have a series of externalities, which, due to the size of the budget, makes our judgment on when it is realistic a real judgment. Giving out an unrealistic number does more harm than good, so we will take a hard-edged view on when we can give a realistic number. As I say, I agreed with every single word of your sentence, Chair. And as the questioner was saying, we need that to be as early as possible. I do not think there is any difference in intent here. I am merely saying, if you get a price shock, an energy shock or any of these sorts of shocks, and you multiply it—

- Q69 **Rachel Gilmour:** Risk analysis?

Sir Chris Wormald: Well, risk analysis—take the energy shock, which was largely dependent on the actions of a foreign power, you can do a lot of risk analysis but you will not get to a number. Nobody did.

- Q70 **Rachel Gilmour:** I will say one more thing. From everything we have heard today, given the scenario behind the scenes and the difficulties that NHS senior and junior staff have to work with, the job they do is more and more exceptional, whether they are a cleaner or a CEO.

Sir Chris Wormald: We would agree completely with what you say.

- Q71 **Chair:** Sir Chris, it is not just the money, is it? It is also the guidance.

Sir Chris Wormald: Absolutely.



HOUSE OF COMMONS

Q72 Chair: In fact, if anything, the guidance is more important than the money, because people can work out roughly what money they are going to get—my local authority does a pretty good job at working out what money it is going to get—but guidance is the system they are going to have to work under. It is just—

Sir Chris Wormald: That is completely true. But just on that energy shock question, I think there was a four-point gap between the inflation projection and what it actually was as a result of the actions of a foreign power. Multiply that by £170 billion, and you have a very large sum of money.

Q73 Chair: I hear that, Sir Chris, and I do not disagree with it, but hopefully that was a one-off—

Sir Chris Wormald: For many reasons.

Chair: Hopefully we will not be able to use that as a reason for not giving late allocations in future.

Sir Chris Wormald: Yes.

Q74 Mr Betts: You described earlier this brave new world where, at local level, everyone works together—councils, NHS bodies—and delivers a joint strategy. How can that happen when the councils get their budget in December, or at least they get a pretty clear indication of what it will be, while their colleagues in the NHS are some months behind? We cannot join up working relationships on that basis, can we?

Sir Chris Wormald: No, absolutely. We do not aim to do allocations late. It comes back to when we can give out a realistic budget, which is partly dependent on the externalities—but your point is completely correct.

Q75 Mr Betts: Right. Do you want to aim to get the same date as the local authority settlement?

Sir Chris Wormald: Whether or not it is exactly the same day, we would aim before Christmas, as we said, partly for the reason that you give.

Q76 Mr Betts: If there are big external shocks, there is such a thing as a supplementary budget on that sort of occasion, isn't there? You do not always want to plan for something that may not happen.

Sir Chris Wormald: No, that is absolutely true. What I am saying is that I am agreeing with everyone that earlier is better. We do have to make a judgment about whether we are giving out a realistic number and whether that number is helpful, therefore. The earlier we can do it, the better, and the closer we can get to being right, the better. As I say, giving people unrealistic numbers helps nobody.

Chair: Okay, we will leave that one there. We are almost at the end of the session, Sir Chris, you will be glad to know—

Sir Chris Wormald: No, I will keep going.



Q77 Chair: I want to come back on something that we have covered, which is productivity. To me, there seems to be great scope to raise productivity. I take you to paragraph 3.13 on page 41: "We think it is important for there to be robust and widely accepted measures of health productivity". We like measuring things in this Committee, and that means you have to have proper baselines and proper data to be able to measure the productivity you are getting. It seems to me that in both those areas, the NHS could do better. Would you like to comment?

Julian Kelly: We think we can certainly continue to improve the measurement of productivity. Relative to a lot of public services, we do a pretty darn good job. In particular, we think we can do better with respect to community services and mental health services, where we have significantly improved data over recent years, but with still more to do. We are in discussion with, for example, the Office for National Statistics and York University—which has some of the leaders in this academic field in the UK—as to how we can better capture the productivity that is derived from activity that leads to prevented ill health, which is otherwise a thing that is really hard to measure, because you are just measuring activity, not capturing the outcome. We are in discussion with them as to how we can improve it, but we—

Q78 Chair: Are we likely to get a clear definition any time soon?

Julian Kelly: We have a clear definition. The ONS publishes data on a regular basis, and that is the national statistic we rely on. We have measures that we use for management purposes within the NHS, in particular for acute care. We started to produce data for management purposes with respect to mental health services and community services in the second half of this year. Those give good baselines, but there are methodological things we think we can do, which the ONS agrees with us on, that mean we can continue to improve it.

Q79 Chair: I do not think one can ever be complacent about these matters. You are clearly a man who is well over the top of the finances and figures. Would you not agree that there is a significant amount you can do to improve productivity from new technologies, from better collection of data and figures, particularly with AI? What are you doing within your organisation to make sure that you are completely up to date and are using and making best advantage of these new technologies?

Julian Kelly: As discussed in one of the earlier answers, we absolutely think we can. I will say though that it is not just about AI. It is putting modern technology into some of our providers, who have lived on paper. We still have some work to do to complete that programme. The aim is to do that over the next 18 months. Just getting the basics right consistently across the NHS is step one.

Q80 Chair: Let me give you a very simple example of where I suspect new technology could help you. There is a world of difference between 999 calls and 111 calls. The 111 calls are a problem because the clinician goes into a situation where they do not have proper information, unlike the clinician who goes into a 999 call. We are told that it is to do with the



HOUSE OF COMMONS

training of the call handlers. With new technology, that is a very simple fix. Why has it not been done? What will you do to adopt new technologies in very simple situations like that?

Julian Kelly: That is a really good example of where new technology is not always a simple fix. There are some things that are simple to do. Creating a really good single patient shared record is, by the way, not a simple thing to do, but that is the plan that we are working out, and we have done the first stages of it with the shared care record. That is the thing we can build on, but that will take time, because you need a consistent data infrastructure across the whole of the NHS, and you need to have sorted out all the information and governance issues. So what sounds simple is not that simple, but we have a plan in progress.

Q81 **Chair:** With great respect, Mr Kelly, you should look at what AI could do in that situation.

Julian Kelly: We are looking at what AI could do in the specific example of triaging 111.

Chair: Let me give you an even simpler example. You cannot ask for an ambulance if you do not speak English. Google Translate would solve that in a second, so can I ask—

Julian Kelly: No, I'm agreeing with you.

Chair: Can I complete my question? Can I ask you to give us a fairly full note of what you are doing to use new technologies in the health service? That would be really helpful.

Julian Kelly: Of course.

Chair: Thank you very much, everybody. I am sorry that the conversation got slightly heated at times, particularly from the Chairman, but you can tell from the frustration of the Committee that we are eager for you to improve the timeliness of what you do in the NHS. We will be looking at these matters very simply. An uncorrected version of the proceedings of the Committee will be available in the next few days. Thereafter we will produce a report with recommendations, and we will look forward with great interest to the Treasury minute reply to our recommendations. Thank you very much. This is a difficult subject. I know that our questions sometimes make it sound easy, but thank you for trying to answer them.